IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Doc. 281

REBEKAH BERLINGER, etc., et al.,

Plaintiffs,

-vs-

JUDGE J.P. Kilbane
CASE NO. 94277

MT. SINAI MEDICAL CENTER, et al.,

Defendants.

- - - -

Deposition of LEON I. MANN, M.D., taken as if upon examination before Dawn M. Hagestrom, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the Cleveland Metropolitan General-Highland View Hospital, 3395 Scranton Road, Cleveland, Ohio, at. 10:00 a.m. on Friday, July 31, 1987, pursuant to notice and/or stipulations of counsel., on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant
Mt. Sinai Hospital;

ALSO PRESENT:

Nancy Iler

- - - -

LEON I. MANN, M.D., of lawful age, called by the Plaintiffs for the purpose of examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF LEON I. MANN, M.D.

BY MR. ILER:

MR. ILER: Let the record reflect that we are taking the deposition of Dr. Mann as on cross-examination and as discovery of an expert's opinion concerning the above-entitled case. All the attorneys involved in the litigation have been notified of the deposition, and if there are any imperfections in the notice of this deposition it's been waived; we are all here by agreement, is that agreed?

MR. MURPHY: I will object to the characterization as if on cross-examination for the discovery.

Q. Doctor, can we have your full name?

A. Leon Isaac Mann.

Q. That is M A N N?

A. Correct.

A. 2 Foxwood Lane, Pepper Pike, Ohio 44124.
Q. How long have you lived there?
A. One year.
Q. And your office address is here at Cleveland Metropolitan Hospital?
A. Correct.

MR. ILER: Can I have his curriculum vitae?

MR. MURPHY: I guess the record could show we will incorporate that into the reccrd.

MR. ILER: That would be fine, Mr. Murphy,

We just received a copy of the curriculum vitae of Dr. Leon I. Mann. We will get a copy of it later on, Mr. Murphy will get me one, so it will help us move along a little bit.

Q. You have written a report concerning the care and treatment of Rebekah?
A. Yes, I have.
Q. The report is dated June the 8th of 3987, right?
A. Correct.
Q. And did you have, do you have a file an this case? Do you have any personal notes?
A. Yes, 1 do.

Q. Can I see them?
A. I don't have them here.
Q. Could you get them for me?
A. Sure.
MR. ILER: Could the court reporter please mark these.
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(Whereupon, Plaintiffs' Exhibit Nos. 1 through 6 were marked for purposes of identification.)
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Q. Thank you very much, doctor. I have had the court reporter mark Plaintiffs' Exhibits Nos. 1 through 6. Can you identify what these yellow sheets of paper are?
A. These yellow sheets of paper represent my notes as I reviewed the materials sent to me by the attorney for the defendant and --
Q. Are the notes made in your handwriting?
A. Yes, they are.
MR. ILER: Can we at a later time get a legible copy of them?
MR. MURPHY: We will *Xerox* them for everybody.
MR. ILER: May I have an agreement-

with you, Mr. Murphy, if I find I cannot rear! the doctor's handwriting for whatever reason, I would rather not make a mistake, can I work through you? If you send me a copy and I can't read a notation can you please ask him, the doctor, so that I don't misinterpret anything?

MR. MURPHY: I think I would rather do that than take time now to have him read everything.

MR. ILER: Yes.

MR. MURPHY: Okay, sure.

Q. I understand from your curriculum vitae, you have attained quite a record and congratulations to you on a marvelous curriculum vitae. Very, very nice. And I just will not go through your medical education because it's all Listed here. And the staff appointments you have are remarkable and you have also published a number of articles, too, in the field of OB/GYN and neonatology; I see those listed.

A. Not neonatology.

Q. Just OB/GYN?

A. Yes.

Q. This is the first time I have seen this. I'll just spend a moment with you on the, in the

immediate past position category of your background and your work.

In July of '85 to June of '86 you were professor and director of obstetrics, the department of obstetrics and gynecology in the Indiana School of Medicine?

A. That's correct.

Q. That was from July to June. That covers about a year or thereabout?

A. Correct.

Q. Was that like on a rotational thing? Why were you there only a year? is there an academic reason that I do not know about?

A. No, there is no academic reason.

Q. Do you. take appointments like this appointment at Indiana University, it being for a year? Why is it only for a year, why isn't it for five years or ten years?

A. Initially it was not for a year, it was when I decided to return to academic medicine from the corporate job that I had that had brought me to Indianapolis, I went and was recruited for a job at the Indiana University as director of obstetrics, not a particular time limit.

Q. Insofar as the Limeframe, did you go to Indiana

University after working with the Lilly Company?

A. Correct.

Q. Did you go from Eli Lilly Company to Indiana?

A. Yes.

Q. The next position that. is earlier than that is from July of '84 to June of '85 where you were the executive director, corporate medica3 affairs Eli Lilly research department,. Eli Lilly & Company, Incorporated,. Indianapolis, Indiana?

A. That's correct.

Q. You were there for approximately a year?

A. Correct.

Q. And what did you do as an executive director of the Eli Lilly Company?

a. I was primarily involved with the medical aspects of the research and development of various drugs.

Q. And are you free to say what those drugs were or is this a corporate, you know --

A. I don't know whether I'm free or not free. I'm not sure I can remember any number of them, but there are a number that I would remember there are certain restrictions in discussion because they were at the early stages of development.

Q. The corporate competitiveness of the subject

matter I understand. You were the executive director of Lilly Corporation in the research and development of drugs?

A. I also had involvement with other parts of the corporation.

Q. Can you describe those for me?

A. I worked with the legal division as medical consultation to various questions and issues that might arise.

Q. And in that regard in the legal field of the Lilly Company, can you tell me a little bit more about that? How were you involved in legal matters of the Lilly Company?

A. If there was a particular product liability that they wanted discussion with a medical person regarding the medical aspects of the case, they discussed it with me, as well as other physicians, as part of my assignment.

Q. When you worked with the legal department of the Lilly Company were you involved in pending claims that users of Lilly products had made against the Lilly Company?

A. Yes.

Q. And in that regard, would you -- did you give medical advice to the Lilly Company insofar as

those claims that users of Lilly drugs or products were making against the company?

A. In some part, yes.

Q. And did you also work together with lawyers in the Lilly Corporation to give them medical advice in defending claims that people who had used Lilly products were making against the company?

a. Yes, I did.

Q. Did you, were you represented and did you give depositions in pending cases against Lilly Company?

A. No, I did not.

Q. Did you ever testify in court for the Lilly Company?

A. No, I did not.

Q. Okay. Was there a, this was in the year 1984 to 1985. At that time were these a series of lawsuits brought against the Lilly Company for a particular drug?

A. A number of lawsuits €or various drugs.

Q. Do any of those drugs stand out in your mind?

A. Not any in particular.

Q. Did Lilly produce an early morning, pardon me, a drug used by, used for women who were pregnant?

A. Yes, they did.
Q. What was that drug's name?
A. Diethylstilbestrol.
Q. Wasn't there Litigation involving that particular drug throughout the country?
A. Yes, there was.
Q. What seemed to be the claim?
MR. ILER: Am I going too far?
MR. MURPHY: I think you are. I'm going to object.
MR. ILER: That's all right.
Q. Insofar as your legal aspect, were you giving the Lilly Company advice about that particular drug?
A. Well, actually for most of the time I was there, counselor, I was sort of learning about it, never paid all that much attention to that one particular drug, learning more about the drug in that short time that I was there.
Q. Well, the issue of learning about the drug was to get you acquainted with the use of the drug, the way the drug operated on pregnant women, I assume?
A. Yes, I would say that.
Q. And then after you had accumulated that

knowledge with your medical background then you were prepared to give opinions either to executives of the Lilly Company or to their legal staff on what your medical opinion was concerning that drug, right?

A. I'm sorry. Could you repeat that?

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. Yes, correct. Strictly the legal department.

Q. Aside from that particular drug, did you ever work on any other drugs?

A. Yes.

Q. Which were they?

MR. MURPHY: Let me note an objection. I think this is far afield of a discovery deposition of an expert unless and if you can show me there are drugs in here that may be an issue that were given by Dr. Schwartz to Mrs. Berlinger, if the doctor knows something about them and can give opinions, but otherwise let's move along and get to this case.

MR. ILER: I'm just trying to get a little more background on the drugs because

there were drugs used here with this lady.

MR. MURPHY: Well, ask him about these drugs.

Q. What other drugs were you involved with with the Lilly Company?

MR. MURPHY: You are not going to answer that question, doctor. Let's move on.

MR. ILER: Would you certify the question to Dr. Mann?

MR. MURPHY: Yes.

MR. ILER: Under agreement of counsel, I want to know what other drugs that Dr. Mann has worked in with the Lilly Company and I also want to know why he was so doing it. and whether it was involved in litigation.

Q. Now then, what I see is on your curriculum vitae, doctor, after you had been to Lilly Company, before that you were professor and chairman of the department of OB/GYN, University of Vermont, and as a professor you were there from 1976 to 1984, am I right?

A. That's correct.

Q. And during that period of time, were you actually practicing OB/GYN or simply the professor, the academic side of that profession?

A. Both.
Q. You were seeing patients then at the University of -- or at the medical center hospital at Vermont?
A. That's correct.
Q. Have you ever, in your experience as a physician, as a teacher of medicine ever heard of Reily-Day syndrome?
A. Yes, I have.
Q. Is that syndrome associated with people of Jewish heritage who have come from Ashkenazi, Poland?
A. I'm vaguely familiar with the syndrome. I'm not sure. I believe it is, but I would not render an opinion.
Q. On that?
A. On that.
Q. Okay. I want to see how far I can go wjth you on your memory so far as Reily-Day syndrome. Is it your understanding that the Reily-Day syndrome is a set of problems that occur from people of Jewish heritage, is that true?
A. I believe that to be true.
Q. In your lecturing and teaching of medical students and residents, I assume, have you ever

talked or discussed this Reily-Day syndrome?

A. I would imagine at some point over the years it's possible.

Q Do you see patients here at Cleveland Metropolitan Hospital?

A Yes, I do.

Q And how much of your time here with your present position, which is director of the department of obstetrics and gynecology -- then also you have marked here professor of reproductive biology, Case Western Reserve.

Can you tell me what your duties are here on a daily basis at Cleveland Metro and then also what you do at Case Western Reserve?

A. My duties at Cleveland Metro are the direct supervision of the department in terms of the clinical care rendered in obstetrics and gynecology, the teaching programs, the research activities, the administration of the department.

Q. And those, you have that kind of supervisory duties here?

A. What kind, sir?

Q. That you have just described. Were those supervisory duties that you have here that you

have described?

