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

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IN THE COURT OF COMMON PLEAS

- - -

Karl McElfish, II, Admin., etc.,)
)
Plaintiff,)
) Case No. 465040
vs.)
) Judge Coyne
Meridia Medical Group, et al.,)
)
Defendants.)

- - -

DEPOSITION OF ELIZABETH RUZGA, C.N.M.

WEDNESDAY, FEBRUARY 5, 2003

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The deposition of Elizabeth Ruzga, C.N.M., called by the Plaintiff for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Reminger & Reminger, 1400 Midland Building, Cleveland, Ohio, commencing at 10:15 a.m., on the day and date above set forth.

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ELIZABETH RUZGA, C.N.M.
called by the plaintiff for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MS. LOUCAS:

Q. Can you please state your full name for the record?
A. Elizabeth Ann Ruzga.
Q. Ruzga?
A. Ruzga.
Q. Elizabeth, since I don't have a copy of your resume or your CV, I want to briefly go through your educational background and your professional experience.
A. Okay.
Q. First of all, give us your current address?
A. 7388 -- home address, I assume?
Q. Home, first.
A. Yes, Kinsman Road, in Novelty, Ohio, 44072.
Q. And are you currently employed?
A. Yes.
Q. Who is your current employer?
A. Drs. Bailin, Karasik and Sundaresh.
Q. And what is the name of their practice now?
A. Drs. Bailin, Karasik and Sundaresh.

*** Notes ***

Q. Karasik and?
A. Sundaresh, S-U-N-D-A-R-E-S-H.
Q. So when Meridia broke up, you went with -- or you stayed with Drs. Bailin and Karasik?
A. Right.
Q. Okay.
Where did you graduate from high school and in what year?
A. Pymatuning Valley High School in 1986.
Q. Did you go on to college after that?
A. Yes, Case Western Reserve University.
Q. And what was your major?
A. Sociology and psychology.
Q. In what year did you graduate?
A. 1990.
Q. What did you do after that?
A. Went to nursing school.
Q. Where at?
A. Case Western Reserve University.
Q. And what year -- did you obtain your R.N. degree, B.S.?
A. B.S. degree in 1993, and an M.S.N. and an N.D. in 1995.
Q. I am sorry, you said M.S.N. and --
A. N.D.

Q. What is an N.D.?
A. A clinical doctorate of nursing.
Q. Do you have to choose a particular area of interest in your clinical doctorate of nursing?
A. In the Master's program, you do.
Q. Okay.
A. It is just an extension of that, yes.
Q. And what was that?
A. Nurse midwifery.
Q. So was your Master's program and your N.D. the extent of your nurse midwifery educational training?
A. Yes.
Q. Any other degrees or certificate programs beyond that?
A. Ultrasound, I had a certificate, I did a certificate program in ultrasound.
Q. And what does that enable you to do?
A. Typically I just use it to do viability in the office, fluid levels at the end of a pregnancy.
Q. Are you certified to perform these types of ultrasounds throughout the course of the pregnancy?
A. Yes, probably. I don't use it as such.
Q. How do you use it?
A. Strictly for viability, rule out, you know, threatened abortions at the beginning of a pregnancy.

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Q. Typically within the first trimester?
A. Right.
Q. And when did you obtain that certification?
A. I don't recall.
Q. After you complete your education, where did you work, what was your first professional job?
A. I started with Stanley Pollack, and that was Eastside Physicians.
Q. And I take it you were employed as a nurse midwife?
A. Yes.
Q. And how long did you stay with Stanley Pollack?
A. About seven to eighth months.
Q. That is kind of a brief period of time. Why did you --
A. Actually, Doctors -- Dr. Bailin and that group was also Eastside Physicians.
Q. Okay.
A. And one of their physicians became ill, and so I went over just to help out, and stayed.
Q. You ended up staying?
A. Yes.
Q. Do you remember what year that was that you joined Dr. Bailin?
A. 1996.
Q. And have you been employed by him consistently?

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A. Yes. Well, it was Meridia at the time, until they bought the practice.
Q. I am sorry, go ahead.
A. It was Meridia at that point, and then when they bought the practice, I was employed by them specifically.
Q. Have you ever taken a leave of absence or has your employment with Dr. Bailin and his groups, whether it be Meridia, or his current group, has it ever been interrupted for any reason?
A. Except for maternity leave.
Q. Were you on maternity leave during the time period when Mrs. McElfish was a patient back in -- from March, 2000 until September of 2000?
A. Yes, I would have been on maternity leave some of that time.
Q. Because I notice in looking at the flow sheet, you had one visit with Mrs. McElfish on March 28th.
A. Yes.
Q. And then not again until September.
A. Yes.
Q. So would it have been during those two dates?
A. Yes.
Q. In what states are you licensed?
A. Just Ohio.
Q. Has your license -- I am sorry.

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Has your license in Ohio ever been restricted or limited in any way?
A. No.
Q. Have you ever been the subject of a Board review?
A. No.
Q. And do you have -- as a nurse midwife, do you have hospital privileges?
A. Yes.
Q. And where would that be?
A. Right now, Hillcrest and Lake West.
Q. Had you ever had privileges at any other hospitals?
A. Euclid Hospital and Richmond Heights Hospital.
Q. Did you have privileges at Euclid Hospital in September of 2000?
A. Yes.
Q. Why do you no longer have privileges at Euclid Hospital or Richmond?
A. Neither one of them have an obstetrics unit anymore.
Q. Wow.
Do you know why that is? Do you know?
MR. WALTERS: Plaintiffs lawyers.
MS. LOUCAS: What is that?
MR. WALTERS: Plaintiffs lawyers.

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Q. (Continuing) Do you know why?
A. Census. Most patients -- when Huron Road Hospital opened, a lot of the patients that had come up from Mt. Sinai had come to Euclid, and when Huron Road opened, the census went down significantly.
Q. Do you know -- and I am asking this because initially the record indicates that Sherry was to deliver at Lake West, and she ultimately delivered at Euclid. Do you know why that is?
A. No, I do not.
Q. Was there a difference in services between the level of services between the two hospitals in this time frame, in September of 2000?
A. Historically, yes, but I don't know at this particular time.
Q. Historically, what is it that you know?
A. Lake is considered a Level I facility, and at some point, I don't know when, Euclid moved to a Level II facility.
Q. And can you tell me what is the distinction between Level I and Level II?
A. Level I would be a more community based hospital, and a Level II facility would handle a little bit more complications. But I am not sure when that happened for Euclid.

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Q. Who makes a determination where a patient will deliver, in your practice?
A. Usually the patient.
Q. If a physician or a nurse midwife anticipates potential complications, would it be within your discretion to advise the patient to go to -- to plan to deliver at another hospital?
A. Yes.
Q. Do you know if that was done in regard to Sherry McElfish?
A. No, I don't.
And insurance could also be an issue, as to which hospital -- a patient might plan to go to one, and insurance might not cover that particular facility, so that could have been an issue, as well.
Q. If a decision is made, or if a change is made as to the hospital where the patient will deliver, is that something that is typically noted in the chart?
A. Not necessarily.
Q. Then how would you know?
A. Probably the patient, or at the time, if an admission was made to a hospital, that would have to be decided at that point.
Q. So if a physician decides that a patient should be delivered at a different hospital and if it is not noted

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in the chart, hopefully the patient will recall that, you are depending on the patient to make that determination?
A. I think there are a lot of different reasons that that is chosen. It could be an insurance issue, it could be --
Q. I want you to assume it is a physician's choice.
A. Okay, then that would be -- at time of admission, that would be the physician's choice where to go.
Q. But it is not noted in the chart?
A. And that could change. It doesn't necessarily have to stay that hospital.
Q. Okay, back to your professional experience.
You are still with Drs. Bailin, Karasik and -- boy, I apologize. I just can't remember that last name.
A. Sundaresh, yes.
Q. And your employment there has not been interrupted?
A. No.
Q. When you were working for Meridia -- and I will just call it Meridia -- how many nurse midwives were employed there?
A. At this time, two.
Q. Uh-huh.
A. Yelena and I.
Q. And can you tell me what the plan was, what was

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the policy and procedure for a new patient, how would --
A. To come into the office?
Q. Yes, how would a decision be made as to whether or not this patient would be seen by a physician or a nurse midwife?
A. Some patients request specifically who they want to see. Some patients might request, not necessarily by name, but choose to see a physician or a midwife.
More often than not, when patients call, the receptionist goes over with them who is in the office and who does what, and they choose from there.
Q. I am sorry, more often than not what?
A. The receptionist will explain who we have on staff and what our roles are, and then the patient chooses who they wish to see at that time.
Q. Is that documented in some way?
A. Not to my knowledge.
Q. As you sit here today, do you recall Sherry McElfish?
A. Not other than the care, what I can recall on the care, which would be 9-8.
Q. Do you specifically remember seeing Sherry McElfish on September 8th of 2000?
A. Some of that, yes, that visit, yes.
Q. So do you have a visual image of her?

