IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

KARL McELFISH, II	:	
ADMINISTRATOR, et al.	:	
Plaintiff,	:	
vs	:	CASE NO. CV02465040
MERIDIA MEDICAL GROUP,	:	
et al.	:	
Defendants.	:	

Telephone Deposition of BAHA SIBAI, M.D., a deponent herein, taken by the Plaintiffs as upon cross-examination, pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement by counsel as to the time and place and stipulations hereinafter set forth, at University Medical Center, 231 Albert Sabin Way, Room 5260, Cincinnati Ohio 45219, at 5:00 p.m., on Thursday, the 11th day of August, 2005, before Ann Belmont, a Registered Professional Reporter and Notary Public within and for the State of Ohio.

APPEARANCES:

On behalf of Plaintiff:

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On behalf of Defendant, Lucille Stine, M.D.:

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On behalf of Defendants, Charles M. Bailin, M.D., Gregory Karasik, M.D., Meridia Medical Group and midwife:

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S T I P U L A T I O N S

It is stipulated by counsel for the respective parties that the deposition of BAHA SIBAI, M.D., a deponent herein, may be taken at this time by the plaintiff as upon cross-examination and pursuant to the Ohio Rules of Civil Procedure and notice to take deposition, all other legal formalities being waived by agreement; that the deposition may be taken in stenotype by the Notary Public Reporter and transcribed by her out of the presence of the witness; that the transcribed deposition was submitted to the witness for examination and signature and that signature may be affixed out of the presence of the Notary Public Court Reporter.

I N D E X

BAHA SIBAI, M.D.,
a deponent herein, after being duly sworn was examined and testified as follows:

CROSS-EXAMINATION

BY MR. BECKER:

Q. Hi, Doctor, this Mike Becker. It's been a couple years since we've chatted. How have you been doing?

A. I'm fine.

Q. What was the reason that you left Memphis, Tennessee?

A. My reason? Yeah, I took a job here of being a chairman.

Q. I understand that, but why did you -- wasn't that a similar position you held at University of Tennessee?

A. No, I was a division chair of that.

Q. Hello?

A. No. I had a division chair of that. I wasn't the chairman there.

Q. I'm sorry. So you changed from a division chief to become chairman?

A. Yes.

Q. Doctor, do you have any notes that

you generated or did you create any notes as a result of your review of this matter?

A. No.

Q. Hello?

A. I said no. You are not hearing?

MR. AUCIELLO: The phone is not working.

A. Your phone probably is not working. Hello?

Q. Okay. The answer is no notes?

A. No, yes.

Q. Doctor, apparently, you were contacted by Mr. George Loucas on this case to review it back in 2001. Do you remember that?

A. I remember I was contacted, yes.

Q. You do remember?

A. Yeah.

Q. And did he send you any materials?

A. I'm sure probably he did, yes.

Q. All right. Do you recall whether you shared any opinions with Mr. Loucas back in 2001?

A. I don't know if I shared opinion,

with whom I shared them.

Q. Doctor, do you feel it's appropriate, ethically, for you to review a case for the other side after you've, apparently, given opinions to one side?

A. Well, you know, again, when I received this, you know, I even forgotten I gave an opinion. But I give the same opinion, it doesn't matter, as long as I kept it the same.

Q. Do you recall what the opinion was you gave Mr. Loucas?

A. No.

MR. AUCIELLO: And, Mike, I've never asked him either.

A. I never discuss it because I don't even remember.

Q. All right. You just told me that you gave the same opinion. So I'm asking if you recall what the opinion was you gave Mr. Loucas?

A. It must be the same thing you are going to hear from me right now, so.

Q. Okay. And why are you certain of

that, that you gave him the same opinion?

A. Because I'm sure I'm not going to change the opinion.

Q. Okay. But as to a specific recollection, you don't recall what opinion you gave Mr. Loucas, when you talked to him in 2001?

A. Correct. You know, specifically word by word, I do not know what we said.

Q. Are there any rules within your -- the ACOG society about doing medical/legal work?

A. What do you mean "rules"? I don't understand the question. I don't know, I don't understand. What do you mean "rules"? I'm not aware there are rules.

Q. Any rules that when one acts as an expert, what rules one is supposed to follow in doing medical/legal work, any rules published by ACOG that you're aware of.

A. I'm aware there are the things, there is a document that says your opinion should be appropriate, so I don't understand other than that.

Q. I didn't understand that answer, Doctor, could you repeat it?

A. Yeah, the ACOG thing, I don't know what you are referring of that. To be an expert, you know, you have to be somebody who is knowledgeable in the field.

Q. Em-hm.

A. And give an opinion that's the same whether you are testifying for plaintiff or defendant.

Q. Okay. Are you aware whether there are any rules whether or not you are supposed to consult with the other side after you have been contacted by one side?

A. I'm not aware there's anything for this regard at all. I don't think the document addresses that.

Q. Do you have an opinion, Doctor, as to the cause of Sherry McElfish's death?

A. Yes.

Q. Would you share that with me, please?

A. Well, she had severe preeclampsia, that's complicated by postpartum HELLP

syndrome and then amniotic fluid embolism.

Q. So it was severe preeclampsia and HELLP syndrome that caused her death?

A. Plus, ultimately, the ambiotic fluid embolism. So it's a combination of these.

Q. What evidence is there of an AFE?

A. Well, clinically, the way she had the sudden changes after delivery, the development of the DIC, her blood pressure increased and then going up to be hypertensive.

Plus, in the autopsy, there was evidence of trophoblast emboli in the lung. So, really, it's mostly clinical.

Q. Doctor, are you aware of any cases reported in the world of literature that permit a clinical diagnosis of AFE when there was a maternal decompensation almost two hours after delivery?

A. Yes, if you look at the register that Steve Clark was collected, this was described. Usually, most of them happen at time of delivery. And then in this case, we

know that the membranes were not ruptured except at time Cesarean section. So, yeah, this could happen. But this is not -- this is not -- sorry, this is not important for my opinion.

Q. All right. So Steve Clark writes about decompensation within 8 to 12 minutes after delivery. I don't recall him writing anything about two hours after delivery. Are you saying it's in his writing?

