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

IN THE COURT OF COMMON PLEAS

PATRICIA TIPPIE, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 299575
)
SHOBHA TAMASKER, M.D.,)
et al.,)
)
Defendants.)

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THE DEPOSITION OF LASZLO SOGOR, M.D., Ph.D.
MONDAY, AUGUST 23, 1999

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The deposition of Laszlo Sogor, M.D., Ph.D., a Witness herein, called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Tracy L. Barker, a Registered Professional Reporter and Notary Public within and for the State of Ohio, taken at University Hospitals, MacDonald Womens Hospital, Cleveland, Ohio, commencing at 5:20 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiffs:

Dennis R. Lansdowne, Esq.
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2400 National City Center
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On behalf of the Defendants:

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LASZLO SOGOR, M.D., Ph.D.

of lawful age, called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

EXAMINATION OF LASZLO SOGOR, M.D., Ph.D.

BY MR. LANSDOWNE:

Q Doctor, would you state your full name for the record.

A Laszlo Sogor.

Q Dr. Sogor, my name is Dennis Lansdowne. We just had an opportunity to meet a second or two before you were sworn in. I represent Patty Tippie and her husband in a case that's pending in Cuyahoga County Common Pleas Court, and you've been identified as an expert witness for the defense in that case. I'm correct about that, right?

A Yes.

Q And the purpose of our being here today is for me to determine what your opinions are relative to that case and what the bases for those opinions are. Do you understand that's the purpose of our being here?

A Yes.

Q And you have authored a report in this case, and I'm going to ask you about that report in conjunction with questions about your opinions. If at any time you don't understand my question, I use a term incorrectly or inappropriately, please tell me that rather than answering the question. Okay?

A Yes.

Q And if you don't hear my question, there's noise outside or overhead, you don't hear the entire question, please tell me that as well as opposed to answering the question. All right?

A Yes.

Q If at any time during the course of the deposition you need to take a break for whatever reason, to answer a page, whatever, please tell me that and we'll do that at your convenience. Fair enough?

A Yes.

Q And if at any time you want during the course of this deposition to go back and change an answer that you've previously given or amend an answer or add to it or clarify it in any way, please interrupt me at any point and go back to that

question if you wish. Okay?

A Yes.

Q Doctor, I'm going to mark this CV, which I understand is not quite current, but we'll have it marked as Exhibit 1 and then we can explain where it leaves off and where we are today. Okay?

A Yes.

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(Plaintiffs' Exhibit No. 1 was marked.)

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Q Doctor, for the record, would you just identify what Plaintiffs' Exhibit 1 is?

A It's my CV as of November of 1986.

MR. AUCIELLO: '96 you mean.

A '96. I'm sorry.

Q Well, can you fill in from '96 to the present?

A I've given several more lectures at various places, written a couple of book chapters I believe that are not on here, and probably have written an additional paper.

Q Okay.

A But I don't remember the exact dates, so that would have to be looked up.

Q Okay. Well, you have a current CV in your

office somewhere, and that can be provided to your counsel at some point, or to some counsel at some point?

A Any time you wish.

Q Very good. As far as your position, is it still associate professor of reproductive biology at Case Western Reserve University?

A Yes, it is.

Q And are you also still the chief of the division of gynecology?

A Yes, I am.

Q And also the director of the OB/GYN residency program?

A Yes, I am.

Q Are you still the chief of gynecology at the Cleveland Veterans Administration?

A Yes, I am.

Q Do you have a subspecialty within the field of obstetrics and gynecology?

A Pelvic reproductive surgery.

Q And what is pelvic reproductive surgery?

A Well, that's repairing "bad bottoms." Put quotes around "bad bottoms."

Q Okay.

A Repairing women's vaginas, perineum from after

delivery, gravity, and aging.

Q And as far as your clinical practice, is that what the greatest percentage of your time is devoted to, pelvic reproductive surgery?

A That's my academic specialty. Clinically I'm still very diverse, so I can't say that because I don't keep numbers specifically that way. To be able to say that that's the dominant, that's a specialty area that I specialize in, but I do a lot of other procedures as well, as well as obstetrics.

Q You say clinically your practice is diverse. Just give me an idea of what your practice consists of.

A What sort of -- I'm not sure what you want.

Q Well, you described that you do pelvic reproductive surgery. What other aspects of gynecology are you involved in?

A Operative endoscopy, obstetrics. Those are the main things.

Q You're still delivering babies then?

A Yes.

Q Are you in a group practice?

A Yes. The faculty practice is a group practice.

Q Okay. And is that University Obstetrics, or

what's its --

A University OB/GYN Associates, Inc.

Q Do you have an office besides the office here at University Hospitals?

A Yes. The corporation has an office at Landerbrook.

Q Do you also have an office at Landerbrook?

A I practice there as well, yes. I see patients there.

Q How much of your time is spent there, as opposed to here?

A Pretty well 50/50.

Q Have you written any papers or abstracts dealing with the subject of episiotomies?

A No.

Q How about episiotomy repairs?

A No.

Q How about complications of episiotomies?

A No.

Q How about with respect to repairs of third-degree lacerations following childbirth?

A No.

Q Never written anything on that?

A No.

Q Have you given presentations on any of those

subjects that I just asked you?

A I don't believe so.

Q Have you, for purposes of your involvement as an expert in this case, done any review of literature on the subjects that are involved in this case?

A Not in the near memory. I probably have not done a review of this literature since probably 1990.

Q Okay. What would have occasioned you to do a review of literature on these subjects back in 1990?

A Possibly for resident education.

Q Are there protocols at University Hospital regarding episiotomies and the repair of lacerations after childbirth?

A No.

Q Are there standing, or standard orders at MacDonald Hospital for those subjects?

A Yes.

Q Okay. Can you tell me what those standard orders consist of?

A No.

Q Why not?

A Because I don't memorize the computer screen.