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A. No, I do not.
Q. No.
Now, the flow sheet indicates that you also saw her on March 28th?
A. Right.
Q. Do you remember that visit?
A. No.
Q. What is it that -- why is it you remember the visit of September 8th?
A. Well, with the outcome, when Yelena called to tell me that the patient had died, I knew that I had seen her just a week or two before, and at that point thought over the visit.
Q. Where were you when Yelena called you?
A. Home.
Q. At home.
Do you know why she called you at home?
A. Just to let me know, and to talk.
Q. What did she say to you?
A. Just explained what had happened, what she knew had gone on, and it was more of an emotional support, to talk.
Q. It is very important that you share with me what it was exactly that she said to you.
MR. WALTERS: She was trying to.

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MS. LOUCAS: I know, I know.
MR. WALTERS: If you let her finish -- if you wouldn't have cut her off, she would have gotten it through, but go ahead.
Q. (Continuing) Where was Yelena when she called you?
A. I don't know.
Q. Do you remember the time of day?
A. In the morning, 9:30 or 10:00.
Q. I am sorry?
A. 9:30 or 10:00.
Q. Do you know how it was that Yelena found out that Mrs. McElfish had passed away?
A. No.
Q. What did she say to you?
A. Just let me know that that is what had happened. I believe she told me that the patient had called, and that she sent her in, and that there was a C-section done, and that she was transferred to the Clinic, and that she had died.
Q. Did she tell you what the cause of death was?
A. No.
Q. Did Yelena know at the time -- well, she didn't mention how she died, what the cause of death was?
A. No, I don't know that that is still necessarily clear.

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Q. As you sit here today, do you know the cause of Sherry McElfish's death?
A. No, I don't know that I do.
Q. What else did Yelena share with you?
A. I think that was about it, just letting me know that it happened, and she was upset.
Q. Why was she upset?
A. It was her patient.
Q. Did she express any concern as to whether or not they had managed her correctly?
A. No.
Q. Did she express any concern as to whether or not they could have done anything differently?
A. No.
Q. Was she surprised that this happened to this patient?
A. I don't think that is something I could answer.
Q. Do you know of any other patients of Meridia who died of preeclampsia or complications from preeclampsia?
MR. WALTERS: Are you assuming -- I believe she said she didn't know why this patient died. You were jumping the lead that she died of preeclampsia.
Q. (Continuing) Do you know of any patients at Meridia who died of preeclampsia or complications from

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preeclampsia?
MR. WALTERS: Go ahead.
A. Not within our practice, no.
Q. I am sorry?
A. Not within our practice, no.
Q. Have you ever experienced -- have you ever treated a patient who died of preeclampsia or complications?
A. No.
Q. And when you say, not within our practice, what does that -- what do you mean by that?
A. I am sure that I have heard stories along the way of things, but nothing that I am specifically aware of with our group.
Q. Have you ever treated patients with preeclampsia?
A. Yes.
Q. Can you estimate as to how many, in your some seven year career?
A. No, I can't say that I can.
Q. One a year? Do you see them annually?
A. At least, yes.
Q. Can you tell me the policy and procedure for how a patient with preeclampsia is managed by a certified nurse midwife?
A. We don't necessarily have specific written policies or procedures. My standard is that I talk with

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a physician each time that I see that patient and decide on a plan of care.
Q. Why is it that you speak with a physician each time you see that patient?
A. That is something that we or I consider should be co-managed, at least, with the physician.
Q. Is there a policy in your office, or was there a policy at the time, that patients with preeclampsia would be co-managed by a nurse midwife and a physician?
A. Not a written procedure or policy, no.
Q. That was something that you preferred to do?
A. Yes.
Q. And why is that?
A. Because it is something that can start to fall a little bit out of the range of normal, and that is something pretty typical that you would co-manage with the physician.
Q. And can you describe for me what you mean by co-management?
A. At least being able to touch base with the physician, whether by phone, or in person, making them aware of the situation, if there are any changes from the previous visit. On occasion we have patients that would go back and forth between seeing us and a physician, as well.

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Q. Is there a policy or procedure that dictates -- when you have a patient who is being co-managed, okay, is there a policy or procedure in your office -- I am saying is, I mean to say was, since Meridia is no longer there.
A. Okay.
Q. Was there a policy that a co-managed patient should be physically seen and examined by a physician?
A. No, it was very one on one basis.
Q. So each case --
A. Yes. If a physician or we felt that it was necessary that a physician follow up with a patient, then that could happen.
Q. As to Sherry McElfish, if you remember, did you actually speak with a physician in regard to her care?
A. Yes.
Q. And who would that have been?
A. Dr. Bailin.
Q. Dr. Bailin?
A. Uh-huh.
Q. And that would have been on September 8th?
A. Yes.
Q. And why is it that you chose to speak with Dr. Bailin on that day?
A. He was in the office with me that day.
Q. And what did you share with Dr. Bailin?

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A. Showed him the chart so that he saw blood pressure, protein, showed him the NST.
Q. And what was his response to you after you shared those things with him?
A. Specifically we talked about if it was necessary to order more blood work. And she just had some several days before that, that were fine, so he felt it wasn't necessary to order again at that point.
Q. Why did you suggest more -- why did you question whether or not more blood work should be done?
MR. WALTERS: I don't think that was her answer, but go ahead.
Q. (Continuing) I think you answered that you asked him, was it necessary to order more blood work. And if I misinterpret your answer, please clarify it for me.
And actually, now is a good time. Have you ever given a deposition?
A. Yes.
Q. And how many times?
A. One.
Q. What kind of case was it? Was it a medical malpractice case?
MR. WALTERS: Go ahead.
A. Yes.
Q. Were you a witness or a defendant?

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A. A defendant. Not a named defendant, no.
Q. Not a named defendant?
A. Right.
Q. So you were not a defendant?
A. Well --
Q. Your group was a defendant?
A. Yes. An employee of.
Q. Is this case still pending?
A. No.
Q. Do you remember the name of the case?
A. The patient's name?
Q. Yes.
A. Cisco.
Q. Can you spell that?
A. C-I-S-C-O.
Q. C-I-S-C-O.
Was that the plaintiff? Because sometimes, if it is a death case, it is filed in the name of the decedent's representative.
A. I believe that was the name, yes.
Q. So this was not a death case?
A. No.
Q. Do you know the outcome of that case?
A. It was a settlement.
Q. Which physicians, if any, were involved?

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A. Dr. Brownlee.
Q. Brownling?
A. Brownlee.
Q. Brownlee.
Is that one word?
A. Yes.
Q. Okay.
A. And I don't specifically know, Dr. Lim, possibly.
Q. Were Dr. Bailin or Drs. Bailin or Karasik involved?
A. I don't know.
MR. WALTERS: I believe Bailin was.
THE WITNESS: Bailin.
MR. WALTERS: I think. I am going by memory. You have to look it up. It is all there.
BY MS. LOUCAS:
Q. Do you remember the underlying reason for the lawsuit, was it -- I don't know what, a hundred things --
A. Fetal demise.
Q. Fetal demise.
So you know somewhat the rules of the game, then, if I begin -- please let me finish my question before you answer, and I will try to do the same. I usually end up in a conversation, so I will try not to do that.
A. Okay.
Q. And if you don't understand my questions, please

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correct me.
A. Okay.
Q. And again, if I misinterpret your answer, please feel free to let me know.
A. Okay.
Q. So I believe you consulted with Dr. Bailin, and correct me if I am wrong, you asked him whether or not it was necessary to order more blood work?
A. Right.
Q. What blood work would you have ordered?
A. Typically we order some clotting studies, liver function, CBC with platelets.
Q. Anything else?
A. That is it.
Q. Would you have had the ability to do that in your office, or would Sherry -- would she have had to have gone to the hospital to have blood drawn?
A. We could have done it in our office.
Q. Would you have sent it out to a lab?
A. Yes.
Q. Did you have an opportunity to review the lab results from the previous hospital admission just a couple days before?
A. That day?
Q. On 9-8, right.

