IN THE COURT OF COMMON PLEAS
OF WAYNE COUNTY, OHIO
- - - - -

ANGEL ROBBINS, etc., et al.,
Plaintiffs,
vs Case No. 00 CV 0027
Judge Wiest

ANTHONY P. TIZZANO, M.D., et al.,
Defendants.

- - - - -

DEPOSITION OF ANTHONY P. TIZZANO, M.D.
MONDAY, DECEMBER 4, 2000
- - - - -

Deposition of ANTHONY P. TIZZANO, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Wooster Clinic Women's Health Center, 1739 Cleveland Road, Wooster, Ohio, commencing at 9:00 o'clock a.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
Skylight Office Tower Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant Wooster Clinic
Roetzel & Andress
JOHN V. JACKSON, II, ESQ.
One Cleveland Center Tenth Floor
Cleveland, Ohio 44115
216-623-0150

On behalf of the Defendant Wooster Community Hospital
Reminger & Reminger
GREGORY ROSSI, ESQ.
200 Courtyard Square
80 South Summit Street
Akron, Ohio 44308
330-375-1311

- - - -

- - - - -

(Thereupon, TIZZANO Deposition Exhibit 1 was marked for purposes of identification.)

- - - - -

ANTHONY P. TIZZANO, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF ANTHONY P. TIZZANO, M.D.

BY MR. MISHKIND:

Q. Would you state your name, please.

A. Anthony P. Tizzano.

Q. You are a physician?

A. Yes.

Q. An OB/GYN?

A. Yes.

Q. We were introduced before the deposition started. My name is Howard Mishkind. I will reintroduce myself officially on the record.

I will be asking you some questions about the lawsuit filed in connection with the

death of Alexus Robbins.

You understand that, don't you?

A. Yes.

Q. Have you ever had your deposition taken before, sir?

A. No.

Q. Even though you are represented by one of the finest, let me just give you a couple of precautionary instructions. I am sure Mr. Jackson has indicated to you not to answer any questions unless you understand them, and I will repeat that. If you don't understand something that I ask you, tell me you don't understand it and I will rephrase it or have Vivian read it back. Fair enough?

A. Thank you, yes.

Q. Also, I will wait until you are done with an answer. I will ask that you wait until I am done with my question just so we are not overlapping each other. Fair enough?

A" Sure.

Q. The reason I tell you these things in terms of making sure that you understand and waiting, as I will wait for you, is that the record is important for all sides. I want to

rely on your testimony. When we leave here today, you understand that I am going to rely on what you have told me for purposes of this case?

A. Absolutely.

Q. Fair enough.

MR. MISHKIND: Now, before we begin the questioning, let me just indicate as a housekeeping matter, I have a copy of the records that were obtained presuit. I am not sure whether they are complete. I see there may be a couple entries after the death that I don't have.

For the record, I would request you to provide me with a complete copy of the records that I have just reviewed, Mr. Jackson.

MR. JACKSON: The materials, our office record here --

MR. MISHKIND: Correct.

MR. JACKSON: -- there are things in there that you don't have?

MR. MISHKIND: There is an entry from February 15, '99 that I don't have and there may be some labs I don't have, as well. I would just as soon have an entire copy of the chart. We will all be working off the same thing for future

purposes. I think Mr. Rossi wanted a copy also.

MR. JACKSON: Show me the February 15th entry.

MR. MISHKIND: The very first entry here, which is actually -- I'm not sure that it's pertinent. There may be some additional labs in here that I don't have.

I am not suggesting that I am missing anything more than that, but I would rather play it safe.

Mr. Rossi would like a copy, as well, I believe.

MR. ROSSI: Yes, I will have a copy.

MR. JACKSON: Okay.

Q. We are at an office called the Wooster Clinic; is that true?

A. Wooster Clinic Women's Center.

Q. You are affiliated with a number of OB/GYN's?

A. Yes.

Q. Are the same group of OB/GYN's affiliated with you that were affiliated back in the latter part of '98 and early part of '99 when Angel was going through her pregnancy?

A. Two exceptions. Dr. Steiner is no

longer here. He retired a year ago, approximately October. And Dr. Theresa Canfield is new July of '99.

Q. I notice there are a number of nurse practitioners and midwives that are here.

A. We have two nurse midwives. Those are both new from just not even a year ago. But there were two other midwives that were here before. And I can't remember if they were here at the time our patient in question was here or not. I would have to look that up.

And then we have some nurse practitioners, Nancy Morgan, who is our nurse educator, and we have Julie Gates, who is a nurse practitioner, who does primarily almost exclusively GYN. And we now have Molly Hastings, who had been a nurse here for a long time but has now become a nurse practitioner here, as well.

Q. In looking at the chart, it appears that the last time that Angel was seen in this office was February of '99; true?

A. Correct.

Q. Have you had any contact with Angel since February of '99, either professionally or in the community in any way?

A. No.
Q. I want to ask you a little bit about your educational background. That will be the first topic, and then I will talk to you about some general aspects as it relates to vaginal delivery following a cesarean, and then I want to talk to you about the labor and delivery of Alexus, just to give you sort of a road map of where I am going. Fair enough?
A. Yes.
Q. Where did you go to medical school?
A. Ohio State.
Q. Graduated what year?
A. '88.
Q. Tell me about your training after graduating from medical school.
A. From there I went to Bethesda Oak Hospital, Cincinnati, and spent four years there.
Q. And was that an OB/GYN residency?
A. Yes.
Q. That takes us up to '92?
A. Correct. From there I went into practice in Franklin, Pennsylvania. I was there for one year and then came here.
Q. What type of practice were you in in

Franklin, PA?

A. Obstetrics and gynecology practice, as well.

Q. Do you have any training beyond the four-year residency? A fellowship?

A. No.

Q. Why did you leave the practice in Franklin, PA?

A. It was a town that was just not what I had hoped it would have been. A great practice, but the town was shrinking.

Q. Where are you originally from?

A. Chesterland. East of Cleveland.

Q. Your practice has then been in Wayne County since 1993?

A. Yes.

Q. What states are you licensed in?

A. In Ohio.

Q. . I take it you were licensed in Pennsylvania?

A. Yes, Formerly I have been licensed in Pennsylvania and Kentucky.

Q. Have you ever practiced in Kentucky?

A. Other than during residency, that was the only time. We actually had hospitals that we

went to there and we needed to be licensed in Kentucky, as well.

Q. Have you ever had your license suspended or revoked?

A. No.

Q. Ever had hospital privileges suspended or revoked or called into question?

A. No.

Q. Have you ever applied for privileges at a hospital and been denied?

A. No.

Q. You are board certified?

A. Yes.

Q. When did you become board certified?

A. I believe it was '94. I would have to look. Either '94 or '95.

Q. Were you successful in your first attempt at becoming board certified?

A. Yes.

Q. Do you have any teaching responsibilities?

A. Not formally. The one area I do spend time in is domestic violence and so I give lectures on domestic violence, the physician's role in domestic violence a few times a year.

Q. Where?

A. The last one was at Lake County West, which was just last Thursday, and I gave a lecture to an ethics committee and a group of physicians a year prior to that. At another symposium that the hospital had, I gave another lecture. The others are to schools and so forth.

I serve on a board or served on a board of a domestic violence agency, and by virtue of that, I would speak frequently to our group and to nurses at the hospital and so forth.

Q. How did you establish that interest?

A. When I first came to town, I was quickly -- I had actually went to a case on behalf of one of my patients and that got noticed and then I got asked to join the Board at Every Woman's House, and it grew from there. So I have continued to do that, as well as develop a sexual assault program at the hospital.

Q. Aside from the lectures and the interest you have in domestic violence, have you had any other teaching responsibilities at any medical schools or with regard to any residents?

A. Only as a resident.

Q. And that would be when you were in Cincinnati?

A. Correct.

Q. Either in the Cincinnati or the Kentucky hospitals?

A. They would have all been at the Cincinnati Hospital at Bethesda.

There are other lectures I give, but those aren't -- those are usually lectures I'm requested to give in areas of gynecology, but I'm not specifically teaching residents. I guess you could say we are teaching.

I have given lectures in the history of medicine as well as relates to pelvic surgery and the development of midwifery.

Q. At what hospital?

A. The Cleveland Clinic. I have given a lecture there. I gave grand rounds a year ago. I did another lecture in the spring, which was part of a retirement postgraduate course, and then most recently at a gynecology course in October of this year,

Q. Doctor, what hospitals are you affiliated with?

A. The Wooster Hospital, Wooster

Community Hospital.

Q. Do you have privileges at Cleveland Clinic?

A. I am on staff at Cleveland Clinic, and how my privileges actually would be worked or looked upon there, I am not sure. I don't know that I can go there and operate or see patients.

Q. Is it fair to say that all of your obstetrical patients that are treated in the hospital by you are seen or treated at the Wooster Hospital?

A. Yes.

Q. As I understand it, you are officially an employee of The Cleveland Clinic Health Systems; is that correct?

A. Yes.

Q. And how long have you been such an employee?

A. Two years in February. Yes, two years this past February.

Q. So February of 1998?

A. Correct.

Q. Before February of 1998, who was your employer?

A. The Wooster Clinic.

Q. Were you an officer of the Wooster Clinic?
A. I was on the board.
Q. What was your position on the board?
A. A board member.
Q. Did you hold a title?
A. No. I was newly elected for about a year before we joined The Cleveland Clinic, and then that board existed for a while during our first year and then dissolved and another board formed.
Q. Do you have privileges at any other hospitals other than the Wooster Hospital or to whatever extent you had privileges at The Cleveland Clinic?
A. No.
Q. Have you practiced at any other hospitals or had privileges at any other hospitals since '93 up to the year 2000?
A. No.
Q. Have you done any writing, any publishing of any articles of any medical literature?
A. Articles during medical school. An article on preeclampsia, and then during

residency, an article on the course of labor in primigravidas with epidural anesthesia.

