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Doc. 365

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I_N_D_E_X

WITNESS: STANLEY_POST,_M.D.

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DR._POST_DEPOSITION_EXHIBITS MARKED

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INDEX_OF_OBJECTIONS:

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(NO OBJECTIONS.)

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STANLEY POST, M.D.

of lawful age, a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

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CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name,, please?

A. Stanley Post.

Q. Doctor, you've got a stack a materials next to you. I assume that's what you have reviewed for purposes of your testimony?

A. Yes.

Q. Could I see what you've got there, please?

A. Some of these are just my notes. I don't know if you want that, too.

Q. Sure do.

MR. KAMPINSKI: Why don't you mark these.

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(Dr. Post Deposition Exhibits A through G marked for identification.)

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Q. Doctor, for the record, would you please indicate what it is you've reviewed in this case prior to our taking your deposition today?

A. I reviewed the nurses' depositions, Dr. Slagle's deposition, Dr. Edelberg's deposition, and the hospital records pertaining to the patient involved.

Q. Anything else?

A. Not that I can recall.

Q. Were you given any verbal accounts of any other depositions or any records?

A. NO.

Q. I'm going to hand you what's been marked Exhibits A through G, and if you would please just identify what those are, sir.

A. This is a summary I have written up about my impressions of Dr. Edelberg's deposition.

Q. What is this, what exhibit are you referring to, Doctor?

A. This is Exhibit A.

Q. Okay. Go ahead.

A. Okay. And these are -- this is -- Exhibit B through G represent notes that I took as I read over the depositions of various nurses or Dr. Slagle or the Labor record.

Q. When did you make those notes?

A. Sometime between the time I received this and coming here today. I don't remember the exact date.

Q. Well, did you do that all at the same time; in other words, did you write down your impressions about: Dr. Edelberg at the same time that you wrote these other notes?

A. No. No. These notes were done as a result of having read over the other depositions, Dr. Edelberg's deposition wasn't until I think later. Yeah.

Q. Doctor, you were the head of the medical staff at Booth prior to its closure; were you not?

A. Yes.

Q. For some period of time?

A. Yes.

Q. As the head of the medical staff, did you get involved in the promulgation of rules and regulations and procedures that were followed by hospital personnel?

A. Yes. To some extent, yes.

Q. And the purpose of having those is what?

a. To give guidelines to the procedures that were to be performed in the hospital.

Q. I assume you'd have some involvement in making sure those guidelines were appropriate and adequate

for your hospital and that they should be followed by the hospital personnel.

A. We had a whole committee that would review our guidelines from time to time.

Q. To make sure they were accurate and correct?

A. Correct semantically and correct in terms of what we intended for them; that was not always easy to do.

Q. Sure. Would those be considered the standard of care required of the personnel at the hospital?

A. No. We tried to not put this in a cookbook style. We tried to leave enough leeway for the professionalism of the nurses and of the doctors to be able to have some variations within a general guideline as to how to perform.

Q. Well, I mean would your procedures read if you see late decelerations you may or may not call the physician, depending on whether or not you feel Pike it; I mean that's not what you're talking about, is it, Doctor?

A. No. No. If you mentioned late deceleration, we would mention specifically if late decelerations were seen repeatedly, then the house physician or the attending physician should be notified.

Q. So in other words, something like that you would

set out specifically so there wasn't any room for misinterpreting it, correct?

A. Yes. That would be correct.

Q. So that certain guidelines, when it came to the health and safety of your patients, you would want to be as specific as possible so when nurses read them, that would be the standard of care applied to them; would it not?

A. It's difficult to give very specific instructions on something that has a subjective quality to it such as an electronic fetal heart monitoring. We'd like to have certain standards, but they should be broad and they have to be broad, If we limit it to specifics, then we're going to have the nursing staff and the physicians acting on things that are not necessary to act on, so we left them rather broad or we tried to leave them rather broad.

Q. But however you left them, within the parameters that you left them, that would be the proper standard of care, correct?

A. Yes.

Q. To what extent did you yourself get involved in training of nurses with respect to their duties and functions or would you delegate that to someone within the nursing community?

a. The nurses had their own nursing instructors and then we as physicians and myself would have short courses on electronic fetal monitoring, discussions from time to time.

Q. So you'd provide them with some instructions on how to read fetal monitors?

a. Yes.

Q. In terms of their day-to-day management of a patient, would that be them left to their nursing administrators to instruct them as to how that should be done?

A. Usually, yes. Yes.

Q. But on the other hand, only you as a physician would have to arrange for the purpose of patient care, right, on a daily basis.

Would you tell them of any peculiarities you yourself might have as it relates to how you wanted them to deal with your patients?

A. I don't think I have peculiarities.

I think the nurses were all given instructions by the nursing supervisors and the nursing instructors who came out. 1 think we'd have more interaction when there was a problem in interpretation of a strip. The doctor would bring it to me or to the nursing supervisor and say look, this

is this and this; they didn't call me for this. When they did call me or whatever, we would become involved in that sense, but on a daily basis, it really wasn't a problem. Most of the nurses were really well, well trained with the fetal monitor.

Q. You would expect that to be true; would you not?

A. Sure.

Q. Of the nurse in the obstetrical unit?

A. Sure.

Q. That is a requirement; is it not?

A. Of course.

Q. That she should be able to read a fetal monitor strip?

A. Yes.

Q. And be able to recognize a Bate deceleration?

A. Late decelerations can be very subtle and when they occur occasionally, I would dare say that if we had ten fetal neonatalogists reading a fetal monitor, that there would be some difference of opinion as to which was or was not a late deceleration.

Q. So is the answer to my question that you don't really know if they should or shouldn't be able to recognize a late deceleration?

A. They should be able to recognize. I think so.

Q. You can recognize one, too, can't you, Doctor?

A. Yes.

Q. Do you agree that -- well, have you been told of the deposition that was taken last Friday of the other expert in this case on behalf of the hospital, Nurse --

MR. MELLINO: Dipasquale.

A. I know the name, but I don't believe I saw her deposition.

Q. How do you know the name?

A. It's come up before.

Q. In other words, she's testified before in cases you have been involved in?

A. Yes.

Q. On the same side?

A. I don't think so. I don't know. I can't say that. I don't know.

Q. Who were you retained by in this case?

A. Mr. Aughenbaugh.

Q. He's the one that contacted you?

A. Yes.

Q. I noticed one letter from Mr. Aughenbaugh dated August 25, 1992. Were there other letters from him?

A. If there was, I don't recall them. There must have been if I got the charts, then there must have been.

Q. Where are they?
A. I don't know. I tried to bring in everything I could this morning.
Q. You didn't remove anything?
A. No. No. Nothing's removed.
Q. Nurse Dipasquale as well as Dr. Edelberg indicated that at least one Pate deceleration existed on the strip; do you agree with that?
A. Yeah, I think there possibly was a late deceleration.
Q. Well, possibly or was it? I mean nobody else has any trouble with that one, do you?
A. Well, I think -- well, I think that it probably was a late deceleration. Yes.
Q. Are there more than one in your opinion?
A. There may have been a second one after that.
Q. We're talking about a 12-minute period span of time, correct?
A. You mean a 12-minute period, of it lasting 12 minutes?
Q. No. There's a span of time of 12 minutes.
A. Two late decelerations. They followed after Vistaril had been given the patient and they recovered.
Q. I beg your pardon?

A. And they recovered. Both of them recovered and were not repetitive after that.

Q. How do we know that? The monitor was taken off,

A. The monitor wasn't taken off. I think she had to go to the bathroom. She was a difficult patient.

Q. Were you there?

A. No. I read the nurses' notes.

Q. I see.

A. And the nurses' notes said that she was screaming and very restless, and I can imagine that a single, 21 year old patient coming in at twelve midnight in a strange hospital would be difficult.

Q. Would it be different if she were a married 21 year old?

A. Probably, yeah, because I suppose *that* she would have a support person with her.

Q. Was there a support person with her?

A. Not that I've ever seen on the record. Maybe there was, but I'm not aware of it.

Q. Let's assume that there was. Would that then change your opinion in this case?

A. I think she probably -- well, it would change what my opinion was. I could see where it would be difficult to control her.