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A. I don't recall.
Q. When he told you they were normal, were you going on his representation to you that they were normal?
A. I don't recall how that came about.
Q. Did you look in the chart to validate that the labs had been received and that they were indeed normal?
A. I don't recall.
Q. Did you compare her labs to see if there was a trend?
MR. WALTERS: She just said she doesn't recall if she reviewed the labs.
A. I don't know.
Q. So as you sit here today, you don't recall whether you reviewed those labs?
A. Correct.
Q. If I represented to you that the chart indicates that those labs, that the copy, the paper copy of the labs was not received in your office until September 21st, is it fair for me to assume that you did not review them?
A. I don't recall. I don't know that I can answer that.
Q. Do you believe it would be have been your duty to review the labs?
A. No, not necessarily.

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Q. And why not?
A. Because they were reviewed by somebody already.
Q. So you were relying on Dr. Bailin's representation to you; is that fair?
A. I don't know if it was Dr. Bailin's representation.
Q. Well, you spoke with Dr. Bailin?
A. Right.
Q. You consulted with Dr. Bailin?
A. Right.
Q. And you asked him if he thought it was necessary to order more labs, and he said no?
A. Right.
Q. Why did he say no?
A. Because she had some labs done previously, and that those had been normal.
Q. Okay, so he did tell you they were normal?
A. Correct, I guess he did. I don't know that -- I don't know -- yes, that is what I would say.
Q. Okay.
So you were relying on his representation that they were normal?
A. Yes, I guess so.
Q. What else did you and Dr. Bailin discuss, if anything, about Sherry McElfish?
A. I don't recall anything else specifically.

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Q. And just so I am correct, you consulted with Dr. Bailin because her blood pressure was high, to you? Did you consider her blood pressure to be high?
A. Borderline.
Q. And she had two plus protein?
A. Correct.
Q. What was your impression of Sherry's condition on this date?
A. Stable.
Q. Did you have -- was there a diagnosis? Did you formulate a diagnosis?
A. No, I did not.
Q. Did you believe that Sherry had preeclampsia on this date?
A. I don't recall that specifically being a diagnosis.
Q. Was it a concern, was it in your -- I don't know if nurse midwives enter into differential diagnoses, excuse me for my ignorance, but did you consider that she may be preeclamptic?
A. I don't recall.
Q. Why was it, then, that you called Dr. Bailin? What was your concern in that you decided to pick up the phone and call him, or if he was in your office --
A. He was in my office.

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Q. -- why you consulted with him?
MR. WALTERS: Other than what she said already?
Q. (Continuing) What was your clinical impression?
A. Our plan, obviously, was that we were seeing her more frequently, and at that point obviously she had been hospitalized prior to that for labs, and it seemed prudent to consult with a physician.
Q. Did you -- again, since you looked at the chart and you knew that you guys were seeing her more frequently, and she was sent to the hospital, and labs were being done, did you have -- if it wasn't preeclampsia, was there a working diagnosis that you had for this patient?
A. At least borderline hypertension.
Q. Just borderline hypertension?
MR. WALTERS: In fairness to her, that is not the only thing she created.
MS. LOUCAS: I am going to go through all that.
MR. WALTERS: I understand, but obviously she doesn't have a memory.
There are other records that you had.
A. Yes, chronic hypertension was listed on her NST that day.

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Q. Now is a good time for me to ask you, I should have asked you before, what did you review before your deposition today?
A. The depositions of Dr. Bailin and Yelena, and the chart for a little bit. Not for very long.
Q. Did you review the deposition of Dr. Karasik?
A. No, I was not given that.
Q. Did you read the depositions of Yelena and Dr. Bailin in their entirety?
A. Yes.
Q. Did you make notes of those depositions?
A. No.
Q. Have you made any notes regarding Sherry McElfish that are independent of this chart?
A. No.
Q. Did you review any literature or textbooks or anything else in preparation for your deposition today?
A. No.
Q. You have the flow sheet there in front of you, correct?
A. Yes.
Q. And that is a copy -- what happens to the original flow sheet, do you know? Typically, in general.
A. What do you mean, what happens to it?
Q. Well, when we reviewed the original Meridia chart,

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there was just kind of like a ditto or a copy --
A. Okay.
Q. -- of the flow sheet. It seems to be a multiple copy record, right?
A. Yes. One copy does go to the hospital.
Q. Can you explain to me how many copies are there, in an original flow sheet?
A. I am not sure if it is two or three.
Q. Okay.
A. But one copy goes to the hospital so they have information when the patient arrives for delivery.
Q. Is it like a color coded thing, like a pink and a yellow and a green, something?
A. No.
Q. No, okay.
Who retains the original Prenatal Flow Record?
A. One copy goes to the hospital. I don't know if it is the front copy or the second copy.
Q. The copy -- well, if it has got ink on it, it is an original?
A. Right, but I am not sure which one is sent.
Q. And when is that sent?
A. Usually 35 to 36 weeks.
Q. Who sends it?
A. Medical assistant, usually.

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Q. I understand that you called Dr. Bailin on the day that you saw Sherry McElfish, but do you know whether or not Sherry McElfish was a co-managed patient?
A. I would say she was.
Q. Did you discuss her care with anyone else in your office? Did you discuss her care with Yelena?
A. No.
Q. How about Dr. Karasik?
A. No.
Q. After Sherry died and you came back to the office, were there any discussions regarding Sherry McElfish, her care and her death?
A. Not specifically her care, no.
Q. What was discussed?
A. The emotional aspect.
Q. And who did you discuss that with?
A. Dr. Bailin, mostly.
Q. And what did he say to you?
A. Just that it was devastating.
Q. Did he tell you the cause of her death?
A. No.
Q. Did he tell you how she died, or the circumstances leading up to her death?
A. I don't recall. After having read the deposition, I am not sure where I heard or saw things at this point.

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Q. Well, what is your recollection as you sit here today?
MR. WALTERS: She just said she doesn't recall.
MS. LOUCAS: She --
MR. WALTERS: That is what she said. She said after having read the deposition, she is not sure where she picked this up from.
MS. LOUCAS: Exactly.
Q. (Continuing) You picked something up, and you just don't know whether it was from your original conversation with Dr. Bailin or from his deposition?
A. Correct.
Q. So I am asking, what is it that you remember, as you sit here today?
A. I don't remember specifically.
Q. You don't remember anything?
A. I don't remember enough to say one way or another.
Q. Did he tell you that she had DIC?
A. I don't recall that specifically, no.
Q. Did he tell you that she had HELLP syndrome?
A. I don't recall that specifically, no.
Q. So it was devastating when you folks learned that this patient died, but you didn't ask why she died or how she died?

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MR. TREU: Objection.
MR. WALTERS: Well, that is not fair, because she said she didn't recall.
MS. LOUCAS: There is --
MR. WALTERS: There is a huge difference, and don't mischaracterize her testimony.
I don't usually get angry, but that was a blatant mischaracterization of her testimony. There is a huge difference between being unable to remember something and somebody saying --
MS. LOUCAS: You can object, but you know --
MR. WALTERS: I can say whatever I want.
MS. LOUCAS: This county has a rule against speaking objections.
MR. WALTERS: File the motion.
MS. LOUCAS: I will rephrase the question.
MR. WALTERS: File a motion, because you know what? I think a judge will read this, and read it as a blatant mischaracterization of the witness' answer. And I think that any judge in any county in any state will recognize that I have a right to speak up as to a blatant mischaracterization.
So go ahead and ask your next question.
Q. (Continuing) Elizabeth, did you ask how she died?