Q. I am sorry, when was that article, the last one?

A. That would have been, I believe, it was in '91 or '92.

Q. Where was that?

A. I'm sorry, that was actually in 1990; a poster presentation at the American College of OB/GYN.

Q. Was it subsequently published --

A. No.

Q. -- in peer review journals?

A. No.

Q. Just a presentation --

A. Correct.

Q. -- that you presented and provided some written material at the time of that?

A. It was actually putting up our data on a series of bulletin boards at the beginning of the American College meeting in San Francisco in '90 and being there to answer questions as persons would come by.

Q. Was this data that was compiled while you were in Cincinnati?

A. Yes.
Q. What I should have done, doctor, and I will do it now, is ask whether you have a professional resume, a curriculum vitae?
A. I do.
Q. Is that something that you could retrieve, not necessarily right this minute, but before we leave today?
A. Sure.
Q. And does that set forth the publications and presentations that we have touched on?
A. Yes, they are all detailed there. And the poster presentation was ready for publication, but the other supporting authors never completed it during our residency, so those are included as pending.
Q. Fair enough. Do you have an area that you specialize in in the area of obstetrics and gynecology?
A. It's general obstetrics and gynecology.
Q. You have never had the misfortune of being named as a defendant in a medical malpractice case before this case; true?

MR. JACKSON: Objection. Go ahead. You may answer.

A. Yes, there have been two other cases.

Q. Two other cases, okay. The other cases, for whatever reason, your deposition was not taken?

A. Correct.

Q. This is the first time that you have had the misfortune of having your deposition taken as a defendant?

A. That's correct.

Q. And for that matter, having your deposition taken in any connection?

A. Correct.

Q. The two other cases that were filed against you, were they here in Wayne County?

A. Yes.

Q. Are either of those cases still pending, to your knowledge?

A. Both of the cases were dismissed. I think that they are within a time period, though, of less than a year from the time of dismissal, so my understanding is that they could still be --

Q. So you are counting the days?

A. Yes.

Q. I take it both of those cases arose out of treatment of your patients that were in this practice here?
A. Correct.
Q. Tell me the names of the patients as it was set forth, so-and-so versus Dr. Tizzano. Who were the plaintiffs in those cases?
MR. JACKSON: Objection, but go ahead, you may answer.
A. Yes, let me just remember the names.
One was Becky Shearer.
Q. Her last name is spelled how, please?
A. S-H-E-A-R-E-R, I believe.
But I much prefer to get the record to find out.
MR. JACKSON: He can check that with the court, doctor.
MR. MISHKIND: Mr. Jackson wouldn't let you get the record.
MR. JACKSON: He is right about that.
What's the second name, if you can recall?
THE WITNESS: And the other one is --
MR. JACKSON: You were personally named in both?

THE WITNESS: Right.
MR. JACKSON: There would be a record at the court. If you can't remember, tell him.
A. It will come to me.
Q. If you think of it, let me know. I don't want you to dwell on it to the point you don't listen to any of my other questions, but if you are like me, you may think, or yeah, it was Mary Jones. Let me know.
A. I can get those. If we have a break, I can get those easily.
Q. That's fine. Thank you.
Did either of those cases have any similarity to this case insofar as a trial of labor in a prior cesarean section, a vaginal delivery?
A. No.
Q. Did either of those cases have to do with a birthing issue?
A. No.
Q. So they were more gynecological issues?
A. No. The first case was a fetal demise that occurred at home.
Q. And the second case, the subject

matter of that?

A. An IUD placement.

Q. Thank you. Have you ever served as an expert witness in a medical negligence case?

MR. JACKSON: Objection. But you may answer.

A. No. Just in domestic violence cases.

Q. Let me refine that, just to make sure that your answer is still no.

Have you ever been approached by an attorney to review a case either on behalf **of** a physician or on behalf of a patient to provide an opinion, either informally, or in writing, on whether the standard of care was met?

MR. JACKSON: With that, I object, and you don't have to answer that question.

If he actually acted as one, I think you have a right to know one, but whether he has been approached, I think that goes beyond what you are entitled to.

MR. MISHKIND: **If** he has been approached, I think I am allowed to ask him. I am not sure I am allowed to ask him anything beyond that as to how many times he has done that, because it may be confidential, but if he

has been approached from either side and provided opinions --

MR. JACKSON: I will let him answer if he ever acted as an expert in a medical malpractice case for either plaintiff or defendant.

THE WITNESS: No.

Q. And you understand the context in which I was asking it?

A. Yes.

Q. I take it in your practice you receive the ACOG practice bulletins?

A. Yes.

Q. And I know that you distributed it to Angel at one point, and we will talk about it during the questioning when we get to the next phase, but the ACOG bulletin on Vaginal Birth After Cesarean Delivery; true?

A. Yes. I didn't personally distribute it, but it was given to her.

Q. By Nurse Morgan?

A. Correct.

Q. Nurse Morgan gave it as part of the practice pursuant to the policies or the protocol of this office; true?

A. Yes.
Q. In other words, she wasn't giving it on her own. This was part of the practice that was to be followed?
A. Right. We subscribe to those, purchase them and use them very liberally.
Q. And do you also get the clinical management guidelines from ACOG, as well?
A. Yes.
Q. And do you follow those, as well?
A. In terms of do I read them?
Q. Yes.
A. Yes.
Q. Are you familiar with the ACOG practice bulletin that dealt with vaginal birth after previous cesarean delivery that was in effect prior to January of 1999?
A. I am familiar with it.
Q. Have you reviewed any medical literature in preparation for today's deposition?
A. Other than to read through the brochure that we provide and to look up the technical bulletin that you mentioned, no.
Q. Do you maintain any type of a file in your personal library on the issue of informed

consent as it relates to the delivery options of a patient who has had a previous cesarean delivery?

A. Not specifically titled as such.

Q. Anything that touches on the issues of the information that a reasonable and prudent obstetrician should provide to a patient so that an informed decision could be made as to what's in the best interest of the patient and the baby as it relates to the anticipated delivery?

MR. JACKSON: I'll object, but go ahead. You are talking about a VBAC; is that right?

A. This is a file, I believe a file for VBAC, trial of labor after cesarean.

Q. Are these journal articles that you have gathered over time?

A. In part.

Q. What else would be in that?

A. There could perhaps be an ACOG newsletter or something of that sort. I actually did not go through that.

Q. Fair enough. But in any event, this is something that you maintained over the years on the topic of VBAC; true?

A. Correct.
Q. Articles that you have read and retained for future reference?
A. And the course work that I do. I don't usually tear those down, but I keep and maintain all the catalogs from the courses that I went to.
Q. But specifically, you would have a file that would be designated VBAC and would have different --
A. I believe I do.
Q. -- would have different sources in there, perhaps course material, perhaps medical literature; true?
A. Yes.
Q. Items that you consider to be reasonably reliable on the topic of VBAC?
A. Yes.
Q. Is that something that's maintained in your office?
A. Yes.
MR. MISHKIND: Let me request on the record, John, if you have no objection, once you have taken a look at it, would you please provide me with a copy of that literature? If you have

an objection to it --

MR. JACKSON: I will let you know if we have an objection to it.

MR. MISHKIND: If you do have an objection, I would ask you to identify on the record or in a letter to me on either, what it is was in the content of that file or a blanket reason for why you would have an objection to providing it to me, okay?

MR. JACKSON: We will consider your request.

MR. MISHKIND: Thanks. I know you will.

Q. Are you familiar with any articles that deal with the issue of vaginal delivery following a cesarean section in terms of broad based studies on the efficacy of VBAC's?

MR. JACKSON: Objection. Answer if you can.

A. Not specifically. I couldn't quote one.

Q. Is there any, in your opinion, reliable medical information contained in any of the standard obstetrical text, whether it be Williams or any of the others, that touches on

the issue of VBAC and the pros and cons of a vaginal delivery or a trial of labor following a cesarean section?

MR. JACKSON: Objection. You may answer.

A. I think there are a number of generally good textbooks. I will say for the most part, outside of the textbooks which I would often use to embellish information, I usually get from ACOG technical bulletins and I look to those as giving us reasonable guidelines, updated as necessary. Oftentimes what's in a textbook, although the publishing date may be such-and-such, the information may be compiled over a lengthy period of time. At least there is some notion that they are dated as such and then their bibliography is very easy to go to if you need more information.

Q. You would deem the ACOG technical bulletins to be reasonably reliable and authoritative?

MR. JACKSON: Objection. Define authoritative as you want that term to be understood.

Q. Do you consider them to be reasonably

reliable sources of information, the ACOG technical bulletins?

MR. JACKSON: Objection. You may answer.

A. I think they have worked well for me in my practice.

Q. You referred to them from time to time and relied upon them for information from time to time in your practice; true?

MR. JACKSON: Objection. You may answer.

A. Yes.

Q. And those ACOG technical bulletins which you deem to be reasonably reliable have bibiliographies, as well; true?

A. Correct.

Q. And those bibiliographies have been the source of additional information for you to embellish or to expound upon what's in the ACOG bulletins?

A. If necessary.

Q. What about some of the standard texts like Williams? Do you consider Williams to be a reasonably reliable source for general information as it relates to the efficacy of

trial of labor?

MR. JACKSON: Objection.