A. 1 don't know I described them, but yes.

Q. Okay. So then on a day-to-day basis at Cleveland Metro, do you check on other people who are working in the department of OB/GYN?

A. Yes, sir.

Q. See that they are getting their jobs done and their assignments are being kept, is that what you do?

A. Partly, yes.

Q. And do you have any financial responsibilities or administrative duties here at Cleveland Metro?

A. I'm sorry. I don't understand the question.

MR. MURPHY: Objection.

Q. Administrative duties like do you have to, what. I mean by administrative duties as the director of OB/GYN here, you have to make like reports to say we have so many doctors, we have done so many cases here, our budget is 50 million dollars, 25 million dollars and we need some more money. That's the kind of administrative thing I'm talking about.

A. Yes.

Q. How much of your time is spent in the

administrative duties that we talked about?

A. A quarter of my time.

Q. Okay. And then insofar as the professor of the department of reproductive. biology at Case, what is that, what do you do as professor of reproductive biology?

A. Well, we are all part of the Case Western Reserve system.

Q. Cleveland Metro is?

A. Yes.

Q. True.

A. My position is a tenured professorship with the medical school which has me participate in the curriculum for the students in research activities of the medical school.

Q. How often do you teach there?

A. I'm sorry, sir?

Q. How often do you teach there?

A. Those students from Case Western come here to Cleveland Metro, and I teach on a daily basis.

Q. Daily?

A. Yes.

Q. Hour, two hours in the morning or afternoons? How much time do you spend each day, approximately?

A. We have morning report each morning where the students are present for approximately an hour. I meet with the medical students on assigned time of approximately an hour, hour and a half once a week, and throughout the day there are various times when I meet with students.

Q. Who is Dr. Dyker? Do you know him?

MR. **GOLDWASSER:** Dierker?

A. Dr. Dierker?

Q. Yes. Who is he?

A. Dr. Dierker is a member of the faculty, department of OB/GYN, here at Cleveland Metro.

Q. What are his duties here? What does he *bo?*

A. Dr. Dierker is director of obstetric and maternal-fetal medicine.

Q. You are the director of OB/GYN and he was the director of what?

A. Of obstetrics, which is a division of the department of OB/GYN.

Q. Okay. Have you -- this is not your first deposition, I assume?

A. No, sir.

Q. Can you tell me if you have given medical reports defending the practice of physicians in given cases before?

A. Yes, I have.
Q. And approximately how many of those times have you done that?
A. I'm sorry, sir. Did you ask me written reports?
Q. Yes, just the reports.
A. Written reports approximately five, six times.
Q. In your entire lifetime?
A. That's correct.
Q. And were those five, six reports done within the last five years or so or three years or so?
A. Yes.
Q. And were they made, were the reports made after review of medical records and. was an opinion rendered in your reports?
A. Yes to both parts of the question.
Q. Do you know the difference between a plaintiff and a defendant?
A. Yes, I do.
Q. And were the reports written on behalf of defendants?
A. Yes.
Q. Have you ever written a report on behalf of a patient against a physician in a suit?
A. Written report?

Q. Yes.
A. Not have I reviewed a case?
Q. No. Have you written a report, on behalf of a patient who was suing a physician?
A. I have not written a report. I have reviewed plaintiff cases.
Q. Okay. Now, these five cases, were they reviewed for Ohio while you were in Ohio or were they reviewed in other states?
A. Most of them since I have been in Ohio.
Q. Have you ever reviewed a case outside of Ohio while you were at Vermont or Indiana?
A. Yes, I have.
Q. How many times have you written a report while you were in the State of Vermont?
A. My figure of five or so is a total figure.
Q. And how about while you were in the state of Indiana, did you write any medical reports while you were in Indiana?
A. I might have written one. I'm not sure.
Q. Okay. So, insofar as medical reports are concerned written on behalf of physicians, would you estimate you have ten to 15 times done so?
A. No, sir. You are asking me, if I understand your question, written reports.

Q. Yes.
A. And I said I believe earlier approximately five or six written reports.
Q. The five or six written reports are included while you were in Vermont, while you were in Indiana and while you were in Ohio, is that correct?
A. That's correct.
Q. How did it come to pass that you were called by the firm of Jacobson, Maynard, Tuschman & Kalur and particularly Mr. Murphy to review this case, how did that happen?
A. I'm not really sure.
Q. Okay. Well, did somebody just pick you up?
A. Mr. Murphy.
Q. Did you inquire of him how he got your name or --
A. I don't recall having asked him that question.
Q. Okay. Are you insured by the Physicians Insurance Exchange Company?
MR. MURPHY: Objection. You can answer.
A. I'm sorry.
MR. MURPHY: I objected for the record. You can answer the question, though.

A. No, I'm not.
Q. Do you know any of the lawyers at the Jacobson, Maynard, Tuschman & Kalur law firm?
A. Yes, I do.
Q. Who do you know?
A. I know Mr. Bonezzi, and Mr. Kalur I have met and somebody else, but I'm not. sure.
Q. Did you help Mr. Kalur with a case?
A. No, I did not.
Q. And did you ever help Mr. Bonezzi with a case?
A. Yes, I did.
Q. Was the case a case here in Cleveland, Ohio, do you know?
A. Yes, it was.
Q. Do you remember the name of the people involved, plaintiff?
A. I do not.
Q. Did you go to trial?
A. No, I have not been to trial.
Q. Do you know who the name of the baby was that was involved or the patient?
A. No.
Q. Do you know who the name of the plaintiff's lawyer was?
A. No, I can't remember.

Q. If at any time during our questioning and our discussion of the Berlinger case you need to look at either your own personal notes or hospital records or charts or anything just take the time to take a look at them so that you are really confident about your answer insofar as applying to a record.

Can we say that insofar as Heidi Berlinger is concerned, we know this was her first. pregnancy with Rebekah, true?

A. Correct,

Q. That her pregnancy was a full term one, true?

A. Correct.

Q. There was no prematurity involved in her pregnancy, correct?

A. Correct.

Q. That her pregnancy proceeded for nine months with no diabetes on the side of the mother, she exhibited none, Heidi, right?

A. Correct.

Q. She had no preeclampsia, right?

A. Correct.

Q. And she had no severe bleeding during her pregnancy?

A. Correct.

Q. She had no heart problems herself, Heidi that is?
A. Correct.
Q. And insofar as the fetus was concerned, Baby Rebekah, during the time that she was in her mother's womb she exhibited no fetal problems and no fetal distress, true?
A. Correct.
Q. That insofar as the mother and child, I will couple them both, both Heidi and Rebekah, that during the time of the pregnancy neither exhibited any lung problems or respiratory problems, is that true?
A. As far as the fetus goes, we have no way of identifying that. From the mother's point of view, there was one episode of dizziness and syncope in June of the pregnancy. Generally, no.
Q. Okay. With the syncope part, do you put any importance of that particular dizziness problem, and I think it was a brief fainting episode. Is that what you understand?
A. That's what I understand. from the record.
Q. Is it important in this case or can we just throw it out and disregard it?

A. I wouldn't. throw it out and disregard it. I'm not sure, I don't believe it does.

Q. You want to keep it €or consideration, see how we go along in this deposition, maybe it will be of some import to you later?

A. Yes.

Q. Now, insofar as Baby Rebekah is concerned, if there was something structurally wrong with Rebekah's lungs, hypothetically speaking, okay, would that show up during her pregnancy?

A. No.

Q. And insofar as the pregnancy of Heidi Berlinger during nine months -- did you want to say something?

A. I think the answer to that question is no. If there was severe pulmonary hypoplasia it's possible that there may be changes that one would see in the amniotic fluid volume, but the general answer is no.

Q. Did you understand whether or not any ultrasounds were taken of Mrs. Rerlinger, Heidi, during the course of her pregnancy?

A. I'm sorry, counselor. Did I understand?

Q. Do you know if there was or wasn't?

A. Yes, there was.

Q. How did they come out? What were the results of them?
A. The ultrasound was done for dating of the pregnancy, I believe on 12/14/86, and Dr. Schwartz felt that the uterus was 14 weeks, that the size of the uterus was 14 weeks when the dates were only ten, and he had *an* ultrasound performed which revealed that the uterus was in fact, the gestation was ten weeks.
Q. So no problems with the ultrasound, I assume?
A. Not that I'm aware of.
Q. Okay. Can we conclude this way then, that the pregnancy of Heidi **Berlinger** moved normally and for all important matters this pregnancy moved along uneventfully?
A. Absolutely.
Q. So now we, you are not a pediatric neurologist., is that correct?
A. That's correct.
Q. You have confined your practice to obstetrics and gynecology?
A. Correct.
Q. Do I understand that you will give no opinion at the trial of this lawsuit on a neonatology basis; is that outside your field?

A. I'm not trained as a neonatologist. My experience would be simply in followup on the obstetrical care that we have been, that we deliver and as an individual who has done research in basic questions, issues surrounding perinatal life which includes both the fetal life, intrapartum period and the immediate newborn training, but not by clinical training.

Q. We have never met before, doctor, and the only reason I'm asking that is so I can be certain as to what to expect from you as to what opinions are concerned, what branch of medicine. I'm just trying to narrow down what branch of medicine you will testify in so I can prepare myself now for questions of you if you testify at trial. I will note that you are going to confine yourself to OB/GYN only, am I right in that point?

A. That's correct.

Q. We have talked to several physicians and they have described for us what a late deceleration is, what an early deceleration is, what a variable deceleration is and what a beat-to-beat deceleration is. We had that discussion with other doctors in this matter, and can I just ask

you, what. is your definition that. you use insofar as a late deceleration; what does that mean to you, doctor?

A. Late deceleration by definition is a deceleration or decrease in the fetal heart rate that has its onset at the peak of the uterine systole, continues into the. diastole of the contraction and into the interval between two contractions.

Q. If we had a graph of a contraction like a mountain up one side and down the other, and as we mentally look at a picture of this mountain and then we impose on that a late deceleration, where, insofar as this mountain, would the late deceleration begin and where would it end?

A. At the peek of the mountain it would begin. Right, yes.

A. And it would end in the valley beyond the base of the mountain.

Q. Okay. Very well. Thank you very much.

And with an early deceleration, let's use our mountain again if we can, if you will permit me to, and now we have an early deceleration; insofar as our mountain is concerned, where would the early deceleration start during the

contraction and where would it end?

A. That is less well defined, hut generally it would start sometimes on the ascension of the mountain, the upwards slope, may start toward the peek, but the characteristic feature of the early is that there is generally recovery, general recovery by the time you come back down the mountain to the valley.