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MR. WALTERS: I am going to object, because she said she can't recall.
So go ahead and tell her.
A. I don't recall.
MS. LOUCAS: Don't testify for her.
MR. WALTERS: I am not.
BY MS. LOUCAS:
Q. Did you ask how she died?
MR. WALTERS: Wait, Cathy, hold on a second. She said she can't recall on four occasions. You are not going to berate her into a recollection.
MS. LOUCAS: Okay. You can object and say, asked and answered.
MR. WALTERS: I will stop her from answering. I am just giving you a warning right now.
Q. (Continuing) Did you review the autopsy in this case?
A. No.
Q. Was it part of the chart?
A. No.
Q. When I asked you, what did you review, you said the chart. Can you please be more specific with me as to what exactly in the chart you reviewed?

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A. I had a few minutes with the chart. I have not had a copy of the chart specifically for me to review.
Q. Okay.
A. So I have had a few minutes with the chart on a couple of occasions.
I specifically reviewed the flow sheet, because that is where I was involved on two occasions.
Q. Anything else?
A. I believe I looked back at the NST that I did that day. And probably some of the lab work from when she was hospitalized on the 5th.
Q. On the 5th.
And I think you said you don't remember, the labs from 8-21 is not something you would have reviewed prior to your deposition?
A. We looked at it briefly.
Q. Did you look at any of the records from the night of her delivery?
A. No.
Q. Why not?
MR. WALTERS: Wait a minute.
Q. (Continuing) Did you not have time?
MR. WALTERS: Wait a second.
MS. LOUCAS: Steve, just let me clarify.
MR. WALTERS: First of all, she has an

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attorney representing her --
MS. LOUCAS: Let me clarify.
MR. WALTERS: -- and I would have provided her with whatever she reviewed.
Q. (Continuing) That was going to be my question, did your attorney provide you with documents to review, and are those strictly the documents that you reviewed?
A. The two depositions, I was provided with.
Q. Okay.
A. There is a copy of the chart in the office, and that I reviewed.
Q. Okay.
A. I reviewed specifically how I dealt with the patient, and I thought that was primarily what this would be about, and I thought that was the most important part to review.
Q. So you did have -- other than what your attorney provided to you, you had access to the chart in the office?
A. I had access to it. It was not something housed in my office and available to me 24 hours a day.
Q. But you didn't review the whole thing?
A. No.
Q. Okay.
A. And I don't know -- it was certainly not as thick

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as this (indicating). So I am not necessarily sure what all was in that chart.
MR. WALTERS: You wouldn't have had it all.
Q. Let's go to the Prenatal Flow Record, and let's mark that as Plaintiff's Exhibit A.
(Thereupon, Plaintiff's Exhibit A (Ruzga) was marked for identification.)
Q. (Continuing) In the top left box, it has a rating, 0 to 2, has no known risk, is at risk, and is at high risk.
A. Yes.
Q. There is a line going through 1, and I just want to know if you know whether or not that is an indication that the patient is at risk, or --
A. I think it was underlining the word Euclid.
Q. Okay.
A. And that apparently shows a change in hospital status.
Q. I couldn't read that, so thank you.
A. I think that is Dr. Bailin indicating Euclid.
Q. So as you reviewed this front sheet, do you -- just by reviewing the record, do you know whether or not Sherry was ever -- whether or not this record ever indicated that she was at any type of risk?
A. Not from this box, no.

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Q. How about from anywhere else on the record?
A. I think looking through the flow sheet.
Q. Okay.
Your first entry was on March 28th; do you see that?
A. Yes.
Q. Can you tell me what your typical procedure is with a patient that you are seeing for the first time, even though she is not new to the practice?
I understand this is not her first visit --
A. Okay.
Q. -- but it is her first visit with you.
A. Okay.
At this point, I would typically go back and review the lab sheet she had drawn initially, and go over those with her. We talked about a triple check.
Q. What is a triple check?
A. A triple check is a blood test that is done on mom that basically can show risk for things like Down's syndrome, neural tube defects, and we obviously discussed that, how she was feeling, and her visit.
Q. Do you perform a physical examination of any kind?
A. Not on a second visit, other than assessing the pregnancy.
Q. And when you say, assessing the pregnancy, you

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mean blood pressure, urine, sugar?
A. Listening to the baby.
Q. And in your opinion, was everything normal on that date?
A. Yes.
Q. Did you make any recommendations or any orders on that date?
A. Nothing other than stating that she would have the triple check at her following visit.
Q. And did she have that done, can you tell from the record?
A. Yes, she did have that done, 4-27.
Q. Then we jump right to September 8th, and tell me, what did you do on this date with Sherry McElfish?
A. Reviewed what she had done as far as weight and blood pressure and urine, we did do an NST.
Q. And why did you do an NST?
A. Assess fetal well-being.
Q. How often is that done?
A. It depends on the patient.
Q. What was your motivation for doing one on this day, or what was your reasoning for doing one on this day?
A. I believe it is something that had been done previously, and we pretty much consistently continue to

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watch for fetal well-being.
Q. It is not done on every visit, right?
A. For every patient?
Q. For her.
A. For her?
Q. It wasn't done on every visit, right?
A. It had been done the previous visit, at least.
And it was ordered again for the next visit.
Q. And I am not trying to be difficult, and I am not being redundant, but what was your reason for having a non-stress test done?
A. Assess fetal well-being.
Q. What was it about her physical condition, or was there anything specific about her physical condition that you wanted to assess fetal well-being, or was it your normal practice to do that at this stage of the pregnancy?
A. No, related to her blood pressure.
Q. Anything else, any other factors? Her blood pressure and the protein, perhaps?
A. Not necessarily.
Q. So you did it primarily for blood pressure?
A. Right.
Q. Which on that day was 134/84, and how would you characterize that?

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A. Borderline.
Q. Okay.
A. But acceptable.
Q. Why did you repeat her blood pressure?
A. I believe it was done with a smaller cuff, and it should be done with a larger cuff on someone pretty much cut off at around 200 pounds, so we repeated it at that point. And typically with blood pressure, we do repeat it. It is not uncommon to repeat it again later in the visit, to assess that it is not going up and down dramatically.
Q. So if the blood pressure is either borderline or high, you will do a repeat blood pressure?
A. It is not uncommon to do that.
Q. So the first blood pressure was with a small cuff, and then you switched to the large cuff.
Are all these subsequent blood pressures, 150 -- okay, 154/84 was with the small?
A. Right.
Q. 134/84 was with the large?
A. Right.
Q. And then you repeated it, and the third blood pressure was 140/90?
A. Correct.
Q. What effect does the large cuff have on blood

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pressure -- I am sorry, the small cuff. Would it tend to be a false low reading?
A. Not necessarily. Just not the most accurate for somebody. It just doesn't fit appropriately.
Q. Do you know -- and obviously from looking at the chart -- whether or not Yelena used a large cuff or a small cuff?
MR. WALTERS: On which visit?
Q. (Continuing) Throughout her -- if you just look at the flow sheet --
MR. WALTERS: Okay.
Q. -- can you tell?
A. I can't read all of her writing. I don't know that I specifically see it stated that way, but I can't read all of her writing.
Q. But was it standard practice in your office to use a large cuff for anyone who is large in size, say over 200 pounds?
A. Yes.
Q. What else did you do on this date, in addition to the non-stress test?
A. Spoke with Dr. Bailin and talked with the patient about some of the warning signs that can go along with increasing blood pressure.
Q. And do you remember what the warning signs were

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that you discussed with her?
A. I don't specifically recall them, but they are pretty standard.
Q. And what are your standard warning signs?
A. Headache, abdominal pain, flashing lights in front of her eyes.
Q. Anything else?
A. Those are the primary ones.
Q. And what could those signs be indicative of?
A. A potentially worsening situation.
Q. Of what?
A. Of blood pressure problems.
Q. Could these signs be indicative of end organ damage, do you know?
A. Of end organ damage?
Q. Yes, if you know.
MR. WALTERS: If you can answer that. I don't know how you can answer the question.
I will object to the question.
Answer it, go ahead.
A. I wouldn't say they would specifically be related to end organ damage, no.
Q. Had Sherry had these symptoms in the past?
A. I believe she had.
Q. Do you give your patients any kind of pamphlets or

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reading material that discusses warning signs of blood pressure?
A. Sometimes.
Q. Are they there in the office?
A. Sometimes.
Q. Okay, why sometimes?
A. Well, there are thousands of pamphlets available for patients, and you can't have them all. So sometimes pamphlets are available, sometimes not.
Q. Do you know, in this case, if you gave Sherry any literature?
A. I don't recall specifically, no.
Q. And again, if you had done so, would you have noted it? Is that something that you would note?
A. If I would do it, yes.
I know sometimes our medical assistants, especially, you know, on visits with standard stuff, would give out literature about things.
Q. I am going to show you a page from the chart -- well, first of all, let's stick with the non-stress test.
Is this your order sheet for a non-stress test, specifically on 9-8, for Sherry McElfish?
A. It is not an order sheet so much as it is a place to hold the NST, and it describes the patient and the date, and what it is that we are looking at.