A. Yeah, there are some reports where they said the facts could be seen up to about two hours.

Q. But you think there's a relationship between the severe preeclampsia and the HELLP syndrome and the AFE?

A. No, I don't think that there is a relationship.

Q. No relationship?

A. No.

Q. No?

A. No.

Q. Okay. Do you feel that had the HELLP syndrome been avoided, she would have

survived?

A. I do not know because she could still have developed the DIC and then have died from the ambiotic fluid embolism.

Q. So the answer to my question is yes or no, or you don't know?

A. No, I just told you. If what caused her death is the ambiotic fluid embolism, whether she had HELLP syndrome or not is irrelevant. The other thing -- the -- really women do not die from HELLP syndrome.

Q. Em-hm.

A. So you --

Q. So the answer to my question is even if the HELLP syndrome would have been avoided, she still would have died?

A. Yes, as a result of the ambiotic fluid embolism.

Q. Okay. Do you know, Doctor, whether or not trophoblasts are found in all maternal deaths?

A. They are found in some, not all of them. It's not true, you don't find them in all maternal death.

Q. Would you defer on that issue to a pathologist --

A. No.

Q. -- experienced in reviewing maternal deaths?

A. Yes, I wouldn't defer to this because, again, based on my experience, I have looked at so many autopsies.

Q. No?

A. No, I wouldn't defer. I was telling you, yes, it is present, but it's not present in every woman who dies, not true.

Q. So it's your opinion, Doctor, that she would have had an amniotic fluid embolism even if she would have been delivered five or seven days earlier?

A. Yes, if what caused her death is ambiotic fluid embolism. I don't think having the severe preeclampsia have anything to do with that.

Q. So had she been delivered five to seven days earlier, she still would have died from an amniotic fluid embolism; is that your testimony?

A. No. You are not listening to what I'm saying. Let me repeat it. If she died from ambiotic fluid embolis, then it doesn't matter. Are you following what I'm saying?

Q. No, I understand exactly what you're saying, Doctor. My question, sir, to you, is, had she been born five or seven days earlier, is it your sworn testimony, under oath, that she still would have sustained an amniotic fluid embolism at that time, five or seven days earlier, and still would have died?

A. See, again, I don't think, you know, you got my answer from the beginning. I said if she had the amniotic fluid embolism -- so, yes, if she had it now, doing it five days before, she would have it.

Q. That's what I want to know.

A. Yes.

Q. Do you feel that she still would have had it five or seven days earlier?

A. Yes, if she had amniotic fluid embolism and this is what caused her death.

Q. It sounds like you're not sure

whether she really had it or not.

A. Yes, this is what I told you at the beginning.

Q. You're not sure?

A. Yes.

Q. I'm sorry, I didn't hear that.

MR. AUCIELLO: He said yes.

A. Yeah.

Q. Doctor, relative to medical/legal work, do you keep track of logs, on either computer or anything else about how frequently you review cases?

A. No.

Q. No?

A. No.

Q. By chance --

A. I said no.

(Telephone connection was terminated and then reconnected.)

MR. AUCIELLO: Trying it with my cell phone because it seems like the phone here, it just isn't working.

MR. BECKER: Okay. So you have me on speaker on your cell?

MR. AUCIELLO: Yes.

MR. BECKER: All right. Are you having any trouble understanding or hearing my questions?

MR. AUCIELLO: Only when you -- the phone doesn't have -- it wasn't a duplex, so when you talked over each other, I don't think one of you could hear the other one.

MR. BECKER: Okay.

MR. AUCIELLO: But I can hear you good on the cell phone.

MR. BECKER: All right. Let's see, Ann, our court reporter, could you read back my last question?

(Pending question was read.)

Q. Doctor, moving on, how many cases per year, let's say in the last five years, on average per year, do you review, medical/legal cases?

A. I would say probably I've reviewed about somewhere around eight a year.

Q. Eight?

A. Yeah.

Q. Eight a year?

A. Yeah.

Q. And how many depositions and trial appearances do you make a year?

A. Do you want the total when I started or which years and so on?

Q. I mean, do you recall?

A. No, let me tell you. What I recall is, that, since I started doing this -- you want the total number of review I have done and depositions? Maybe this is easier.

Q. Sure.

A. Okay.

Q. If you recall.

A. Since 1981, I have reviewed probably about 170, my records. I have given, probably, I think, probably about 70 depositions.

Q. Okay.

A. This is it.

Q. And trial appearances?

A. About 15.

Q. Fifteen?

A. Yeah.

Q. 1-5?

A. 1-5.
Q. All right. And have any of those depositions or trial appearances been on behalf of the patient, the plaintiff?
A. Yes.
Q. Let's deal with trial appearances, first of all. How many have been on behalf of the 15 for the patient?
A. I think probably two or three.
Q. Okay. And did any of those cases involve failure to timely diagnose preeclampsia?
A. Yeah.
Q. And where were those cases at, who were the plaintiffs' lawyers?
A. Well, I think there is one in Houston.
Q. Okay.
A. There was one in Vermont.
Q. Vermont?
A. Em-hm.
Q. And do you remember the name of the lawyer in Vermont?
A. I think his name is -- actually, I

testified there, and it was a woman who died from complications of HELLP syndrome. His name is probably -- it will come to me as we go along.

Q. Okay.

A. I think it's Mr. Curtis-something.

Q. Do you remember what city in Vermont he was in?

A. I have no idea. It was some time in January so cold, and it was probably at least one hour away from the capital.

Q. Okay. Was that recently you testified?

A. No, this probably was, at least, eight or nine years ago.

Q. Eight or nine years ago?

A. Yeah.

Q. And you don't have a listing of your depositions given?

A. No.

Q. Let me -- let's talk a little bit, I know you've written an enormous amount of journal articles and chapters and textbooks on preeclampsia. Let me just talk about some

general principles about preeclampsia, and let me know if you agree or disagree with this, okay?