Q. So whether she's single or married affects your opinion in this case?

A. Yeah. I think that single women coming in in labor are quite often under more pressure than the married woman in a good relationship. I'm not advocating it, I'm saying that they would be and they are.

Q. Was the monitor put back on after thns 12-minute period of time?

A. They had -- they were using the doppler.

Q. At any time you don't understand a question, I'll be happy to rephrase it.

A. I understand.

Q. But if you understand it, why don't you answer it?

A. You asked was the monitor put back on.

Q. That's right.

A. They monitored her by doppler.

Q. So the answer is no?

A. No. It was the monitor.

Q. Was the fetal monitor put back on, Doctor?

A. The fetal monitor as used by the doppler was.

Q. Was the fetal monitor?

A. You mean the electronic monitor?

Q. Yes.

A. No. No. The electronic monitor, no.
Q. Why not?
A. From the nurses' notes it looked like it was difficult to keep one on her.
Q. Should it have been put back on?
A. I think it should have if it could have.
Was it a violation of the hospital policies at Good Samaritan Hospital to have allowed Miss Aumen to go to the bathroom after being given an enema?
A. No.
Q. That's based upon what, your answer is based upon what?
A. On experience.
Q. Excuse me. I asked you if it was a violation of their policy.
A. Not that I'm aware of.
Q. Did you ask for the policies in this case?
A. No.
Q. The procedures and policies of the hospital?
A. No.
Q. The reason I asked you the question earlier about whether or not the policies and procedures established standards of care was to see how interested you were in determining what the standard of care was at this hospital, because

I didn't see them in the records that you reviewed and apparently they haven't been given to you.

A. No.

Q. So you're not aware of what those policies and procedures set out, Doctor?

A. I'm aware of what 35 years of doing obstetrics and gynecology involves.

Q. So the answer to my question is no, you're not aware of what those policies and procedures were?

A. I think I did read over the policies but I don't recall them.

Q. Could you show them to me?

A. I don't know if I have them here.

Q. Well, take a look.

A. They're riot here. If you're going to ask me do I have everything here, I would hope so, but maybe I don't, you know.

a. Well, you know, Doctor, this is not a game. I mean 1 asked you --

A. I don't have any game with you. I don't have any game.

Q. Sure you don't. I asked you what you reviewed you told me what you reviewed. Are you saying there's now other things that you reviewed?

A. There may have been.

Q. Why don't you get them. I'll wait here as long as I have to.

A. Well, let me see if I have them. I'm not hiding anything.

Q. Fine.

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(Interruption in proceedings.)

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A. This was on the floor. E didn't hide it.

Q. You didn't what?

A. I didn't hide it or anything, this was on the floor.

Q. Were you given this to review?

A. Yeah.

Q. When were you given this?

A. I don't know, Maybe the other day. I don't know. I've had it with this.

Q. You happen to be under oath, all right, and I'd appreciate your giving me honest answers.

When were you given this, Doctor?

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a. I am giving you an honest answer. I don't know.

Q. Were you given it within the last day or so?

A. I don't know. I don't remember.

Q. Were you given it today?

A. I don't know.

Q. You don't remember if you were given it today?
A. No, because I brought in all of these records. I carried all of these records in.
Q. Would you remember if you were given it today?
A. Probably not. It's very important to you, but it was not important to me.
Q. Bylaws aren't important to you?
A. NO.

MR. KAMPINSKI: Mark that H.

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(Dr. Post Deposition Exhibit H marked for identification

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Q. I'm going to hand you what's been marked Exhibit H, Doctor, and I'm going to ask you if you were give that today by Mr. Aughenbaugh or Mr. Shafer?
A. I got this.
Q. When?
A. E don't know whether I got this today. I really don't know. If you want an answer just so you get an answer, I can make up an answer, but I don't know. I don't know if E had these before.

You're both grinning as if I would be lying. I'm not lying about anything. I don't have

anything to be lying about.

MR. AUGHENBAUGH: They're just teasing you. That's the way they are.

A. I understand. He's got a stupid grin on his face. You can put that down.

MR. KAMPINSKI: Put everything down.

Q. Is there anything in Exhibits A through H that refer to the policy and procedures or the bylaws, Doctor?

A. In here?

Q. Yes, sir.

A. I don't think so.

Q. Why don't you take a look.

A. Nope.

Q. If you had received that along with the other materials, Doctor, would you have marked down what was important that was contained in those bylaws or procedures?

A. Probably not.

Q. Because they're not important to you?

A. No.

Q. What texts do you consider authoritative in the obstetrical field?

A. What texts do I refer to from time to time?

There's no text that's absolutely authoritative. All text books are opinions of the authors. What do I use? Danforth, Williams.

Q. Would you agree that Williams is authoritative?

A. Williams is good. Yes.

Q. Is there a correlation between hypoxia during labor and cerebral palsy?

A. Yes,

Q. Would you agree that late decelerations are an indication for early delivery?

A. No.

Q. Would you agree that a heart rate less than 100 is a problem or a potential problem with the child, especially if it's coupled with late decelerations?

A. Depends how often they occur and when they occur. It depends on the entire record that you have rather than just the isolated event of a bradycardia.

Q. So you don't agree or disagree?

A. No.

Q. Do you agree that it's appropriate to rupture membranes to check if there is meconium present and then put on an internal. lead if in fact you have an instance of an abnormal strip, a late decel or bradycardia?

A. Not in itself, no. You're talking about

one episode of bradycardia or you're talking about repeated episodes of bradycardia?

Q. Define "bradycardia" for me.

A. A decrease in heart rate, usually below 100 lasting for anywhere from three to ten minutes.

Q. Would you agree that bradycardia is anything that falls below 120?

A. No.

Q. Would you agree that you need a pediatrician present to do suctioning of meconium if in fact it's present on a newborn?

A. I think it would be nice to have one. One can't always have it.

Q. Does a child respond to fetal distress by changing its heart rate?

A. Does a child respond to --

Q. Child in utero?

A. By changing its heart rate? Yes.

Q. Which authors would you consider authoritative -- that's not a fair question.

Do you know Dr. Sussman?

A. Yes. Sure.

Q. Would you consider his writings authoritative?

A. No. I mean not anymore so then anybody else's writings, even my own writings.

Q. What are your writings?
A. They represent my experience.
Q. When was the last time you published anything?
A. I don't publish.
Q. What writings are you referring to, your memoirs?
A. No. It's an idea, though. No. It comes about as a result of my years of practice and continuing interest in obstetrics.
Q. My question is: What writings are you referring to? You don't have any writings, do you?
A. Yes, I do. I have all these notes that I have prepared for review of cases and review for the hospital staff when I worked as a chief of staff. You asked me about my writings. Every meeting we had, I would write up cases for discussions.
Q. No. I asked you about Dr. Sussman's writings and when I referred to his writings, I meant his published writings and you said you didn't consider him authoritative.
A. I think he's authoritative in one respect, in his writings on hypertension.
Q. Would you agree that if you have a normal blood pressure reading, that that would not cause you to ignore elevated ones in terms of determining whether

or not that's pregnancy-induced hypertension?

A. Would you repeat that?

MR. KAMPINSKI: Could you read that back?

- - - - -

(Question read.)

- - - - -

A. There's so many negatives that I have difficulty, so let me reword it if I might and then give you an answer, and if it's not appropriate you can give it back to me.

If the blood pressures were normal and I had elevated ones mixed in there, E would ignore the elevated ones and take the lower blood pressure,

Q. What if you had elevated ones and you had a normal one mixed in there, would you ignore the elevated ones because you had a normal one?

A. Yes.

Q. You would?

A, Yes. I always take the lowest one, the lowest systolic and the lowest diastolic. Yes.

Q. That would then assure you of the pregnancy-induced hypertension?

A. If this patient had absolutely no evidence of pregnancy-induced hypertension.

Q. Well, evidence of pregnancy-induced hypertension can be elevated blood pressure, can't it?

A. Yes, not isolated ones.

Q. When you say isolated ones, you're talking about once again how you responded to my question, that is an elevated one mixed in with a number of low ones?