Q. Okay. During this period the mountain that we have talked about as being a contraction, right?

A. As you have described it, yes.

Q. When you say a recovery you mean that the baby's heart recovers from that contraction, is that correct?

A. Recover may be a poor word. Return to baseline value.

Q. Okay. Yes. During the period, as I understand it, doctor, that, during the period of a contraction, that is a mother's contraction during labor, that the circulation of blood to the mother and, of course, to the fetus is stopped, is that right?

A. To the mother and the fetus, I'm sorry. You will have to be a little more specific.

Q. During the period of a labor contraction, is

there any interruption of blood flaw between mother and/or child?

A. Between mother and child?

Q. Yes.

A. Yes.

Q. And when does that occur?

A. That occurs when the pressure within the muscle of the uterus, myometrium, exceeds that of the pressure within the blood vessel carrying blood to the area of the placenta where exchange occurs between mother and fetus.

Q. Okay. Then during the, this period of pressure changes, during a contraction, is it so that oxygen, which is carried by the blood and is exchanged at the placental area to the baby, is that also stopped?

A. When the pressure of a contraction is greater than the pressure within the blood vessel, yes.

Q. All right. Hypothetically speaking, if we took a contraction, this mountain that we talked about as an illustrative point, and instead of the mountain just going up and then coming down we had a contraction which went up and extended out for a long period of time and then came down the child would be without oxygen during that

period of time, is that correct?

A. No, that's not.

Q. Okay. Is there a relationship between the time and length, is what I mean, of a contraction and the oxygen supply that the baby is getting?

A. There could be.

Q. And can you explain what could effect that?

A. You would have to have a contraction whose intensity was greater than the pressure within the vessel for this long period of time in order to prolong the obstruction of the exchange from mother to baby of the oxygen.

Q. Within the period -- strike that.

You, of course, are familiar with external and internal monitoring of babies?

A. Yes, I am.

Q. Rehekah had both an external monitor and she had an internal monitor, true?

A. Correct.

Q. Of the phenomenons or the occurrences such as late decelerations, early decelerations, variable decelerations and beat-to-beat losses, of those four items, are they important to be observed during the monitoring of the mother?

A. Yes, they are.

Q. Tell me why?
A. Because the association between the type of deceleration and the severity of the deceleration and most importantly the persistence of the deceleration is correlated in some manner with the condition of the fetus.
Q. Okay. You used the word decelerations. Does that include all of them, earlies, lates, variables, or are there certain specific ones you believe require careful monitoring because of their importance to this process?
A. Well, as I said, the importance of the monitoring is to be able to identify deceleration or examine acceleration pattern. The answer to your question is that once you look and determine the type of either acceleration, deceleration patterns of the heart rate in relation to the contraction one can classify them in to what is referred to as innocuous or ominous, again, as it correlates to the objective biochemical and newborn evaluation of the fetus and newborn.
Q. Which of the decelerations, first of all, do you consider to he ominous?
A. Generally considered ominous decelerations are

moderate to severe variables and moderate, mild, moderate or severe delayed decelerations, particularly if they persist for any substantial length of time they might, should he considered as indicators of fetal stress and need to be evaluated.

Q. When we use the word decelerate, what is decelerated?

A. Decrease.

Q. Decreased. Pardon me, what is --

A. When you use the term deceleration?

Q. Yes.

A. I'm sorry. I don't understand your question.

Q. What is decelerated, the heart heat of the child or the heart beat of the mother for purposes of this record?

A. It's the heart rate of the fetus as we are talking about fetal heart rate monitoring.

Q. Yes, yes. Do you agree that you can have *a* late deceleration with a fetal or have a baby's heart, rate of 120 to 130 beats per minute?

A. I'm sorry, counselor. I don't understand that question.

Q. Okay. Can you have a late deceleration and still have a fetal heart beat of 120 to 130

beats per minute?
A. By still have a fetal heart rate of 120, 130, you mean in between the contractions, you mean at the lowest level of the delayed deceleration? I'm not sure I understand what you are asking me.
Q. Let me see if I can move that one along for you. You see, sometimes it is said that you can have a late deceleration between a fetal heart rate of 120 to 130, anywhere within those parameters, you see; in other words if you have a fetus who has a heart rate of 120 to 130, within those two numbers?
A. That's the baseline heart rate?
Q. That's right. Within the beat of 120 to 130 do you have an opinion as to whether or not you can still have a late deceleration within that fetal heart rate?
A. The fetal heart rate, baseline heart rate between contractions, 120 to 130.
Q. Yes.
A. And your question again, counselor, is can you have a delayed deceleration associated with the contraction when the baseline heart sate is 120 to 130?

Q. Exactly?
A. Yes.
Q. Then is this true, you cannot, rely on a fetal heart rate of 120 to 130 to exclude a monitored tracing that. may indicate a late deceleration, is that true?
A. I'm sorry, I don't --
Q. You don't understand the question?
A. Not reaily.
Q. That's good. Whenever you don't understand I would really appreciate your telling me what you are doing now, telling me you are not clear about it. I can try to reword it for you.

Is the oxygen supplied to the baby interrupted during a deceleration?

A. Yes, it is.
Q. Why? Just as briefly as you can without compromising your medical opinion.
A. During the uterine contraction as we reviewed before, there is, there can be depending upon the pressures generated in the myometrium vis-a-vis the intravascular circulation of the placenta, there is an interruption in the oxygenation of the fetus in the terms of the oxygen tension.

Oxygen tension is measured in millimeters of mercury, and it is the oxygen tension that the chemoreceptors in the carotid arch and the aorta are sensitive to.

Changes in the oxygen tension that occur as a result of this interruption of the oxygenation of the fetus result in the stimulation of a reflex that is an afferent stimulation to the brain stem of the fetus, and the cardioregulatory sense which sends out an afferent stimulation to the heart by the parasympathetics that results in a slowing of the fetal heart rate.

Now, this is oxygenation in terms of the oxygen tension that initiated the reflex slowing deceleration. It says nothing about the true oxygenation of the fetus in terms of its consumption of oxygen, which is calculated entirely differently as a product of the arteriovenous difference across the umbilical circulation of oxygen in terms of blood flow which one requires to speak specifically and objectively about, quote, oxygenation of the fetus.

It's possible to have a decrease in the

oxygen tension in the fetal circulation as a result of the interruption of the exchange of oxygen from mother to fetus that can stimulate a reflex deceleration of the fetal heart rate which in no way has an effect on the actual consumption of oxygen by the baby that could result in anaerobic glycolysis, formation of lactic acid, lacticacidemia, an increase in the carbohydrate oxygenation and decrease in pH. So that on the one hand, oxygenation can refer to oxygen tensions, and on the other hand, in terms of milliliters of mercury to oxygen, which is a reasonable measure of whether the fetus is oxygenated or not.

Q. Is that the true measure?

A. In a purely scientific matter, that's correct.

Q. Now, during the time that Rebekah Berlinger had her internal monitor on, were the nursing personnel that were watching and observing the monitor strips that were on Rebekah Berlinger supposed to know what you just have described to us in your answer?

A. They really don't have to know that. No, the answer is no.

Q. Insofar as the, let's say, the nurse that

observes the internal monitoring strip from the time it was placed on Rebekah, which we know was after 8:00 in the morning, is that right, on July the 10th, the membranes were ruptured?

A. I'm sorry. The internal system?

Q. The internal system.

A. I believe was placed at --

Q. We all know it was in at 8:00.

MR. MURPHY: Maybe a little before that.

A. The internal system was placed at 8:00 a.m. after artificial rupture of membranes where there was clear fluid.

Q So from 8:00 a.m. on July the 10th of 1984 and up until the time a cesarean section was done on Mrs. Berlinger the internal monitoring strip was in place, is that what your understanding is?

A That's correct.

Q And that would bring us for a period of how many hours, doctor, that the internal monitoring strip was on?

A The strip that is available here -- well, I'm sorry. The internal electrode, if we agree it started at 8:00, I believe the strip ends at 3:30. I'm not exactly sure of that. I'm

sorry. The last panel is 126 and I believe that time is 3:30, although there is a part of that -- so the answer to your question would be 8:00 to 12:00 is four, it would be 7 hours and 20 minutes, approximately, that I have a strip available to me.

Q. All right.

A. 126, yes, sir.

Q. Now, during these seven and one half hours, right, give or take a few minutes, we know it's in excess of seven hours, was the monitoring, the strip itself, was that, in your judgement., to be observed carefully for decelerations?

A. Decelerations, yes.

Q. For arrhythmias?

A. Arrhythmias, I'm not sure what. you are --

Q. Okay. Accelerations of heart beat?

A. Correct,

Q. Decelerations of the baby's heart beat?

A. Correct.

Q. And any other unusual cardiac responses from the child?

A. Correct.

Q. Should a person who is taking on that task of watching the monitoring strip from approximately

8:00 in the. morning of July the 10th until approximately 3:00, 3:15, 3:20 in the afternoon have the ability to know what a late deceleration is, what an early deceleration is, what coupling is and what beat-to-beat variabi1ity is?

A. What was the personnel? I'm sorry. Which personnel, any personnel?

Q. The person who is supposed to be watching it.

A. *Yes.*

Q. Okay. Would you say that based upon your experience as a physician and experience you had that if somebody was assigned between the hours of 8:00 a.m. and 3:30 or 3:15 in the afternoon and did not have the ability to know what a late deceleration on a monitoring strip was or what an early deceleration was or what beat-to-beat variability was that that would be below the standard of care?

A. That's correct.

Q. Here at your hospital when you have an internal monitor on one of your patients, let's assume, are your nurses here instructed that as the doctor €or the mother and the baby that you want to be told when there are late decelerations; is

that what you instruct your people?

MR. MURPHY: I'm going to object, You can go ahead and answer.

A. I'm sorry. Here we have a resident staff who while I may be the attending the resident physicians are the first line of reporting.

Q. Yes. The resident would be your eyes and your ears. Well, I mean, what you do here at the hospital, you say, look, we have qualified residents, we think they are good people and if the person who is watching the monitoring strips goes to tell the resident, if you can't find the resident, find the floor supervisor of nursing, if you can't find the floor supervisor, and you can't find them, come talk to me about it, is that about right?

A. It may be a nurse, it may be a medical student, it may be a resident. Everybody is the attending on these cases evaluating the monitor strip.

Q. Do you think that Dr. Schwartz in this case of Rebekah Berlinger should have been present in the very room that Mrs. Rerlinger was in during the time the internal monitoring strip was running?