A. All right.

Q. Can blood pressure be labile in preeclampsia?

A. Yes, it can.

Q. Is preeclampsia a specter?

A. Yes.

Q. And it generally will be care progressive?

A. In general, yes.

Q. Can we agree that the 24-hour urine is the most accurate measure of protein in the urine?

A. If the woman has hypertension, yes.

Q. Let me just get off that issue for one second. Doctor, what is something called "an automated dipstick urinalysis," what does that mean?

A. Say that again.

Q. Hello?

A. Yes.

Q. Have you heard of the phrase

"automated urinalysis"?

A. I don't know what you are referring to to be honest with you. When you talk about urinalysis, there is urinalysis that is done in the lab.

Q. Right.

A. And there is a urinalysis that's done in the clinic with a dipstick.

And more recently, there are people in Australia and Europe who are testing a machine that can read the dipstick. I don't know which one you are referring to.

Q. Well, it's something I'm looking at an article here, it's called "Automated Dipstick Urinalysis."

A. Who are the authors?

Q. Hello?

A. Yes, who are the authors?

Q. It's an Australia article.

A. Okay, yeah. So this is probably, yes, this is -- they are testing a new machine, yes. It's not that available in the United States.

Q. It is not available?

A. No. This is why I asked you from the beginning. Those are the people, Mark Brown from Australia, who is a nephrologist.

Q. Doctor, are you aware of any articles in the American College of OB/GYN that talks about the accuracy of urinalysis dipstick techniques predicting significant proteinuria in pregnancy?

A. Yes, I'm aware of all the literature on that.

Q. What's the conclusion that the most recent literature draws on that issue?

A. Regarding what? You see, again, this is from what you reading from, there are several things. As I said, the 24-hour is the more accurate and give you a quantitative amount of urine protein, if this is your question.

Q. Is there a belief among the specialists in this area of obstetrics that a negative urinalysis can predict what a 24-hour urine would reveal?

A. What do you mean by that?

Q. In other words, if there's a

negative urinalysis, there's no need -- one needn't bother with a 24-hour urine?

A. In which patients?

Q. I'm sorry, Doctor, I didn't hear that.

A. In which patients?

Q. Which patients?

A. Yeah.

Q. In the patients that you suspect might have preeclampsia.

A. I'm still not following you. If a woman has hypertension, then the 24-hour is the most accurate way to make a diagnosis proteinuria; is this your question?

Q. Yes.

A. Okay, yes. Actually, I'm the person who wrote the article.

Q. Well, maybe I'm not making myself clear here. If there is a 24-hour urine -- strike that.

If there is a negative urinalysis, does that remove the responsibility -- strike that, let's start over.

If there is a negative urinalysis,

does that predict that had a 24-hour urine been done, what the likely result would be?

THE DEPONENT: Am I supposed to answer this?

MR. AUCIELLO: If you understand it, yeah.

A. Say that again.

Q. If there is a negative urinalysis.

A. Em-hm.

Q. Can that be predictive of what a 24-hour urine would reveal, had one been run?

A. In a woman who is hypertension, the answer is no. In a woman who is --

Q. Well, --

A. Wait, let me finish. In a woman who is normotensive, the answer is yes.

Q. Can you explain that answer, please?

A. Okay. The urine dipstick is a screening test, all right? It's a very good screening test in normal pregnancy. However, once the patient is diagnosed with hypertension or preeclampsia, then it doesn't have the same predictive value because, then,

you have to do what we call a "diagnostic test."

Q. What does that mean?

A. The 24-hour.

Q. Okay. Now, patients with chronic hypertension, are they increased risks for preeclampsia?

A. Yes.

Q. Yes?

A. Yes.

Q. Now, is HELLP syndrome one of the most severe forms of preeclampsia?

A. I don't know, I don't know how to answer this question. Say that again.

Q. HELLP syndrome.

A. Well, HELLP syndrome is severe preeclampsia, so I don't understand.

Q. It's one of the more severe forms of preeclampsia?

A. Yeah, it is severe by definition. HELLP syndrome is severe preeclampsia.

Q. Patients with HELLP syndrome are at significant risks for hypovolemia?

A. Some of them are, yes.

Q. Okay. And the best way to assess a patient with HELLP syndrome for hypovolemia is to put in a central line or Swan-Ganz?

A. No, I disagree with that. This is not the best way.

Q. What's the best way to assess for hypovolemia?

A. You can do it clinically. You just follow the patient clinically.

Q. I didn't hear the answer.

A. You do it clinically.

Q. One more time, please.

A. You don't need to do central monitoring, you can know if a patient is hypovolemic by looking clinically.

Q. What do you look at?

A. You look at their urine output, you look at their hematocrit, and their response to fluid and/or blood.

Q. If they have hypovolemia and they're not responsive to fluid, then you should give blood?

A. If the etiology is blood loss, yes.

Q. When is blood indicated in a HELLP

syndrome?

A. If the patient has a low hematocrit.

Q. Any other times?

A. No, this is it.

Q. Would you agree that preeclampsia may be more subtle when it is superimposed on chronic hypertension?

A. I don't know. This -- really this term, no, I disagree. I don't know what it means. Why should it be more subtle?

Q. Do you think that the signs and symptoms of preeclampsia on a chronic hypertensor are just as overt as a non-chronic hypertensor?

A. Yeah, they are the same.

Q. They are the same?

A. Yes.

Q. Would you agree that the key to successful management of preeclampsia is intensive surveillance and delivery of the fetus if maturity permits?

A. Yes.

Q. Hypertension during pregnancy is

non-maternal and perinatal in morbidity and mortality?

A. Yes.

Q. Delayed diagnosis of preeclampsia increases the incidences of HELLP syndrome?

A. Yes.

Q. The ultimate treatment of preeclampsia is delivery?

A. Ultimate treatment, yes.

Q. EIP is a world recognized complication of HELLP syndrome?

A. Yes.

Q. In a HELLP syndrome patient, hematocrit can rapidly and significantly decrease?

A. It's not necessary rapidly and significant. In some patients, it could, but most patients they don't have rapid and significant decrease. I would say in the minority, yes.

Q. Women with preeclampsia are sensitive to blood loss due to vasospasm and constricted blood volume?

A. I will say the minority of this is

true. Most women, they don't have this.