Q. Following cesarean section.

A. It may be. I am not familiar with having read in Williams those chapters, but Williams is an outstanding text.

Q. Have you ever had occasion to lecture on the topic of VBAC?

A. No.

Q. From your reading of the ACOG technical bulletins, any of the journal articles or things that you have accumulated in your VBAC file, are there any randomized trials to prove that maternal and neonatal outcomes are better with a VBAC than with a repeat cesarean delivery?

MR. JACKSON: Objection. You may answer.

A. I don't know that there are those specific studies.

Q. I am going to move off of the general topic with you and start talking a little bit about Angel, okay?

A. Okay.

Q. As I understand it, Angel was a

patient of this office for a prior delivery?
A. Correct.
Q. Were you at all involved in her prior obstetrical care?
A. I believe so. I would have to look at the record to be sure, but that was in '95, as I recall, and I would have been here then.
Q. This is not a memory contest, although you are doing fairly well so far. Please feel free to refer to the chart, which is to your right, when you answer those questions. I don't want you to come back later on and say I was inaccurate because I saw something.
A. Let me go ahead and do that then.
Q. Fine.
(Pause.)
A. During her prior pregnancy, when she began care here in 1994, I saw her on two occasions, three occasions during that pregnancy.
Q. You were not involved in the actual delivery, were you?
A. I did not do her C-section, and the assistant is not listed on this, so I can't tell for sure.
Q. You are not certain whether you were

the unnamed assistant?

A. Right. It's just on his little -- if I had the hospital record of that, I would know. Oh, wait one second. No, I was not.

Q. That would be Dr. Brown, would it not?

A. Dr. Brown, yes.

Q. And the doctor that delivered Angel's first child was Dr. Bellow?

A. Correct.

Q. Is Dr. Bellow still affiliated with this group?

A. Yes.

Q. So you would have been aware that the first pregnancy that Angel had that resulted in the birth of her child was a cesarean section due to a failure to progress?

A. Correct.

Q. And she had a baby that was 8 pounds, 3 and a half ounces from her first delivery; true?

A. That's correct.

Q. She also had a number of other diagnoses or complications, at least documented in the record at the time of the first delivery?

A. Cesarean section, yes.

MR. JACKSON: Excuse me. You said diagnoses and complications. Did you mean to say it that way?

MR. MISHKIND: I did, because that's how it's referenced, secondary diagnoses or complications.

Q. Just from your read of the record, what were some of the secondary diagnoses or complications?

A. Mild preeclampsia during the course of her pregnancy and there was a 20 percent partial abruption of the placenta.

Q. As I understand it, she had a low transverse cesarean section?

A. Low transverse uterine incision cesarean section.

Q. The baby was fine at the time of delivery, according to the record?

A. Correct.

Q. Was this a planned cesarean, as you could tell, as best as you could tell?

A. I would say not. She had failure to progress, so they allowed her to labor at some point.

Q. The baby's apgars were ten and ten, so

the baby was fine?

A. Did well.

Q. Between the cesarean in '95 and the pregnancy, which is the subject of this lawsuit, were you involved or was your office involved in any obstetrical care for Angel?

A. That, I am not sure of. I know she had another pregnancy, but -- yes.

Q. And she had an elective termination of a pregnancy with a D&C; true?

A. That's correct. That would have occurred somewhere besides here, but we had seen her for a pregnancy in April of '96. She was six weeks along.

Q. And do your records then reflect that the elected termination occurred on or about May of '96?

A. I have '96. I didn't put down the month, but I put down '96.

Q. At this point, I should identify Plaintiff's Exhibit 1, which is a typed one-page sheet of information on Angel Robbins. Is this something that you are familiar with?

A. Yes.

Q. Something that you prepared?

A. I did.
Q. When did you prepare it?
A. In the last two days.
Q. And why did you prepare it?
A. In discussing with my attorney the case to refresh my memory and review the chart, I put this together.
Q. Does this exhibit contain anything that is not otherwise reflected in the chart?
A. There were items in here that I looked at, both the hospital chart and office chart, but that's it. And this was a summary of the findings at the time that she presented to labor and delivery. So it was just to refresh my memory in that regard, her history and so forth.
Q. Doctor, besides reviewing the chart and the hospital chart, have you reviewed anything else as it relates to this case prior to today's deposition?
A. Outside of her medical record?
Q. Right.
A. Other than the brochure and the technical bulletin.
Q. Those would be the only items?
A. The two items.

Q. Those would be the two medical literature that you would review?
A. Right.
Q. Plus her chart and the hospital record; true?
A. Right.
Q. Okay. Go ahead.
A. And excuse me, one other brochure that was given to you that was on postpartum tubal ligation, I looked that over, as well. Those three items and two charts.
Q. The postpartum tubal ligation, was that an ACOG bulletin?
A. Yes.
Q. When was that given to her?
A. During the course of her prenatal care in this last pregnancy.
Q. Do you know the date that that was given to her?
A. Not specifically.
Q. Is it referenced in the chart that she was given a brochure about tubal ligation?
A. Let me check. I believe so.
(Pause.)
Q. I think I may have the reference that

you are looking for.

A. Oh, yes, here we are. This is on the face sheet of the prenatal record on line four requests postpartum BPS, gave ACOG pamphlet, 10-3-98.

Q. And then it's got --

A. Nancy Morgan.

Q. -- Nancy Morgan's initial, NM?

A. Yes.

Q. I think there is also another reference on the flow sheet, probably under plans and education, where it says, tubal sterilization, gave ACOG pamphlet. Do you see that?

A. Yes.

Q. In the upper right-hand corner of that bottom portion?

A. Yes.

Q. Would that correspond with the October 3, '98 date, most likely?

A. That, I can't be certain of, but I would assume.

Q. You weren't involved with that exchange between Nurse Morgan and Angel; true?

A. No, that would be a separate

appointment.

Q. Is there any type of standard intelligence that's given by the nurse to the patient as it relates to what's in the ACOG pamphlet? In other words, is there a standard protocol followed when the nurse gives the tubal sterilization ACOG pamphlet to the patient?

MR. JACKSON: I'm going to object. That was a little confusing. I am not sure what you are asking.

A. Is what you are asking, does the nurse cover the ACOG brochure during the course of her appointment?

Q. Yes.

A. Yes, I would assume that's what she does.

Q. And does she go through the entire thing and explain what the ACOG pamphlet says?

A. I would assume that is true, as well.

Q. Is that standard procedure in the office?

A. Nancy Morgan does a very thorough job and that is what her purpose is as nurse educator, and so because she has a lot of time to spend during those appointments, we give her

great latitude in taking her time to go over all that.

Q. Are you ever present during any of these information sessions, whether it be with regard to the tubal sterilization or VBAC counseling?

A. No, but what we do is, these take place in our morning meetings that we have on Wednesdays, and whenever there is information that she is going to be considering to provide the patients, we get to review it during those meetings and we approve of it at that point or disapprove of it and it goes from there.

Q. Is it fair to say that you would expect that in order to comply with reasonable care that the nurse wouldn't just provide the pamphlet on tubal ligation to the patient without some verbal explanation as to the content of the brochure?

MR. JACKSON: Objection. Go ahead and answer.

A. Yes.

Q. And provide additional explanation to the patient and perhaps even facilitate answers to any questions that the patient has; true?

A. Yes.
Q. The brochure on tubal ligation does not replace or dispose of the need for informed consent; true?
MR. JACKSON: Objection. Go ahead and answer.
A. Correct.
Q. That's sort of as a supplement to help the patient?
A. Yes. You know, it's something that the patient gets to take home. I think that oftentimes their questions as we are going over them may not be present in their minds at that point in time. It gives them a chance to go home and look over the information and then come back. As I often tell them, if there are any questions, you have been given the brochure, please write down any of the questions you have and we will be happy to take time to cover them with you.
Q. In this case, were you present when the discussion took place or any portion of the discussion took place between Nurse Morgan and Angel about the issue of tubal ligation?
A. No.

Q. Were you present when the discussion took place between Nurse Morgan and Angel as it relates to the topic of VBAC?

A. No.

Q. Do you know whether anyone was present besides those two people, Nurse Morgan and Angel Robbins, when the brochure for tubal ligation and the brochure for VBAC was given?

A. Not to my knowledge.

Q. Are there any formal consents or written documents that you have the patient sign -- let's move away from the tubal ligation for a second and talk about VBAC.

When the VBAC brochure, the ACOG patient education brochure is provided, is there anything that is signed by the patient acknowledging that the risks and benefits of VBAC have been fully explained to the patient?

A. Not to my knowledge.

Q. Is the VBAC brochure -- and again, just to maybe to make the record clearer --

- - - - -

(Thereupon, TIZZANO Deposition Exhibit 2 was marked for purposes of identification.)

- - - - -

Q. Since we are on the topic, we will cover Plaintiff's Exhibit 2, which is a document provided to me by your attorney. For the record, if you would just identify what that is.

A. This is the April 1990 ACOG patient education pamphlet entitled Vaginal Birth After Cesarean Section.

Q. Do you have reason to believe that this is the bulletin that would have been given to Angel Robbins?

A. Yes.

Q. Now, it says on the front provided to. If you could read the balance of that.

A. In the handwriting, provided to patient on 10-1 by Nancy Morgan.

Q. Whose handwriting is that?

A. That's mine.

Q. Now, in looking at the record, I see that we have documentation that we have talked about in terms of the ACOG pamphlet that was given on October 3, '98 by Nurse Morgan, and that was the sterilization ACOG pamphlet; true?

A. Yes.

Q. Where in the record does it reflect

that the VBAC ACOG patient education pamphlet was given to the patient on October 1, '98?