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Q. And is that your handwriting?
A. Yes.
Q. And am I correct in that the reason -- well, you put chronic hypertension down, and why did you write that?
A. I don't recall specifically.
Q. NST reactive.
So no concern at this point for the well-being of the fetus?
A. Correct.
Q. And warning signs, I can't read that.
A. Reviewed, I think.
Q. Reviewed?
A. Yes.
Q. And then you want her to come back to the office in three days on 9-11?
A. Correct.
Q. And why is that?
A. Continued watch over her and the baby.
Q. And again, because of her blood pressure?
A. Primarily, yes.
Q. Anything else? When you say, primarily, it makes me wonder if there is anything else.
A. Continue to watch for warning signs and protein.
Q. Now, when you saw her on 9-8, would you have

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reviewed her entire chart?
A. Her flow sheet, yes.
Q. Just her flow sheet?
I am sorry, you would have just reviewed the flow sheet?
MR. WALTERS: If you recall.
Q. (Continuing) If you recall.
What is your normal practice? I mean, you know, somebody comes in, you know, what do you typically review?
A. Even if I have been seeing them, I would review the flow sheet.
Q. Would you have reviewed labs?
A. Potentially, if there were any there. It would be on a case by case basis.
Q. You don't recall going back and reviewing labs on this case in regard to Sherry McElfish?
A. Right, except for talking with Dr. Bailin about the labs from 9-5.
Q. I am going to show you a lab result from -- it looks as though the sample was drawn on August 28th and the results were returned on August 31st.
A. Okay.
Q. Had you seen that before?
A. Yelena had previously written it in the chart on

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8-31.
Q. And what did she write?
A. GBS positive.
Q. And what does that mean to you?
A. What it means is that we do antibiotics during labor to prevent infection.
Q. Antibiotics during labor?
A. During labor.
Q. Anything else?
A. No.
Q. What is a GBS positive indicative for, what is that?
A. It is group beta strep, it is a normal flora to be in the vagina, but we know that it can, on rare occasions, cause infections in babies.
Q. How about in the mother?
A. Even more rare, but yes. Not in a standard pregnancy, no.
Q. How about in a case, a pregnancy where the patient has chronic hypertension?
A. No.
Q. How about --
A. I don't believe that would be --
Q. I am sorry?
A. I mean, we use it specifically to prevent

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infection in the baby. It is a normal flora to be in the mom.
Q. Is it an additional risk for women with preeclampsia?
A. No, not to my knowledge.
Q. Can you give that back, please.
(Thereupon, the document was handed to Ms. Loucas.)
Q. (Continuing) So in order to treat this, would you consider -- if this was GBS positive, did she have a urinary tract infection --
A. No.
Q. -- or a kidney infection going on?
A. No.
Q. No.
A. This is specifically a vaginal culture.
Q. And so your therapy would be strictly antibiotics at delivery?
A. Right.
Q. Did you do anything else on this date in regard to Sherry McElfish?
A. On the 8th?
Q. Yes.
A. Besides talking with her about warning signs, no.
Q. Let me show you an ultrasound record from that

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date. Did you order that?
A. That is my handwriting, yes.
Q. That is your handwriting?
A. Yes.
It is the head.
Q. I am sorry?
A. It is the head, just ensuring that the baby was head down in the pelvis.
Q. Did you perform this ultrasound?
A. I guess so.
Q. So that was one done in your office?
A. Yes.
Q. You didn't have to send her out for that?
A. Right.
Q. All right.
A. It was not assessing anything other than that the baby was vertex.
Q. No reading, then, no report issued as a result of that ultrasound?
A. Right.
Q. And under doctor, can you read those initials?
A. No, really I can't.
Q. So first I wonder if they were Yelena's, it looks like a B. I didn't know --
A. I don't know if I was putting that down, if it is,

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because it was typically her patient, or if it was Dr. Bailin that was there that day. I am not sure what it means.
Q. That is your handwriting, though. Okay.
Did you ever meet Sherry's husband, was he there with her on that day, do you know?
A. I don't recall.
Q. I just want to discuss some terms with you, okay?
What is chronic hypertension?
A. Elevation in blood pressure above a patient's normal or -- pretty standard, we use 140/90 as a kind of a borderline cutoff.
Q. And what makes it chronic to you?
A. That it is happening a couple of times.
Q. Is that significant in a pregnant woman?
A. I think it is significant in everybody.
Q. Is that considered -- if a pregnant woman presents with chronic hypertension, does that place her at any greater risk?
A. Yes.
Q. For what?
A. For preeclampsia.
Q. And what is preeclampsia?
A. It is a blood pressure problem specific to pregnancy that exhibits more things than just high blood

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pressure.
Q. Such as?
A. Excessive protein in the urine, the headaches, clotting factors changing, liver function changing.
Q. What is the relationship between chronic hypertension and preeclampsia, other than chronic hypertension being an additional risk for preeclampsia? Is there any other relationship between the two?
A. I am not sure I understand what you mean by the question.
Q. That is a bad question.
Speaking of protein, on 9-8 when you saw Sherry, she had a two plus urine protein. Was that the highest protein level she had had up until this point?
A. Yes.
Q. Did you make that -- and you informed Dr. Bailin of that?
A. Yes.
Q. And I know you asked her to return on 9-11, but did you and Dr. Bailin formulate a plan of care for her during your conversation with him? I know he said you don't need to do any other labs, but did you change or reformulate your plan of care for Sherry McElfish?
A. I think our plan was to return and continue to do monitoring mostly.

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Q. And how often would you do that?
A. Pretty standard, every three to four days to a week.
Q. Had you ever -- first of all, did you utilize 24 hour urine tests in your office at Meridia?
A. Sometimes, yes.
Q. In what cases would you recommend a 24 hour urine?
A. When we do them, it is usually when they are spilling protein plus three, plus four in the office.
Q. You typically don't -- okay, I take it that with a woman spilling two plus, you would not usually order a 24 hour urine?
A. Not necessarily.
Q. When you say, not necessarily, are there some instances where you would order a 24 hour urine?
A. Possibly. It is a case by case basis.
Q. How about urine volume, when would you perform those?
A. We wouldn't necessarily perform them in the office.
Q. When would you instruct a woman to do that?
A. I can't say I have ever instructed a woman at home to do that. I think by that point, you know --
Q. That is something that is done in the hospital?
A. That might be something that is done in the hospital.