Q. Okay. Early delivery should be considered in women who manifest in organ -- in the end organ involvement?

A. Yes.

Q. Symptoms that suggest end organ involvement of pregnancy induced hypertension include visual disturbances, upper gastric pain?

A. Yes, if they are persistent, yes.

Q. What do you mean by your use of the word "persistent"?

A. They have to be severe, localized to certain areas and they are persistently present. If a patient say, I have headache, it's not enough. The headache should be severe, and you give them analgesic and it doesn't go away, then we say it's persistent.

Q. When you say "analgesics," you mean what, sir? What type of medicine is that?

A. Extra Strength Tylenol. You keep on giving this and it is not getting any better, this is what we mean.

Q. Now, first-time moms, do they have

increased risks to develop preeclampsia?

A. Yes.

Q. And moms that are obese, or overweight, are at an increased risk to develop preeclampsia?

A. Yes.

Q. So would it be fair to say that Sherry McElfish had three risk factors to have preeclampsia?

A. Yes.

Q. Number one, first-time mom, number two, obesity, and number three, chronic hypertension?

A. Yes.

Q. So she was at high risk to develop preeclampsia?

A. Yes.

Q. Once HELLP syndrome is suspected, the caregiver should recognize this is a life-threatening emergency?

A. As a general term, yes.

Q. Doctor, I didn't ask you to delineate for me, or for us, all the materials you reviewed, but is it safe for me

to assume -- and, Ernie, you can correct me if you would like, that you looked at all the medical records, the autopsy report, the depositions of the various caregivers and reports and depositions of experts on this case?

A. Yes. Not all experts, you know.

MR. AUCIELLO: I don't think I gave him my other experts, Mike, I just gave him some of the other experts. He has a list right here he could read for you.

A. I have -- let me read what I have. I have the report of all defendants. I have really, except, Steven English.

MR. AUCIELLO: He has Steven English, Lucille Stine --

THE DEPONENT: No, I'm talking about experts. He's the only one I have deposition for.

Q. Okay. Did you look at Dr. Stine's depo?

A. Yes.

Q. Yes?

A. Yes, I did.

Q. Tell me about her training.

A. She had training in obstetrics and gynecology, and then she did a fellowship in maternal-fetal medicine. But she then start practicing maternal-fetal medicine and she was working in her capacity as a house physician. So, really, she did have training long time ago.

Q. That doesn't forgive -- that doesn't forgive her -- that is, Dr. Stine from bringing all her knowledge to bear when she rendered care to Sherry McElfish, does it?

A. No, it's not true, that, you know, she hadn't been practicing maternal-fetal medicine, I don't see how she can act as a maternal-fetal medicine. You have to continue practicing. The speciality has been changing over the years. You are wrong with that.

Q. Are you saying that she can -- it's okay for her to forget her knowledge and training?

A. No, that's not what I said. What I

said, she did her fellowship in the early '80s, and then she hasn't practiced maternal-fetal medicine. And her capacity was, she was acting as a house doctor in that hospital. She was not practicing maternal-fetal medicine.

Q. Doctor, can we agree that when a patient -- obstetrical patient, is diagnosed as having chronic hypertension, or considered a chronic hypertensor, that that patient needs a baseline workup?

A. In general, yes.

Q. And that's what you do, sir, correct?

A. Yes.

Q. Would you tell me what is included in that baseline workup?

A. Usually, you have to make sure they really don't have heart disease, and you get evaluation for the renal function.

Q. Okay.

A. This is it. Again, it depends on the duration of the chronic hypertension and whether the patient has been on medications.

So there are so many things involved.

Q. Okay. But, routinely, if you make the diagnosis of being a chronic hypertensor, you have -- your office has a work-up regimen that you follow, correct?

A. Which is really, as I said, mostly we do the urine culture and 24-hour urine.

Q. Why do you want them to do a 24-hour urine in a baseline workup?

A. I want really to know about their -- whether they have any preexisting renal dysfunction.

Q. Okay. Because maybe you can treat it, right?

A. You cannot treat it, no. There is no treatment for renal dysfunction.

Q. I mean, do you ever bring in nephrologists for your patients?

A. No.

Q. No?

A. No, I don't.

Q. For consultation?

A. No, I don't.

Q. Do you regularly work with

midwives, Doctor?

A. Yes. Hello?

Q. Doctor, your standard workup for a chronic hypertension includes a comprehensive metabolic profile, complete blood count, 24-hour urine and antinuclear antibody?

A. No, not for every patient, it's not true. That's what I told you. It depends on whether the patient --

Q. Some patients, yes; some patients no?

A. Yeah, it depends. That's what I told you.

Q. If the baseline workup uncovers renal disease, does the risk of superimposed preeclampsia increase?

A. It might be. It's not an issue in this case. We know that this woman had perfect renal function throughout pregnancy, so really it's irrelevant for this case anyhow.

Q. Okay.

A. She had perfect --

Q. Would you agree with me, Doctor,

that managing a patient prenatally that antihypertensive medication is indicated when systolic blood pressure gets into the 140s or 150s, or diastolic into the 90s or 100s?

A. Absolutely not. I disagree 100 percent. This is a stupid statement even. We do not -- let me finish. We don't ever recommend this. I am the person who did all the studies saying actually it's not good to do it. So I disagree with Dr. English. I don't think really he's knowledge about this.

Q. Okay.

A. So all the recommendations we said we do not give treatment at this level. All the studies that have reported by me said that you should not treat blood pressure in this level. So the answer is no.

Q. All right. Do you engage in roam blood pressure monitoring, Doctor, with your patients?

A. No.

Q. No?

A. No.

Q. You do not do that?

A. No.

Q. When do you -- do you ever have your patients do 24-hour urine?

A. Yeah, I just told you, you know.

Q. All right. Other than baseline chronic hypertension, what other conditions do you recommend 24-hour urines for?

A. When a patient has gestational hypertension, or you are having a diagnosis preeclampsia, this is the only time.

Q. To help you make -- or to rule in or rule out preeclampsia?

A. Yeah.

Q. Doctor, it would help me to distinguish these terms. PIH, gestational hypertension and preeclampsia, would you distinguish the three for me?