A. To my knowledge, I don't believe it does.

Q. How did you arrive at that October 1 date?

A. From asking Nancy.

Q. Do you know how it is that Nancy was able to determine that she gave it to Angel on October 1, '98?

A. Not specifically.

Q. Did you ask Nancy whether she recalled -- strike that.

I take it you asked Nancy for the date sometime since this lawsuit has been filed; true?

A. Yes.

Q. And you probably were responding to the written questions that I had sent to Mr. Jackson, the interrogatory answers; true?

A. That's possible. I can't remember when I wrote this on here.

Q. When you asked Nurse Morgan about the ACOG bulletin on VBAC, the patient education bulletin, did you ask her whether she had any recollection of her discussion with Angel?

A. I don't recall having that conversation. Actually, as my memory is coming back to me with regard to your question about when I had written this down, Nancy Morgan very frequently when we have any cases -- in fact, most of the cases -- she will review after the time of their delivery, and she actually brought it to my attention that this has been given at one of our Wednesday morning meetings as we customarily would discuss that this was a case we had and what had happened.

And I believe that Nancy at that time provided me with, she had given them the information. I looked at the brochure and jotted this down on my copy and that's where, I believe, this came from.

Q. Do you know for a fact whether Nancy remembers the specifics of her conversation with Angel in terms of what questions, if any, Angel asked and what information, if any, Nancy provided to her in addition to providing her with this brochure?

A. We have not had that discussion.

MR. JACKSON: You were looking for reference when that was given?

MR. MISHKIND: Right.
MR. JACKSON: It is in the chart.
MR. MISHKIND: The date that it was given?
I see it says VBAC pamphlet, but it doesn't say the date. I think you would agree with me, would you not?
THE WITNESS: Right. That's what I was looking at.
MR. MISHKIND: As opposed to the tubal ligation, that does have the date of October 3.
MR. JACKSON: Okay. I thought you were suggesting there wasn't any record of the pamphlet being given.
MR. MISHKIND: No, the date of it.
MR. JACKSON: I think Nancy can address that for you.
MR. MISHKIND: Right, and I suspect that she will.
MR. JACKSON: He will ask you another question.
Q. Was it your office practice to provide anything else in writing to patients concerning the issue of VBAC other than the ACOG patient education document?

A. No.
Q. Any videotapes?
A. I am not sure that we have videotapes on VBAC. We may have them on VBAC.
Q. Would you make the videotapes available to patients to see?
A. Right. The entire education room is available to patients any time.
Q. Do you know whether that practice was followed with Angel?
A. It would have been at Nancy's discretion. We typically will mention it to patients. I, generally, as a common practice, will mention to patients that we have that available to them if they would like to use it.
Q. Would you suggest any other reference sources if patients want further information in order to make an informed decision?
A. Not in general. I felt that all along these really provide a fairly good basis for decision-making. I think they in generalities point out most of the significant problems that one might encounter and take patients through a reasonable course of thought and then provoke questions. And it's hopefully having provided

the questions that we would answer something they perhaps did not understand.

Q. Doctor, a moment ago I asked you about the prenatal care during the previous pregnancy and you said that you saw her on several occasions and probably did not participate in the delivery; in fact, after further reflection, you can say with reasonable certainty that you did not participate in that delivery.

Do you remember the patient from the '95 prenatal care?

A. Remember her in terms of her history or seeing her and recognizing the face?

Q. Seeing her and recognizing the face.

A. I can't say that I did or didn't.

Q. I take it you have a fairly good recollection of the patient from the 1998, 1999 pregnancy?

A. Yes.

Q. True?

A. Yes.

Q. This is a general question and it's intended in that manner, but how would you describe your relationship with the patient up to and including the delivery of Alexus?

A. I thought it was very good.
Q. Did you find Angel to be noncompliant in any respect with regard to her obstetrical care?
A. No, I think, in general, she was compliant, in terms of looking at the record and seeing there weren't any cancelled appointments.
Q. There were other physicians, other obstetricians that saw Angel during the pregnancy in question; true?
A. Yes.
Q. When did you first see her in this pregnancy?
A. September 5th.
Q. It looks like she had an upper respiratory infection at that time?
A. Right. She was given a prescription.
Q. What was the prescription?
A. For Zithromax, Z-Pack, and that is the way it's administered.
Q. Anything of significance by way of your exam at that point that you were concerned about in terms of her pregnancy at that stage of the game?
A. No.

Q. And in reviewing the history from her first prenatal visit, up through and including September 5, were you satisfied that this was an uneventful early term pregnancy?

A. Correct. There was one phone call that related bleeding and that was it.

Q. Was that before September 5?

A. Yes. That was on May 19th, '98. That was very early in her pregnancy.

Q. Who provided the information to respond to that telephone inquiry? Which of the doctors?

A. This is my signature.

Q. Oh, it is, okay.

A. It has always been my habit if there is a patient who has bleeding in the first trimester that I offer to see them, and in this case, she was very early. She declined to be seen. She had this experience, she states, in her prior pregnancy and was not overly alarmed.

Q. You offered her an appointment for an ultrasound or serial --

A. HCG's, yes.

Q. And your note says that the patient declined that; true?

A. Yes.
Q. Did this have, in your opinion, any adverse consequences on the subsequent course of her pregnancy?
A. No.
Q. If there had been an ultrasound done at that point or serial HCG's, would this have altered in any respect the manner in which you would have handled the pregnancy?
A. Could you ask that again?
Q. Sure. Had an ultrasound been done or serial labs been done, would that likely have altered the manner in which you would have handled her pregnancy?
A. Only to the extent that they had been abnormal.
Q. Do you have any reason to believe that they would have been abnormal?
A. No.
Q. So after September 5, with that one exception of some bleeding, which you have told me was not significant and certainly did not impact the pregnancy, when did you see her next, sir?
A. After September 5?

Q. Yes.

A. I saw her on the 16th. I'm sorry, January 16th. No, that can't be correct. No, that's correct. January 16th.

The page was cut off a little there. I wasn't sure if I had missed something.

Q. The balance of the prenatal visits then would have been a combination of nurse practitioners and other obstetricians in the office; true?

A. Yes.

Q. After January 16th, the nest time you would have seen her then would have been at the time of the delivery?

A. Correct.

Q. I am not going to go through all of the visits with you prior to January 16th, but I do want to ask you a couple questions about some of them.

Before I do that, though, obviously you would have had the flow sheet available to you with each of the ensuing visits recorded on there, so you would have known what the vaginal exam showed, you would have had all the measurements, you would have had the vital signs;

true?

A. In general.

Q. Do you have any reason to believe that when you saw her on January 16th that you wouldn't have had the information from January 9 or January 2nd, or December 26th, for example?

A. No. I would have for certain had that.

Q. Do you have any recollection of having any discussion in any of these meetings that you talked about before -- I think Wednesday meetings?

A. Yes.

Q. -- where the topic of Angel's pregnancy was discussed --

A. No.

Q. -- before January 16th?

A. No.

Q. On December 26th, who was it that saw the patient?

A. Dr. Wayne Bare.

Q. That's B-A-R-E?

A. Yes.

Q. Does the record reflect any concerns as to how her pregnancy was proceeding as of that

time? And just in the context of that, it appears that she was about 37 and a half weeks?

A. Yes, 37 and a half weeks. Her size was appropriate for dates. She was head down. Fetal heart rate was 150. She reported decreased fetal movement. She had normal blood pressure, 112 over 74. Her weight gain was appropriate; 188, a pound from her last visit, not quite, not quite a pound. And they did a nonstress test.

Q. Because of the decreased fetal movement?

A. Yes.

Q. Was the nonstress test reactive?

A. From looking at that, I can't say. I would have to see the NST slip, which we do keep.

Q. Is that in a separate chart?

A. That, I'm not sure. I don't know where they keep the NST's. I think we keep them all in a separate file.

Q. Would you ask someone in the office to try to search that down and provide a copy of that to Mr. Jackson and he to me?

A. Yes.

Q. So a laundry list thus far, we are talking about getting your CV, talking about your

producing your VBAC information to Mr. Jackson for his review, and now we are talking about the results from the NST. I think that was the only items.

A. The name of the other person.

Q. Exactly. I knew there was something I was going to forget.

As of December 26th, doctor, was there -- strike that.

The context of this question is recognizing that you had seen her once before and then didn't come into play until January 16th -- so I recognize that you may not able to answer some of these questions -- but as of December 26th, does the record reflect or does it give you enough information to tell me whether there was a concern on your part at that point that Angel was going to have a big baby?

A. No. The contrary would be true. I think her size was equivalent to dates throughout her entire prenatal care from June 9 to January 16th, with only one exception, and that was on her December 16, '98 visit. At 36 weeks gestation the assessment of fundal height was 37 to 38 centimeters.

Q. Can you tell me on December 26th what would be a reasonable estimate as to the estimated fetal weight of the baby?
A. No.
Q. You would be surprised then on December 26th if any such statement was made to Angel that she was likely to have a big baby?
MR. JACKSON: Objection. You may answer.
A. Would you please restate that question?
Q. Would you be surprised or would it surprise you if you learned that a statement was made -- and again, I am recognizing that you are not there, so in that context that Angel was told -- would you be surprised to learn that Angel was told that she was carrying a big baby or was going to have a big baby?
MR. JACKSON: Objection. You may answer.
A. I would be surprised.
Q. Based upon what you see in the record?
A. Based upon what I see in the chart.
Q. Had you seen Angel on that date, would you have had any concerns with regard to the

continued progress of her pregnancy toward a trial of labor, given that she was a prior cesarean section?