A. No. What I'm referring to is the records khat we're dealing with,

Q. I'm Just asking you general questions, Doctor.

a. Well, the general questions don't have specific answers to them.

Q. They don't?

A. No. Not in my opinion they don't.

Q So that just so I understand and we're both on the same page, I mean if you had a number of elevated blood pressure readings and you had an isolated normal blood pressure reading, you would ignore the elevated ones, correct, for the lowest reading that you got and that would assure you of the non-existence of the pregnancy-induced hypertension; is that correct?

A. No.

Q. Then you tell me what's correct.

A. Because you made the sentence so long and involved as to lose the meaning for me as to what you're talking about.

Q. Where did you get lost?

A. I don't know what you're implying- If I had a series of blood pressures that were elevated and one that was normal, which would I think was the correct one?

Q. Yes.

A. I would think that the low one was.

Q. And you would ignore the elevated ones?

A. In essence, yes.

Q. Why is that?

A. Because most of the elevated ones will be due to nervousness and tension and pain and that's been my experience. Pregnancy-induced hypertension requires two separate blood pressures six hours apart no matter what: the first blood pressure is.

Q. What do you teach nurses to look for on a fetal. heart monitor3

A. Baseline,

Q. What else?

A. Tachycardia.

Q. Anything else?

A. Variability, late, variable, and early decelerations.

Q. Anything else, is that it?

A. Yes. I may think of others as we yo along, but

right now --

Q. Would you agree that when there is a change in a fetal monitoring strip that can be harmful to the child, that it's the responsibility of the nurse to report the change to the physician?

A. When there's a change in the monitoring strip that can be a danger? There is never a change on the monitoring strip, one change, that is ever a danger to the baby.

Q. So the answer to the question is no?

A. No.

Q. Would you agree that if an individual, a nurse, does not have the ability to read and recognize and interpret significant changes in the fetal monitoring tape that she shouldn't be doing that particular job then?

A, If she is not competent to read the tape, then she shouldn't be doing the job. Yes, I agree.

Q. I said shouldn't. I think you meant she should not be doing the job.

A, Should not, yes.

Would you excuse me for a second?

MR. KAMPINSKI: Sure,

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(Interruption in proceedings.)

BY MR. KAMPINSKI:

Q. Would you agree that Dr. Berman is authoritative?

A. Dr. Berman is authoritative.

Q. You do agree?

A. I don't know if I would agree with everything he would write anymore than I would agree with everything Dr. Sussman writes. If you show me what particular piece.

Q. Just in general.

A. I don't know if he's authoritative on everything or if I would agree with everything he writes anymore than Dr. Sussman. No.

Q. Have you given opinions previously about nursing care?

A. Yes.

Q. In those instances where you've done that have you showed the charts to nurses to get their opinions about the nursing care?

A. If I have I don't recall doing it.

Q. If you have a problem with a patient having decelerations, do you then put an internal monitor lead on?

A. Not the way you ward that. No.

Q. Does an internal monitor give you better reads

than an external monitor?

A. Internal monitor, yes, will certainly show variability.

Q. If you had a pattern on a monitor strip that you weren't sure of, would you put on an internal. lead?

A. If I h d a problem with the monitor?

Q. No. If you had a pattern that you were not sure of, would you put on an internal lead?

A. Only if the cervix were dilated to an extent that I could get one on easily and if the vertex was well into the pelvis.

MR. KAMPINSKI: Could you read that back, please?

- - - - -

(Answer read.)

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Q. Could an internal monitor have been put on Susan Aumen at midnight?

A. I'll have to look at the record.

Q. Sure. At any time you need to look at the records look at it.

A. At 12:45 she was 5 cm. dilated. I think they could have tried to put a monitor on then, a fetal monitor.

Q. How about at midnight?

A. She didn't have difficulty then. She was only -- may have had difficulty with a 1 to 2 cm. dilated.

Q. Could they have done that then?

A. They might have tried but they didn't, and I could really see where it might be difficult to put one on. I think it would be difficult to put an internal monitor on a patient who was as they describe here, you know.

Q. Why is that?

A. Because she's moving around a great deal and you really need the cooperation of the patient to be able to do it..

Q. Well, I mean did they tried to do it and they weren't able to; is that what you're saying?

A. I don't know that, but I do know that she was difficult to control, fussy. They kept mentioning several times that she was very fussy, which I suspect meant that she was moving around quite a bit. She was having a lot of abdominal pressure, screaming with pain. That kind of patient is not one to put on -- not easy to put on internal monitor. In fact, it might be very, very difficu t to put one on.

Q. Is that a physician's decision or a nurse's?

A. well, I suspect it would be a physician's.

I don't think the nurses are permitted to put on internal monitor.

Q. Did you read Dr. Slagle's deposition in this case?

A. Yes, I did.

Q. Do you have any opinion as to whether or not he did anything wrong in this case?

A. No. No. I don't think that he did anything wrong. I think that he worked within the framework of what his experience is and what his abilities take him -- took him.

Q. Did you disagree with any of the testimony given by Dr. Slagle?

A. I don't remember specifically. I think -- excuse me.

Q. Sure.

A. I may have it written somewhere. I don't have anything. No. I'm sorry, I don't have. Whatever notes I had on Slagle's, I just don't see, but as I recall, if I might be permitted to remember, did he say had he been notified he would have done something else, Like he would have done a cesarean section? At what point he would have done that I'm not quite sure, at least from my memory.

Q. Well, do you agree or disagree with Dr. Slagle's

testimony that Miss Aumen should have used a bed pan if she was on a monitor as opposed to having a monitor removed; do you agree?

A. That's silly.

Q. Does that mean you disagree?

A. Absolutely it means I disagree.

Q. Do you know that that's what the policy and procedure of Good Samaritan Hospital required?

A. No, I didn't know that.

Q. Is that then silly of them to require that?

A. Yes.

Q. Do you agree or disagree with Dr. Slagle when he testified that he should have been contacted if there was an abnormal heart rate or when the heart rate was 88 beats per minute; do you agree or disagree?

A. You have to repeat it.

MR. KAMPINSKI: Read that back.

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(Question read*I

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A. I think they could have notified him.

Q. This is not a toughie, either you agree or you don't agree.

A. It's tough for me. It's riot tough for you to ask, but it's tough for me to answer if you want a

truthful answer,

Q. That would be nice.

A. Okay.

Q. What's the answer?

A. The answer is that they could have notified him, but certainly we've never made that an absolute requirement.

Q. He said he should have been notified, is that different?

a. Yes,

Q. Answer my question then. Should he have been? Do you agree that he should have been notified?

A. I can't put it in that kind of framework.

Q. So you disagree then?

A. I can't put it in a framework that he should or shouldn't have been. He believes *that* he should have been, so therefore he should. have been,

Q. So you agree with him?

A. But the nurses feel that he shouldn't have been and they didn't, so I can agree with that, too, so you cannot pin me into the position about either one as being right or correct.

Q. Well, I guess I can't. If you don't want to answer the question, I suppose I can't pin you down to a position. So you have no opinion as to whether or

not they should have contacted him on that?

A. I understand the nurses not contacting him. I do not think it is a failure to respond correctly by not contacting him with one episode of a bradycardia.

Q. With one episode?

A. Yes,

Q. Was that all there was?

A. That's all I saw there, unless you have something else to show me.

Q. Well, what do you consider one episode, one reading?

A. One reading. Yes.

Q. And you didn't see more than one reading of bradycardia?

A. Well --

Q. Is that right?

A. There were episodes after the monitor came off in which the heart rate was down but did respond. From the time that they had the major bradycardia, I have the time episodes here. "Bradycardia at 12:23 a.m."

Q. What are you reading from, Doctor?

A. My notes.

Q. Which one? Which exhibit, please?

A. I'm sorry. Exhibit A.

Q. Those aren't your notes. Those are your notes of Dr. Edelberg's deposition.

A. Right. But I'm commenting on his discussions of the bradycardia I presume that you're discussing.

Q. That's fine. Just so we understand what you're reading from. He's the one that set forth the time sequence, you're just copying down what he said in his deposition.