A. Yes. PIH is a garbage term, it should be in the garbage. This is what I teach. So, really, what we use now, we use gestational hypertension, preeclampsia, or superimposed preeclampsia.

Q. And distinguish the three, please.

A. Yeah, the problem with PIH, it

could mean any one of these things. This is why I think it's garbage, because under PIH, the woman could have HELLP syndrome, preeclampsia, superimposed preeclampsia, gestational hypertension or preeclampsia. So it's very confusing, because everybody interprets it differently.

The term "gestational hypertension" refers to women who do not have any history of chronic hypertension, and during pregnancy, they have systolic blood pressure more or equal to 140 and/or their diastolic blood pressure more than 90 on two occasions at least two hours apart -- sorry, at least six hours apart. You got that?

Q. I did. Next, term.

A. The next term is "preeclampsia." Preeclampsia is diagnosed when you have gestational hypertension, plus proteinuria of at least 300 milligram in 24 hours.

Q. All right. And in lay terms, 300 milligrams in 24 hours, how does that equate to a dipstick? Plus one, plus two, plus three, what?

A. I will say in most of the studies we did for the INH, it is more secure if you have the patient who has at least two plus on two occasions.

Q. And those two occasions, how far apart do they have to be?

A. At least six hours apart.

Q. Okay. Last term?

A. Is "superimposed preeclampsia." And this refers to women who are known to have chronic hypertension. And then they are diagnosed with superimposed preeclampsia when they have proteinuria.

Q. Okay. Are the rules of management any different if you are dealing with just general preeclampsia versus superimposed preeclampsia?

A. I will say the difference for superimposed preeclampsia, you have more effect on the baby than you see with additional preeclampsia.

Q. There's greater danger to the baby?

A. Yeah, they are more like the baby grow retarded.

Q. What?
A. With fetal growth restriction.
Q. You're saying that with superimposed preeclampsia there's a greater likelihood of IUGR?
A. Yes, than you see with preeclampsia.
Q. Okay.
A. This is really the only difference.
Q. But as far as management between the two as to when delivery is indicated or to when you put your moms in the hospital, your rules are the same whether you're dealing with a preeclampsic or superimposed preeclampsic situation?
A. Yeah, again, it depends on the patient, the condition there are some -- as a general term, yes.
Q. Delivery is indicated in preeclampsia whenever the risk to the mother outweighs the benefit of continuing the pregnancy?
A. Yes.
Q. The standard of care in

preeclampsia is deliver patients if they have mild or superimposed preeclampsia, if they are at 36 or 37 weeks?

A. I would say it's a general. It's not the standard of care, it's a general recommendation that if a patient has preeclampsia and she has a favorable cervix for induction, to go ahead and deliver them around 37 weeks or more.

Q. What is your definition of standard of care?

A. What a reasonable physician will do in a similar situation.

Q. And how is it, is it what you've just given me is not the standard of care?

A. Because you just were reading about like a thing as that. All I'm saying, two physicians will manage the same patient differently, and both of them are still reasonable. A physician might say I'm going to induce the patient if she has unlapsed cervix at 37 weeks and be consistent with standard of care. Another person say, I'm going to do testing and continue the

pregnancy. Both them are accepted, and both of them I have a flow chart which I said is reasonable to do. This is why I'm having problem with you saying this is a standard.

Q. All right. Doctor, what is -- what does the term "delivery plan" mean?

A. I don't understand. What do you mean delivery plan mean? What do you mean by the question?

Q. When you have a chronic hypertensive patient, is it important to develop a delivery plan?

A. What do you mean by that?

Q. Well, for example, have an agreement, bring the mom into it and say, you are a chronic hypertensor, and if you develop this sign or this symptom, we're going to deliver you. You set that up, and then you have intense surveillance for that sign or that symptom.

A. I'm still not following you, you know. Once you make a decision about the delivery, I don't understand. What do you mean?

Q. This is before. This is like a game plan, a delivery plan. Do you engage in a game plan or delivery plan with your patients or chronic hypertensors?

A. I'm still not following you. Maybe, let me answer it, do it probably, I think you want to know. When we are managing patients as a set, there are indications for delivery, you mean? Is this what you want?

Q. Okay.

A. So as I told you, the patient -- is the patient developing severe disease, is she having changes in the platelet count, is the patient have the symptoms we talked about that are persistent, like persistent headache, blurred visions, nausea and vomiting, then, yes, once the patient reach the stage, she should be in the hospital and then a plan is going to be made to deliver her.

Now, this does not mean you deliver the patient immediately. Because even with women with HELLP syndrome, you can wait 72 hours before you deliver them to give them

fetal serums for fetal like maturity. Is this what you mean, you want to know? Even women with HELLP syndrome we wait 72 hours before we deliver them. So what's your question?

Q. Well, with a chronic hypertensor, do you search carefully for signs of superimposed preeclampsia?

A. Yes, which they did in this case. Her uric acids were normal and twice, so we know she didn't have it.

Q. We know she didn't have what?

A. Superimposed preeclampsia, because they did blood test on her twice. The uric acids were normal, and this is the -- one of the sensitive things we look for.

Her creatinine was normal, so we know that as of September 5, she didn't have superimposed preeclampsia.

Q. When did she -- did she ever develop superimposed preeclampsia?

A. Yeah, ultimately later on she did. She did it somewhere. Hello?

Q. When did she develop it?

A. Somewhere between that visit and the 9/16 visit.

Q. Somewhere between the 5th and 16th?

A. Yeah, because we know her blood tests were perfectly normal, as of September 5, so I assume --

Q. Somewhere between September 5th and the 16th she developed superimposed preeclampsia?

A. Yes.

Q. Yes?

A. Yes. Let me check the prenatal record to be sure, okay?

Q. Yeah, take your time.

A. Somewhere between September 11th and the 16th.

Q. Okay. Why do you say that?

A. Because I'm looking, the visit on the 11th was not any different than the 8th.

Q. Okay.

A. We know that she had amniotic fluid index was normal, reactive NHG, we know that the baby was born with good baby size. So it must -- whatever happened, must have happened

suddenly.

Q. Does the obstetrician search for opportunities to end chronic hypertensive pregnancies prior to the development of superimposed preeclampsia?