A. No.
Q. Do you think that Dr. Schwartz should have had accurate reliable information as to what the monitoring strip was showing insofar its decelerations of any kind or beat-to-beat variability, should he have known that or been told that?
A. Yes.
Q. Did you review the record from Mt. Sinai Hospital for both mother Heidi and the baby?
A. Yes.
Q. Did you review the nurses' notes made on both Heidi and the baby from the time she was admitted at about 11:00 on July the 9th of '84 until the cesarean was completed?
A. Yes, I did.
Q. Anywhere in those notes did you ever find a note in the nurses' notes that told you when a contraction started in labor and when it ended and how far the contractions were separated from each other and whether or not the decelerations occurred or not; did you ever see that. written down?
A. Yes, I believe I did.
Q. Do you want to get that?

A. On several occasions.
Q. Okay. And how often should those notes have been made in the hospital records? Let me withdraw the question first of all.
Let's see if there is a, your judgement is for a requirement that the contractions in a mother such as Heidi should be recorded in the medical record; do you believe that is true?
A. We have a continuous monitor both externally and internally.
Q. Just listen to my question.
A. I'm sorry.
Q. What do you think about it?
A. Would you repeat the question?
Q. Do you think that the contractions, the number of contractions and the spacings and time between contractions should have been recorded in the Mt. Sinai Hospital records during the time the internal monitoring strip was being run on Mrs. Berlinger?
MR. GOLDWASSER: Now you are including the monitor as part of the hospital record, I trust, because it is, are you or are you telling the doctor to include the monitor?
MR. ILER: No, I'm not telling him

to include anything. I'm saying should there he a recording.

MR. **GOLDWASSER:** He answered your question, that's why I'm curious, because he told you it was in the monitor. That's why I didn't understand why you were repeating the question. That's my point.

Q. I have to start over from the beginning here. You confused me.

Is it required in your judgement that in a case where an internal monitoring strip is being run on a mother such as Mrs. **Rerlinger,** that there be a record kept in the hospital records during the period of time the internal monitoring strip is running which indicates the contractions, the number of contractions, how they were separated by time one from the other, the severity of the contractions and any abnormalities in the contractions, should those be recorded?

A. They are recorded on the monitoring strip, which is a part of the record, it's a continuous, on-going. If the, if we did not. have continuous monitoring then there is the requirements that the nurses' notes and the doctor's notes record

and the types of deceleration patterns or no deceleration patterns with a certain frequency in the hospital record. Hut with a continuous record, counselor, it's right there. We sometimes make notes on the record, which is part, on the monitoring strip which is part of the record, we sometimes make a progress note at intervals depending on where we are. It's difficult to answer your question with a yes or a no.

Q. Okay. Can we do it this way then so we move along. The answer is if you do not have a monitoring strip that is running on paper and that's not. being done then notes should be made in the hospital record that indicate the number of contractions, the time between them and the severity?

A. Yes, 1 agree with that.

Q. If there is a monitor strip I think your testimony is no, you don't have to record them other than on the monitoring strip if you wish because you have a record with the strip itself, is that true?

A. It's partially true, counselor. I would also

want, certainly, progress notes written at intervals to summarize what, has gone on on the monitor strip for a while.

Q. Why do you want that, why do *you* want the progress note?

A. Because it's going to take what. is OR the monitor strip and incorporate it into the total picture of the case as it relates to dilatation, effacement, maternal condition, et cetera.

Q. Why should it be on the progress note?

A. I'm sorry.

Q. Why should it be put on the progress note?

A. Because that's where we record OUT observations of the progress of the patient.

Q. In this case was the internal monitoring strip run continuously from the time it was put on at approximately 8:00 a.m. on July the 10th, 1984 and run until 3:00 or 3:15 continuously?

A. I believe by looking at the number of the panels on the monitoring strip the answer is yes.

Q. How do you reach that conclusion? If you could just explain how you reach that conclusion I would appreciate it?

A. I reached that conclusion by first noting a confusing print on the record an Panel 77 that

indicates 11:00 a.m. and then a note on the pane3 that indicates 13, which would be 1:00 p.m., but the numbers on the chart paper are consistent in the progress of the numbers wjth no interruption in the strip, so I assume that what was done in error in putting in the time and that, in fact, this was 11:00 when it was meant to be, when it says 13.

Q. When you say 11:00 you mean 11:00 in the morning of July the 10th?

A. That's correct.

Q. So the first reporting you have on the internal monitoring strip is at what time?

MR. GOLDWASSER: You are changing streams now. That's a whole different question. Okay.

A. The first report, I think it says right here an Panel 37, internal EKG.

Q. Okay. And what time would that be?

A. That time says 7:42 and a half.

Q. Okay. At 7:42 and one half do we take it now the internal monitoring strip, internal monitor was placed in Mrs. Berlinger?

A. Written on the monitor strip is internal EKG, so I assume --

Q. That would be Panel Number 37, correct?
A. Panel Number 37, I believe, sir.
Q. Okay.
A. About there. Now, I don't know if you are asking me specifically when that electrode was clipped and when we began getting a recording, I don't know. We would, this may be that they are going to do it, this may be that they had done it. I would say that we have to have a range here of somewheres from 7:42 and a half to, I don't know, I guess about 8:00. So I'm not sure, counselor, exactly where this is, hut. it's at this point that we were putting on an internal electrode.
Q. Let's assume that the electrode is placed in at that time, let's say 7:42 or 8:00, whichever that is, would you now tell me how you concluded from the numbering of the panels or from the times that. the monitoring, internal monitoring strip ran continuously from the time it was starting to record, let's assume the latest point at 8:00 a.m., till when it was discontinued?

MR. MURPHY: I'm going to just object because it was just asked two minutes ago

and answered. If you can answer the question,

A. Well, we can do a calculation, counselor, if you want me to get my computer. We can assume about 8:00, and went to Panel 126. We can go from panel -- yes, sir, I believe we can do the calculation. I may be off by two or three minutes.

Q. Okay.

A. If we take, for instance, 37, Panel 37, which is a little bit earlier than 8:00, and I agree we don't know, and that's Panel 37.

Q. Right.

A. And we go to 126, we subtract the two, is 89 panels with 5 minutes in a panel, that's 445 minutes, 60 minutes in an hour divided into that would give us 7 hours and 25 minutes; and I believe we calculated 7 hours and 20 minutes.

Q. We considered a little over seven hours.

MR. GOLDWASSER: Seven, seven and a half hours.

MR. ILER: I think that's where we are.

MR. GOLDWASSER: Between those two.

A. If I did it correct.

Q. The question now then is did you review each of those panels before rendering your opinion in your letter report. of July, pardon me, June the 8th, 1987?

A. Yes.

Q. From your report of June 8th, 3987 you indicated some of the items which you reviewed before making up your report, that's true, but I notice in your letter of June 8th you had not read the deposition of the defendant Dr. Robert, Schwartz before writing out your opinion, is that true?

A. That's correct.

e. You did not read the deposition of the plaintiffs' expert Dr. David Abramson?

A. Correct.

Q. You did not read the deposition of Nurse Thomas who was watching the monitoring strip?

A. Correct-

Q. From the medical records that we have in this case, your report indicates on Page 2, if you would not mind getting that, doctor, that on July the 9th of '84 Mrs. Berlinger was admitted to Mt. Sinai Medical Center for approximately three hours €or observation of early labor. That's what you gleaned from the records?

A. Correct.
Q. And she was sent home?
A. Correct,
Q. And then she returns back to the hospital later that evening and is admitted at approximately 11:00 or so?
A. Correct.
Q. Is she in labor then?
A. She is in very early Patent phase labor.
Q. When you say latent phase, what does latent mean?
A. Before the active phase of labor.
Q. Well, anyhow, she is admitted and when she is admitted your notes reflect that the cervix was one centimeter dilated and 50 percent effaced, right?
A. Correct.
Q. Where was the baby in position?
A. The position was not determined.
Q. It says effaced with the vertex at minus two station.
A. That's station.
Q. Okay. Does -- let me see. I'll show you a diagram, it's not anatomically exact, perhaps it will help us, maybe it won't, but can I show you

this diagram. And I'll have it marked, if you would.

- - - -

(Whereupon, Plaintiffs' Exhibit No. 7 was marked for purposes of identification.)

- - - -

Q. Okay. Doctor, I brought out a diagram and I had it marked Plaintiffs' Exhibit No. 7 and it shows in a way a baby's head coming in a position and it's got a center line where it says zero then minus one, minus two, minus three, a midpoint and then it's got plus one, plus two, plus three below the midpoint point.

Now, when Mrs. Berlinger has come to the hospital and the station is -- this diagram, can I use this diagram to indicate the baby's station?

A. Yes.

Q. Now, when the lady comes into the hospital she is at minus two station, am I correct?

A. As reported, yes.

Q. Okay. Can you mark or can I mark an arrow at minus two admitted, can I do that on this diagram? Would you mind doing that on this diagram?

MR. GOLDWASSER: There is nothing to suggest. you can't do it.

MR. MURPHY: Why don't you do it, Don.

Q. What I'll do is next to minus two I'll put OR this baby was at minus two station?

A. Correct.

Q. From the time that she was admitted at 11:00 on July the 9th of '84 did the baby's head ever descend below zero station?

A. Yes, sir.

Q. And how far down below zero station did it go?

A. I believe plus one.

Q. What record, can you show me a record that thfs baby descended below zero station?

A. Panel 106 here, sir.

Q. What does it say?

A. What I read on the chart is E to plus one, nine centimeters, pit drip. Then I can't read that.

Q. What time would that monitor strip reflect?

A. 106 would be, if my calculations are correct, 1:21.

Q. Okay. And what the note shows on the monitoring strip is a range on Plate 106 from *zero* station,

correct, and zero on our little diagram would be right where the diagram says zero in the middle, right?

A. Correct.

Q. And on the monitoring strip it shows zero to plus one, so there is a range between zero, according to this monitor note, and plus one?

A. Correct.

Q. Can we agree that the baby never descended from the time of admission, insofar as stations are concerned, anywhere below, giving the zero to plus one interpretation on the monitoring strip?

A. Would you repeat that, counselor.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. That's correct.

Q. There is a note in the progress notes, doctor, if you would not mind turning to the progress notes.

MR. MURPHY: What time?

MR. ILER: That would have to be at 3:30 on 7/10/84.

Q. Do you have that progress note?

A. Yes, sir.
Q. On the progress notes, what is the time that it was written, the date and time?
A. 7/10/84, 3:30 p.m.
Q. What does it say?
A. You want me to read the note?
Q. Sure, yes.
A. Despite two hours of good pushing patient has not brought head down past the zero, minus one station, therefore, a symbol, will do cesarian section.
Q. Go ahead.
A. Well, then there is red parentheses.

MR. MURPWY: That's mine.