Q Okay. When we're talking about standard orders, so I'm sure I'm talking about the same thing, I'm referring to orders that would be placed in a patient's chart as a routine matter, a patient who's received an episiotomy, for instance.

A Oh, I'm not too sure that -- those fall into -- there's several categories of this. Okay? How do you do standard ordering? Number one, you have a standard order with some variation to suit the particulars on the patient. So if the patient doesn't fall out into some particular category, they get a standard order set. And, you know, you just check it off on the computer as to what you want of those standard orders.

If you don't check anything, pretty well the standard orders are followed by nursing, their protocol. But if there's some unique situation that stands out that you want something different in addition to or less than, then you have to make a specific order for that.

Q I guess there would be a standard set of postpartum orders?

A Correct. There's a standard set of postpartum orders. There's a standard set of orders for post C-section, one for hysterectomies, one for

vaginal hysterectomies, one for bladder repairs, and for all the basic procedures that are done in significant volume.

Q And then the physician can either cross out or check those things that they want or don't want out of that sort of menu of those'standard orders; is that --

A Correct.

Q Okay. What have you reviewed for this case?

A Well, I guess the obstetrical records that were provided to me two years ago.

Q And do you know what --

A Whatever those were. And I have no recollection of that, what the specifics of that were.

Q And you probably don't have them anymore?

A I have not saved them because when all this happened, I assumed I would no longer be a party to this case. As you all know, your records get beyond belief in terms of storage capabilities, and the hospital has not seen fit to give me adequate storage.

Q Well, what do you have left of your file, your report?

A This was in my computer and that's it.

Q Okay. "This" you're referring to your August

28, '97 report?

A Yes.

Q Written. to Ms. Susan Renker?

A Correct.

Q I just have to run through a couple quick questions. **Do** you know when **Ms.** Renker contacted you about this case?

A I don't recall that.

Q Or how it is that you were contacted about this case?

A I believe she -- the usual way that Jacobson lawyers contacted me, by telephone asking me if I would review a case, and then they would send the case out to me by courier. I'd look at it and give them a verbal opinion as to whether I thought it was defensible or not defensible.

Q Okay. Let me ask you about your involvement in medical-legal cases. How often do you review medical-legal cases as an expert?

A I probably get one every other month.

Q Okay.

A You know, that is someone actually sends me a case.

Q How long has that been the case?

A Probably since 1986. But it hasn't been of that

volume, so, you know, you start out low and you eventually build up a volume. So early on there certainly may have been one case a year, and gradually this has evolved into a busier case presentation.

Q And the present volume would be about one every other month?

A That's about what it boils down to, yes.

Q Have you ever been involved in a case besides this one involving just generally episiotomy and repair of a tear?

A I've been an expert on a similar case before, yes.

Q On a similar case, is that what you said?

A Yes.

Q When was that case?

A Probably last year.

Q And did you testify in that case?

A No.

Q Did you author a report?

A I don't believe so.

Q Did you give an oral opinion?

A Yes.

Q And was that to an attorney representing a physician?

A No. It was to the attorney representing the plaintiff.

Q Okay. And could you just generally tell me what that case involved'and what your opinions were?

A Very vaguely, it was very similar to your case. The patient had a fourth-degree episiotomy that broke down and required a couple of surgical procedures to correct.

Q And your opinion was?

A There was no malpractice involved.

Q Is that the only other case similar to this one you've been involved in?

A To my recollection, yes.

Q Okay. Have you ever been a defendant in a lawsuit?

A Personally?

Q Yes.

A Yes.

Q On how many occasions?

A Don't know. Many of my cases are hospital-based cases with the residents.

Q Okay.

A So I don't keep track of those.

Q In terms of your own, personally being named in a case, approximately how many times?

A About four.
Q Were those all in Cleveland?
A Yes.
Q Did any of those cases go to trial?
A One.
Q When was that?
A '87.
Q What was the result of that?
A Verdict for the defense.
Q Were you represented by someone from Jacobson-Maynard in that case?
A Yes, by that time we were with Jacobson.
Q The other three cases?
A Never materialized.
Q Okay. In terms of the cases that you act as an expert witness in, approximately what percentage are for the patient and what for the physician?
A Lately it's been pretty even.
Q Lately, say in 1999?
A Past couple of years.
Q Last couple of years?
A Yes
Q Prior to that?
A Prior to that, it was mostly defense work.
Q What are your charges for expert consultation?

A I don't know. It's in the computer.
Q Okay.
A My secretary has those in the computer, and I don't pay much attention to it, so I'm sorry. I'd misquote you. If you need that --
Q That's all right.
A -- you're welcome to ask for it.
Q I'm sure we'll get a bill and we'll deal with it then.
A Okay.
Q Do you know Dr. Tamasker?
A Just -- I don't know her personally. I've seen her at OB/GYN Society meetings, but beyond that, I don't know her.
Q Have you spoken with her about this case?
A No, I have not.
Q When you say you see her at Society, you mean the Cleveland Society?
A The Cleveland OB/GYN Society, yes.
Q How often does that meet?
A Five times a year.
Q And Dr. Tamasker is, apparently, a member of that society?
A I would presume so.
Q Okay. Have you ever discussed a patient with

Dr. Tamasker?

A Not to my knowledge,

Q Has she ever referred a patient to you?

A She may have. I don't recall.

Q Other than the, I think you said the obstetrical records, what other records did you review regarding Patty Tippie?

A Nothing else.

Q Did you review any of the records of her attempted repairs?

A No.

Q Do you know what attempted repairs she had?

A No.

Q Do you know what her condition is today?

A No.

Q Let me just ask, with respect to -- do you know if she had any pudendal nerve damage?

A I don't know.

Q That's something that can be checked using manometry?

A Well, there's a lot of different ways to check for pudendal damage or other neurologic injuries. That's a technique.

Q Okay. Do you know if that was done?

A No.

Q Does it matter to you in your opinion whether she has pudendal nerve damage?