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Q. Okay.
What is mild preeclampsia?
A. I think there is a lot of interplay between these. Having some of those additional risk factors that I listed before. Not necessarily. Some might have those and not have preeclampsia.
Q. What is severe preeclampsia?
A. I believe when you start to change your clotting factors and your liver study changes and spilling more protein, plus three, plus four.
Q. What is preeclampsia superimposed on hypertension?
A. If you had chronic hypertension and then added those additional things, some or all of those things that start to change as you go along.
Q. And HELLP syndrome?
A. Specifically it is when you have a decreased platelet count, as well, the clotting once again starts to change, elevated liver enzymes and hemolysis.
Q. Is that along the spectrum of preeclampsia?
A. It can be.
Q. And what about DIC?
A. Disseminated intravascular coagulation.
Q. Are women who have preeclampsia at increased risk for HELLP and DIC?
A. Increased risk, yes, but it is not always a

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sequelae of it.
Q. And how about pregnant women with chronic hypertension, are they at increased risk for HELLP and DIC?
A. They are at increased risk for preeclampsia.
Q. Since you read Yelena's deposition, she had indicated that there may have been some group discussions regarding Sherry's care. Had you ever been -- did you ever participate in any of those group discussions?
A. I don't recall anything specifically other than talking with Dr. Bailin that day.
Q. Can you tell me what the typical procedure is when a patient is going to be co-managed with the nurse midwife and a physician?
Now, the brunt of her care was by Yelena.
A. Uh-huh.
Q. Are you guys interchangeable in this office? Were you interchangeable at that time, you and Yelena, or was this primarily Yelena's patient?
A. Well, considering I was on maternity leave most of the time, primarily it was Yelena's patient.
Q. But under normal circumstances, are you interchangeable?
A. If the patient desires us to be so, we can be.
Q. So patients in your office, they are not

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necessarily assigned to one nurse midwife?
A. Correct.
Q. Is it fair to say that they are assigned to the group?
A. Assigned to the group?
Q. Yes.
A. I mean, if they come to our office, we anticipate that they will seek care through us.
Q. If it came time for Sherry to deliver under normal circumstances, okay, would you have been available to deliver her child, or would it have been Yelena?
MR. WALTERS: Object to form, because I don't know about the circumstances.
Q. (Continuing) Well, if you are interchangeable, and let's say Sherry presented to the emergency room, this was a nonrisk, noncomplicated pregnancy --
A. Uh-huh.
Q. -- would you be able to step in Yelena's shoes and deliver that baby?
A. Yes. And that was Sherry's request (indicating).
Q. And how do you know it was her request?
A. Because it is written down here that she have a midwife.
Q. But it wasn't a request for you?
A. No. That was Sherry's request. And Yelena and I

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worked very hard to try to deliver patients that requested a midwife.
Q. And can you tell me, it looked like you were pointing at something that that was her request?
A. Yelena wrote down, midwife. And that was our way of allowing the group and hospitals to know that the patient requested that.
Q. Again, back to office procedure, how are follow-up appointments made in your office?
A. When the patient leaves a visit, they will go out and make the following visit with the receptionist there.
Q. Do they take the chart with them?
A. No.
Q. Do you tell the patient when they are supposed to come back in, and then the patient goes to the receptionist desk and tells them?
A. Yes.
Q. Are there ever times where you give them a slip for a specific appointment to come back, or for her to see anybody else, or anything like that?
A. They probably get a reminder card from the receptionist, but we wouldn't necessarily -- I wouldn't necessarily hand the patient a slip saying to return on this date. I would just tell them to.
Q. While they are making the appointment, the

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receptionist would give them a reminder card?
A. Right.
Q. Do you know, Elizabeth, whether or not in a patient who has been diagnosed as being chronic hypertensive, in a pregnant patient who is chronic hypertensive, is it true that in cases of superimposed preeclampsia, the manifestations may be more subtle?
MR. WALTERS: Manifestations of what?
MS. LOUCAS: Of preeclampsia.
MR. WALTERS: Okay.
Q. (Continuing) Based on your experience, or education and training.
A. Not specifically, no.
Q. If you suspect preeclampsia in a patient, do you agree or disagree that you must wait at least six hours between blood pressure readings?
MR. WALTERS: I have to object, because I don't understand the question. For what?
Q. (Continuing) If you suspect preeclampsia, if you are trying to rule out or rule in preeclampsia --
A. Okay.
Q. -- and you want to take repetitive blood pressure readings --
A. Okay.
Q. -- do you agree or disagree that there should be

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six hours between -- or the blood pressure readings should be at least six hours apart?
A. I don't specifically know.
Q. Had you or Dr. Bailin or anyone in your practice ever instructed patients who are either chronic hypertensive or you suspect are preeclamptic to engage in home monitoring of blood pressure readings?
A. We have on occasion.
Q. And under what circumstances would you recommend home blood pressure monitoring?
A. Some patients that have either training in or have access to equipment, those patients are pretty easy to ask to do some additional monitoring at home.
Patients that are -- I hate the word -- but noncompliant, and don't necessarily always follow up with visits very well, would be good patients for home monitoring with a company.
Q. Oh, okay.
So patients who are noncompliant, you think they are good candidates for home monitoring?
A. (Witness nods).
Q. Was Sherry McElfish noncompliant, do you know? In your experience with her, or from what you could tell from the record, was she a compliant or a noncompliant patient?

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A. She came to her visits, so that is pretty compliant, from what I know. I don't have a camera on her at home if she was on bed rest. If she was on bed rest, I don't know.
Q. As you sit here today, can you point to anything that would indicate that she was noncompliant?
A. Not specifically, no.
Q. Did you understand that she had been placed on bed rest?
A. I don't know specifically if she was.
Q. That was not something you were aware of on 9-8 when you saw her?
A. I don't recall specifically knowing that one way or another.
Q. Had you ever had any discussions with -- do you want to look at that? I am sorry.
A. Go ahead.
Q. Had you ever had discussions with anyone from Sherry's employment?
A. No, I did not.
Q. Had you ever had discussions with anyone in her family regarding Sherry's condition?
A. Not that I recall.
Q. What does toxemia in pregnancy mean to you?
A. It is not necessarily a word that is used very

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often anymore. I think historically it was the whole gamut of preeclampsia to eclampsia.
Q. But that word is no longer --
A. It is not as in favor as it was.
Q. And in its place is now used the word preeclampsia?
A. Preeclampsia and eclampsia.
Q. At what point in time, if you could answer this, at what point in time does a patient risk out, does a preeclamptic patient risk out of certified nurse midwife care?
A. What do you mean by risk out?
Q. Okay, meaning she is at risk that you would refer her care strictly to a physician. At what point would you do that?
A. I guess specifically, you know, higher blood pressures, 160/100 or 110, presenting with those things much earlier in the pregnancy, those high blood pressures.
Q. Okay, anything else?
A. I would say case by case basis, but you always have to look at other medical problems, as well.
Q. I read your standard care agreement, and it doesn't relate specifically to preeclampsia, but was there a policy and procedure in place that would dictate

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when preeclamptic patients would be referred specifically to the management of a physician?
A. No, that would be specifically between the physician and the midwife when that would happen.
Q. Is that Standard Care Arrangement like the one you have in place now with Drs. Bailin and Karasik?
A. Yes.
Q. Would you say it is identical?
A. I can't say that.
Q. Okay.
At the time you were working for Meridia, you also signed a Standard Care Arrangement?
A. Yes.
Q. Did you have one with each physician in that office?
A. I don't recall.
Q. Okay.
A. Initially when they came about, your primary backup was the person, and it was understood to be a group thing. And they, in a sense, changed it to make it with each physician that you work with, and I am not sure when that -- I can't look back to see exactly when that happened.
Q. So initially your Standard Care Arrangement was with the group?
A. Right, that Dr. Bailin would have signed, because

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he was the primary medical backup at that point, but it was understood as a group thing.
Q. And why was Dr. Bailin the primary medical backup?
A. He was the --
Q. Was he the senior partner, more or less?
A. Well, he was kind of the head medically, at that point.
Q. How long had Dr. Karasik been with the firm? Been with the practice, I am sorry.
A. I would say five or six years.
Q. If a patient that you have been primarily responsible for, like Sherry McElfish, called, let's assume you have a patient -- this is a hypothetical -- assume you have a patient like Sherry McElfish who calls you, and she is going into early labor -- I suppose this could be considered early labor -- and you advise her to go to the hospital for delivery, would you typically go to the hospital with that patient, even if her pregnancy has taken on different measures that put her at higher risk, would you typically go to the hospital to assist the physician in delivering that baby? This is just your practice.
A. I am not sure if I understand your question. That is on a very case by case basis, I think.
Q. I suppose my question is, if you have been

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managing this patient throughout her entire prenatal care --
A. Uh-huh.
Q. -- and a complication develops at the late -- you know, late term, and she unexpectedly goes to the hospital, and she is going to be delivered by a physician instead of you, would you normally go to the hospital to assist the physician in the delivery?
MR. WALTERS: What is the complication?
Q. (Continuing) Well, in this case, early labor.
A. To me, early labor is not a complication.
Q. Okay.
A. So if it was going to be -- I guess I am not sure I understand your question.
Q. Would you follow that patient through, even though she did develop some complications at the end --
A. Okay.
Q. -- she calls you and she says, you know, I am having labor, I think I am going into labor, you instruct her to go to the hospital, but in this case, you know, Sherry McElfish did present signs, at least you guys knew -- well, she was considered by some members of the group as being chronic hypertensive, okay?
A. Uh-huh.
Q. Do you know why Yelena called Dr. Bailin? Why didn't Yelena go to the hospital?