A. What do you mean "opportunities," I don't understand. You either develop it or not. What do you mean "opportunities"?

Q. Well, do obstetricians -- is the standard of care to try to deliver chronic hypertensive before she develops full-blown superimposed preeclampsia?

A. The answer is no. Why should we deliver the patient because -- I still don't understand your question. It all depends what gestation it's on. We don't -- if you want what I recommend, I recommend a woman with chronic hypertension who do not require any hypertension therapy. Pregnancy can be continued to 41 weeks, if this is your question.

Q. I didn't hear that answer, Doctor.

A. If you look at my recommendations, what my writing, I said in women who have

mild, chronic hypertension, who are not receiving antihypertensive medications, you can continue pregnancy to 41 weeks. So I don't understand, what's the question? There is nothing wrong with continued pregnancy all the way even beyond 40 weeks.

Q. Doctor, do you -- when you put -- when you suspect preeclampsia, you told me earlier, when you suspected, you like to have 24-hour urines. Do you also put the woman in the -- mom in the hospital for any period of time?

A. No, you don't need to be in the hospital, all you need to do is the testing. And they did the testing twice in her case. They tested on August 21, they ruled out preeclampsia, they tested her September 5 and they ruled out preeclampsia.

Q. Right, they never did a 24-hour urine?

A. No, but the uric acid, I will say almost rule this out.

Q. Well, you're saying the uric acid will obviate the need to do a 24-hour urine?

A. No, what I'm saying, put the two together.

Q. Putting what two together?

A. The information about the uric acid. I will say more likely than not, she didn't have superimposed preeclampsia. Then, she had a normal serum, creatinine, everything was normal.

Q. So are you saying that a uric acid obviates the need to do a 24-hour urine?

A. Some people might use 24-hour, some people rely on the uric acid. You are notified, both of this are written in the literature.

Q. What to you write, Doctor?

A. I use the 24-hour, but --

Q. I see.

A. -- there are people in Pittsburg who use the uric acid. Each center have decided this is what they go by.

Q. Going back to the 24-hour urines, and I don't know if you answered my question, maybe you did. With the 24-hour urine, if you are going to have a patient do a 24-hour

urine, do you let them do that at home or do you put them in the hospital and then regularly monitor the blood pressure as well?

A. No, you do it at home. There is no need ever to put the patient in hospital to do 24-hour urine.

Q. You do that at home?

A. Yeah.

Q. Now, when Sherry McElfish came into the hospital, Doctor, by 11:50 p.m., Dr. Stine had already concluded she was acutely and severely ill, correct?

A. She had severe preeclampsia. That's all I can tell you.

Q. She needed to make Dr. Bailin aware that he was needed in the hospital immediately, correct?

A. You need to get the information first. And she did, she called Dr. Bailin once she had the information.

Q. Right, but when she contacted him, can we agree that she had a responsibility to let Bailin know that he was needed in the hospital immediately?

A. Well, I don't understand why. All what she needed was to report the information, and she gave him all -- Dr. Bailin all the information.

Q. Did she need -- did Dr. Stine have a responsibility to impart to Dr. Bailin that he was needed immediately in the hospital?

A. No.

Q. Yes or no?

A. No. Absolutely no.

Q. No?

A. No. All that she needed to give the information, is Dr. Bailin's decision. It doesn't matter whether Dr. Bailin came immediately or not. As I told you, it doesn't really matter.

Q. Why?

A. It doesn't have changed the outcome a bit.

Q. Okay.

A. As I told you, women with HELLP syndrome, I can wait on them two, three days. There is no need to do a cesarean section for HELLP syndrome. I have written this, so I

don't --

Q. Isn't it true that the sooner you get the baby out, the greater your chances of avoiding a catastrophe in HELLP syndrome?

A. No, you are absolutely wrong about that. Most of the problems of HELLP syndrome actually happen after delivery, and I have written about that.

Q. Right, but the sooner you get the baby out, the less chance you have of severe complications?

A. No, it's not true, sir, again.

Q. So with the HELLP syndrome, you have written, Doctor, that it is okay to leave the baby in the uterus --

A. I just told you.

Q. -- while you monitor severe HELLP syndrome?

A. Yes, I just told you, we wait for three days before we deliver a patient when they are premature.

Q. I'm talking about a 36, 37 weeker, Doctor.

A. Then the standard of care just to

start the process of delivery, and I usually --

Q. That's right --

A. -- yeah, but you don't do it --

Q. -- and the standard of care is to start the process immediately?

A. Not by cesarean section. Actually, I said this would be inappropriate. Actually, if you read the article I wrote of this, I said you should never do cesarean section when HELLP syndrome is the indication. This woman you can give her pitocin and deliver them vaginally. So there was no need to do cesarean section. The C-section was done for fetal reason. So whether this patient was delivered six hours later, it wouldn't have affected the outcome for the mother.

Q. Right.

A. So really the C-section is irrelevant. So we are not talking about something we have to do immediately.

Q. Doctor, should Dr. Stine have foreseen that it is likely that we will need

to consult with a anesthesiologist and other specialists, critical care people, because of this condition?

A. No, absolutely not. The standard of care does not require it then or now at any time.

Q. You're saying that Dr. Stine had no reason to foresee that there was a substantial risk that Sherry McElfish would need services from subspecialists?

A. No, it's not necessary.

Q. By 11:50, when she suspected HELLP syndrome?

A. Absolutely not, I disagree you with 100 percent.

Q. Okay. When do you engage in hemodynamic monitoring?

A. I don't think hemodynamic monitoring are indicated at all in women with preeclampsia. And, actually, I have wrote over and over, it's rarely needed.

Q. How about in HELLP syndrome?

A. It's not needed in HELLP syndrome.

Q. It's not indicated?

A. No.
Q. No?
A. No. This past week, let me give you an example. I have managed probably two or three patients with HELLP syndrome, we never used it. If you look at the 700 women I have managed, it's rarely used. So HELLP syndrome is not an indication for hemodynamic monitoring, period.
Q. Let's turn to your report, Doctor, dated October 13, 2004.
A. Yes.
Q. Do you have that?
A. I have it.
Q. Is that the only report you generated on this case?
A. Yes.
Q. Yes?
A. Yes.
Q. Do you want to make any changes, additions, corrections or modifications to that report?
A. I don't know. I haven't -- I don't think I'm going to do changes.