A No.

Q I'm asking about that because you have a sentence in your report that, the incontinence may be then due to the magnitude of the separation or it may be due to pudendal nerve damage.

A Correct.

Q If, in fact, Mrs. Tippie underwent testing for pudendal nerve damage and that testing revealed no nerve damage, you'd have no reason to dispute that, correct?

A Correct.

Q Based on some earlier questions, I can move through some of this a little quicker, so give me a second.

Have you discussed this case with any other physician?

A No.

Q Just so we can make sure I understand what your understanding is of what occurred, at the time of the birth of her first child, Dr. Tamasker performed a midline episiotomy on Mrs. Tippie?

A Yes.

Q And during the birth process, Mrs. Tippie sustained a third-degree perineal tear?

A Well, either that or it was cut. I can't tell which it was. But either wag, she sustained a perineal third-degree laceration, either by incision or by tearing.

Q Have you read Dr. Tamasker's deposition?

A No.

Q Okay. I mean, would there be a reason why you would do an incision that went all the way into a third-degree laceration?

A Well, yes. There are situations where you need to do that to effect adequate room to deliver the baby atraumatic and to minimize further damage to the mother's perineum.

Q And in this case, you just don't know which, whether it was done intentionally or whether it was just an extension of the episiotomy as a result of the birth process?

A Correct.

Q And it doesn't make any difference to you?

A It doesn't make any difference.

Q And so I'm clear, how do you define a third-degree perineal tear?

A The fascia encasing the sphincter is torn or

cut, but the sphincter muscle itself is intact.

Q Do you know why Dr. Tamasker did an episiotomy?

A Well, there's usually two reasons to do that. Number one is the principal reason that we believe in episiotomies is that it reduces maternal injury. The second reason is to reduce or shorten the length of time to deliver a baby.

Q Do you know specifically why Dr. Tamasker did it in this case?

A No.

Q You do episiotomies, I take it?

A Yes.

Q Do you do midline episiotomies?

A Yes.

Q Is that the episiotomy of choice for you?

A Exclusively.

Q You don't do the mediolaterals?

A Never done one.

Q Does a midline episiotomy increase the likelihood of third-degree and fourth-degree tears?

A Yes.

Q Over mediolaterals?

A Correct.

Q But you prefer it, in any event?

A Yes.

Q Why?

A The complications of the mediolateral, which means you're invading a different muscle group. There you're cutting the levator ani as part of that process, which can lead to more severe complications, in my view.

Q Dr. Tamasker went on to do a repair near the time of the delivery, correct?

A Yes.

Q Do you know if it was before or after the delivery of the placenta?

A No. Don't know.

Q Generally, what percent of births do women end up with third- or fourth-degree lacerations?

A Well, fourth degrees are probably around 1 percent these days. Third degree it's very hard because, you know, different physicians have a little bit of a different threshold for reporting. So I would probably say, in my experience and my observations at this institution where we do 5,000 deliveries a year, third degrees are probably 10 to 20 percent, if honestly reported.

But a lot of this is somewhat subjective

as to what you call a third degree. Because, you know, is a little fascial tear a third degree, or does it take a lot of fascial tear before you call it that? So there is a bit of room on that one to wiggle. Fourth degrees, there's very little room to wiggle. I mean, you tear the sphincter and you're into the rectal mucosa. That's what you've got.

Q In terms of the repair, do you know what kind of repair Dr. Tamasker did?

A No. I don't recall. I don't know if it was described.

Q What type of repair do you utilize for third-degree tears?

A Third-degree I generally -- and not always, it just sort of depends on the patient's anatomy, their parity. I usually interrupted do a repair of the fasciae as an interrupted set of sutures. At that point you're back to a second degree, then I do a standard running closure of the second degree.

Q So sort of like a two-layer repair?

A Yes. That's what I do.

Q Okay.

A But I'm not saying that that absolutely has to

be done. I think most of these heal just fine practically no matter what you do. I had a professor once who threw one suture across the whole dang thing, tied it, and that was it, . . .

Q Most third-degree repairs are successful?

A The majority are successful.

Q Do you know what the percentages are on that?

A You know, it's such a low number that it's hard to realistically measure what the breakdown is on episiotomies.

Q I mean, specifically with respect to third-degree repairs, do you know how many of those fail?

A I don't.

Q I mean, percentage wise?

A I don't have a rough number at all. Probably maybe one or two per thousand.

Q Is the best chance for a success of a repair the first repair?

A Always.

Q Why is that?

A Don't know. But this *is* our experience with all surgical procedures that fail for function, no matter what you're talking about. If it fails the first time for some functional result, it's

likely to be less successful the next time you do it.

Q All right.

A And it may have to do with tissue denervation, you know, that is some of the nerve injury that occurs with the first surgery, something to do with why the first one broke down in the first place. It may have to do with the patient's specific tissue type. A lot of factors come into play on that. This is not clear to us, but it's true no matter what you're doing.

Q In your own experience, have you ever had a third-degree repair fail?

A I'm not sure I've ever had a third degree fail. Fourth degrees, yes.

Q Following the repair of a third-degree laceration, are there certain things that should be done or ordered for that patient?

A I don't discriminate. I don't think third-degree lacerations are any different in terms of outcome than second degrees, so I don't make any special distinction personally.

Q Well, what about for second- or third-degree lacerations that are repaired, are there orders that you utilize for those patients?

A I use the same orders for second and third.
Q What are those orders?
A I have to look at the computer. I haven't entered one in years. I have the residents do it for me. They're so good to me. So I honestly can't tell you what our data set is currently because I haven't done it in a while.

But, basically, it would involve vital signs, drugs that you typically would use for postpartum woman, whether lactating or not lactating, pain medications, and then perineal care. Okay. That is, the nurse is going to look at that time a couple of times a day, cold compresses for 24 hours followed by a sitz bath if you feel you need it and whatever ancillary drugs you wanted to use for stool softening depending on the patient's history.