A. Cervix-complete, pushing since approximately one p.m., Dr. R. Schwartz present.
Q. We can conclude then at 3:30 p.m. in the afternoon the baby's head never descended below zero, minus one station, correct?
A. According to this note, correct.
Q. And we notice that Pitocin was administered, Oxytocin was administered to Mrs. Berlinger, am I correct?
A. Correct.
Q. What do you understand the reason to be why Dr.

Schwartz ordered that Pitocin to be administered?

A. He felt that he had inadequate uterine contractions that were related to a protraction disorder and correctly augmented the labor with Oxytocin.

Q. When we use Oxytocin, we have been agreeing for a long time Oxytocin, Pitocin means the same thing?

A. Correct," --

Q. So with the use of -- and when do you understand, I think it was at 11:45 in the morning that Pitocin was first administered to this lady Heidi, right?

A. Your time, sir?

Q. 11:45.

A. Correct.

Q. What. was the dosage?

A. I believe it was infused at two milliunits per minute.

Q. That's how it was started, right, at two milliunits?

A. I believe so.

Q. Was it done with an IV, right?

A. Infusion pump is my understanding.

Q. What do you mean?
A. It is a pump that regulates the infusion rate. The settings are according tu the dilution that you have.
Q. Right.
A. I believe in this case they put ten units in 250 cc's.
Q. But. through an IV?
A. Correct, yes.
Q. NOW, the doctor believed that this lady now has been in labor -- strike that. Strike that question.

When do you believe that Heidi Berlinger went from latent labor to labor, to legitimate labor?

A. I don't understand your question.
Q. Okay.
A. To labor or legitimate labor.
Q. Okay. You know earlier you mentioned on your report that she was in latent labor.
A. Correct.
Q. When she was admitted, and you characterize that. labor as being what?
A. As a stage prior to active phase labor.
Q. NOW, when do you believe that Heidi went into

active labor?
A. Somewheres between 9:00 and 10:00 a.m.
Q. What day?
A. The 10th of --
Q. July?
A. July.
Q. 1984?
A. Right.
Q. So then she was in active labor from that point until when?
A. Until she reached full dilatation.
Q. And what time would that be?
A. That would be somewheres about 1:30, to about 1:30. It's difficult.
Q. So at 1:30 in the afternoon on July the 10th active labor ceases in Heidi Berlinger, true?
A. The active stage of labor ceases.
Q. Now, we're going to be talking to jury people who don't understand all of this medicine or may understand some of it, so what I'll try to do, and if you can do it without compromising *your* medicine, maybe you can help us along.

Now, do I understand that her active labor ended at about 1:30 in the afternoon of July the 10th of 1984?

A. At approximately 1:30 on that day she reached full dilatation, which puts her into the second stage of labor,

Q. Which is called what?

A. Which is called second stage of labor.

Q. Okay. All right.

A. At the time period from approximately 9:00 or thereabouts to that time she was in what is called the active phase of the first stage of labor.

Q. Okay. And was she progressing normally during that first stage of active labor?

A. After the use of the Pitocin augmentation, yes.

Q. No, before the use of Pitocin, from 9:00 -- oh, I'm sorry. Okay. Go ahead. After the use of Pitocin at 11:45, go ahead, sir, she was proceeding normally in active labor, is that. your judgement?

A. Correct.

Q. So everything was proceeding satisfactorily insofar as the active stage of Heidi's labor is concerned after the Pitocin was administered at 11:45?

A. That's correct.

Q. What is the protraction of active phase of

labor, what does protraction mean?

A. Protraction basically means that the expected dilatation, centimeters per hour, that one would expect during the active phase in a primigravida patient was not being met. The curve, the tracing of time versus dilatation is flattened from the normal.

Q. Therefore, the use of Pitocin assists in that regard?

A. I'm sorry.

Q. The use of Pitocin assists in that regard?

A. After evaluation of the patient who has a protraction disorder of the active phase Pitocin augmentation is one of the options and is within the standard of care.

Q. Okay. When Pitocin was started on Mrs. Rerlinger at 11:45 a.m. should somebody personally be watching the effects of the Pitocin on Mrs. Berlinger?

A. The answer to this relates back to the discussion we had previously. With a continuous monitor and an internal system in place you are doing that continuously.

Q. Okay, So the answer to my question is what; no, somebody does not, have to be standing over Mrs.

Berlinger watching the drip, drip, drip of Pitocin into her?

A. That's correct.

Q. Okay. Is it true that wjth the use of Pitocin the labor contractions become more severe?

A. Could you define severe?

Q. Increased in severity from what they were without the use of Pitocin.

A. Well, if they were less than normal the Oxytocin would bring their intensity to normal.

Q. And does the use of Pitocin extend the time of the labor contraction?

A. The use of Pitocin generally would reestablish a normal labor contraction frequency and intensity. That is the objective of using the Oxytocin or Pitocin.

Q. So is it true that in your judgement the use of Fitocin on Mrs. Rerlinger was to establish the normal frequency of the contractions and the normal severity of Mrs. Berlinger's contractions?

A. If we can replace the word severity with the ward intensity, yes.

Q. When you say intensity what do you mean by it?

A. I mean as measured by the internal pressure

catheter in millimeters of mercury.

Q. Okay. Now, what was the basis or the baseline for Mrs. Berlinger's contractions before the

A. She was having irregular contractions every three to four, five minutes of an intensity that, was low.

Q. And for how long a period of time had that been going on before the use of Pitocin?

A. A good many hours.

Q. So then how, in your mind, do you determine what the normal contraction would be in Mrs. Berlinger with the use of Pitocin?

A. I would not know exactly what the normal is for any one individual. I would only have a range of normal.

Q. All right. What would you expect if you were looking at Mrs. Berlinger while the Pitocin is running?

A. I would like --

Q. What would you like to be looking at?

A. I would like to be looking at contractions that are occurring every two to three minutes, regular, with that regular frequency with an intensity that was somewheres between 50 and 60

millimeters of mercury above the baseline.
Q. When you say with frequency, how frequent would you like those contractions?
A. Every two to three minutes.
Q. With that formula that you have described on what you would have liked to have seen did that, in fact, occur to Mrs. Berlinger with the use of Pitocin?
A. She began to get contractions that were of increased frequency and intensity.
Q. After the use of Pitocin did they go to two to three minutes per contraction?
A. Yes, fewer intervals of time.
Q. And also did the contractions with the use of Pitocin on Mrs. Rerlinger also accomplish the purpose of the Pitocin?
A. Well, as we discussed earlier, the flattened curve of time versus dilatation 'that allowed us to make the diagnosis of protraction disorder began to accelerate and come back to the normal curve, and between 11:45 when the Pitocin was initiated and 1:30 or thereabouts she had progressed from five to six centimeters to full dilatation.
Q. Okay. So at approximately 1:30 she is now fully

dilated, is that right?
A. That's correct.
Q. And what does that mean, for purposes of the record, when you say fully dilated?
A. It means the cervix is approximately ten centimeters or greater dilated.
Q. The cervix then is ready for the baby to descend into, right?
A. Correct.
Q. All is in readiness for delivery wjth one exception, the baby must now enter the birth canal, true?
A. Must descend the birth canal.
Q. Right. Now, at the time Mrs. Berlinger reached full dilatation of ten centimeters at 1:30, what was the position of the baby's head in Rebekah insofar as station is concerned?
A. Position as defined by a correlation of a landmark of the fetal presenting part to the landmark of the maternal pelvis is recorded only one place, and I believe it's from the transverse position.
Q. Well, doctor, if you would look at the progress note of the 10th of July and at -- will you look at the note of the progress note. July 10 at

12:30 there is a progress note. Would you take a look. It says CX, what is that, at 12:30?

A. Cervix.

Q. FCM is what?

A. No, that's a 7.

Q. I'm sorry. Seven centimeters dilated, right?

A. Right.

Q. Then slash C. What is C?

A. Complete.

Q. And what is zero?

A. I didn't write this, but 1 imagine it's the station.

Q. Can we conclude at 12:30 on July the 10th of 1984 this baby is at zero station?

MR. GOLDWASSER: You asked the doctor what position now. You are confused, Don, between position and station.

MR. ILER: That's all right;.

MR. MURPHY: It's not. all right.

MR. ILER: I want to stay with station.

Q. What station is the baby at at 12:30 in the afternoon?

A. Well, according to this note, it's zero. I'm getting confused on the times now. This is 106,

106 is 1:21, other notes -- I'm just trying to check if these were other notes.

I think that's correct, counselor.

Q. Okay. So now the baby's head being at zero station that we see from our diagram, Exhibit No. 7, the baby's head is approximately in the position shown on the arrows in this diagram, am I correct, on the big line?

A. As you have pointed to that diagram at the left of the ischiospines at zero station, correct.

Q. I'll mark in red at zero station 12:30, 7/9/84 -- 7/10/84, pardon me.

Now, doctor, insofar as the station of the baby Rebekah, we know that at 7:30 there is a progress note, also, which indicates that the station of the baby is at zero station, minus one, right?

A. That's what it says.

Q. Okay. At 3:30 in the afternoon on July the 10th of 1984 the baby has been receiving Oxytocin or Pitocin for close to four hours, right?

A. Correct.

Q. The dosage of Pitocin was increased from its initial dosage of two millileters to -- two what?

A. Milliunits.
Q. Milliunits to how many milliunits?
A. I believe it was doubled to four, and I can't determine from the records whether it was increased beyond that, but I don't believe so.
Q. Okay. Would it make any difference to you as to whether or not the Pitocin was increased beyond four milliunits?
A. No.
Q. It would make no difference in your medical judgement as to whether or not the increase of Pitocin in Mrs. Berlinger increased beyond four milliunits despite the fact the child had not descended beyond zero station?
A. No, because I have the monitor strip regarding uterine contraction frequency and intensity and I have no significant abnormality recorded on that monitor.
Q. Okay. Now, did the child Rebekah ever descend below station, zero station before the cesarean was performed.

MR. GOLDWASSER: The doctor has answered that question already.

Q. Did you, did you answer that?
A. Well, we spent time on Panel 106, counselor,

that says zero to plus one.

Q. And the cesarean was performed at about 4:14 or 4:12 in the afternoon?

A. The baby was delivered at 4:14. The cesarean, preparation for and incision I believe was made at 4:04.

Q. Now, do you believe that based upon reasonable medical certainty that Pitocin should be stopped in a patient who is suspected of having a cephalopelvic disproportion?

A. Are you through with the question? I'm sorry.

Q. Yes, I am.

A. Now I have to have it repeated.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. Absolutely not.

Q. If there is a **cephalopelvic** disproportion, does that mean that the baby's head is bigger than the pelvis of the mother?