Q. Well, let's turn to the second page of your report, Doctor.
A. Okay.
Q. Under "Comments."
A. Em-hm.
Q. You say that, "she ordered blood tests which revealed hemoconcentration," which blood test revealed hemoconcentration?
A. Where are we?
Q. I'm under "Comments" on the second page of your report.
A. The hematocrit.
Q. Okay. Any other --
A. No.
Q. -- indication of hemoconcentration?
A. No, hematocrit was the only thing.
Q. And you go on to say, a few sentences later that, "she communicated appropriately with the patient's physician," do you see that?
A. Yes.
Q. And what do you mean by that?
A. She gave them the information.
Q. Okay. What are you assuming she

told Dr. Bailin?

A. Well, the blood pressure results and all the things that was discussed in her deposition.

Q. You're assuming that all took place?

A. Yeah, and there is a nursing note that said she discussed -- spoke with Dr. Bailin twice. But as I told you before, it doesn't matter whether Dr. Bailin --

Q. You say it doesn't matter because the die was cast, as soon as she arrived at the hospital she was going to die?

A. Yes, definitely. She came in a very serious condition at that point.

Q. Right.

A. And this is why whether Dr. Bailin came 30 minutes before or an hour or two hours later, it wouldn't have made any difference.

Q. And it doesn't matter, in your mind, whether they had given her blood before this, it wouldn't have made any difference?

A. What do you mean? Now, you're

asking a completly different question. I thought we were talking about --

Q. I'm talking about the care wouldn't have made any difference, the die was cast, didn't you say that?

A. Yes, sir. There was no need to give blood because the hematocrit was normal as of 2 a.m. The blood was needed later on.

Q. All right. So if she would have received blood by 2:30 a.m, would that have helped her chances of survival?

A. There was no need to give blood, because all I'm saying, according to her hematocrit and platelet count, both of them were normal. So this woman, as of that time, she didn't even have HELLP syndrome. All what she had severe preeclampsia with abnormal liver enzymes. So she had el, E-L, this is it. She later developed all the manifestations of HELLP syndrome.

Q. What time did she develop that?

A. After the blood test, after the second blood test was obtained.

Q. What time was that, sir?

A. Somewhere after 2:30, it could be. Look at the chart?

Q. Sure, just give me an exact time if you can.

A. All right. This patient developed HELLP syndrome or satisfied the criteria for HELLP syndrome somewhere between 2:10 and four in the morning.

Q. Okay. And had she been given blood by three o'clock?

A. Yes.

Q. Would that have made a difference in her survival?

A. We really don't know. I don't think so. I will say more likely than not, the answer is no.

Q. Okay. But you'd defer to a hematologist on that issue?

A. Absolutely not, absolutely, 100 percent. I don't think hematologist have training and experience that I do in this area.

Q. Okay.

A. I have managed more women with

HELLP syndrome than any hematologist anywhere in the United States.

Q. Do you give your patients -- have you ever given any of your HELLP syndrome patients blood?

A. Of course, I give them blood when they needed it.

Q. Do you call on any hematologists for any consultation --

A. No.

Q. -- or do you manage it yourself?

A. Absolutely not. I don't -- I don't need hematologist to manage a HELLP syndrome.

Q. The next paragraph of your report you refer to something called FDP, what does that stand for?

A. The fibrodegenerative product. I said it's unnecessary, it shouldn't be obtained or required. It has nothing to do with the diagnosis of a woman with HELLP syndrome.

Q. Do you order that test?

A. No.

Q. Okay.

A. I don't even look at it when it is there. This is why I said it's unnecessary.

Q. You mentioned that old urea does not result in DIC?

A. Yeah, absolutely. This is absolutely a false statement.

Q. What is?

A. Do what?

Q. What statement are you referring to, Doctor?

A. That somebody said that all urea results in DIC, it doesn't make any sense. It has absolutely -- this is -- I don't know even nobody somebody mentioned this in one of their reports.

Q. You're not sure who mentioned it?

A. Yeah, somebody that, I said this is stupid for somebody to put it. So I have to emphasize it.

Q. Okay. Doctor, your writings, the ones that were certainly done before year 2000 that outline appropriate management, you are attempting, in those writings, to set forth what's prudent and safe care for an

obstetrician, correct?

A. They are one of the recommendations.

Q. Is that yes?

A. Yes, a recommendation.

Q. If the attending obstetricians, including Dr. Stine, didn't comply with many of your recommendations that I read about, would you agree that that would be a standard of care violation?

A. First, let me say that Dr. Stine was never an attending physician. Dr. Stine was a house doctor. Dr. Bailin was the attending physician, so this statement is false.

Second, is that, not doing what I have said, that it doesn't mean they violated standard of care because there are so many other recommendations there. So there is a difference between the two.

Q. Any further thoughts of the Vermont lawyer you testified for either eight or nine years?

A. Oh, Cassidy, thank you. Cassidy, I

think.

Q. Is he from Vermont or a nearby state?

A. I have no idea. I think he's from Vermont.

MR. BECKER: Ernie, could you repeat that for me?

A. I think he's from Vermont.

MR. AUCIELLO: Somebody named Cassidy from Vermont.

Q. Cassidy?

A. Yes.

Q. C-A-S-S-I-D-Y?

A. Yes.

MR. BECKER: I'm looking over my notes here. Does anybody have any more questions while I'm looking over my notes?

BY MR. WALTERS:

Q. I have some. Doctor, my name is Steve Walters, I represent Dr. Karasik, the nurse-midwife and Dr. Balin's group. I have had the good fortunate of looking at your CV. You have, it appears, written about 369 peer review publications.