Q You would utilize some stool softening?
A Depends. Some patients take them, some won't. I don't think it's a big deal for either third or fourth degree -- or second or third degrees, whether you use them or you don't. I think a lot of these patients don't take them even if you give it to them. I don't think it makes a difference in outcome whether they do or not.

It's a pain situation rather than an outcome situation.

Q What about enemas?

A Well, I don't use enemas on anybody. I think, it's cruel and unusual punishment.

Q Specifically in a patient who's had a repair, would you agree that an enema would be contraindicated?

A I think it's contraindicated for fourth degree. I don't think it is for anything else.

Q Why it is contraindicated for fourth degree?

A Because. you have the mucosal incision line which can be stressed by having an enema. Okay? Again, it depends on how high that mucosal tear goes. When you don't have mucosal tears, I really don't think an enema's going *to* cause an episiotomy to separate or break down.

Q Would an enema increase the likelihood that you're going to disrupt a repair?

A Not for anything but a fourth degree, because the sphincter relaxes when you're having a bowel movement, so it has no real effect on the sphincter mechanism.

Q What about just placing the enema in the anus, given that you've just repaired a laceration?

A There is no laceration in the anus. This is through the vagina, of the sphincter mechanism, and it's nowhere near the anus actually. If you look at it in three dimensions.

Q So the placing of an enema would not -- your testimony would be that that would not increase the likelihood of the repair failing?

A That is my testimony.

Q Okay. And that you would see no reason not to order an enema for a patient who has a third-degree repair?

A Would order it on a specific need basis, if the patient was really struggling and did not have a bowel movement. As I told you, I do not do this on a routine basis for anybody. I could see that there are situations in which a patient may need an enema for other reasons that aren't, you know, obvious at this point.

Q Would you order or recommend ordering an enema in a patient such as the one we're talking about, third degree?

A I might. What I don't know was what was her exam at the time of delivery? Is she full of stool. Is it impacted? These are all questions that I don't have the answer to and those all

may lead me to request an enema. I don't see it as a contraindication given the fact that she had a third degree. That's all I'm saying.

Q Okay. I didn't quite finish my question there. I apologize.

Would you order **an** enema **as, or** recommend ordering an enema to such a patient as part of a routine order?

A As I've stated, I do not do that.

Q In this case, have you reviewed the report of Dr. Baggish?

A No, I have not. I think we talked about this just before you came, and I did not see his written thing, but I was given sort of a summary statement of his opinions.

Q Okay. Do you know Dr. Baggish, by the way?

A Not personally.

Q Do you know of him?

A *Yes.*

Q How is it you know of him?

A Well, I know he's chairman at -- which hospital is that in Cincinnati? I have a very good friend at that hospital, Mickey Koraim, and he told me that Dr. Baggish was coming to be his chairman.

Q Good Samaritan Hospital.
A That's the one.
Q Dr. Baggish in his report states that the patient should have been placed on a low residue diet. Do you agree with that?
A Whatever that is, sure.
Q Okay. Stool softeners?
A Fine with me.
Q No rectals?
A I don't know. I think if a rectal is indicated, you do a rectal.
Q No enemas?
A As I mentioned, I don't think it's a contraindication. If you have a need to do that.
Q Closely followed up?
A I don't treat them any differently than a second degree. As I mentioned, I don't think these are at any higher risk to have an adverse outcome than a second-degree episiotomy.
Q Okay. What kind of orders do you give for the fourth-degree tears?
A For those, we're very insistent. Okay? On stool softeners, to make sure that the stool softener -- I usually typically will even give

them antibiotic therapy for the fourth degrees, and generally give the patient kinds of precautions. You know, avoid digital rectal examinations. Definitely no enemas. If symptoms change, they're to report in immediately.

And what we look for is a worsening pain. We recognize that they hurt, but over time they're supposed to improve. If all of a sudden the pain starts getting worse again, we want to see them immediately for evaluation.

Q And the no enemas again, what's the reason for that?

A Well, because you now have a row of sutures in the rectal mucosa, and when you put the enema in under those situations, the tip of the enema bag, you can actually disrupt that suture line. But now you have an actual suture line in the rectal mucosa and you have to protect that. That's the primary reason. Now, the other issu is, depending on how far it goes, where the rectum causes force and that may cause the sutures to break.

Q But, again, I'm just, because I don't understand the anatomy as well as I should, you don't think

that an enema poses any kind of risk to a third-degree repair?

A That's my opinion.

Q And the reason for that, again, and I know that you tried to explain this, but I'm just trying to understand anatomically why that is.

A Okay. The best way to view this is that the damage is on the opposite side of the rectum. So it's very much away from the rectum is where the fascial separation occurs. So you're putting your stitches way away from it on the far side of the sphincter muscle, and so the rectum has really nothing to do with a third degree. You just -- and if you didn't repair it, it probably would be fine too. Okay? So you could probably just not bother putting sutures in and scar tissue would fill in the gap. But, you know, we try to reproximate anatomy, and it's so far away from anything with the rectum, it just has nothing to do with it.

Q Do you know why -- well, let me ask this. Did Dr. Tamasker's repair fail?

A Obviously, it failed.

Q Okay.

A That's a matter of record.

Q Well, I mean, you know that because somebody told you that, I assume?
A Correct.
Q Because you said you hadn't reviewed any records of the repair.
A Well, obviously, the patient felt it fail. Because she underwent voluntarily other procedures to try to get a better fix. Whether this was a cosmetic or a functional situation, from the patient's perspective, something failed.
Q And do you know when it failed?
A No.
Q Do you know why it failed?
A I have a reasonable suspicion.
Q And what is that?
A An infection.
Q And why do you have that reasonable suspicion?
A Because that's what the majority of these are, is an infection remote from the time that they leave the hospital. That is, typically infections in most tissues occur seven to ten days after the event. And so my belief is, since that's the majority of how these things ultimately fail, is that it's either a low grade

or serious infection. Usually we see the serious infections because the patients get pretty sick, but you can get kind of a low grade infection that then causes the sutures to prematurely separate and leaves you a bad outcome.