A. No.

Q. No contraindications in your mind looking at the record as of December 26th; true?

A. Correct.

Q. January 2nd is the next office visit, and who would that have been?

A. I am going to have to assume it was Dr. Brown, although it's not with his typical pen, and for that reason, when I looked at that signature, I wasn't sure.

Q. I will represent to you that I am advised by Angel that her recollection is that Dr. Brown was the doctor.

A. Thank you.

Q. So your deciphering of the penmanship and her recollection are consistent.

A. Thank you.

Q. At that time, she was 38 and 4/7 weeks?

A. Yes.

a. Did you ever talk to Dr. Brown about this office visit?

A. No.
Q. Did you ever talk to Dr. Bare about the previous office visit?
A. No.
Q. The same question on that date as to whether or not, as you look at the notes, were there any concerns that a reasonable obstetrician should have had as to her ability to continue to progress toward a trial labor?
A. This is on her January 2 date?
Q. Yes, sir.
A. No, I still think we are okay.
Q. On that date, are you aware of any discussions that Dr. Brown had where Angel was told that she was going to have a large baby?
A. Not directly.
Q. Indirectly?
A. Well, there is a phone message that makes reference to comments that Dr. Brown may have made, and that's where I have some inclination that there was conversation that took place.
Q. Based upon the phone conversation, which occurred subsequently; true? That's what you are referring to?

A. Yes.
Q. We will get to that in a moment.
Did you ever inquire of Dr. Brown whether he had such conversation with Angel indicating that she was going to have a large baby?
A. No.
Q. Would the records support such a contention?
A. There is nothing here that shows that she appears to be large. In fact, her size and centimeters is 37, and there is error in measuring that for certain, but at 38 weeks, four days, she is measuring 37 centimeters, which would be perfectly compatible for a normal size infant at that gestational age.
Q. January 9 looks like, is that Dr. Steiner?
A. Yes.
Q. Dr. Steiner is the obstetrician that's retired now?
A. True.
Q. Angel is 39 and 4/7 weeks?
A. Correct.
Q. Again, the same question I had with

regard to the previous visits. Is there anything that is or should have been of concern to a reasonable obstetrician at that date as to whether Angel could be allowed to continue to progress toward a trial of labor given the obstetrical findings at that time?

A. Things still look favorable at the point of January 9.

Q. Was the plan to allow her to go postdates, if necessary?

A. Our plan in general with regard to being postdates is once a patient has reached 41 weeks, if they have a favorable cervix for induction, that we would proceed at that time.

Q. Do you know whether that sentiment was shared with Angel as she was getting closer to that magical 40 week thought process?

A. I wouldn't have any information that would tell that one way or the other.

Q. I am going to sort of jump ahead, because I know after the delivery and the uterine rupture, you had conversations, even during the postpartum period, with mom and with dad?

A. Yes.

Q. And we are going to talk about that.

But in the context of any of those discussions or while mom was in the hospital after the uterine rupture, did you have any discussions with her that touched on the issue of why I was allowed to go past a certain date?

A. Not that I can specifically recall.

Q. Anything that you can recall that generally touched on that?

A. Not that I can recall.

Q. That's not to say that such conversations didn't take place, just that you can't remember one way or the other; true?

A. That's correct.

Q. Did Dr. Steiner have privileges to deliver babies at Wooster Hospital in January of 1999?

A. I'm not certain.

Q. Why do you --

A. Well, he stopped doing deliveries at a point in time. I am not sure when his privileges to do so would have been changed. And I don't know what he applied for or didn't apply for when he applied for privileges.

Q. Let's talk about the January 12th telephone call. Do you have that handy?

A. Yes.
Q. The response that was given to her inquiry, to her call, it appears that a physician provided that response. Was that you?
A. No.
Q. Who was that?
A. Dr. Bellow.
Q. And am I correct from what was noted on the left-hand side of this message pad, this is information that the patient is relaying to someone at your office?
A. Correct.
Q. Who would that someone be that she spoke to?
A. The phone nurse.
Q. JKW?
A. Yes.
Q. Can you help me out as to who that would be?
A. Jennifer, and I cannot recall her last name. But it was Dr. Bellow's nurse and so -- oh, no. Well, I need to take that back.
JKW is who took the message. I think that is Joanie, our phone nurse. The person who talked to the patient and completed the message,

that was Jennifer, who was Dr. Bellow's nurse.
I need to check on her last initials to know that is correct.
Q. As to Joanie's last initials?
A. Right.
Q. Is Joanie still employed?
A. Yes.
Q. Is Jennifer still employed?
A. No.
Q. When was Jennifer last employed here?
A. I'm not sure.
Q. Do you know why she left?
MR. JACKSON: Objection, but you may answer.
A. I believe she just left to stay at home with her newborn.
Q. A good reason.
A. Yes.
Q. This patient on January 12th was indicating some desire to be induced?
A. Correct.
Q. What I want to try to understand is, given the fact that the patient had been seen by a number of people, most recently by -- I guess it would have been Dr. Steiner -- yes, Dr.

Steiner would have been the last visit. When she calls in or when any patient calls in that has been seen by multiple doctors in the office and they have a concern because they are either past their expected date of confinement or approaching it, are they directed to ask for any particular person?

A. Yes, every one of these phone notes would need to go to a physician, and this one did.

Q. Would she call in and say I want to speak to Dr. Brown, or I want to speak to Dr. Steiner, or how would she be directed to handle telephone inquiries?

A. The physician that would be on the day the message came in would be the physician that would get an OB message.

Q. This was 9:56 a.m. and I am not sure which day of the week January 12th was, but assuming that was a weekday, would anybody in this office be available to handle such a telephone inquiry or would it be assigned to a particular doctor even though it was normal business hours?

A. It would be assigned to the OB doc on

call.

Q. So, for example, today is Monday at a quarter of 11. If one of your patients called in, and assuming you weren't tied up in a deposition like you are, there is a doctor that you have designated to handle calls?

A. Correct.

Q. As opposed to interrupting you with such an inquiry?

A. He would be the first line, he or she would be the first line for that question.

Q. In any event, Dr. Bellow was the person on call and he provided information, either back to Joanie or to Jennifer; true?

A. Right. He provided the information. I can't say for certainty that he was on call, but he is the one that answered this.

Q. Can you decipher for me what he has written there?

A. I can.

Q. Would you, please.

A. Three days ago, long, closed and posterior, referring to the cervix. Fundal height not excessive. Poor induction candidate as of now. Recommend keeping visit.

Q. Do you have a sense as to why he would have indicated that she was a poor induction candidate?

A. He would have been looking back at Dr. Steiner's examination, which said that the cervix was closed and long.

Q. That would have been --

A. From January 9.

Q. I'm sorry, the last line of Dr. Bellow's note would say what?

A. Recommend keeping visit, her next appointment.

Q. And that's the one you saw her on; true?

A. Yes.

Q. So she was not apparently offered a visit on January 12th; true?

A. Not according to this note.

Q. And according to this note, was this just a call back to the patient where a nurse would have relayed what the doctor was saying, or would the doctor have actually made this call to the patient?

A. I can't tell that from this. I can't say with certainty. I'm assuming that because

the signature is his nurse that she may have made the note -- or the call back, but I can't be certain.

Q. As to the time that the follow-up call was made, other than it being in the a.m., it's hard to tell what time it was after her 9:56 a.m. call into the office; true?

A. True.

Q. If this telephone call had been received by you, would you have handled the patient any differently as of January 12th?

A. With the information given here, no.

Q. And with the information available in the chart at this point, would you have handled her in the same way Dr. Bellow did?

A. Yes.

Q. Let's talk about the January 16th visit. You see her. You obviously know that she had called with concerns about wanting to be induced four days earlier; true?

A. Correct.

Q. Do you have a recollection --

MR. JACKSON: Excuse me, Howard. You say she wanted to be induced and I'm not sure that is what that note says.

MR. MISHKIND: She prefers to be induced is what it says. Prefers, wants, whatever.

A. I was familiar with her note, but as to what she was thinking at that moment --

Q. Well, we can certainly agree -- I don't want to mischaracterize anything on the record -- we can agree that when you saw her on the 16th that you had the benefit of this January 12th, '99 office note, as well as her prior prenatal visits; true?

A. Yes.

Q. And you knew that four days earlier that she had called, concerned, and in fact preferred or wanted, until information was conveyed back to her by Dr. Bellow, she had wanted to be induced; true?

A. According to that note, yes.

Q. Do you have a recollection of talking with her on the 16th about her level of anxiety or concern on January 12th or how it continued, if at all, between the 12th and when she saw you on the 16th?

A. I don't have any recollection of a conversation of that matter.

Q. She is now post -- she is post -- well, how'far along was she? Let me leave it at that.

A. Four weeks and four days.

Q. Now, that is not, in your definition, postdates; true?

A. True.

Q. 41 weeks is postdates?

A. 42.

Q. 42, okay. You would not allow her to go past 41 weeks?

A. I would let her go past 41 weeks if her cervix wasn't favorable enough for an induction. And in the case after VBAC, I would hope that I would not have to do that.

Q. What did you estimate the baby's weight to be on this visit?

A. I would estimate from reviewing the chart that the baby was appropriate for dates and perhaps a little behind size for dates. Fundal height of 38 centimeters.

Q. Do you have a recollection of any discussion that you had on that date with Angel?

A. I have no recollection.

Q. Does your record reflect that you had

any concerns about the status of the pregnancy and her ability to continue to proceed toward a trial of labor?

A. No.

Q. The comments to the right of the January 16th exam, are those in your handwriting?

A. No. The first part, the first line, right along with the 1-16 entry, is Lisa Woods, who is my nurse, and that entry relates to the 1-9 visit.