A. No.

Q. Okay. What do you understand cephalopelvic **disproportion** to **be,** what is that?

A. First, determination of **cephalopelvic** is made

retrospectively after one has evaluated the situation. What it is is the relationship between, if you will, as simplistic as I could explain it to you, the power, the passenger and the pelvis.

Sometimes the, quote, "cephalopelvic disproportion" may be due to inadequate uterine contractions that need Pitocin. Sometimes the pelvis is of adequate size and the passenger is too big. Sometimes the passenger is of normal average size and the pelvis is too smali. It's a relationship between those three parameters.

Q. Is it your medical opinion that Rebekah Berlinger's head or skull was too big for her mother's pelvis?

A. I'm sorry. There is one word you said in there that. I didn't hear. Stuck?

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. It would either be that the head was somewhat larger than the size of the pelvis or that there was a position change from the normal well-flexed head.

Q. Hypothetically speaking, if Rebekah's head was too big to pass through the pelvis of the mother you could not deliver this baby vaginally?

A. That's correct.

Q. If it was determined that her head, Rebekah's head, in fact, was too big for her mother's pelvis should you do a cesarean as quickly as possible after making that determination?

A. No.

Q. Okay. And you indicated earlier you still would not stop Pitocin once you recognized that the baby's head was too big for the mother's pelvis?

MR. GOLDWASSER: Objection. I don't think that's what he said at all.

A. That is not what I said.

Q. Okay. Thank you. If you learned while the mother is getting Pitocin that the baby Rebekah's head is too big for her mother's pelvis and cannot be delivered vaginally, would you stop the use of Pitocin?

A. I would stop the use of Pitocin when I made the decision to do the cesarean section for cephalopelvic disproportion.

Q. When would that be, doctor?

A. In this case Dr. Schwartz made this decision

after two hours of full dilatation, appropriate time for Mrs. Rerlinger to push and to try to effect the descent of the baby's head.

3:30 in this case would be the answer, counsel.

Q. Would you change your mind on the timing to do the cesarean section insofar as Mrs. Rerlinger is concerned if Mrs. Rerlinger was pushing and gushing ineffectively during her labor?

A. I don't know what that means, pushing ineffectively. I'm sorry, counselor.

Q. If during the point in labor Mrs. Rerlinger is determined that she is not getting any result from her pushing during the labor contraction, you know, would that alter your opinion as to when you would do the cesarean section?

A. What would alter my decision would be less related to her perception of pushing as it would to the progress that was being made in the descent of the fetal head.

After a period of time, which was appropriate in this case, where no further descent, it arrested, there was an arrest of descent, and during which time the fetus was, in my opinion, positioned to be all right, at that

point I would have stopped and done the cesarean section.

Q. All right. And would you have done the cesarean section early if active labor failed to progress?

MR. GOLDWASSER: Objection. Early is a relative term. I object to the question.

Q. He objects to the question. Let me give a nonobjectionable question.

We know the decision to do the cesarean section was made by Dr. Schwartz at 3:30 p.m., true?

A. Correct.

Q. Let us assume that there is a point earlier than that that is earlier than 3:30 when active progress of labor has ceased in Mrs. Berlinger, would you then change your mind and make an earlier time, earlier than 3:30 p.m. to do the cesarean?

MR. MURPHY: Objection.

MR. GOLDWASSER: The record should reflect --

MR. ILER: Just make an objection.

MR. GOLDWASSER: At 3:15 a nurse said, Dr. Schwartz examined, no progress, will

do C-section. There is a progress note written by a doctor at 3:30 that says C-section will be done, but the nurse says Dr. Schwartz decided.

MR. ILER: What do you want to do?

MR. GOLDWASSER: I want you to use facts accurate in the record.

MR. ILER: What fact do you want?

MR. GOLDWASSER: 3:15.

Q. Doctor, let's change this question around and say at 3:15 Dr. Schwartz has indicated to somebody he is going to do the cesarean section and you find that there has been no active progress of labor; would you change your mind of doing the cesarean earlier?

MR. MURPHY: Objection.

A. I'm not trying to -- it's hard for me to understand the question.

MR. MURPHY: That's why I object.

A. At 3:15 or 3:30 Dr. Schwartz, as I reviewed the case, looks back over two hours of full dilatation, plus or minus a certain period of time.

Q. Right, right,

A. And he says fully dilated, good pushing, I have not, I do not observe further descent of the

fetal head. I'm going to do a cesarean section.

He has to experience that time period which is normal accepted standard of obstetrical care and then look back over that period of time in order to make that decision. He can't start back here at full dilatation and say, well, she is now fully dilated and zero station, I'm going to do a cesarean section, that would he a deviation from standard of care, because these is no reason to do the section.

Q. He has no reason to do the section when?

A. When she reaches full dilatation.

Q. Okay.

A. She has now reached full dilatation. He then within good obstetrical care allows a period of time, as Song as the fetus is okay, to allow this lady to deliver vaginally by pushing. At that point he then looks back and he said in retrospect here, I am two hours, I'm not going to go any further. I'm going to stop because there is no further descent.

Q. Was that the main reason that Dr. Schwastz decided to do the cesarean was because the baby's head had not descended into the birth

canal?
A. Well, I believe in the operative report, discharge summary I think he also, somebody also adds on, I say I think there is a couple of, question of fetal stress or mild decelerations.
Q. Was it two reasons then, mild decelerations and also --
A. I need the records in order to answer. If I understand the question asked me is why he did the section. That's his primary reason for doing the section.
Q. If that's your judgement.
A. Fine.
Q. During the period of time that the Pitocin was running, that would be from 11:45 until the time that it was stopped, approximately shortly before the cesarean section, was Mrs. Berlinger still going through labor contractions?
A. Yes.
Q. During the period of contractions between 11:45 and the time that the cesarean was done was there pressure exerted on Rebekah the fetus in a downward position?
A. You mean was there fundal dominance?
Q. What is fundal dominance?

A. Fundal dominance reflects coordinated contractions that begin in the cornual, the sight and left cornual.

Q. The upper portion?

A. The upper portion of the uterus that then comes down from the upper myometrium, upper segment, the midsegment, the lower segment establishing fundal dominance and downward pressure.

Q. I'm interested in downward pressures. Was that occurring?

A. There is absolutely no way one can determine that.

Q. There isn't?

A. Not by the methods that were involved in this case.

Q. Isn't there a way to tell by clinical feeling by a trained physician as to whether or not there is pressure being exerted downward to the fetus?

A. The only objective way of establishing fundal dominance is to have a series of tocodynamometer or internal myometrium balloons at the upper and mid and lower and to establish the propagation of the wave in a downward. A clinical observation would give a feeling, but the best evidence of downward pressure would be further

dilatation, effacement of the cervix and descent of the head. Those are the clinical parameters that we use to coordinate with this downward pressure concept that you have asked me about.

Q. Is it your medical judgement that after the Pitocin was used that there was no downward pressure on the fetus?

A. If we determine -- are you asking me after 3:30 when the Pitocin was turned off?

Q. Yes. After it was turned off. I want your opinion as to between the period of time from 11:45 when the Pitocin was started until it was turned off at say approximately 3:30 in the afternoon, was that baby being propelled downward by the contracting force of the uterus?

A. Well, obviously there was no descent of the baby's head beyond zero station, as you have identified zero to plus one station in the diagrams. But at the same time the downward pressure that I agree has been exerted was not being excessive because there was no molding of the fetal head. Neither described by clinical examination of Rebekah Berlinger during the labor nor in the immediate newborn period could I find a description of abnormal molding.

There is always, thank God, a normal amount of molding that we all go through as we descend the canal. It was created this way to allow us to accommodate to our moms' bony pelvises, but there was no excess molding.

Q. How would you describe that excess molding?

A. I would describe excess molding as clinically suspected by the inability to determine suture lines in fontanels on the baby's presenting part and an actual deformation of the skin with formation of edema over the baby's head, the scalp.

Q. How about a misformation of the forehead?

A. That's a general statement, counselor. A misformation of the forehead, there is no normal, what a normal forehead looks like on birth. I think we a31 have different foreheads.

Q. Would you consider then a dysmorphic presentation of the forehead to be indicative of this kind of pressure which was excessive on the baby's head?

A. No. A dysmorphic would appear differently.

Q. Doctor, insofar as meconium is involved, we know the individual --

A. As far as what is involved?

Q. Meconium. These is no question it was heavy meconium on delivery of Rebekah, wasn't that right?

A. I'm sorry, sir. I don't mean to be rude, hut meconium.

Q. Right.

A. And the question was was meconium found? Yes.

Q. Was it in heavy quantities?

A. The meconium was found at the cesarean section and the quantity I'm not sure. There was enough of it so that appropriate and immediate intubation in attempting to suck out that meconium was done, I believe, three times.

Q. What did that mean to you insofar as when the meconium occurred first; does that, give you any indication?

A. Does what give me an indication of when --

Q. The heavy meconium which was found.

A. It could have occurred -- well, we know, if the records are correct, at 8:00 a.m. artificial rupture of membranes is clear fluid, and I don't. remember seeing any note about any meconium during the labor in the doctor's notes or the nurses' notes that I reviewed until clearly there was meconium noted at. the time of cesarean

sectinn?

A. Right.

Q. Right.

A. The baby was given to Dr. Lee, I believe and -- I don't know it is Dr. Lee. The pediatricians in the room who immediately intubated, which is the important part of the management of the meconium here.

If it's found at delivery, it's not there at 8:00 and there is no notes all the way along the line here, I can't answer the question. I don't know when the meconium was passed.

Q. Meconium can result from stress on the fetus, is that right?

A. That's one of the causes, yes.

Q. Did you find any evidence of stress on the fetus between 8:00 a.m. in the morning and the delivery of the child at 4:12 or 4:14?

A. Any stress that has me concerned or any stress?

Q. Any stress.

A. If we use the appearance of some isolated and nonpersistent early -- I'm sorry, late decelerations, there are a couple of those somewheres through there.

Q. When did they occur, the late decelerations?

A. I'm not sure, questionable where they are, what they are. I think if you go to panel --

Counselor, can I go back? Are you asking me about decelerations, when decelerations are occurring, because I can go through here and pick out. any of these. These are isolated nonpersistent early decelerations.

Q. I would like to have you --

A. Do you want one particular or a series of a couple that you want me to interpret? I don't know what you want me to do.

Q. See, you have given an opinion that in reading the monitoring strips you find no decelerations which cause you any concern, am I correct.?

A. That's correct.

Q. Ail right. And I want to test your opinion by you going over and finding for me each deceleration, where it is and tell me whether it is early, whether it is late or whether it is variable or whether there is a beat-to-beat problem that you see so that I can take your opinion and have it matched as to what somebody else may think is a late deceleration, is an early deceleration, is a variable deceleration or is a beat-to-beat deceleration, so then I'm

in a better position to evaluate your opinion, see?