A. No.

Q. NO?

a. No. This is what I got.

Q. Well?

A. Well, I wrote down "Doctor's discussion on page 72 suggesting possible notification of a fetal heart of 117 is bizarre," I don't know if you're referring to that as a bradycardia,

There was a bradycardia that occurre and I thought that Dr. Edelberg -- Dr. Slagle was referring to the bradycardia that occurred at 1:23 because the patient delivered at 1:57. I don't know what they would have done at 1:23 when the bradycardia occurred.

Q. Is that the first bradycardia then?

A, That's the one that they mentioned there was what he refers to as a bradycardia. At 117, that's

not a bradycardia,

Q. E thought you defined it as less than 120.

A. That was your definition.

Q. I'm sorry. You disagreed with that.

A. Yes.

Q. Do you disagree with Dr. Slagle when he testified that he should have been contacted if there was a severe drop in the heart rate; do you disagree or agree, Doctor?

A. Say that again.

Q. Sure. Do you disagree or agree with Dr. Slagle when he testified that he should have been contacted when there was a severe drop in the heart rate?

A. If there was a severe drop in the heart rate, he should have been.

Q. Was there a severe drop in the heart rate, sir?

A, The one that I have as a severe drop was at 1:23.

Q. What do you define as a severe drop in the heart rate?

A. A drop below 100 for a period of time.

Q. Is a drop of 20 or 30 beats per minute a severe drop?

a. No. It depends on how it recovers.

Q. What if it doesn't recover?

A. For how long?
Q. Ever.
A. If it doesn't recover forever, of course he should be notified; that's ominous.
Q. Do you agree with Dr. Slagle that that should have been done if a nurse was not getting good readings?
A. If Dr. Slagle feels he should have been told, he should have been told.
Q. So you agree?
A. If he felt that he should have been told, then he should have been told. I don't know what he would have done about it because they were listening with the doppler.
Q. No. We was referring to the fetal heart rate monitor, Doctor.
A. Well, I don't know. Well, I don't know what he's referring to on the fetal heart monitor that he should have been notified, at what point.
Q. At any point are there good heart readings throughout on the fetal heart monitor?
A. I'd like to go over them with you if you like.
Q. I just asked a question. If you'd like to point them out to me --
A. I think the fetal heart monitor was fine,

exemplary.

Q. Superb?

A. Not superb, no.

Q. That's pretty good on a lady that they were having difficulty controlling, isn't it?

A. I assume at the beginning that they had less difficulty with her than later on, than when she progressed in labor,

Q. Did there come a time when it was very difficult to interpret the monitor strip?

A, The monitor strip is fine to 11:40, 11:50, fine; this is okay. Here we have -- obviously she was given -- she was only 1 to 2 centimeters dilated. This was now at 23:53, that's seven minutes before 12:00. Obviously she was given an enema. She was only 1 to 2 centimeters. There's nothing that contraindicates use of an enema at that point, She was only 1 to 2 centimeters dilated.

Q. Do you understand my question, sir?

A. I thought we were reading EKG's. I forgot your question.

Q. I asked if there came a point in time where the EKG's were no longer -- not the EKG's, the fetal monitor was no longer readable?

A. Was there a time? Yes.
Q. When was that, sir?
A. This is at 12:50, about ten to 1:00.
Q. Was it readable from 12:05, after 12:05?
A. Yes, sure.
Q. It was?
A. Yes.
Q. Till 12:35?
A. Till -- this is 12:50, 12:35, okay.
Q. You can read it from 12:05 to 12:35, Doctor?
A. Yeah.
Q. Good reading?
A. I mean and it's relatively obvious there was a baseline of 150 with no decelerations with somewhat decrease in variability.
Q. Just so the record is clear, what frames refer to the frame numbers that you're looking at, sir?
A. 49519.
Q. Keep going from 12:05 to 12:35.
A. This is 12:35 I'm up to. Let me take it back. Do you want it from 12:05?
Q. So you don't even know what you were looking at, sir, Is this funny to you?
A. Yes.
Q. Is this humorous?

A. Yes. *Yes.*

Q. Do you want to answer my question now?

A. What would you Like?

Q. How about the truth for a change?

A. I didn't hear you,

Q. Can you read the monitor strip between 12:05 and 12:35, sir?

A. Yes.

Q. What panels are we referring to?

A. 49517, 49518, 49519, 49520.

Q. 'Phose are all adequate tracings for your purposes, correct?

A. Yes,

Q You said they became problematical, I'm sorry, you said at 12:50?

A. Yes. Probably a little bit before 12:50 maybe.

Q. What time?

A. 12:45, something like that.

Q. What panel was that?

A. 49522.

Q. What's the problem?

A. You can't get a good reading,

Q. Should the doctor have been notified if the nurse was not getting a good reading?

A. *Yes.* If after a period of time they couldn't

get a good reading, but as soon as you don't get a good reading, you can't call immediately because you have to see if you can get a good contact on the patient. So it took a while of trying to get a good contact, You can't know from second one that you don't have a good contact, that you call the doctor immediately. You try to get a good contact.

Q. Bid they get a good contact?

A. That was at -- no. They did not get a good contact. This was at 12:45 and they still did not have a good contact. No.

Q. Doctor, would you turn to the Pate deceleration for me, if you would, please, Have you got it?

A. Yes,

Q. What panel number, sir?

A. 4951 -- I guess this is 7 because it's not listed on this side, but -- it is 7. Yeah.

Q. Is that the only one?

A. And -- well, that's -- yeah, 49517.

Q. Bow about 16, 49516; is that a late decel, sir?

a. 16?

Q. Yes, sir.

a. No.

Q How about 49515?

A. No.

Q. No?
A. Absolutely not.
Q. Really?
A. Absolutely not. No.
Q. Any other late decels other than 49517?
A. That's all I see.
Q. Now, let me see if I understand.

What happened to the fetal heart monitor after the contraction on 49517, was it removed?

A. No. It was on 49518.
Q. Can you tell whether or not that is a response to a contraction at all on 49518? There's no contraction, is there?
A. Sure. That's a contraction.
Q. Where?
A. At 0035.
Q. Well, can you tell what the baby's heart rate is in response to that contraction?
A. Well, certainly the baby's heart rate is hung at a baseline of 150. I don't see any decelerations or any indication that there was a deceleration, nor in the three previous or the two previous contractions.
Q. So that when we see contractions then on -- where do we see the next contraction, 49519, between

that and 49520?

A. There's one at 9 and there's one at 20; between 9 and 20, yes.

Q. What do you see on the baby's heart rate?

A. I see a baseline of 150.

Q. And that's reassuring then to you?

A. Yes. I see somewhat decrease in variability from what it was before.

Q. Does that concern you at all?

A. Not at all, because she had Vistaril and Vistaril causes a decrease in variability.

Q. So what you see then on 49519, 49520, that's all reassuring to you as a figure, correct?

A. Yes, absolutely.

Q. Wow about 49521?

A. Fine.

Q. That's good, too?

A. Yes.

Q. What we're talking about now is the baby's heart rate, right?

A. Yes.

Q. Which is the upper portion of these fetal monitor strips, correct?

A. Yes.

Q. So am I correct then that it's your

interpretation that after this late deceleration which we saw on 49517, the fact that there was some reassurance on the panels thereafter would preclude any concern about this baby being in fetal distress; would that be a fair statement?

A. Yes.

Q We wouldn't be able to be assured of that, though, if for example there was no fetal monitoring after the late deceleration?

A. Well, you -- say that again?

Q. For example, if we had the Late decel, I think you said on 49517, correct?

A. Yes.

Q. And then we didn't have any further readings to reassure the nurse or the physician, that would be somewhat troublesome?

A. You're assuming there wasn't a reassurance?

Q. Yes,

A. As I interpret these fetal monitoring strips in the nurses' notes, there was presence of reassurance.

Q. Okay.

A. You say if there wasn't the reassurance, yes, it would be a concern, but if there was, there wouldn't be a concern, and especially when she had just received this Vistaril and she obviously had to change

positions in order to get the Vistaril,

Q. What was the baby's heart rate after 12:45?

No. I mean from the monitor strip, Doctor.