Q. So where it says repeat left side, that goes with the 1-9?

A. Yes.

Q. Where it says vertex floating, discuss VBAC --

A. That's me.

Q. That's you?

A. That's me from the 16th.

Q. Explain to me what it means when you say the vertex is floating.

A. It means that I went to examine her and touch the fetal head. It would just bob away from my finger.

Q. And of what significance is that?

A. That the head has not been engaged

into the pelvis; that adequate contractions haven't taken place to do so.

Q. Your cervical exam in terms of dilatation and effacement and station reflected what on the 16th?

A. She was long, the cervix was long, closed and thick. The vertex was at minus four station, which would agree with the floating.

Q. So your reference to the vertex floating and the minus four station are entirely consistent?

A. Yes.

Q. Tell me what you meant when you noted discuss VBAC.

A. I believe it says desires.

Q. Oh, I'm sorry.

A. Desires VBAC. And then a period. That I would have gone over with her once again. Her desire to continue to pursue VBAC, because one of the options for her would have been, as it would have been throughout the course of her pregnancy, would be to elect to have a cesarean section repeated.

Q. On this particular date, again, we have the benefit of knowing that she had called

and was concerned on the 1st about what she perceived to be a large baby and her desire to be induced on that date.

With that context in mind, do you have any recollection of what you and her discussed before you marked down she still desires VBAC?

Do you follow my question?

A. I believe I do.

Q. Okay.

A. I don't have any recollection of a conversation, and I am going by what I see that I have written.

Q. If the patient at that point expressed concerns, and in fact, a preference to change from a VBAC to an elective cesarean, would you have complied?

A. Yes.

Q. Would it have been unreasonable on your part to have insisted or even suggested to the patient that she just stay the course toward a trial of labor?

MR. JACKSON: Objection. You may answer.

A. It would be reasonable to go through the risks and benefits once again, but, you know,

never have I been one to strong-arm a situation. I think the patient and I can make that choice together and I think her decision in that regard outweighs mine. Her desire, I should say.

Q. Did you ever explain to Angel on that date that the risk of VBAC included uterine rupture?

MR. JACKSON: Objection. But go ahead and answer.

A. I don't have any specific recollection of what I would say, but it would be my convention to have done so.

Q. But as to whether such a conversation occurred on January 16th, in terms of what the risks are associated with a VBAC, as opposed to the benefits associated with a vaginal birth, looking at what the risks are, do you have any such recollection of having such a discussion?

MR. JACKSON: Objection. You may answer.

A. I don't have any recollection of having discussed the risks or the benefits, but in looking at the record and saying that she still desires VBAC, that, I believe, would have prompted me to have discussed it, but I don't

have a specific recollection of the discussion.

Q. So your testimony is that your custom and practice would have been to discuss the risks of proceeding with a VBAC; true?

A. Yes.

Q. And would you agree that if you did not follow your custom and practice and discuss the risks of proceeding with a VBAC where you are having the discussion about the mode of delivery, that that would be less than acceptable care?

MR. JACKSON: Objection. Howard, basically, I think he says it's noted that she desired it and we have discussed it. Now you are saying that what is noted isn't noted or didn't happen; is that what you are asking?

MR. MISHKIND: No. Let me give you the proper context. He already indicated that he does not specifically recall advising her of the risks of proceeding with a VBAC. He has also told me that his custom and practice would be to discuss the risks of VBAC. He knows that there was a discussion about VBAC on that date.

Q. Those are the things that we can agree upon; true?

A. True.

Q. I am asking you that if you did not discuss the risks of VBAC in the contents of your discussion with her on that date, would you agree that that would be below accepted standards of care?

MR. JACKSON: Objection.

Q. You can answer.

MR. JACKSON: Go ahead, you may answer.

a. In this patient's situation, she has already had covered and known to me that she already had a discussion of the risks and benefits, so I would assume hopefully that she still remains aware of those risks and benefits.

Given her visit on the 16th with a vertex that remains long, closed and thick at minus four station -- not a favorable induction -- I would certainly have gone over that again with her to let her know what the significance of this examination today meant, and that it would turn out to be a surprise to me that evening if she indeed was in labor.

Q. Would you have indicated anything else to her, given what you see on the 16th, given your normal custom and practice as it pertains to

the risks of proceeding with a VBAC?

MR. JACKSON: Objection. I don't understand your question, but go ahead, if you do, doctor.

A. Please say that to me again.

Q. Sure. Would you have indicated to her during that visit, based upon your custom and practice, anything that would touch upon the risks of proceeding with a VBAC?

A. Yes. That would be my custom.

Q. And what would you explain to the patient of 40 weeks and some days as to the risk of proceeding in this particular patient with a VBAC?

A. This is forecasting the future for her, a risk of continuing, or her risk as of the moment.

Q. Forecasting if she were to continue to proceed on a trial of labor after leaving your office?

A. If she were to go into labor, I would tell her that she has the risk of uterine rupture as the single most important risk of pursuing a trial of labor after cesarean section.

Q. Do you embellish at all what that

means to the baby and to the mom, if there is a uterine rupture?

A. It is also customary for me to say that the course of events which occur with a uterine rupture are very unpredictable and that serious harm can come to babies where that happens.

Q. Do you always have that discussion or is it driven by the exchange that the patient has with you at that time?

A. No, in general, when we have someone that continues to go even beyond the 40 week mark, we begin to have those conversations of what is the risk of continuing pregnancy, if it was a VBAC or not.

. And one of the risks are -- I mean, fetal demise is increasingly prevalent after 40 weeks gestation, all by itself, regardless of VBAC. And so in the case where you have a patient who has an unfavorable cervix and she is not in labor and she has had a prior cesarean section, that would be something that I would cover, as well.

Q. So again, in order to comply with the standard of care, part of the discussion about

the risks of continuing with a VBAC should include the indication of a uterine rupture; true?

MR. JACKSON: Objection. You may answer.

A. Yes, I know it is my habit to include a discussion of a uterine rupture and as to what the standard of care is. I don't know that's something that I could be one to put on paper what everyone else in the region does.

Q. Do you consider yourself to be a reasonable and prudent obstetrician?

A. Absolutely.

Q. And do you attempt to comply with what is expected of you by your peers and others when you approach the practice of obstetrics and gynecology?

A. Absolutely.

Q. And would you believe and concur that it would be reasonable and prudent for a physician treating a patient such as Angel that is 40 weeks and some days that has had the prenatal history that you are aware of as of January 16th, where you are having a discussion about VBAC on that date, to indicate to the

patient that one of the risks of continuing toward a trial of labor is that you can experience a uterine rupture?

MR. JACKSON: Objection. You may answer.

A. I do believe it's reasonable and prudent in this patient who has already been counseled to repeat that again.

Q. And in that discussion, a reasonable and prudent obstetrician that would tell the patient that a uterine rupture is a potential complication in the context of that discussion, the patient should understand that if a uterine rupture occurs, that grave consequences can occur, not only to the baby, but to mom, as well; true?

MR. JACKSON: Objection. *Go* ahead.

A. That's true.

Q. And those are what you would consider to be reasonable and prudent steps by any obstetrician with this fact pattern; true?

MR. JACKSON: Objection. You may answer.

A. True.

Q. And can we agree that it would be less

than reasonable and prudent, hypothetically speaking, if the discussion of a VBAC took place on that visit to omit discussion about a uterine rupture and the implications if a uterine rupture does occur?

MR. JACKSON: Objection. You may answer.

A. I agree.

Q. When did you first learn that Angel had gone to the hospital?

A. At 6:00 a.m. on the 17th.

(Recess had.)

Q. Let's clean up a couple housekeeping items. You were kind enough, doctor, when we took the break to check with regard to the other patient concerning the case that we had talked about. Mr. Jackson indicated to me that that patient's name was Stephanie Morris, now known as Stephanie McGuire?

A. Right. She actually lists her name as Morris-McGuire.

Q. And this was the IUD case?

A. Correct.

Q. And the other item you were checking on was the identification of the initials?

A. JKW. The phone note, it was Joanie K. Wadsworth.

Q. Is Joanie the one that is now home with her baby?

A. No, that's Jennifer Jordan who would have returned the call. Joanie K. Wadsworth was the phone nurse who would have taken all the incoming calls and distributed them to all the offices and that would have went to Dr. Bellow's suite and Jennifer Jordan is his nurse at that time.

Q. And is Ms. Wadsworth still employed here?

A. Yes.

Q. When you say his suite, is it in this building here?

A. Yes. We kind of divide it into four suites. We have four nursing stations and four physician stations.

Q. When I came in for the deposition, there was a nursing station in the greeting area. Is that one of the stations?

A. No. These are patient, actually patient care areas, and they are just four stations around the circumference of our

building.

Q. Got it. So that's just literally the reception area where everyone comes in and the four stations are within the interior of the office space?

A. Correct.

Q. You were also kind enough to obtain a copy of your CV and I will have this marked as Exhibit 3.

- - - - -

(Thereupon, TIZZANO Deposition Exhibit 3 was marked for purposes of identification.)

- - - - -

Q. . It looks like Exhibit 3 is your curriculum vitae as of July 23, '99; true?

A. Yes.

Q. If we were to bring this up to date to December of 2000, what would we need to add?

A. The only area to add would be in the publications and presentations area. And I made mention of some of those before.

Q. Are there any others that you would need to reference that we have not already talked about?

A. No.

Q. Were you able to check on the location of the results from the NST?

a. They are doing that now.

Q. Great. We started to move toward the hospital. Before we do that, I want to ask you a couple questions about that last visit and then we will get into the labor and delivery.

A. Okay.

Q. Did you give Angel any instructions when she left your office on January 16th as to when to come to labor and delivery for delivery?