Q Okay. You're saying that just based upon generally --

A Statistical probability, yes.

Q You're not saying that based upon any specific information about Patty Tippie, correct?

A Correct.

Q You don't know whether she had any symptoms of low grade or serious infection, correct?

A Do not have that information.

Q Okay. And so you couldn't really testify with any reasonable degree of medical probability that infection is what caused this failure, correct?

A That I can do. Because almost all of these bad outcomes from episiotomy repairs are due to infections, so within reasonable probability, hers was too.

Q Well, but, I mean, that's just statistical answer, isn't it? I mean, you really --

A That's what we go by is a statistical answer.

MR. AUCIELLO: You asked him for a probability.

A That's a probability and I've given it to you.

Q I know, but wouldn't you want to look at the rest of the records?

A I don't have to. 90 percent of the time this is infectious based, whether the records support it or not.

Q Well, what is the other 10 percent?

A Well, the other 10 percent could be potentially that it wasn't correctly repaired. It could be due to other factors. For example, we see this all the time, the patient has intercourse before they're supposed to. That would be another factor, and a significant percent of the time a patient has premature intercourse.

Q What other factors?

A Those are the main ones that I'm aware of.

Q Okay. So do you know what the repair -- do you know in what manner the repairs failed? I mean, other than the infection, do you know what specifically?

A It's very hard for me because the records that I had at the time of her postpartum visit didn't

indicate anything significant, so it's hard. I don't know what the -- I don't have any subsequent records from other treating physicians to look at exactly what the deficit was.

Q And do you know how many repairs she had?

A Not off the top of my head.

Q If a repair does fail, is it important to treat that failure promptly?

A No. I think it's just the opposite.

Q What do you mean?

A I think you delay and you delay and you delay.

Q Why?

A The success -- as I read this literature, the success of early repairs is very poor. The success of later repairs is much better. Secondly, I think you can take a significant percentage of patients who feel that their repair isn't right and it will be right by six months. That is, scar tissue will form. It will sort of heal itself. So I'm a firm believer in delay. I believe that's what our literature supports.

Q And I guess we're talking about re-repairs, as opposed to -- because we talked about the

initial repair?

A Well, you have your primary repair, which is, here's the episiotomy, I fixed it. So that's your first repair.

Q Right.

A Anything subsequent, I delay six months.

Q And the reason for that delay, again, is?

A So that enough scar tissue forms, that a lot of those patients don't need anything. They're okay. Not perfect, but okay and functional. All the inflammation surrounding it -- because, as I mentioned, 90 percent of these are infection. That infection has to clear up. If you jump in too soon, you're guaranteed failure because you still have a lot of infection and. inflammation in that tissue. So you can't fix it. So if you're going to bother with an early repair, it is very difficult to get that area sterilized.

There is some evidence in the literature that you try to use a lot of antiinflammatory agents, use a lot of antibiotics. But their success rate still isn't that good. Still around 50 percent with early repairs and it's 70 percent with late repairs. These are tough

fixes. This is a very difficult area because it's always contaminated.

Q And because it is tough to do, to have successful re-repairs, it's important to give the initial repair every chance to be successful, correct?

A I have no problem with that concept.

Q Have you read Mrs. Tippie's deposition?

A No, I have not.

Q What are the signs or symptoms that a repair has failed?

A Typically it's pain, or the patient notices it fell apart. And typically for fourth degrees, when we see them in the office, they usually come in, and 10 days or 14 days, it's obviously infected and all the sutures are broken and it's just falling apart. That's typically what we see. The patients come in.

For a few patients who kind of simmer with a low grade infection and then their own body clears it or they'll call the doctor and some antibiotic is called in, and we'll see that occasionally. The patient kind of heals herself but then has functional deficits. Either dyspareunia or pain with intercourse because

things aren't healed quite right, or they have incontinence of either stool or gas.

Q I'm sorry, did you say that's with fourth degree?

A That's it. Because I don't see very much with third degrees. And the literature doesn't have a whole lot to say about third degrees.

Q Mrs. Tippie has incontinence of stool and flatus. Are you aware of that?

A Now I am.

Q As of tonight you're aware of it?

A Correct.

Q Would that indicate to you that she probably had a fourth-degree tear?

A It certainly is a reasonable hypothesis. Or the other option you have to address is, did she have those symptoms at her postpartum visit? If she did not, then I would venture to say you have to ask the question, did the subsequent treating physician cause it?

Q Well, let's assume that at her postpartum visit she complained of incontinence stool.

A Okay.

Q Would you agree that she probably had a fourth-degree tear at the time of her, the

birth?

A That doesn't necessarily follow. I think what you do, if a patient comes in postpartum on her regular visit complaining, you look for rectovaginal fistula is your first diagnostic test. So you have to look for a rectovaginal fistula. If that exists, then your third degree may have had an abscess in it, i.e. an infection, and you rode it into back into the rectum. That can happen. That's a mechanism for getting that with a third-degree or even a second-degree episiotomy. That just happens. It's infectious process that leads to the blowout of the rectal mucosa.

Q That would be a fistula?

A That would be a fistula. But the patients complain of rectal incontinence because when they have bowel movements, it can come out of the vagina or it can even come out the vagina when the patient is not even having a bowel movement. I can tell you it's not guaranteed that it's due to a missed fourth degree.

Q But if no fistula is identified --

A So when you do a careful exam and you find that the mucosa's intact and the rectal sphincter is

intact, then you have to wonder, is this neurologic injury? And that can be very transient and takes up to six months for the neuron, the pudendal nerve, to regenerate itself to give you continence. And we see this at the other end quite often in terms of bladder incontinence postpartum. It's almost universal.

Q What does it mean when the anterior anal muscle is found to be absent in the midline?