A. Well, the monitor strips didn't have good contact so we had to use the doppler, which is standard of care when you don't have good contact with an external. monitor, you use the doppler.

Q. Is it?

A. Do you want to know the heart rate now?

Q. What are you looking at to find it?

A. At the nurses' notes.

Q. Okay.

A. At 12:35, 150, 152.

Q. Excuse me. Was that related to a contraction?

A. I don't know.

Q. Well, wait a minute, I mean isn't it?

Well, what's the importance of relating a heart rate to a contraction?

A. To determine whether it was a late deceleration or not.

Q. If you don't know when the contraction is, how can you determine if there is a deceleration?

A. This woman is in the second stage -- getting close to the second stage of labor. They're getting a

doppler on her as often as they can. The fact that they -- I don't know whether they did it right after a contraction or not.

Q. Could you answer my question or not?

A. Your question is was it after a contraction?

Q. Yes.

A. I don't know.

Q. Then what assistance is that heart rate to you?

A. It tells me it was a normal rate,

Q. But it doesn't tell you what the rate is after a contraction, which is the important rate that you need to know, isn't it?

A. Yeah, At this point, if she had if she had a normal rate when you're listening to a doppler and you aren't. necessarily getting it after contraction, I think with getting along in labor as rapidly as she was at this point that you would be following hex, and I suspect that you would be getting it after contraction, but E don't know.

Q. I'm sorry. What was the medication, Vistaril?

A. Yes,

Q. How long does that have an effect on heart rate?

A. It may have an effect for some time.

Q. How long?

A. It may have been 30 mintites.

Q. I'm sorry. Go ahead. You were telling me the heart rates.

A. Petal heart rate at 1:02, 142 to 150. "Patient feels lots of abdominal. pressure, screaming with pain." 1:10, 136; 117 at 1:15. Dr. Edelberg made it seem that 117 as being very significant.

Q. Why are you laughing again?

A. It's not unusual in the second stage of labor for a patient to have decelerations with head compression as they push and that's almost par for the course.

Q. Let me ask you something, Doctor. You have been analyzing a number of these findings as indicating that they're not unusual and this can happen and you've taken that view of things in this case as you have in many other cases because you testify a lot for the defense,

A. I've testified for the plaintiff, too.

Q. Have you?

A. *Yes.*

Q. What are the names of the cases?

A. I could tell the names of the lawyers, but. I can't tell you names of the cases.

Q. Tell me the names of the lawyers.

a. Lancione, Janet Stitch. 1 have a list of them.

I'll give you a list of plaintiff's attorneys.

Q. Let me have them.

A. Do you want them right this minute?

Q. Right this second, We'll get back to what we're doing.

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(Interruption in proceedings*I

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Q. I'm sorry. Would you give me the list?

A. She's making up the list.

Q. Any others that you can think of?

A. Yes, She's making up the list. She'll yet an accurate list foe you.

&- As a physician treating patients, Doctor, do you look at potential problem signs and prepare far the worst, hoping that of course the worst doesn't happen, but you know, recognizing that that is a possible result of these warning signs as opposed to just thinking the best; which do you do, Doctor?

A. What do you think?

Q. Well, E don't know. Why don't you answer me?

A. Well, of course.

Q. Of course what?

A. Of course you always have to keep in mind what might happen, but that might be with any patient, with

anything.

Q. So you find Dr. Edelberg's concern about this drop to 117 to be -- I'm sorry, how did you phrase it?

A. Biza.rre.

Q. Bizarre.

A. I would like Dr. Edelberg someday to be able to explain his readings of this monitor strip to me or before a medical panel.

Q. So Dr. Slagle is also bizarre in his belief that he should have been told of that?

A. No. I think he felt he should have been told. It's his patient, he has a right to know, I don't object to that. I do Dr. Edelberg.

Q. His name is Engelbert

MR. AUGHENBAUGH: No, it's not. It's Edelberg.

You don't have to believe everything he says just because he said it.

MR. KAMPINSKI: That's true, a. I would like to publish my opinions in cases and I'd like Dr. Edelberg to publish his for other doctors to read, not just Lawyers.

Q. Do you believe that. the nurse in this ease that was watching Susan Aumen deviated from the appropriate standards of care required of her in failing to

recognize the existence of a late deceleration?
A. No.
Q. So it was okay that she didn't know that there was a late decel?
A. There was one late decel or two late decels.
Q. Doctor, if you can answer my question, I'd appreciate it.
Was it okay that she couldn't recognize a late deceleration? Was it okay for this woman to be caring for Susan Aumen, someone who couldn't recognize a late deceleration; was that okay?
A. No.
Q. Was it a deviation of the policy and procedure of Good Samaritan Hospital for her to fail to notify the attending physician of the existence of a late deceleration?
A. No.
Q. Doctor, whenever you were given Exhibit -- and if you'd hand me the policy and procedures, Exhibit H, I assume even though you didn't really care what it said, you looked at it, didn't you?
A. (Indicating affirmatively.)
Q. You have to answer verbally.
A. Yes.
Q. And the fact that it was on your floor in your

office, I mean you probably had it on your desk at some time, didn't you?

A. Yes. Oh, yes. I remember looking at it, but -- I remember looking at it.

Q. Today?

A, I may have today. I came in in a hurry and I was trying to go over stuff.

Q. Is this all you were given in terms of the policy and procedures, it consists of four pages there, Doctor, that's stapled together?

A. I assume so.

Q. Could you identify each of those pages for me so that we don't have any confusion later on?

A. "Rules and Regulations for Fetal Monitoring."

Q. That's the first page of Exhibit --

A. I see this is the first page of Exhibit H.

Q. Does that have a number at the bottom of the page?

A, That number?

Q. Yes.

A. Or this number?

Q. Well, it's got an "8" written there?

A. 8.

Q. And it's called what?

A. It's called "Rules and Regulations for Fetal

Monitoring."

Q. Next page is what?

A. 8A.

Q. All right.

A. "Bylaws of the staff, continued."

Q. Okay.

A. This is 9, "Fetal Heart Monitoring Policy," and 10 is "I.V. Pitocin Policy," page 10.

Q. Could I see that, sir?

All right. On page 9, which is the fetal. heart monitoring policy', could you read please what the policy is as it relates to indirect fetal heart monitoring; would you read that, please?

A. Out loud?

Q. Yes.

A. Do you want me to read it?

Q. Yes.

A. "Indirect fetal monitoring may be started by the nurse on patients in labor with a physician's order. It should be left on at least long enough to establish a baseline. It should be continued on the patient who shows any deviation from normal pattern such as late deceleration."

Q. Wait. Read that again,

A. "It should be continued on patient though who

shows any deviation from normal -- from normal pattern such as" -- and then it says "Late deceleration,"

Q. Go ahead.

A. I don't know whether it means "A Bate deceleration" or it means "Late decelerations,"

Q. It doesn't say "Late decelerations," does it, Doctor? I asked you to read it,

A. I am trying -- trying to understand. If it says "Normal pattern," how can a pattern be one deeeleration?

Q. Why, Doctor, why are you arguing with me? I didn't make up the procedure, the hospital did.

A. But you're asking me to --

Q. I'm asking you to read it,

A. "From normal pattern suck as late deceleration or any questionable contraction pattern, the physician should be notified immediately should this occur."

Q. That wasn't done, was it?

A. Well, I don't. know that there was a deviation from normal pattern.

Q. Doctor, was there a late deceleration?

A. Yes.

Q. Was the physician notified --

A. No.

Q. -- of the late deceleration?

A. No.
Q. You've demonstrated that you can read that accurately. I've read it as well. In terms of what it says --
A. *Yes.*
Q. -- was it deviated from?
A. Yes. Except for the fact that it says "Normal pattern," which you interpret as being ---
Q. No. Excuse me.
A, I don't interpret it at all --
Q. Excuse me. Let me finish. It says "Normal. pattern, such as," correct? They interpreted what a normal. pattern is, Doctor. It says "Such as," in other words, it gives an example of a normal. pattern and the example given is late deceleration;,— am I correct?
A. I didn't hear you, You don't have to yell.
Q You're right. I don't. That's what it says and they interpreted it, didn't they?
A. Yes.
Q. And that was deviated from, wasn't it, sir?
A. Yes.
Q. Was Miss Aumen post date?
A. She was past the due date.
Q. How long past?