MR. MURPHY: Can I ask you a question? Do you want to match it with somebody else's? Can we match it with at least the timeframe of Dr. Abramson?

MR. ILER: No. I want to know what his judgement is on these panels.

Do you want me to start in the beginning of the monitor strip.

Yes, sir, that would be wonderful. Just run through each of those plates so I can understand the foundation for your judgement.

I thought your original question was where you found ominous, where I found ominous deceleration.

No. I'm sorry. I want you to start wjth the very first plate. I think you said it was 37?

MR. GOLDWASSER: Internal or external or both?

MR. ILER: I'm sticking with internal.

We have agreed that internal is beginning at 37. Now, during the period -- do you want me to go 37, 38, 39?

Q. That's it, that's exactly right.
A. Okay. 37, there is a pattern of reactive tachycardia probably due to the placement of the internal electrode.
Q. Okay.
A. You want an interpretation of significance to the fetus?
Q. No.
A. Or do you just want classification?
Q. Just tell me what your thinking is with Plate 38. If you want to comment go ahead.
A. Excellent condition of the baby.
Q. All right.
A. The reactivity continues through 38, 39, 40. Baseline heart rate is 150 with good charted long tern beat-to-beatvariability. Panel 41 may have an early deceleration. 42, an early deceleration but the reactive tachycardia continues reflecting no concern on my part for the fetal condition.

Panel 45 and 46 shows --

Q. What happened to 43 and 44?
A. 43 and 44?
Q. Yes.
A. 43 is, I think I just said, has an early

appearing deceleration. 44 looks fine, may have a very slight early deceleration.

Panel 45, when you get to variables, variables cannot be determined by simply one panel. You have to look at the profile of panels because they vary from one to the other But 45, 46 look to me as the possibility of a variable deceleration.

47 shows nice reactive tachycardia.

Q. Is that tachycardia on 47?

A. Reactive tachycardia, yes. 48 has variable appearing --

Q. Decelerations?

A. Correct Good variability. 49 there is a deceleration of probably the early type. Through 50, 51, 52, 53, 54 there are some early decelerations, greatest deceleration being about 25 beats per minute with heart rate of about 150.

Panel 54, and these are always plus or minus a couple of minutes here where we go forward or backwards, there is no decelerations associated with the contraction. Another early in 55.

57 appears like an early, may have the

characteristics of a variable, it's indeterminate.

59 has some nice reactive tachycardias. This may be an acceleration pattern which reassures me, this acceleration pattern asures me of good fetal oxygenation.

62, 63, good beat-to-beat, again a reactive tachycardia or an acceleration pattern. 65, 66, 67 fine, good.

Q. Was that a deceleration then?

A. Where is that?

Q. At 65, 66 and 67.

A. No. 65, 66 and 67 the heart rate looks fine to me.

Q. I was *just* interesed in knowing --

A. You want to know ~he::the deceleration are?

Q. Yes. I want you to look through a17 *of* these.

A. You want me to go through and identify only the decelerations?

Q. J thought that's what you were doing.

A. I thought you wanted me **to** look at each panel and give you an interpretation.

Q. No. What I want from you, doctor, is your decelerations, your variables, your lates, that's all **I** want.

A. The ominous stuff, you don't want the innocuous?

Q. Listen to me carefully. What you call ominous some other physician may not think it's ominous. You may look at an early deceleration and somebody else may look at it and say that's a late deceleration.

A. Fair enough.

Q. So what I'm trying to get, from you is your opinion on each plate that you consider to he a deceleration or a variable so I can say this is what Dr. Mann says about this, see.

So we are -- apparently 65, 66 and 67 are okay, you wouldn't include those as a deceleration. Okay. Just if you want to just go right ahead.

A. Panel 73, maybe there is an early deceleration there. 74 may be a mild early. Good reactive tachycardia throughout here at 77, 78, 79.

Q. They're normal then or are they tachys?

A. No, those are nice reactive tachycardias. Those are reassuring.

Q. Without the characterization, because it's confusing me, about your reassurance, the only thing I want to know is are they evidence of

tachycardia or no, if you would, doctor.

A. Counselor, there are different types of tachycardia. There is persistent tachycardia of the baseline, there are intermittent tachycardias that are in relation to uterine contractions, and then there are tachycardias that are related to fetal movements. There are all kinds of tachycardia. It's hard for me to understand what you want or don't want me to do.

Q. If you say a tachycardia that is a result of fetal movement I think that would be fine, okay.

A. Most of what I see here as tachycardias are reaction to fetal movement or uterine contraction which prognostically is --

Q. Is that 74 or 75?

A. This is the whole record.

Q. What whole record?

A. As we are going along here there are, has been these recurrent reactive tachycardias to fetal movement or uterine contractions. I have not seen to this point a persistence of a baseline tachycardia above 160 or so.

Q. Okay. What panel are we on now?

A. We are up at Panel 88.

Q. What happened from 74 to 88?

MR. GOLDWASSER: You just told him to go through, Don.

MR. MURPHY: You said just tell me when there is a deceleration.

Q. My question is is there anything on 74 to 88.

MR. MURPHY: He said on 74 there might be a slight mild deceleration.

MR. ILER: I have a mild early maybe. Now that's the last record I have.

A. Panel 84 there is a deceleration that cannot be determined because there is temporary discontinuation of the toco.

Q. Doctor, would you listen to me for just. a minute? Between Panel 74 and 88 is there anything there insofar as a deceleration?

MR. GOLDWASSER: Don, you have got to get your act together.

MR. MURPHY: It would he nice if you listen to your own question. You asked him t.o go through and call to your attention when he has seen a deceleration so he has gone from 74 to 84.

Q. That's my only question. There are none between 74 and 88. I'm just confirming a point. Am I

right?

A. Yes, other than the suggestion of maybe a few early, mild early decelerations.

Q. And when are those, what panels show me mild early deceleration? That's what I want.

A. 78. Maybe 77.

Q. Okay.

A. Now, counselor, where are we?

Q. I'm at panel 78.

A. My instructions now are to go to the next deceleration?

Q. Wait a minute. Hang on a minute here. You see what I want from you, doctor, is as you go through these panels, and we are now at 78, what I want is your opinion OR each of the panels as to whether like Panel 79 or 80 or 81, which will follow, indicate some kind of a deceleration, a beat-to-beatvariability or a late or early deceleration in your judgement so that when I finish all of the panels I'll know what your opinion is as to each panel as to whether they show a deceleration which is either a late one or is an early one or is a mild early or is a mild late or is a variable.

A. Earlies, lates and variables with mild moderate

or severe. You don't want to hear about acceleration patterns? I want to follow your instructions, counselor, as best I can. I'm very confused at this point.

Q. I'm really interested in the deceleration here.

A. Okay. 79 --

Q. Let me help you a bit. The next panel is 79. Okay. Does that show a deceleration?

A. No, it does not.

Q. Does 80?

A. 80?

Q. Panel 80.

A. Maybe a mild early deceleration.

Q. How about Panel 81, does that show a deceleration of any kind?

A. No, sir.

Q. And 82?

A. No, sir.

Q. 83?

A. There is something here on 83 but there is no contraction, so there is a very mild something, some type of deceleration.

Q. You can't identify whether it's early or late?

A. No, sir.

Q. What panel was that?

A. 83.
Q. All right. How about Panel 84?
A. 84 there is a deceleration.
Q. And how long does it last?
A. That's approximately a minute -- no, two centimeters, about 45 seconds.
Q. Okay. And the next panel, Panel Number 85?
A. 85, no deceleration.
Q. 86?
A. There is, from 86 there is an increase in this -- you don't want me to comment on that.
Q. That's all right. Comment.
A. There is no specific deceleration.
Q. On 86?
A. Correct.
Q. 87?
A. Maybe mild early.
Q. 88?
A. No, sir.
Q. 89?
A. No, sir.
Q. 90?
A. No, sir.
Q. 91?
A. 91 is where I would have gone to if I had gone

specifically to the way we started this. These have -- it's hard to classify these.

Q. When you say these, do you mean PI, 92, 93?

A. 91, 92, 93.

Q. Okay.

A. There are just three of them and then 94, 95, 96 other than a 160 beat per minute baseline heart rate with good beat-to-beat variability, you don't see them.

Q. I'm confused. Start me back, doctor, with Pane! Number 91. Do you see any decelerations on 91, 92 and 93?

A. Yes, sir.

Q. How do you classify them?

A. I would classify them as early decelerations.

Q. All right. And then with 94, 95 and 96, are there any decelerations in those panels?

A. No.

Q. And are there any variabilities in those panels?

MR. MURPHY: I'm trying to figure out what he is asking. Any variable decelerations?

MR. ILER: Yes, right.

A. There is on Panel 93 a deceleration which

doesn't really fit into any classification. It might very well be a variable, somebody might call it a deceleration, somebody might call the 91, 92 a mild deceleration. It would have no significance to me because it does not persist.

Q. Your next panel would be?

A. 94, 95 no deceleration. 96, 97, 98, 99 no deceleration.

Q. Okay. And the next ones?

A. Where were we?

MR. MURPHY: 99 you left off.

A. 99, no deceleration.. 100, maybe a mild early maybe in 101 or just over the hundred mark maybe a mild early, 100 -- you don't want accelerations.

102 has a little acceleration. Maybe a little deceleration as an early, I'm not sure whether that's just not normal changes. 103, maybe a mild early. 104, mild early.

In each of these my determination of them being an early is that they return to the baseline heart rate by the time the pressure has reoccurred, has returned to baseline.

104, again mild early. 105, no deceleration. 106, a nice -- sorry. I'm not

supposed to identify acceleration patterns.

Q. You can if you want to. If you want. to offer it. in go ahead.

A. 107, it's hard to tell because the uterine contraction is not recording well. Again I would say that's an early, though.

Q. Why isn't the uterine contraction recording well?

A. Well, this happens from time to time. It depends upon the pressure being reflected in a tube that's passed into the uterine cavity and that tube very frequently gets blocked, you have to flush it through. This is a very frequent occurrence.

I believe at this point already she is now pushing.

Q. What time would that be?

A. We're at Panel 108. 110, we are beginning to see, we're about 2:00, I believe, sir, and from this point forward we have multiple -- let me be a little more specific.

Panel 108 to Panel 113 we see decelerations that somebody might call earlies, somebody may call them variables. They are not late decelerations.