A That means that the muscle has separated. So that that generally means that, to some degree, either the infectious process destroyed the bridge, or it was cut. That is, some part of the muscle had been cut.

Q And if some part of the muscle is cut, what does that mean?

A That means that it's a more advanced third degree. You see, as we're talking, as I mentioned earlier, you know, third-degree episiotomy's somewhat fuzzy in terms of their definition. Because in principal, you can cut half the muscle and it's not a fourth degree. The definition of a fourth degree is that you cut the entire muscle or the entire muscle tears. Half of it tears, some people would

label that as still a third degree. But that's now more risk to separate.

Q But if the muscle is absent in the midline --

A Well, it will become absent because the rest of the fibers will separate and tear over time. Especially if an infection sets in or if you have a particular hard bowel movement, it will just go boing and that's it. There's nothing there.

Q How long would that take?

A It could take months, or it could take a week, just depends on how much strain is in the system and when the infection sets in. And this is what we don't know in this case, is exactly what does a third-degree episiotomy mean?

Q Well, again, have you ever seen a patient with a third-degree episiotomy end up with permanent incontinence of stool?

A I have not personally seen this, no.

Q If Mrs. Tippie has permanent incontinence of stool, would you be more inclined, based upon your statistical knowledge that we've discussed, to believe that she had a fourth-degree tear?

A I don't think so.

Q Well, what would you attribute this permanent

incontinence to?

A Attribute it to an infection that went unrecognized by the patient so that she did not present to a doctor and ended up with some degree of loss of separation in the rectal sphincter and/or couple that with some neurologic damage at the time of delivery that led to her incontinence.

Q Okay. Well, what if we assume she doesn't have any neurologic or pudendal nerve damage?

A Okay. Well, then I think an infection led to the complete separation of the rectal sphincter and her dysfunction.

Q So she had an infection --

A But that can occur whether you have a fourth degree or third degree. Infections occur in this area, be it, thank goodness, at a low rate, but they do occur.

Q This would be an infection that, apparently, she didn't know she had; is that right?

A Or didn't respond to any signs or symptoms.

Q Well --

A I mean, if it's a low grade --

Q If she testifies that she didn't have any signs or symptoms of infection --

A I accept that.
Q Okay. So it would have to be a low grade infection, so low that she didn't have any experience any signs or symptoms of it, but virulent enough to destroy this repair?
A Correct.
Q And cause a complete separation?
A Cause a separation of the muscle, yes.
Q Have you ever read of any such thing happening?
A Don't recall.
Q Ever heard of any such thing happening?
A It happened to me.
Q What's happened to you?
A I've had patients who have no -- not exactly this scenario. But I've had patients who have had second or third degrees who when they come back have no anterior rectal sphincter. I mean, they're still continent, okay, because -- 'the majority of these patients are still continent because the scar tissue forms an adequate bridge to give them closure.

And a few patients -- and, again, this is why I bring up the neurologic issue, I'm very suspicious. That even if the anterior segment is missing, there's enough scar tissue there to

give adequate closure for continence. But if your neurons aren't working well, then you're not going to get enough force generated to get good closure.

So this happens, I think, fairly routinely. I mean, I see hundreds of pregnant women over the years, some which I've delivered, some of which other obstetricians delivered, and quite honestly, you'd be amazed as to how much sphincter deficit you see that are asymptomatic, and I don't view that as particularly anything interesting, that observation.

Q Sphincter deficit meaning --

A Meaning there is an anterior gap. So you do a rectal exam, there's no sphincter there. That's what that means. It's very, very common. It's just most women don't have any symptoms related to it because the system works. Even if it's three-quarters.

Q All right. So in this case, are you aware of what Dr. Tamasker ordered postpartum for Mrs. Tippie?

A Roughly, I remember seeing the post-op check-off box order sheet.

Q Okay. Are you aware that Dr. Tamasker says that

she does not order enemas for patients like Mrs. Tippie?

A As I said, I have not read her deposition, so I don't know.

Q Well, in this particular case, Dr. Tamasker, we know based upon the records, did order enemas for Mrs. Tippie. You're aware of that now, right?

A Correct.

Q And you don't find that to be below the standard of care, correct?

A I do not

Q Not something that you would do, but you don't find it to be below the standard of care, correct?

A That's correct.

Q And this patient, do you see any reason to have ordered an enema?

A There's none documented.

Q There's nothing on the records that indicates to you a need for an enema for Mrs. Tippie, correct?

A Correct.

Q Let me just ask this: Any indication in any record you've seen that Mrs. Tippie did have an

infection at the episiotomy site?
A No.
Q Did you read the obstetric discharge summary?
A I probably did.
Q You have the obstetric discharge summary in front of you?
A Yes, obstetric discharge summary.
Q And do you see where it says, complications, operative and postpartum?
A Yes. It says "none."
Q And under that section there's boxes for what degree of perineal laceration and vaginal and cervical laceration?
A Yes.
Q And "none" are marked?
A It's not filled in, correct.
Q That would be inconsistent with the other parts of the record?
A Not necessarily because it may reflect how you interpret these words. To most of us, a laceration is an incidental thing when you didn't do something. In other words, something tore as part of a mechanical act. And she may be viewing the interpretation here as, well, I cut a third-degree episiotomy, and therefore,

there was no laceration.

Q Well, did you read the labor and delivery summary?

A Probably did.

Q And --

A I mean, I don't know. You'd have to ask Dr. Tamasker. I'm just hypothesizing. I interpret these forms, when I cut an episiotomy, I cut a second-degree episiotomy, or a third-degree episiotomy. If --

Q Intentionally?

A Intentionally. If that's what I did, then there's no laceration. Okay. Because a laceration has a different meaning in the English language to me.

Q Okay.

A Now, the problem is that people get this all mixed up and muddied up. They call one the other, the one this. I just try to keep it very precise and keep those words separated. "Laceration" is something that happens inadvertently.