A. You know, at any point in time when we are at term and anticipating labor to be coming at any point in time, I always instruct them on two things: One is the frequency of contractions with which they need to pay attention. And I generally say if you are having contractions in the neighborhood of five or ten minutes over the course of an hour, I would like to see you in labor and delivery or like to hear about that; get called if you have rupture of membranes or a leaking fluid and you are not sure as to whether or not you ruptured your membranes or not, that I want to see you in the hospital or to be

evaluated.

And then with regard to fetal movement, if you have any departure from what you perceive to be the norm with respect to your baby's movement, then I want to hear about that as soon as it occurs.

Q. Aside from those instructions which would be part of your custom and practice, would you have given any additional instructions to Angel, given the state of her pregnancy and what had occurred up to January 16th?

A. Not that I have recollection of, nor that would be my habit.

I think in the case of someone who has a vaginal birth, we would always preface, we prefer to'see you when you are in labor, period. Just so that we can continue to monitor the situation since the labor is, you know, intrinsically at a greater risk.

And just in looking at the note and reflecting on this, the fact that I write desires VBAC implies -- and again, I don't have an absolute recollection of the conversation -- implies that if I had gone over that once again and that she would have responded that she

desires VBAC, I would have been surprised for her to say I desire VBAC without me having prompted that response.

Q. Do you know whether the discussion about VBAC was initiated on that last visit by you as a normal part of your custom and practice, or the opposite, where the patient was asking questions about the VBAC and then you provided information in response thereto?

A. I have no recollection of that conversation --

Q. Okay.

A. -- ever taking place.

Q. You can't say which way it came in?

A. Right.

Q. Fair enough. Did you try to strip Angel's membranes on the last office visit?

A. It doesn't say so.

Q. Do you --

A. I can't say that I didn't. It would also be typical of me to have done that.

Q. How does one strip the membranes?

A. You insert one finger into the cervix if it's able to be dilated. By the fact that she is long, closed and thick, I am thinking I

probably couldn't.

If I could, I would introduce my finger and then around the head move my finger in a kind of conical fashion separating the cervix from the membranes in hopes that it would begin to provoke labor if labor was on the threshold of naturally occurring.

Q. Is it your testimony that you probably tried to strip the membranes?

A. No, it would be my testimony that I don't think I could have, given the nature of her cervix being long, closed and thick, but I may have tried.

Q. Does the fetal head need to be engaged to attempt to strip the membranes?

A. For the most part, yes. Sometimes you can hold the head down with fundal pressure.

Q. Is there anything else about that January 16th visit, before we move to the hospital, that you recall?

A. No, sir.

Q. I said to you that we were going to move to the hospital.

A. That's okay.

Q. I am one step ahead of myself. I need

to ask you a couple questions about the VBAC pamphlet for a moment. We will get to labor and delivery, believe it or not.

The VBAC pamphlet marked as Exhibit 2, you have testified that Nurse Morgan gave it on October 1, according to the information that she provided to you; true?

A. Yes, I believe that's the case.

Q. Was there a particular protocol in your office as to when in the gestational period the pamphlet was distributed back in '98 and early '99?

A. No. There is not a specific protocol. There again is the convention.

Q. A convention?

A. There is a convention that Nancy typically tries to see patients somewhere before their glucose tolerance tests are done so she has a chance to review the things that will be forthcoming for the remainder of the pregnancy.

We do a glucose tolerance test at 24 to 26 weeks and so we try to get the patient to Nancy before then so she has time to answer questions and at that point they are being seen about once a month.

Q. We have talked about this in terms of your custom and practice and the discussion about VBAC, but would you agree that when the VBAC brochure, Exhibit 1, is distributed, at or around that time, that the mom, Angel, should be told that VBAC is associated with a small but significant risk of a uterine rupture with the potential for poor outcomes for both mom and the baby?

A. Yes.

Q. And would you agree that in order for Angel to have made an informed decision about proceeding with a VBAC, she needed to be told of the potential complication of a uterine rupture associated with a vaginal delivery after cesarean?

MR. JACKSON: Objection. You may answer.

A. Yes.

Q. If Angel was told not to worry because if she was having a failure to progress or if there was any problem during labor, that you or whoever it was that was scheduled to do the delivery would move to a C-section, without explaining the risks to mom and baby associated

with a uterine rupture and the potential catastrophic results, would that be a violation of the standard of care?

MR. JACKSON: Objection. Let the record reflect there was a knock on the door.

(Pause.)

(Record read.)

A. I am confused by that question. Is this during counseling the patient about VBAC?

Q. Yes.

A. Okay, so you are counseling her about VBAC and now you are saying, not to worry, because the doctor is so available that even if an untoward event were to occur -- I'm sorry, if failure to progress were to occur, that you don't have to worry because he would be there to do the cesarean section or she would be there? I guess I am just --

MR. JACKSON: Is that your question?

MR. MISHKIND: I am waiting for him to articulate and I will address it.

MR. JACKSON: Rephrase your question.

Q. I will rephrase it. That's not a problem.

And you are doing exactly as I had said to you before, if you didn't understand a question.

At the time of counseling --

A. Nancy Morgan's counseling?

Q. Right. If Angel was told not to worry because if she had a failure to progress or if there was a problem that took place during labor, that the doctor that was going to deliver the baby would move to a C-section, and in the context of that counseling Angel was not advised that by opting for a VBAC that she could develop a uterine rupture with potential catastrophic consequences to her and the baby, would that be a violation of the standard of care?

MR. JACKSON: Objection. You may answer, doctor.

A. I would like to answer that in two parts.

Q. Do it however you feel comfortable with.

A. With regard to failure to progress, if the only problem was failure to progress, then having a team come in and set up and do her cesarean section would not be an issue.

On the other hand, to have that complication be something other than that, fetal distress, a uterine rupture, then it's not fair to say that she would not be at risk despite any availability of the physician.

Q. So I guess the bottom line is that in order for a patient to make an informed decision about pursuing this course of delivery, they have to be advised that a uterine rupture is a risk and catastrophic results can happen if the patient opts for this form of delivery?

MR. JACKSON: Objection. You may answer.

Q. True?

A. True, if the patient opts to have a VBAC, they should understand that the results can be catastrophic.

Q. The chart reflects that the patient was given the VBAC pamphlet and it says VBAC counseling, VBAC/pamphlet on that document. We have already talked about that it doesn't reflect the date that it was given, but you have reason to believe that it was given on October 1, based on what Nurse Morgan told you; true?

A. Yes.

Q. Does the chart reflect in any way that the risks to mom and baby were discussed with Ange1?

MR. JACKSON: I'll object, but go ahead and answer. So that I understand you, Howard, beyond where it says VBAC counsel, you want to know if there is a specific reference in the chart that says what you just said, using those words?

MR. MISHKIND: You are partially correct. Where it says VBAC counseling, which is printed on there, right next to it, it says VBAC slash pamphlet and there is an X in it.

MR. JACKSON: It says VBAC pamphlet added on to that line.

Q. My specific question is, does the chart indicate that the risks to mom and baby were discussed with Angel?

MR. JACKSON: With these specific words you used?

MR. MISHKIND: We can approach it that way and break it down as necessary.

MR. JACKSON: Do you understand what he is asking, doctor?

THE WITNESS: I believe so.

A. I believe that what Nancy Morgan did that day was to cover the contents of the ACOG pamphlet. And as I look at the document in the chart that refers to this, where it says VBAC counseling, and the box is X'd, then there is VBAC pamphlet. And 1 guess when I look at this, I think that the word below is, the slash that's coming up is actually the end of an S, but I guess it could be, so I'm assuming that she counseled her with regard to that pamphlet and would have covered the materials contained within the pamphlet.

Q. You would certainly agree that the patient should be told of the risks and complications associated with a VBAC; true?

MR. JACKSON: Objection. Asked and answered. *Go* ahead. You may answer again.

A. I agree that she should be told about the risks and complications.

Q. And being given the VBAC brochure, Plaintiff's Exhibit 2, should not replace or supplant the responsibility of the obstetrician or the representatives of the obstetrician's office, Nurse Morgan, to provide the material risks and complications of the patient before a

particular course of treatment is elected; true?

MR. JACKSON: Objection. We talked about that earlier, Howard, and about that being also a vehicle by which the patient should read it, and there would be additional discussions or should be by the patient if they had questions.

MR. MISHKIND: I am not suggesting that that isn't accurate.

Q. I am asking, would you agree that this does not replace the requirement to provide the patient with the material risks and complications associated with a VBAC?

MR. JACKSON: I'll object.

MR. MISHKIND: That's fine.

MR. JACKSON: I want to understand what you are saying. Doesn't that contain the complications and risks?

MR. MISHKIND: Well, let's assume that it does.

A. Does giving this, in your opinion, meet the standard of care as opposed to verbally explaining the risks and complications to the patient?

MR. JACKSON: Objection. You may answer.

A. I think that the brochure cannot stand alone; that someone has to ask, do you understand what is contained in the brochure, and if they say yes, can assume that they have read it and understand it. But if they say no, then it needs further embellishment, or needs further explanation, and I think there could be things that they may ask that require more explanation.

Q. To your knowledge, does this brochure outline the significant risk, small but significant risk of a uterine rupture with the potential of a poor outcome to mom and baby?

MR. JACKSON: Let's take a look at it.

THE WITNESS: May I answer?

MR. JACKSON: Go ahead.

A. The brochure does make mention of the risk of rupture of the uterus, saying that your doctor will need to consult the medical records from the previous cesarean section to verify which type of a uterine incision was used.