Q. Okay.
A. Panel 113 -- I'm sorry. Panel 114 to, through Panel 117 is very reassuring. These is an acceleration pattern. I'm sorry.
Q. All right. There is an acceleration pattern.
A. 117, you have got some moderate early or variable, it's very hard to distinguish these. It is not an uncommon pattern when a lady is pushing in the second stage of labor, these are not deep decelerations, there is a good return to baseline in between them with good beat-to-beat.
Q. What is your conclusion?
A. My conclusion is that --
Q. 114 to 117 are okay, moderate, earlies or what?
A. 114 to 117?
MR. MURPHY: He has commented.
A. I believe we just commented on.
Q. What was --
MR. MURPHY: 117 to something.
Q. To what, sir?
A. 117 -- the reason that I get into looking at the pattern of panels, a number of panels is because no interpretation of a monitor, of the monitor heart rate and its relationship to contractions

can be made by one panel. You have to look at a profile of these.

Q. So you are looking from 117?

A. 117.

Q. To where?

A. To basically to the end.

Q. What would the end be, Panel 116?

A. 126, sir.

Q. What do you see in there?

A. I see periods of early or maybe they're variable decelerations that at most are of 30, 40 heats maximum, never much below 120 beats per minute. They always recover. There is good beat-to-beat. There continues to be some good reactive tachycardia and acceleration.

Q. so --

A. I'm not particularly concerned about the baby at this point.

Q. In concluding, from Panels 117 to Panel 126 you see some of those as being early and variable decelerations, is that true?

A. I said they may. I don't know what they are, early or variables.

Q. You cannot tell me what they are?

A. I can tell you what they are not.

Q. What are they not?
A. They are not late decelerations.
Q. Okay.
A. And they are not severe variable decelerations.
Q. Okay. That's fine. Now we have concluded with the monitoring strip, doctor, and I want to take a ten minute break for just a minute and see how far we have to go.

- - - -

(Thereupon, a recess was had.)

- - - -

Q. Okay. Let's go to the doctor's notes, if you would, doctor. These are Exhibit No. 1, they are your notes that you made during your review of this case. On page, it looks like the second page under orders, which are orders that yon have marked, I can't read the first line after orders,
A. These are just some notations from the external monitors. 20 minutes every two hours.
Q. What does that mean? Was that the orders the doctor made?
A. Yes.
Q. That was done, right?
A. In fact, I don't know what time that refers to

but she had a continuous monitor on.
Q. The next line, Pitocin begun at two?
A. Two milliunits per minute.
Q. Underneath that it says what?
A. Mefoxin at cesarean section. It's an antibiotic.
Q. Then you have an asterisk and it says what?
A. It says there is an order €or activity in the postoperative orders ad lib, and I say inappropriate.
Q. What is that, what do you mean by that.?
A. Why did I write inappropriate?
Q. What does the whole thing mean? Why did you write inappropriate and --
A. The order was written for activity ad lib as the patient wanted to get up and walk around, and my feeling was that she had a spinal headache and I just as soon her not up walking all over the place. Inappropriate. Deviation from standard of care, no, just not appropriate.
Q. At the top of the Page 2 you have got what looks to be with an asterisk, it's got FHT, fetal heart rate, is that mild late decels?
A. Correct. That's from the nurses' notes.
Q. Okay. That's when you believe she was given

oxygen and turned on her left side?

A. I believe so.

Q. That's appropriate for a late deceleration, that's what you should do or not, it doesn't make any difference?

A. It's not. inappropriate. Yes, it's appropriate,

Q. Is it necessary to turn the patient on the left side and give her 02 after a couple of late decels?

A. You mean in general?

Q. Yes. Is it required? Do you do it?

A. Yes.

MR. ILER: Pat, I have trouble reading all of his writing. Do you want him to transcribe this and send it to you or do you understand it all?

MR. MURPHY: I haven't read it all.

MR. ILER: I'm having a little trouble reading it and I don't know whether I should take the time to go through his notes, maybe that would be actually easier.

A. Actually you are doing a wonderful job of reading my writing, counselor.

Q. I just don't want, to misinterpret.

MR. MURPHY: Why don't we do this, at the outside if there are particular things that you say, I don't know what that means, call me and I'll call Dr. Mann and I'll get back to you. I'm not going to impose on him to sit down and dictate this for us.

Q. On the first page at this point where it says --

A. Uterine size equal 14 weeks.

Q. We already got that. No allergies?

A. Allergies Erythromycin, codeine. This is all taken from the --

Q. The hospital record?

A. There is nothing that appears OR the first two pages other than what you have identified as order for activity ad lib --

Q. Okay.

A. -- that is not in the chart somewheres and at some point I put it into my notes.

Q. Okay. Do you know Dr. Schwartz?

A. No, I do not.

Q. Dr. Nudelman?

A. No.

Q. Do you do any work at Mt. Sinai?

A. No, sir.

Q. The second last page, would you turn t.o that,

doctor?

A. Second to last page?

MR. MURPHY: Exhibit 5, Don?

A. Okay.

Q. On 5 there are some notes here that say, I think it says ominous decelerations?

A. No, sir. That says, right there it says gushing, decelerations, accelerations, and it says no bradycardia or ominous decelerations.

Q. Okay. 4:14 you have marked as the delivery on that page?

A. Right.

Q. Under the summary portion?

A. Yes, sir.

Q. What is the first thing it says, number 1?

A. It says need cord gases.

Q. Who needs cord gases?

A. We need to, I need to inquire of whether there were cord gases obtained.

Q. why? Why do you need the cord gases?

A. It's not that I need the cord gases. It would be a question of -- on Page 3 I write the same thing up there, question mark result of cord blood gases.

Q. Yes.

A. I'd like to know if cord blood gases were done and what the result was to help me interpret the case.
Q. Yes. And what will cord gases give you?
A. Cord blood gases will give me the pH, the PC02 and the P02.
Q. AI1 right. And that would be during labor?
A. No, sir.
Q. During?
A. Cord. That's -- cord is only in the newborn period.
Q. And did you ever get those?
A. I believe I was told that they were not done.
Q. Okay. And so, therefore, what information can you not have because there is no cord gases done?
A. I cannot have the information of the pH, P02 and POC2 on the cord on delivery.
Q. What, would those relate as to whether the chjld was acidotic?
A. That's correct.
Q. Number 1 under summary, would you tell me what. that is?
A. It says labor and delivery management. okay.
Q. Okay. And Number 3?

A. Monitor, it says occasional earlies, mild, few variables, not persistent.
Q. Okay. Number 4?
A. It says no encephalopathic picture.
Q. What does that mean?
A. It means the newborn did not have any picture that was suggestive of hypoxic encephalopathy.
Q. And then Number 5?
A. It says dysmorphic picture.
Q. What does dysmorphic mean?
A. Dysmorphic means abnormalities in the morphology of the individual.
Q. Okay. And what do you have under that?
A. I have -- these are all from the notes of people that are written here. Hypontonia, questionable hearing loss, hemivertebra.
Q. Okay. And then Number 6?
A. It says syncope dash dizziness and postpartum seizure. The question I'm asking was the mother's problem, was any further follow-up done and what, is this related.
Q. Okay. And then the last item, Number 7 says what?
A. Defendable.
Q. Do you mean defendable suit?

A. Correct.
Q. When were these notes made? Is there a date on any of these?
A. Oh, boy.
Q. We know that there has been correspondence.
MR. MURPHY: Check when I sent you the records and we will know it's from that point forward.
A. November 13th, 1986 I received the records.
Q. Did you receive any other reports from any other physicians to review?
A. In this case?
Q. Yes.
A. I have said I have the deposition of Dr. Schwartz, the deposition of Dr. Abramson. Is that right, Dr. Abramson?
Q. Yes.
A. And the written report of Dr. Scher, since I reviewed, made these notes.
Q. Okay. But before, as you were going through the case did you get in any other medical reports? Did you get Dr. Milley's report to read? Do you know who he is?
A. Could you spell it?
Q. M 1 L L E Y. From Pittsburgh.

A. No.
Q. Did you get Dr. Scher's report.?
A. Yes, I think I said that.
Q. Did you get any other doctor's reports to review?
A. What I have reviewed for the case is what we went over in my opinion letter of June 8th and since then Dr. Schwartz, Abramson and Scher.
Q. Okay. Are there any medical textbooks that you consider to be authoritative in the field of obstetrics and gynecology?
A. No, sir.
Q. Do you use any textbooks when you teach your residents?
A. Will I refer to a textbook from time to time for information regarding one thing or another.
Q. Yes. That's the question, well, it wasn't, hut I'll take your question.
A. Yes.
Q. Which one?
A. Which one?
Q. Ones, one or which book or books would you refer to?
A. We would refer to many of the textbooks of obstetrics and gynecology because on many issues

each textbook presents something a little bit different in terms of the interpretation.

Q. Which books would they be?

A. They would be Williams' Textbook of Obstetrics. They would be Danforth's textbook, Wilson's, Romney's, Creasy, the Resnik, on and on.

Q. With each of those textbooks I think what your testimony is, they each may be, each may contain a portion that you consider to be valuable or authoritative or not the entire book?

A. No, sir. I don't consider any textbook to be authoritative. I think I consider them informational.

Q. Do they use any of these textbooks to teach people who, students who are going to be OB/GYN's?

A. I'm sorry. Who is they?

Q. I mean do medical schools use any textbooks in the teaching of medical students?

A. Yes, sir.

Q. Which books do the medical schools use at Case Western Reserve?

A. At Northwestern you are going to use Dr. Danforth's. If you are in Boston you are likely to use Dr. Reed's hook, Dr. Romney's bonk. If

you are in California you may use Drs. Creasy and Resnik's.

Q. How about Case Western Reserve?

A. I really don't know which textbook we used. We usually, because of the cost of these books, usually use them as a resource for the students and the students will pick up their information from the series of lectures that we give in some condensed form or a curriculum type of book and then refer in our library to any of the several books that I mentioned and others for more detailed information. And more particularly they and us, residents and faculty refer to the literature, the present literature and past literature, journals for information.

MR. ILER: I think those are all the questions I have of the doctor at this time, and I thank you and ask for a waiver of signature.

MR. MURPHY: When it's written up I'd like you to review it and then we will decide whether you want to waive it or if you think something is inaccurate we can make a change and we can indicate why.

THE WITNESS: You don't want us to

waive?

MR. MURPHY: No.

THE WITNESS: Okay.

LEON I. MANN, M.D.

CERTIFICATE

The State of Ohio,) SS:
County of Cuyahoga.)

I, Dawn M. Hagestrom, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named LEON I. MANN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19__.

_____

Dawn M, Hagestrom, Notary Public, State of Ohio
650 Engineers Building, Cleveland, Ohio 44114
My commission expires October 20, 1987