Q Okay.

A But I don't know. You'd have to ask her how she views that.

Q And labor and delivery summary, she has X'd out third-degree perineal laceration. Are you aware of that?

A Yes.

Q That's not on the page in front of you?

A Right. I know.

Q So, apparently, at least at some point in the record she had indicated third-degree laceration, correct?

A Yes.

Q I want to clarify something I'd asked before. You said that you had not read anything in the literature about a case of a woman having an infection that did not produce any signs and symptoms yet went on to break down the repair of the episiotomy. Is that what you said? You had not read any literature --

A No. What I think I said was that I'm unaware of any literature on third-degree episiotomies breaking down.

Q You're just unaware of any at all?

A I just have not read anything in the literature about third-degree episiotomies. In other words, there is fair literature on fourth-degree episiotomy. If you go into, type in

"fourth-degree episiotomy," you get a literature on it. If you type in "third degree," you get nothing. If you type in "episiotomies," and "episiotomy complications," you get literature. That then separates, gives you a big general picture of episiotomy problems but doesn't discriminate between first, second, and third degree, but it will discriminate into fourth degree.

Q And let me just be clear then.

A Okay.

Q Because later on you said something about patients that you had, but let me ask you specifically, have you ever had a patient with a third-degree laceration and the repair failed?

A I have not had a patient -- I mean, this is very difficult to answer.

Q Right.

A Because it depends what you mean by "failure." And you have to be very, very specific. If by failure you mean incontinence of stool or gas, I have had no such thing. If you mean failure that anatomically there are defects, then I've had that.

Q Okay. And in those cases in which you've had

anatomical defects, you attribute that to infection?

A I think a low grade infection is what does the significant majority of those defects, or did a lousy repair. Those are the only two choices you really have.

Q Or the premature intercourse you mentioned?

A Well, that's a possibility certainly.

Q Well, do you know why Mrs. Tippie, if she had a third-degree episiotomy or laceration and does not have pudendal nerve damage, can you explain why she would end up with a permanent incontinence?

A Well, I think there are a lot of factors as I mentioned earlier. I think the number one is she did have an infection. In her particular case, it led to incontinence. Now, I would venture to say I'm very suspicious that I think she probably also had a transient pudendal nerve palsy, which may not be a chronic thing. If you just wait, it will go away.

Q What do you mean wait and it will go away?

A Well, as I mentioned to you before, most of these are transient and very temporary and it will clear up. That is, the nerve palsy will

clear up in six months. So their incontinence will go away in six months.

Q Well, that didn't happen.

A I don't know that because I'm not aware of those records.

Q Okay. Well, I'm just telling you that she is incontinent. It's now --

A Yes. But I'm going to ask you then, did she have pudendal nerve testing prior to her first attempted repair?

Q Not to my knowledge.

A Okay. I rest my case.

Q What does that mean?

A That means if she did have at that point a pudendal nerve palsy, surgery was guaranteed to fail.

Q So are you critical of the doctor performing the surgery?

A I have no idea since I was not asked to review those records and I did not review those records. So I can't be critical at this point.

Q So let's see what you're going to say here next week. You would say that based -- that you've reviewed the obstetrical records relating to the birth of Mrs. Tippie's first child, right?

A Correct.
Q And no other records?
A Correct.
Q And that based upon those records, you know that, or it appears that there was a third-degree either laceration or episiotomy, you're not sure which, using your terminology, correct?
A Correct.
Q And a primary repair?
A Yes.
Q And that Dr. Tamasker gave some postoperative orders, postpartum orders, that included an order for an enema, and you don't think that the ordering of an enema under those circumstances was below the standard of care, correct?
A Yes.
MR. AUCIELLO: Yes meaning you don't believe that it's --
A Yes, I believe that it's correct.
Q Okay.
MR. AUCIELLO: It is not a violation of the standard of care?
A It is not a violation of the standard of care.
Q That will be your answer. Okay. I understand.

And that although you don't see any indication in the records for doing an enema either, correct?

A Correct.

Q And you, yourself, based upon the records, would not have ordered an enema, correct?

A Correct.

Q And then you believe, based upon statistics, that Mrs. Tippie -- well, because you've been told that her repair failed, although you don't -- you haven't reviewed any documents or records to tell you that it had failed, because you've been told that it failed, your conclusion would be, based upon statistics, that there must have been some infection?

A Correct.

Q And that's based merely upon the fact that in the majority of cases infection is what causes a repair to fail?

MR. AUCIELLO: Forgetting the word "merely."

Q And I apologize for going over this, but I really didn't expect it to be part of your testimony.

So I just want to be clear. You've never

examined Mrs. Tippie, correct?

A I have never examined Mrs. Tippie.

Q Did you ask to examine her?

A I did not.

Q And you don't know of any records that would indicate that she had **an** infection of any kind, correct?

A Correct.

Q There are other possibilities for the repair to have failed and you're excluding those statistically, I guess?

A Yes. And there's lack of evidence for that, for those hypotheses. So intercourse, you know, I don't know. That's not documented anywhere in the records, but, you know, we can ask.

Q All right.

A If it's a missed diagnosis fourth degree, that's usually evident very quickly after the episiotomy was badly repaired, and you'll know about that with the first bowel movement. So since that didn't occur, we have to exclude that.

Q What would you know with the first bowel movement?

A Well, they're going to have it -- either the

whole thing breaks apart because the stool's coming out of all the breaks and openings that you didn't fix -- and especially if you gave them an enema. You couldn't miss that one after an enema.

Q Okay. And I take it you're not going to be offering any testimony about Mrs. Tippie's current condition, correct?

A Correct.

Q You're not going to be offering any testimony about whether that condition is permanent, correct?

A Correct.

Q Back to your report here, and I take it this is the only report you've ever produced, correct?

A Correct.

Q When we were talking about that sentence where you said the incontinence may be then due to the magnitude of the separation, what do you mean by that?