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MR. WALTERS: First of all, I don't know how she would know what Yelena did or didn't do.
A. What transpired, I don't know, that night.
Q. She never shared that with you?
A. No.
Q. And my question is, typically what is your practice? Would you go to the hospital to assist the physician in delivering this child, or no?
MR. WALTERS: I will object.
Go ahead.
A. It would very much be a case by case basis.
Q. Okay.
A. If it was to a physician, I might not even know what was going on at the time, if the hospital would have called a physician.
Q. Well, in this case, she would have called you -- scratch that, never mind.
Did you and Yelena have identical or the same practice parameters?
A. We had Standard Care Arrangements.
Q. And you have never practiced in any other state, correct?
A. Correct.
Q. Have you ever managed a patient with severe preeclampsia? I asked you previously about preeclampsia.

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So my question now is, have you ever managed a patient with severe preeclampsia?
A. I don't know that I can answer that.
Q. Because you don't remember, or --
A. Yes, I don't specifically recall.
Q. Have you ever co-managed a patient with severe preeclampsia?
A. I don't specifically recall.
Q. A patient with severe preeclampsia, would she typically, in your practice at Meridia, would she typically be referred to a physician for further care?
A. Typically.
Q. Are you familiar with ACOG?
A. Yes.
Q. Do you read any of their literature, publications?
A. Rare occasions.
Q. What things do you consult, what kind of journals or textbooks or things do you typically consult in your field?
A. I get a couple of midwifery journals.
Q. Which ones would those be?
A. Journal of Nurse Midwifery, Midwifery Today.
Q. If the ACOG standard in 1996 indicated that symptoms such as headache, visual disturbances or epigastric or right upper quadrant pain were symptoms

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suggestive of end organ involvement in a patient with preeclampsia, would you have any reason to disagree with that statement?
MR. WALTERS: First of all, it is an unfair statement. As I understand, the ACOG guidelines are directed towards the American College of Obstetrics and Gynecology.
But if you can answer that question --
A. Can I ask you to repeat the question?
Q. Sure.
If the ACOG standard in 1996 regarding patients with pregnancy induced hypertension, if it said that symptoms suggesting end organ involvement include headache, visual disturbances or epigastric or right upper quadrant pain, would you have any reason to disagree with that statement?
MR. WALTERS: Well, first, I will just state my objection again, because now you have changed the question. You said a patient, it sounded like the ACOG standards, the standards of pregnancy induced hypertension, with these symptoms, and I would like her to see -- if you have got the document, I would like her to see it, because obviously it sounds like a different -- it sounds like you are going to -- obviously since

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you asked the question in this case, you are going to try to use it in this case. So if we have got it, we will look at it.
Q. (Continuing) Elizabeth, as you sit there, do you have an -- do you know whether or not, in patients with pregnancy induced hypertension who present with end organ -- I am sorry -- who present with headache, visual disturbances or epigastric pain, do you know whether or not those symptoms may be related or suggestive of end organ involvement? And that is if you know.
MR. WALTERS: It is a hypothetical.
A. Yes, suggestive, guidelines. I can't say that I know the answer to that.
Q. Do you agree or disagree that the acute onset of proteinuria and worsening hypertension in a pregnant woman with chronic hypertension is suggestive of superimposed preeclampsia?
A. I will ask you to repeat.
MR. WALTERS: I will object to the form of the question.
Q. Do you agree or disagree that the acute onset of proteinuria and worsening hypertension in a pregnant woman with chronic hypertension is suggestive of superimposed preeclampsia?
MR. WALTERS: Same objection.

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Go ahead, if you can answer. Do you understand?
A. It is not an either/or.
Q. Do you agree or disagree that those -- that proteinuria and worsening hypertension in a pregnant woman with chronic hypertension is suggestive of superimposed preeclampsia?
MR. WALTERS: She just said it is not an either/or. I think that was her answer. You gave her an agree or disagree, and she said it is not an either/or.
In other words --
Q. (Continuing) Are there times when these symptoms may be suggestive of superimposed preeclampsia?
A. It could be.
Q. In your experience, what would that be?
A. What do you mean by that?
Q. You were saying, could be. So --
A. Everything is a case by case basis.
Q. Would you agree that in a patient with pregnancy induced hypertension, it is prudent to overdiagnose rather than underdiagnose?
A. I can't answer that.
Q. Would you agree that chronic hypertension complicates pregnancy and is associated with several

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adverse outcomes including premature birth, intrauterine growth restriction, fetal demise, placental abruption and cesarean delivery?
A. Lots of things have that potential.
Q. Including chronic hypertension in a pregnant woman?
A. It could have that potential.
Q. More likely than not, is kidney dysfunction involved in preeclampsia?
A. I am sorry, could you repeat the question?
Q. More often than not, is kidney dysfunction involved in preeclampsia?
A. I don't know that I can answer that.
Q. How do you measure kidney function?
A. You do some through blood work, watching urine.
Q. What specific blood work are you looking at to measure kidney function?
A. Some of the creatinine levels, BUN levels, those types of things can show what is going on.
Q. What is a more accurate test of kidney function, a 24 hour urine with a serum creatinine or a serum creatinine alone?
A. I don't know the answer to that.
Q. How many babies have you delivered, if you can -- do you keep a running tab?
A. No, I don't have a running tab.

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Q. Can you give me a guesstimate?
A. Three or four hundred.
Q. Do you also provide general gynecological care to patients, or is your --
A. Yes.
Q. Tell me the parameters or the scope of your practice?
A. Full scope.
Q. Full scope?
A. Uh-huh. Full scope midwifery. Full scope midwifery, yes.
MR. TREU: Can we take a break, please?
MS. LOUCAS: Sure.
(Short recess had.)
BY MS. LOUCAS:
Q. Early on in your deposition, Elizabeth, you had indicated that you also performed ultrasounds to check fluid levels?
A. Uh-huh.
Q. Did you do that on 9-8? Is that something that you were looking at on September 8th when you performed that ultrasound?
A. No.
Q. And why not?
A. It is typically done once a person goes past their

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due date.
Q. So it is something you typically don't do if they are still within their term?
A. Correct.
Q. What are the criteria for superimposed preeclampsia? And when I say, criteria, what is the criteria for your working diagnosis of superimposed preeclampsia in a woman with chronic hypertension?
A. What do you mean by criteria?
Q. I am sorry?
A. What do you mean by criteria?
Q. How would you make a diagnosis, at what point would you make a diagnosis of superimposed preeclampsia in a woman with chronic hypertension?
MR. WALTERS: I am going to object, because I think she has answered that, but go ahead.
A. It has to be a case by case basis. Some of it is just too subtle, there are so many similarities between the two. I think when it starts to pull away with higher blood pressures and spilling protein, plus three, plus four, changes in those.
Q. And I believe -- now you are refreshing my memory, I believe you said earlier that you would be looking for a blood pressure of 160/110 --
A. Somewhere in that range.