A. Let me think about it. She had a non-stress test after one week, so it must have been ten days, 41-plus weeks.

Q. I take it from some of your earlier responses you don't believe that she had hypertension, pregnancy-induced hypertension?

A. No, I don't.

Q. Would you agree that if she had pregnancy-induced hypertension and was post dates that she required under those circumstances close observation and continuous electronic fetal monitoring?

A, Yes.

Q. How would you define "tachycardia"?

A. A rate that persists over 160 over a period of several minutes.

Q. Did this child have tachycardia?

A. NO.

Q. Did the child ever have decreased variability?

A. Yes,

Q. Why is that?

- - - - -

(Interruption in proceedings.)

- - - - -

Q. As a matter of fact, I think you indicated that

there was decreased variability?

A. Yes, there was. Yes.

Q. Was that at all worrisome to you?

A. Not after Vistaril.

Q. At what time was there decreased variability?

A. Okay. Decreased variability from around -- right at the same time that late deceleration occurred, around twelve o'clock and there's a decrease in variability from twelve o'clock on, so it sort of disappears over here.

Q. You have to tell.

A. I'm sorry. At 12:45, something like that.

Q. What time was she given Vistaril?

A. She was given Vistaril at 11:50.

Q. And that. was for pain?

A. Excuse me?

Q. What was that for?

A. It's a calming influence.

Q. Bow much was she given?

A. 50 milligrams.

Q Did that calm her?

A. Yeah. Yes.

THE WITNESS: Excuse me. Can we go off the record for a second?

MR. KAMPINSKI: Sure.

(Discussion had off the record.)

- - - - -

Q. Should a pediatrician have been notified by the nurses of a potential. resuscitation that had to be done?

A. At what point.?

Q. Well, at any point?

A. At any point?

Q. Yes.

A. No. Not at any point, no,

Q. Had membranes been ruptured on Miss Aumen at any time that evening, would meconium have been found?

A. 1 don't know. We have no indication that there would have been, but there might have been.

Q. Is that because you don't know when the meconium formed?

A. Right.

Q. The fact 'chat there were tracings earlier in the evening prior to the late deceleration that were normal, would that be reassuring for you as a physician in terms of the health of this child?

A. Reassuring, yes.

Q. Do you have any opinion, Doctor, as to when the brain damage occurred in this baby?

A. None.

Q. Can bradycardia cause brain damage?

A. No.

Q. What is bradycardia?

A. The slowing of the heart beat.

Q. What happens when the heart slows? What happens when the heart slows?

A. The vagus nerve is stimulated because the parasympathetic nervous system protects the baby by reducing the amount of requirements for his oxygenation.

Q. Does that affect the oxygenation to the brain?

A. Yes, to the extent it's a signal to the brain, the same way if you're running that your heartbeat goes faster because that's the way your brain is protected. Yes,

Q. So it does decrease oxygenation to the brain then?

A, No. What it does -- no. What it: does, it decreases the requirements of the heart and of the brain.

Q. So the brain doesn't need as much oxygen when your heart is beating slow?

A. It's a teleological method,

Q. Teleological?

A. Yes. This is a method that an animal uses to protect itself. It may obviously if it's continued be ominous and dangerous for it, but one episode is not.

Q. How long does it have to occur before it becomes ominous and dangerous?

A, We really don't know, but obviously if we see a bradycardia that goes ten minutes, ten minutes, that has an ominous aspect to it.

Q. So the response then to bradycardia can in fact cause brain damage?

A. Yes.

Q. Did you also review Nurse Rado's deposition?

a. I believe so.

Q. Why don't you take a look?

A. I don't know who this was. I don't know which one this was. I'm trying to find the name on it. This was Norma Lance and this one was Loftus, Lance, this is I guess Slagle. No. This is Slagle. Stalfa, is that what you said? No. What did you say3

Q. Rado?

A. Rado?

MR. AUGHENBAUGH: I don't think I sent you that, Dr. Post.

A. Okay. Thank you. No, I didn't.

MR. KAMPINSKI: As long as you're helping out, maybe you could help us out in terms of when he got the policies and procedures.

MR. AUGHENBAUGH: That I'm not sure of, either. I'm not clear. It was obviously after it was brought up by one of your experts. I'm not sure which one, but I can't tell you because --

MR. KAMPINSKI: Was it since Friday, last Friday?

MR. AUGHENBAUGH: No. When the depositions of your experts came through, we put that stuff together and sent it out. I know you think that's fun --

MR. KAMPINSKI: I'm sorry?

MR. AUGHENBAUGH: I said I know you think that's fun, but I think it went with the depositions of Rado and -- I'm sorry -- the deposition of Edelberg to Dr. Post after we got the transcript.

BY MR. KAMPINSKI:

Q. Doctor, you refer a number of times to there being two decelerations, two late decelerations; which two were you referring to?

a. 49517. Those are the two.

Q. You just told me one.

A. No.

MR. MELLINO: There's two on that panel.

MR. KAMPINSKI: I see.

Q. There's two of them on that?

A. Right.

Q. I apologize if this is all repetitive, but I want to make sure there is no confusion in my mind as to your opinion.

The lack of variability, okay., that you've described for us following the late decelerations is not significant to you because of the fact that she was given Vistaril?

A. They not only were after the late deceleration, they were before late deceleration,

Q She had decreased variability before?

A. Yes, and they came as a direct -- as a result of the Vistaril.

Q. What panels are those, Doctor?

A. This is 49515.

Q. How do you define "Lack of variability"?

A. Anything less than three to five beats per minute,

Q. Where do you see khat on 49515?

A. No. That's -- that's when she got the Vistaril.

Q. Yes,
A. Oh, it doesn't occur immediately. It's thought to occur right after the Vistaril, it bas to be absorbed.
Q. You said she had it before the Late decels?
12
A, Yes, late decels on 49517.
Q. Where does the decrease --
A. Where does the decreased variability start?
Q. Yes.
A, Somewhere in here between 49515 and 516.
Q. Between 49515 and 49516 you see decreased variability?
A. Yes,
Q Which parts of those panels are you looking at there, Doctor?
A. Excuse me. Which parts?
Q. Yes, sir,
A. The fetal monitoring results,
Q. I understand. But we can do it in minutes, we can do it anyway you want so that you can cite specifically what parts of the panels you're looking at.
A. Okay. 23:53, 54, 55, starting around 55, 56.
Q. 23:55 and 56?
A. Yes.

Q. Well, why did she continue to have decreased variability, Doctor, if this was due to the Vistaril?

A. She did have continued.

Q. I mean at 23:57, 23:58, 23:59, if that was?

A. Wait a minute, 23?

Q. I'm talking about the times.

A. Okay.

Q. You told me there was decreased variability at 23:55 and 56?

A. Yes, and twelve o'clock. I'm sorry. This is all decreased variability from twelve o'clock to 12:40.

Q. I'm listening, Doctor, Please don't laugh at me. I'm very fragile.

a. I know, 12:49 -- no. 12:48 there's some decrease. Now she starts getting some aecelesations back.

Q. Then the decreased variability continued all the way from 23:55 and it continued pretty much continuously then according to your testimony until 12:45, correct?

A. Yes.

Q. Non-stop?

A. Non-stop?

Q. Well, I mean pretty much continuously throughout

that period of time,

A. Yes.

Q. And that's your testimony under oath based on your careful review of this record?

A. Yes.

MR. KAMPINSKI: That's all I have.

MR. AUGHENBAUGH: Do you want to know the names of the lawyers?

MR. KAMPINSKI: I do. You got these?

THE WITNESS: Sure. Can I take these and yet them copied?

MR. KAMPINSKI: My suggestion is give it to court reporter and attach it to the transcript, please, and you'll yet your transcript back with the exhibits attached,

THE WITNESS: Fine. I'll send it to the Smithsonian Institute.

MR. AUGHENBAUGH: I assume you're going to order a copy?