A That anterior portion of the sphincter that wasn't there on that examination, okay, how big is it before you get incontinence?

Q You mean how big the separation between the two ends of the muscle is?

A Yes, a circle.
Q Right.
A And how much of the pie is missing. The more you're missing, the more likely it is going to be dysfunctional as a sphincter. Because it loses mechanical advantage the bigger that separation is.
Q So technically a third-degree tear or episiotomy can be right to the very edge of that muscle, correct?
A Correct.
Q Leaving only a tiny, tiny part?
A Bit intact.
Q Part of the muscle intact?
A Correct.
Q And you'd still call that a third degree?
A You'd still call that a third degree.
Q And would you still treat that kind of patient who had that kind of a third-degree tear the same as a second degree, or would you treat them more like a fourth degree?
A Well, there's no substantive information for me to make a scientific judgment on that, so I tend to treat all third -- if I don't have a tear of the mucosa, I treat them all the same,

personally. But there's no information on this. This is a very subjective thing and nobody has written a paper saying, well, if I cut one-third of the muscle, two-thirds of the muscle, 90 percent of the muscle, what are the different outcomes? No such thing, .

Q So you don't treat --

A I do the best repair that I possibly can for the system, and as long as the rectal mucosa isn't cut or torn, I don't treat those any differently. If the rectal mucosa is cut, then absolutely that becomes an automatic fourth degree and I treat them differently. They're high risk.

Q And you say, it certainly seems reasonable in a patient who presents with rectal sphincter incontinence to attempt a repair, especially if no clinical evidence for neuropathy exists. Neuropathy, you're referring to the pudendal nerve damage again?

A Yes.

Q And you mentioned before some possibility or consideration that the subsequent physician, treating physician, caused some type of damage to the patient; is that right?

A It's always a possibility. I don't know if they did or not. I have not reviewed those records. I have not looked at that. I have no opinion at this point. But every time you do a surgical procedure, you cause more harm than good. You can.

Q You can?

A You can cause more harm than good. You can.

Q Just give me a minute, Doctor.

If at the time of the six-week checkup Mrs. Tippie had been having incontinence of gas and stool at that point, you would have done nothing; is that correct?

A Correct. I would have discussed the situation with her extensively. I might have ordered some sort of testing of the nerves. Might have. But, generally, I don't at that point. I encourage my patients at this point to just wait. Time does wonders. And then re-see them on a monthly basis to see how they're coming along. That's what I do.

Q And if she continued to have --

A If she continued to have symptoms at the time that about six months has transpired, I would certainly before entertaining doing a repair, I

would check on the nerves. If the nerves are fine, I would go ahead and do it myself.

Q Do you do that kind of surgery?

A Yes, I do.

Q Sphincter plasty, is that what that would be called?

A That's a technically okay word.

Q All right.

A I mean, you know, some physicians prefer a colorectal surgeon does it. It really doesn't matter. I think it's just somebody who's experienced and skilled at doing this, it's reconstruction. This is kind of a branch of that.

Q Right. Do you know Dr. Priebe?

A No, I don't.

Q Do you know Dr. Strong?

A No, I don't.

Q Your report indicates that this seems to be an unfortunate consequence of childbirth, as opposed to any negligence on Dr. Tamasker's part. Do you recall that last sentence of your report?

A Yes.

Q What do you mean as consequence of childbirth?

A Well, there are risks to having a child. The mother can die., She can bleed significantly requiring transfusion. She can get an infection. And generally risks that we don't talk about much are risk of incontinence of both stool and urine, significant tearing and laceration of the pelvis and perineum, fistula formation. These are all risks of childbirth that, in many instances, are independent of obstetrical management.

We have tried to tighten up our obstetrical management to limit these. We do C-sections if the baby's too big. We do C-sections if the labor isn't going just right, and that minimizes some of these so that we don't hear much about these. Fifty years ago that stuff was rampant because we didn't know how to manage them any better. We couldn't do C-sections safely. So now we have a 25 percent C-section rate to get rid of the majority of this type of problem. But it's a risk of having a kid. And that doesn't mean the doctor did anything bad.

Q Fifty years ago the --

A Fifty years ago the Cesarean section rate in the

United States was 3 percent.

Q And women developing incontinence of stool after childbirth was rampant?

A It was very common, yes. Stool and urine. Because we delivered big babies. You deliver a ten-pound baby through an orifice that doesn't accept it, you're going to rip all of these. You're going to have long labors with prolonged pushing that led to neuropathies.

Q Well, what were the percentages back --

A I don't know. I didn't practice obstetrics. This is just historical reading and talking to the old-time guys.

Q I was just asking you because you have the percentages for the Cesarean rate, I thought you --

A It's very common. It's just the historical stories, if you will. Reading the older literature, which I don't review in particular steady rate. But this was a very common problem, related to the fact that we didn't do C-sections with such low thresholds.

Q How do you know Dr. Tamasker did an adequate repair?

A I don't know. The record indicates at the time

of discharge the -- or the nurse, the visiting nurse visit, the episiotomy appeared intact. And given the fact --

Q Had she had a bowel movement by then?

A I don't know. I don't recall whether that was documented.

Q Okay. Doctor, that's all the questions I have for you. Have we covered the opinions that you're prepared to offer in this case?

MR. AUCIELLO: I think you have.

A I think we have.

Q Okay.

THE STATE OF OHIO,) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Tracy L. Barker, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Laszlo Sogor, M.D., Ph.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, and that the foregoing is a true and correct transcript of the testimony so given by him, as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 26th day of August 1999.

Tracy L. Barker, Notary Public
within and for the State of Ohio
My Commission expires May 23, 2000.

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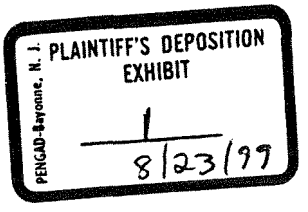

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