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Q. -- for superimposed preeclampsia or severe preeclampsia?
A. Well, to note that there is a difference between hypertension and that it is moving away from that into something else, that you would expect to see increases more.
Q. But there is no range -- there is no cutoff values for you?
A. I don't know that there can be.
Q. They are just too subtle to make that distinction; is that your testimony?
A. As far as strictly blood pressure.
Q. Well, what kind of things --
A. Spilling protein at higher numbers.
Q. So you would need to see a blood pressure of 160/110 or spilling protein at three or greater in order for you to come to the diagnosis of superimposed preeclampsia?
A. I think it would have to be a case by case basis.
(Thereupon, Mr. Herbert left the room.)
Q. Are you aware that hypertension is directly responsible for 15 percent of maternal deaths in the United States?
A. No, I didn't know that.
Q. How would you consider -- would you consider that

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a low --
MR. WALTERS: Is that a fact?
Q. (Continuing) Would you consider that --
MR. WALTERS: How do we know that?
Q. -- a low, moderate or high risk?
MR. WALTERS: Go ahead. I don't know how we know that.
A. Would I consider what?
Q. That hypertension -- first of all, that hypertension is directly responsible for 15 percent of maternal deaths in the United States.
MR. WALTERS: First of all, you don't have to accept that to be true unless we somehow can prove it.
But if you want her to assume that to be true --
MS. LOUCAS: ACOG 219, January, 1996.
Q. (Continuing) Would you consider that a low, moderate or high risk?
MR. WALTERS: What?
A. What?
Q. Fifteen percent risk of death for a pregnant woman with hypertension.
MR. WALTERS: So the ACOG Bulletin says anybody with hypertension has a 15 percent risk of

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fetal demise, is that what it says? That is what you have represented.
If you want to show her the bulletin, that is fine. But if you want to represent that the ACOG Bulletin says that any woman with hypertension has a 15 percent risk of fetal demise, that is what the question asked, and I don't think the bulletin says that.
MS. LOUCAS: First of all, I have never had to, at a deposition, produce the material with which I can impeach the witness.
Q. (Continuing) I will present it to you in the form of a hypothetical, okay?
In the ACOG Bulletin 219 that was published in January of 1996, it stated that hypertension is directly responsible for 15 percent of maternal deaths in the United States.
Do you consider that to be a risk for the pregnant woman with chronic hypertension?
MR. TREU: Fifteen?
MR. WALTERS: Fifteen.
Go ahead, if you can answer that.
A. I am not sure what I can consider a risk.
MR. WALTERS: The 15 percent, or --
MS. LOUCAS: Do you acknowledge that

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chronic hypertension -- I don't mean to argue, I really don't, but I just want to limit speaking objections, and nodding of the head and answering for the witness.
MR. WALTERS: Wait a minute, hang on a second. This is a silly question. And I think anybody that reads it will find it to be a silly question, and I will make that statement on the record.
But the reality is, I am not doing anything for this witness other than pointing out that the question you are asking is unfair.
The fact that you have never had to produce literature that you are reading from in another deposition is not my problem. That, perhaps, is the lawyer who was defending the deposition's problem. When you quote literature, you have to do it accurately.
She has not told you that ACOG is a standard on which she lives by. In fact, she says she doesn't read it.
But I will allow you the leeway to ask the question, but do not prohibit me from trying to make it a logical question or a question that makes any sense.

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So go ahead.
MS. LOUCAS: For the record, there have -- throughout the course of this deposition, Steve, whether you realize it or not, you nod your head yes or no, and even on occasions have verbalized yes or no.
I take that to be an instruction to the witness, and all I am doing is asking you --
MR. WALTERS: Well, you better take that very seriously. And I would suggest, if that is in fact true, you report it to the Bar Association, because that is not only inappropriate conduct, it is conduct that is set forth in the ethical guidelines and rules that we are not allowed to engage in. And if I am engaging in that conduct, I should be disbarred, okay?
So I suggest, when you make an accusation that is that serious, you better be prepared to back it up. Because I have defended cases for 20 years, and I have never heard anybody say that to me, all right?
MS. LOUCAS: Well, I noticed it in this deposition.
MR. WALTERS: Well, whatever you noticed, be prepared to back it up.

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MS. LOUCAS: I will bring a videographer with me from now on.
MR. WALTERS: Guess what? You have videos of every deposition I have defended here.
MS. LOUCAS: You are not on the video, the witness is.
We will continue.
(Thereupon, Mr. Herbert reentered the room.)
BY MS. LOUCAS:
Q. I take it you don't feel comfortable answering that question, is that correct, Elizabeth?
A. No.
MR. WALTERS: And I suggest you get an affidavit from Mr. Becker, as well, because perhaps -- he has been doing this for a long time. Maybe he didn't see it, these subtle clues.
BY MS. LOUCAS:
Q. Do you agree or disagree that some of the risks of conservative management of HELLP syndrome include abruptio, pulmonary edema, acute renal failure, eclampsia, perinatal death and maternal death?
MR. WALTERS: I am sorry, could you read that back. I wasn't paying attention, I got aggravated.
(Record read.)

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MR. WALTERS: First of all, I will object, because I don't know that she treats HELLP syndrome.
Go ahead.
A. I don't know that I can answer that.
Q. Do you agree or disagree that a woman with severe preeclampsia should not be managed expectantly after 34 weeks?
MR. WALTERS: Objection.
A. I don't know that I can answer that.
Q. Do you agree or disagree that the only definitive cure for preeclampsia is termination of the pregnancy?
A. I don't know that I can answer that.
Q. Do you know whether or not Sherry McElfish was ever offered the option of early delivery?
A. I do not know that.
Q. Have you ever offered that to one of your patients, to one of your patients with superimposed preeclampsia?
A. I don't recall that I have had that exact scenario to answer that question.
Q. Is that something that you would recommend, or a physician, one of the obstetricians in the office?
A. It would be a case by case basis, but it would be the two of us together, if we were co-managing a patient.
Q. I am sorry if I asked you this. Did you ever

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consider Sherry McElfish to be at risk?
A. At risk.
I don't know that I specifically thought of it the day that I saw her, that I would use those words in my mind, so I don't know that I can answer that.
Q. Did you have a maternal fetal specialist in your practice?
A. At the time?
Q. Yes.
A. I don't know his specific background. Dr. Kushnir. But I don't know his specific training, to say that he was thought of as that.
Q. But you are saying that Dr. Kushnir may be a maternal fetal specialist?
A. He may be.
Q. Did you ever refer -- did your group ever transfer high risk patients to Dr. Kushnir's care?
MR. WALTERS: He was in the group.
Q. (Continuing) That is what I mean.
But let's say you had a patient who was being managed by one of the nurse midwives and either Dr. Bailin or Dr. Karasik or some other physician, had you ever known of a patient to be transferred to the care of Dr. Kushnir?
A. Transferred, no.

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Q. No, okay.
Had high risk patients ever been managed -- I mean, ever been transferred out of your practice and referred to another group or to a high risk group?
A. I don't specifically recall.
Q. Did your group manage high risk patients? And I am asking because some groups do and some groups don't. So did your group manage high risk patients?
A. Yes.
Q. Do you know what the plan for delivery was in regard to Sherry McElfish?
A. No.
Q. Did you, on that visit, advise Sherry that she may be at risk for complications in her pregnancy? I know you advised her of warning signs, but did you advise her of the potential complications?
A. I don't know that I specifically recall that.
Q. Is first trimester ultrasound important for patients with chronic hypertension?
A. I would say if we were concerned about dating.
MS. LOUCAS: I just need a minute to review my notes, and I think I am almost done.
Let's go off the record for a minute, Ivy.
(Thereupon, a discussion was had off the record.)

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BY MS. LOUCAS:
Q. Do you check -- you take urine samples in the office, correct?
A. I don't specifically, but yes, we do.
Q. Your office does.
Do you check for potassium levels there in the office?
A. No.
Q. You send it out to a lab?
A. If we are looking for that, yes, we would have to send it out.
MS. LOUCAS: I don't think I have any further questions.
MR. WALTERS: Anybody else?
MR. TREU: No questions.
MS. REID: No questions.
MR. HERBERT: No.
MS. MITCHELL: No.
MS. ATKINSON: No questions.
MR. WALTERS: We will read it.
MS. LOUCAS: Thank you, Elizabeth.
- - -
(DEPOSITION CONCLUDED)
- - -

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CERTIFICATE

State of Ohio, } ss:
County of Cuyahoga.)

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named ELIZABETH RUZGA, C.N.M., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 20th day of February, 2003.

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.

My commission expires November 5, 2003.

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