A. They are up to 370 now.
Q. And a good deal of those -- how many of those deal with the subject matter of this case?
A. A large number.
Q. And the book chapters that you've written, somewhere around 100, 111, 120, something like that, correct?
A. Yes.
Q. How many of those deal with the subject matter of this case?
A. I would say probably almost all of them.
Q. All right. And I think you've given -- you have 414 Nastracs, correct?
A. Yes, I stopped even mentioning because they are much more than that, correct.
Q. And I assume a majority of those deal with the subject matter of this case, correct?
A. Correct.
Q. And you edited nine books, correct?
A. Yes.

Q. Given multiple lectures and presentations on the issues of gestational hypertension preeclampsia, superimposed preeclampsia and HELLP syndrome, right?

A. Yes.

Q. It appears that for such an expert in this field, plaintiff sought your opinion in this case?

A. Yes.

Q. I'm assuming that whoever asked you for your opinion, you would give an honest and forthright opinion, correct?

A. Correct.

Q. Doctor, I'm assuming you are licensed to practice medicine in the state of Ohio?

MR. AUCIELLO: You have a license to practice medicine in the state of Ohio?

A. Yes, I do.

Q. And you spend more than 50 percent of your professional time in the active clinic practice of medicine and/or teaching?

A. Yes.

MR. WALTERS: And that is all the

questions I have, Doctor, thank you.

THE DEPONENT: Who's next?

MR. AUCIELLO: Anybody else?

MR. AUSTRIA: This is Bob Austria, I have no questions.

MR. CROUSE: Steven Crouse, no questions.

BY MR. BECKER:

Q. Doctor, let's go back, would it be fair for me to say that the vast majority of your medical/legal work, the cases that you have agreed to act as an expert on behalf of medical/legal matters, are done on behalf of medical providers?

A. Yeah, this is the way it happened, you know, but it doesn't mean -- as I told you, I have testified numerous times for the plaintiff. It depends who's calling.

Q. Well, I think you just said you testified in trial a total of 15 times?

A. Yes.

Q. And two of those times have been for the plaintiff. And I happen to have the Texas deposition, Doctor, and you're telling

me the other case in Vermont was eight or nine years ago. So both of these cases, at least, have not been in the last eight or ten years. Have there been any plaintiffs' cases you've come into the courtroom in the last eight or ten years?

A. Oh, yeah, I told you -- if you remember, I told you three. I think the one from Houston, probably, was within the past three years or something.

Now, the main reason you don't see me doing more, because once I'm involved with the plaintiff, the cases got settled. This is the real reason. So when I am on the side of plaintiff, a lot of times, you know, the cases get settled.

Q. But as far as the cases you review, do you review as many for plaintiff as the defendant?

A. Yes.

Q. Yes?

A. Yes. All I'm saying, when people know I'm an expert on the plaintiff side, a lot of these cases, they get settled.

Q. I see. Have you given any depositions in the last five years on behalf of the plaintiff?

A. Several of those, many of those. That is what I'm telling you, you know.

Q. Can you give me some names of other attorneys in the last five years?

A. Well, you know, there is Mr. Gillaspie from Houston. There is Mr. Harts from Miami, Florida. There are several in Chicago. Mr. Goldberg and Goldberg, whatever their name is, so, yes.

Q. In Chicago?

A. Yeah. And there is Mr. Rogers, I think he's from Oregon.

Q. Rogers?

A. Yeah.

Q. From Oregon?

A. Yes.

Q. Is there a Rogers in Chicago?

A. No, it's Goldberg from Chicago.

Q. Okay.

A. Is this enough?

Q. Well, that's enough.

A. All right.
Q. And how do you spell the guy in Miami?
A. Hartz, H-A-R-T-Z.
Q. How do you spell the gentleman in Houston?
A. Gillaspie, I think. G-I-L-L-A-S-P-I-E, I'm just guessing.
Q. Okay. Doctor, do you have any handouts that you give your fellows and medical students on preeclampsia or superimposed preeclampsia or managing chronic hypertensors?
A. No, what I do, I drill them everyday on the labor and delivery on the floors.
Q. You do what?
A. I drill them by asking them questions about patients.
Q. Right, but you don't have any handouts, per se?
A. No, I'm sure you are going to see some handouts I give when I give lectures, but I don't keep those.

Q. You don't keep the handouts?
A. No.
Q. Do you have any powerpoint presentations of lectures on chronic hypertensors?
A. Yes, actually, I have one that I give at the American College every year.
Q. Okay. And would it be difficult for you to reduce that to hard copy and give that to Ernie?
A. I will find it for you and be glad to give it to him.
Q. Okay. And relative to any type of powerpoints where you would speak to the need for 24-hour urine? Would that also -- I guess that would cover the chronic hypertensor as well?
A. Yes, I don't think I have any powerpoint that talks about doing 24-hour. It might be present in the chronic hypertension presentation. But whatever I have, I'll give it to him.
Q. Okay.
MR. BECKER: Ernie, do you have a

problem with that request?

MR. AUCIELLO: No, no, that's fine, as soon he -- if he can locate it and give it to me, I'll forward it on to all the parties.

MR. BECKER: That's all I have, Doctor.

BY MR. WALTERS:

Q. Doctor, this is Steve Walters again. I just have one more question. Has Mr. Becker or Mr. Loucas, asked you to review any additional cases besides this one?

A. No, this is probably the only one. I reviewed for him.

MR. WALTERS: Thank you. Have a good evening.

(The deposition was concluded at 6:42 p.m.)

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BAHA SIBAI, M.D.

_____

DATE

C E R T I F I C A T E

STATE OF OHIO
: SS
COUNTY OF HAMILTON

I, Ann Belmont, the undersigned, a duly qualified notary public within and for the State of Ohio, do hereby certify that BAHA SIBAI, M.D.III, was first duly sworn to depose the truth, the whole truth, nothing but the truth; foregoing is the deposition given at said time and place by said witness; deposition was taken pursuant to stipulations hereinbefore set forth; deposition was taken by me in stenotype and transcribed by means of computer; deposition was submitted to the witness for examination and signature; I am neither a relative of any of the parties or any of their counsel; I am not, nor is the court reporting firm which I am affiliated, under a contract as defined in Civil Rule 28(D) and have no financial interest in the result of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Cincinnati, Ohio, this 25th day of August, 2005.

My commission expires December 5, 2005

Ann Belmont, RPR,
Notary Public State of Ohio.