MR. KAMPINSKI: Yes.

MR. AUGHENBAUGH: We'd like a copy, please, complete with exhibits.

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(Discussion had off the record,)

THE WITNESS: She's making up names.

MR. KAMPINSKI: What's that? On the record. Say that again.

THE WITNESS: We're off the record. We're not finished?

MR. KAMPINSKI: We may have just a couple more questions and that's it. We'll get out of here.

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(Discussion had off the record,)

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MR. KAMPINSKI: That's all I have.

You have a right to waive your signature, you have a right to read your testimony; your attorney can advise.

MR. AUGHENBAUGH: Do you want to read it?

THE WITNESS: Yeah. I'd like to read it.

MR. AUGHENBAUGH: Submit the transcript to him, please, with his original exhibits on it.

MR. KAMPINSKI: I don't: have a problem with his seven-day requirement,

Write it up, give me a copy because a lot of times they will send you a letter. Just send it to him. He'll yet it back quickly.

- - - - -

(Deposition concluded; signature not waived,)

- - - - -

ERRATA SHEET

PAGE: LINE:

I have read the foregoing transcript and the same is true and accurate.

STANLEY POST, M.D.

The State of Ohio, :

County of Cuyahoga.: ~~CERTIFICATE.~~

I, Jacquelyn Hellwig, Registered Professional Reporter, Notary Public within and for the State of Ohio, de hereby certify that the within named witness, STANLEY POST, M.D., was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel, or attorney of either party, or otherwise interested in the outcome of this action,

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 21st day of September, 1992.

Jacquelyn Hellwig

Jacquelyn Hellwig, Registered Professional Reporter, Notary Public/State of Ohio.

Commission expiration: 10-24-95.

THE STATE of OHIO, :
: SS:
COUNTY of ASHLAND. :

- - - - -

IN THE COURT OF COMMON PLEAS

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MICHAEL SPARR, et al., :
plaintiffs, :
:
vs. : Case No. 34518.
: Judge Robert E. Henderson
SAMARITAN HOSPITAL, et al, :
defendants. :

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Deposition of STANLEY POST, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination, pursuant to the Ohio Rules of Civil Procedure, taken before Jacquelyn Hellwig, a Registered Professional Reporter, a Notary Public within and for the State of Ohio, at the offices of Stanley Post, M.D., 26300 Euclid Avenue, Euclid, Ohio, on Tuesday, the 15th day of September, 1992, commencing at 11:30 a.m., pursuant to agreement of counsel.

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ERRATA SHEET

PAGE: LINE:

DR. Seespan is DR. Zuspan

I have read the foregoing transcript and the same is true and accurate.

STANLEY POST, M.D.

Summary of Dr Edelby deposition

— By any medical criteria-
Patient did not have pre eclampsia
(Pregnancy induced Hypertension)

— 41 wks of gestation especially
with a recent "reactive Non stress test" is not high risk
or ominous
— loss of variability on fetal monitor
after Vistril is expected not ominous

— DR. E. fails to note nurses notes
Concerning Patient "screaming", difficult to control
+ pressy - Clearly we have all had
the experience of the occasional Patient in labor,
ex 21 year old single patient in pain in labor

— What delay in delivery???
— What tachycardia is DR. E. referring to
Also what is wondering baseline.
What reason does Dr. E. feel that
Prompt delivery would have altered Outcomes.
Brady Cardia at 1:23
Delivery occured at 1:57 within 30 mins
of C. Section if done immediately.

DEPOSITION EXHIBIT
9-15-92
Post A

Span. S. Aumen

(1)

Span vs Samaritan Hosp (Augenbaugh)

Deposition: Slagel DO.

Family Practice doing OB-Gyn

Pediatrician DR. Murthi

15-20 del./yr.

EDC confirmed July 14

ultrasound 4/7 26½ wks

NST 7/15/86 7/22/86

Nurse called at 22:15

11 days post EDC is not "past term"

12 AM

Panel 49518.

Monitor off 12:05 - 12:35

Doppler 120 AM

Nurse Notes Lt'd rec'b

Pg 66. NO Notification nursing c FH 117

DR's discussion pg 72. suggesting

Possible Notification c FH. 117 is bizarre!

Del. 1:57

Nurse notes 1:35 → 3 PM

PH 7.07 PaCO2 41.3 Normal

PAO2 - 29. (lo)

- 16 Base Bicarb. 11.7

DEPOSITION EXHIBIT

9-15-92

Post B

seems to "Blame Nurses"

(2)

If [illegible] to [illegible] intubate.
→ without airway [illegible]

[illegible] of [illegible] [illegible]

"Broken clavicle - hip luxation
[illegible] [illegible] at 1^{56}

Tube [illegible] 3.5, 3.0 then 2.5

Edelberg deposition

Used to be at Metro Hosp of Cleveland
Problem c̄ Chief of Staff.

"dropped the ball"

Page 11 -

ERROR pt. not 42+ weeks
B.P. not [illegible] of PIH.
? Tachycardia + ↓ variability

"Clown is ominous" (OMINOUS?)

Tracing is poor
FH. 88 - 156.

[illegible] + [illegible] [illegible] of monitor [illegible] day

No pre eclampsia
FH - 160 - NOT [illegible]

I [illegible] ~~[illegible]~~ late decel
Not [illegible] to all Data

DEPOSITION EXHIBIT
9-15-92
Post C

(3)

Monitor off 23:10 · 23:53 49515

↓ Variability ? DR E

Pg. 19. 160 is not tachycardia

question of mild ~~tachycardia~~ late decel

is not significant unless unless

repetitive

2 late decel + not mean to call

DR

1st Bradycardia c̄ recovery

POST DATISM ? Pre eclampsia ·

Description not befitting the case

Reviewed DR. S + DR E. deposition

Called MR. Aigenbaugh 8/24/92 to give Review

+ decided to dictate · 3 hrs

DEPOSITION EXHIBIT

Post 9-15-92 D

(4)

Spaan. - Michael James. Children Hosp

discharge Summary

ApGar 3 + 5 (1 + 5m

Intubated at 19 min

pH. Mixed Acidosis.

Least ph. 7.31, pCO_2 29 PO_2 77 Hco 14.3

Initial 7.07 Hco 10.2

Baby Pink.

Start Amp. + Gent.

"Meconium Aspiration

Twitchy + irritable - Early convulsions

Children Hosp 6 hr. + 13 m.

	WT	Height	Head
%.	15	65	15

41 wks Pale

chest. Rt pneumothorax

Patchy densities - Meconium Aspiration.

CT Scans x 2 ~~days~~

EEG. multiple foci

DEPOSITION EXHIBIT

9-15-92

Post E

(b)

Fetal Monitoring

7/22/86 - good acceleration c FM.
very well documented

7/25/86

START 2150 BP. 134/80 c None

1 cm. — 1.

good AP. No decel

2306 ↓ N/O suspicion What so ever
of any abnormality - No reason not to
give pen... "good results were recorded.

Vistaril 50 mg at 1109

Subsequent ↓ variability as expected

lost contact at 12:40 AM appears
4.5 am. ~~Pt~~ Pt found on side

O_2 - 0110 None FH recorded on record.

0124 Heart to 88

0130 " 126

140. 156

No time to C-section

Obvious Meconium Aspiration

DEPOSITION EXHIBIT
9-15-92
Post F

(6)

LaBow Reed

Se. BP ↑ 140/90. - Mar usual especially on admission

0115 Starting to push

absolutely flared on a BP of recovery Room

DEPOSITION EXHIBIT

9-15-92

Post 6

BYLAWS OF ME STAFF

Page

Samaritan Hospital

Hosp

City Ashland, Ohio State

Adopted by the Staff 12/16/77

Approved by the Board of Directors 12/28/77

RULES AND REGULATIONS FOR FETAL MONITORING

GOALS

1. Identify and treat the fetus at risk.
2. Decrease fetal and maternal morbidity and morality.
3. Use far Augmentation and Induction *of* Labor.

RESPONSIBILITY

1. Attending physician makes the decision ta use Fetal Monitoring as a voluntar basis except induction and augmentation for which it i s required.

2. Attending physician gives the order to the R. N. for monitoring the patient. After R. N. obtains the order they do indirect monitoring and report to the physician any abnormal monitoring pattern such as lace dcce aration, variab deceleration. bradycardia and tachycardia. etc.

3. Only physician is allowed *to* initiate direct monitoring.

4. Priority of monitoring - If there is more than one patient in Labor, monito ing should be used for the more high-risk patient and the R N. should cons both physicians and let the physicians make the decision depending on the risk factor.

These patients should be considered for continuous monitoring *of* fetal heart rate and uterine activity during labor - also have priority to have monitor

OBSTETRICAL HISTORY FACTOR

1. *Age* over 35 or under 16 years.
2. Diabetes
3. Chronic Hypertension and toxemia
4. Cardiac Disease
5. RH Sensitization
6. Sickle Cell Disease or Trait
7. Previous C-Section

PRENATAL AND EARLY INTRAPARTUM FACTORS

1. Anemia under 11hgb, 32hct.
2. Post-erm - over 42 weeks gestation
3. Polyhydramnios
4. Clinical evidency of intrauterine growth retardation.

DEPOSITION EXHIBIT 9/15/92 Post

5. Vaginal Bleeding
6. Abnormal Fetal-Placental tests
7. Induction of labor
8. Premature rupture of membranes
9. Premature Labor
10. Meconium stained fluid
11. Abnormal fetal heart tone by auscultation
12. Twins
13. Pyelonephritis

DEVELOPING INTRAPARTUM FACTORS

LABOR RISK FACTORS

1. Prolonged latent phase
2. Dysfunctional Labor
3. Secondary arrest of cervical dilatation
4. Prolonged second stage
5. Augmentation of Labor
6. Meconium passage
7. Amnionitis
8. Tachycardia by Auscultation
9. Abruption
10. Previa
11. Bleeding of unknown cause

STORAGE OF MONITOR TRACINGS

The monitor tracing should be considered a portion of patient's record. Rec should include patient's name, Hospital No. and data and time of admission delivery. Pertinent data such as examinations, changes in position of patie and medications should be recorded.

Chorgustu-K. Dheenan M.D

Approved 12/16/77
Dr. C. K. Dheenan
President, Medical Staff

Gladys H. Thomas

Gladys Thomas
Secretary, board of trustees

8a

SAMARITAN HOSPITAL
OBSTETRICAL UNIT

FETAL HEART MONITORING POLICY

The Fetal Heart Monitor is kept in the Labor Room area.

I. Indirect Fetal Heart Monitoring:

A. Indirect fetal monitoring may be started by the nurse on patients in labor with a physician's order. It should be left on at least long enough to establish a baseline. It should be continued on the patient who shows any deviation from normal pattern ouch as late deceleration, or any questionable contraction pattern. The physician should Le notified immediately should thie occur.

B. For priority use, refer to Rules and Regulations on preceding page.

11. Direct Fetal Monitoring:

The internal electrodes must be applied under sterile conditione by the physician,

A. Chart on the Nurses Notes vhen the fatal monitoring is begun and when it is discontinued. Also write on the delivery Room Record when Direct monitoring eo that the Nursery copy will alert personnel to obaerve the baby's ecalp at the site of the clip insertions.

8. When fetal heart monitoring is begun, mark whether "Direct" or "Indirect" on the tracing. When Indirect monitoring is changed to Direct, write on the tracing, at the point the change is made, "Internal Monitoring Begun".

C. When monitoring is discontinued, identify with addressograph, apply appropriate stickers, and mark tracing with Delivery time, sex of baby, and baby's weight.

Origin: 5/3/1978 By: H. Strine, RN-OB
Reviewed: 10/80, 7/30/81 By: H. Strine, RN-OB
Reviewed: 9/82, 4/84 By: H. Strine, RN-OB
Reviewed: 4/16/86, 4/87 By: L. Loftis, RN/M.S.

SAMARITAN Hospital

City ASHLAND State OHIO

Adopted by the Staff June 17, 1977 Revision: 1/23/86 By: Dr. Lee, Chr.-OB Dept.

Approved by the Board of Directors August 23, 1977 Approved:

I.V. PITOCIN POLICY

Policy for Medical Induction **and** Augmentation *of* **Labor**

1. Utilization of an Infusion Pump to control the rate of administration of I.V Oxytocin with continuous electronic fectal monitoring throughout the entire period of Oxytocin administration.

2. The patient must have been seen by her physician within the last *24* hours **before** induction; and within four hours before the augmentation before startin I.V. Pitocin.

3. When the physician does not have the privileges ***to*** manage complication resultin from Oxytocic agent, consultation with Obstetrician must be obtained.

4. The **I.V.** Oxytocin rate should not exceed 30 mu/min. for induction, and 10 mu/mi for augmentation.

5. Once Oxytocin **has** been stdrted, a responsible physicidn should be present in t labor area during the first 20 minutes; thereafter, should *be* accessible in 10 minutes **for** the management **of** any complications.

6. In the Emergency situation, such as Hyperstimulation, Abruption, Fetal Distres nursing personnel:
   a. Turn the infusion pump off.
   b. Pull the whole Pitocin administration set with its needle from main **I.V.**
   c. Disconnect the I.V. tube from the main **I.V.** needle and flush the tube and reconnect the tube to needle.

7. Qualified personnel familiar with the effects of Oxytocic agents and able to identify both maternal and fetal complications, should be in attendance while Oxytocic **agents are** being administered.

Dr. R. B. Davis
President, Medical Staff

Mr. Gene Yeater
Secretary, Board of Trustees
(Board **approval** not necessary per CEO)

Dr. J. S. Lee, Chairman
O.B./Gyn Department

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Revised: 9/1986 By:

STANLEY POST, M.D. DEPOSITION INDEX

6). Promulgated rules and regs and procedures at Booth

7). Committee would review and insure their accuracy

8). Something like late decelerations would be set out specifically so they couldn't be misinterpreted. They are proper standard of care

10). Requirement that obstetrical nurse be able to read monitor strip and be able to recognize late deceleration

12). Probably a later deceleration on strip, may have been a second one

13). Both decels recovered

14). Whether she's married or single affects his opinion

15). Monitor should have been put back on if it could have

16). Policies and Procedures were not given to him

17). Had policy on floor in his office, doesn't know when he got it

19). Bylaws not important to him

20). Williams, Danforth are authoritative
There is a correlation between hypoxia and cerebral palsy
Late decels are not an indication for early delivery
Doesn't agree that its appropriate to rupture membranes to check if there is meconium present and place internal lead with abnormal strip

21). Brady is decrease below **100** for **3-10** minutes
would be nice to have a ped.

22). Zuspan **is** authoritative on hypertension

23). He would ignore elevated bp if all others normal
Always take the lowest one

25). Even if all elevated and one normal would take normal one and ignore elevated ones
Teaches nurses to look for: Baseline, Tachy, Variability, late, variable and early decels

26). If nurse cannot read monitor she should not be doing the job

30). Doesn't think Slagle did anything wrong

31). Slagle's testimony re: bedpan is "silly"

32). Slagle believes he should have been notified so therefore he should have been
Can agree with not calling him too

35). Slagle should have been notified of severe drop in heart rate

36). If Slagle feels he should have been told of inability to receive good readings then he should have been told
Fetal Heart Monitor was fine, exemplary

38). Can read monitor from 12:05 to 12:35

39). Strip readable until 12:45

40). Panels 49517, 49516 have late decels

45). Doppler doesn't tell the rate after a contraction
Vistaril affects heart for 30 minutes

48). Edelberg's concern over HR dropping to 117 is "Bizarre"

53). Hospital Policy was deviated from
Policy interprets what abnormal pattern is

54). Pt was 10 days past due date
If she was PH she required close observation and continuous EFM because also post dates
No tachycardia

55). Decreased variability from midnight to 12:45

56). Pediatrician should not have been notified

57). No opinion on timing of brain damage

58). Bradycardia that last 10 minutes has an ominous aspect to it. Can cause brain damage

62). Decreased variability from twelve o'clock to 12:40
decreased variability continued from 23:55 to 12:45 non-stop