This is because the main risk to both you and your baby during an attempted vaginal birth is separation or rupture of the scar left by that incision. Rupture may be more or less

likely depending on what type of incision was used.

Q. And does the brochure -- and I will let you continue to peruse it -- does it indicate that if there is a rupture of the incision and thus a uterine rupture, that that poses a substantial risk to both mom and baby?

MR. JACKSON: I'll object. You want to know if those words --

MR. MISHKIND: Or anything to that extent.

A. It says with regard to a classical or high vertical incision that unfortunately a complete rupture or opening of the scar is more likely to occur during labor if a classical incision was used in a previous cesarean delivery. This can result in serious bleeding that can pose danger to both fetus and mother.

MR. JACKSON: Does that answer your question or do you have another question?

MR. MISHKIND: The reason I am waiting is because he is looking. I want to give him an opportunity to finish looking at it.

THE 'WITNESS: That completes my answer.

Q. There is nothing referencing the risk of a uterine rupture and the complications of a uterine rupture in a woman who has had a low transverse incision, in that document, is there?

MR. JACKSON: Objection. You may answer. Go ahead.

A. Yes, it does say that; that rupture may be more or less likely depending on what type of incision was used.

Q. But then it talks about an incision other than a low transverse incision; true? You just mentioned that.

A. Correct. It then breaks it into three different types of incisions.

Q. And the type of surgery that Angel had had previously, does it specifically address that a uterine rupture with potentially serious consequences to mom and baby can occur with a low transverse incision and a trial of labor?

MR. JACKSON: Objection. I think that's asked and answered, but go ahead and answer again, doctor.

A. I think it does state in saying that it is the least likely to result in complications in a subsequent vaginal delivery; that of the

three types, it's the safer, but nonetheless is not absolutely safe.

Q. We have talked about this before in a round about way, but you don't take issue with the proposition that the patient has the right to withdraw their consent to a VBAC; true?

MR. JACKSON: Say that again, please.

Q. We talked about this before, but a patient certainly has the right to withdraw their consent to have a VBAC; true?

A. Correct. They have a right to a C-section in this case at any point in time.

Q. In 1999, you had to be readily available when a VBAC patient is laboring; true?

A. Correct.

Q. What did you understand the definition of readily available to mean?

A. It has for a long time been my understanding as we have, you know, worked at least at this hospital to assume that a physician must live within 20 minutes of the hospital, so that when they are on call, they can respond to the hospital within that period of time.

It's also our understanding that that is the time in which a call to the physician must

be answered by the physician, so if you were paged within that 20 minute period of time that we need to respond.

So those are the two distance requirements and kind of time requirements that we traditionally had.

Q. How close in '99 did you live to the hospital?

A. I live five minutes.

Q. Do you live now five minutes and did at that time?

A. Right.

Q. I presume you live in the same place?

A. Yes.

Q. Thus the lack of change in time. Still in the same place, so it doesn't take you any longer now?

A. No.

Q. Your path to the hospital would be following what streets?

A. I would be driving down Bucholz, making a left on Oak Hill, a right on Wayne, and then onto Cleveland Road to the ear, nose and throat specialist, across their parking lot and into the hospital parking lot.

Q. And under even worse case circumstances, assuming there is a rush hour in that area, what is the longest it has taken you to get to the hospital?

A. I can't recall having ever taken more than, let's say more than six minutes to get to the hospital from my home.

Q. With a complete uterine rupture, how long does it take, if you know, from any studies, for brain damage and death to occur?

A. I think it's a very difficult question for a study to entertain. You know, within my experience, we have had a uterine rupture which we deliver at the time of cesarean section that was unbeknownst to us, and when we open the abdomen, the uterus was ruptured, the baby was in the abdomen in nothing but a bag of water, but the baby was perfectly fine, so I have no way of knowing how long that a uterine rupture had been there.

At the same time, it can rupture, perhaps during the course of the labor when contractions are taking place, and by extruding the baby through the wall of the uterus through contractions and having all this squeezing

occurring to the baby and its umbilical cord, I think that's a much more devastating course of events than the one I first described. So I think there is a broad range and it's very difficult to say other than by patient-to-patient that would vary with tremendous latitude.

Q. Have you ever experienced a uterine rupture other than with Angel?

A. Not other than the one previously that I mentioned before. That was at the time of cesarean section.

Q. So you have had two uterine ruptures?

A. Correct. And I was the assistant surgeon on the one where the abdomen was open at the time of C-section.

Q. I am not intimately familiar with Wooster Hospital, but what level hospital is Wooster Hospital?

A. We have a Level I nursery, and that's really the only level that I am familiar with it being referred to as. I can't account for what the remainder of the hospital is classified as.

Q. It's not a tertiary care facility, is it?

A. No.

Q. Would you agree that women contemplating a VBAC would be best advised to labor in a tertiary Level III hospital --

MR. JACKSON: Objection.

Q. -- that's staffed --

MR. MISHKIND: You can object after I am done with my question.

MR. JACKSON: I will withdraw that objection and see what happens.

MR. MISHKIND: Fair enough. I will see if I can remember the balance of my question now.

Q. -- would be best advised to labor in a tertiary Level III hospital staffed by personnel capable of performing a crash C-section within minutes after serious complications arise?

MR. JACKSON: Objection. You may answer.

A. Can you state the beginning of that question again?

Q. Would you agree that every woman contemplating a VBAC would be best advised to labor in a tertiary Level III facility?

MR. JACKSON: Same objection, but answer it. Go ahead.

THE WITNESS: I would like to answer that question. I would like to answer it with this case and then what thinking has changed in that regard.

Is that fair, or should we be answering in the context of this case?

MR. JACKSON: His question is should every woman contemplating, et cetera, et cetera, be advised that they should be in a tertiary care hospital. That's the question you should answer.

THE WITNESS: Correct. But I need to know whether to answer it today or on January 17th of '99, because my answer will be different.

MR. MISHKIND: Let's take it as of January 17th, 1999 and then for purposes of the record, I will have you explain to me why your answer would be different as of December 2000.

A. I think that in our case, with the patient before us, it's reasonable to deliver at our hospital and a tertiary care center would not be mandatory.

Q. Why?

A. Because the assumption of the risk of uterine rupture at the time that this patient

delivered is less than it is considered to be now; that when you look at the literature, the notion is that the incidents of uterine rupture has been far underreported and that has probably been the reason for the American Colleges change of view, which I believe was in July of '99.

Q. Any other reasons why as of January 1999 any woman contemplating a VBAC would not necessarily be best advised to have labor in a tertiary Level III facility, other than what you said?

MR. JACKSON: Objection. But go ahead, doctor.

A. No, because to the best of our knowledge, we have a long track record of successful VBAC's and the literature reflects the same; that physicians can feel comfortable in pursuing VBAC's in a community hospital setting, and with a quoted one percent rupture rate, that we would, you know, be serving our patients well.

Q. Now, as of December 2000, forgetting about the consequences or the outcome in this case, if you were to have had an Angel Robbins contemplating a VBAC, would she be best advised to labor in a tertiary Level III hospital staffed

by personnel capable of performing a crash C-section within minutes after serious complication arises?

MR. JACKSON: Objection. You may answer.

MR. ROSSI: Same objection.

A. She would be advised as such, and she wouldn't be delivered here to begin with, today.

Q. Now, if you have a VBAC candidate with an anticipated trial of labor, how do you handle such patients now in terms of the planning stages?

MR. ROSSI: Show a continuing objection to any questions about care and treatment rendered to patients now.

Go ahead, you can answer.

MR. JACKSON: You can answer.

A. Currently, if we have a patient who has had a previous cesarean section of any sort of scar type, I would explain to them that we are not delivering prior cesarean section patients at our hospital anymore; that we are more than happy to work in concert with an institution to provide supporting antepartum care, with the understanding that those people then would be

taking care of them, and ultimately would help her to pursue labor at that institution.

Q. Let me try to understand a couple things. One, if Angel were your patient now, and she had previously had a delivery at this hospital and is contemplating VBAC, would you recommend a particular facility to her for purposes of the delivery?

A. Yes.

Q. What hospital?

A. Akron City or General.

Q. They are tertiary Level III facilities?

A. I don't know what level they are. I know that they have in-house anesthesia, OR crew, and residents that are there around the clock, and so they have ability to respond immediately.

Q. How long has it been since you have stopped doing VBAC's here at Wooster?

A. I'm not sure of the date. I want to say it was this past spring.

Q. Spring of 2000?

A. Spring of 2000, I believe.

Q. Was that a practice decision made by your group or was that a dictate that came from

the hospital?

MR. ROSSI: Objection.

MR. JACKSON: You may answer.

A. That was the outgrowth of the ACOG technical bulletin. It was an outgrowth of continued review by the hospital's obstetrics committee, which includes us, as well as any of the other OB/GYN and delivering physicians at the hospital, and that was the primary force behind it. And then there was information also from the hospital's insurance carrier.

Q. Do you follow the ACOG 30 minute decision to incision rule?

A. That's a number that I am familiar with and is one that we have always tried to view as a minimum standard.

Q. That minimum standard is something that you try to improve on; correct?

MR. JACKSON: Objection, but go ahead.

A. Yes.

Q. From the decision to incision in this case, how many minutes passed?

A. What do we have? I need to look at the record.

(Pause.)

A. So we have 22 minutes from the time the incision was made until -- I'm sorry, from the time the decision was made until the incision was actually made.

Q. And then the baby was delivered how many minutes later?

A. Three minutes.

Q. Do you believe that the 30 minute ACOG rule applies or guideline applies in VBAC cases?

A. I think it does apply, because I think we have to, when ACOG presents us with a guideline, they have to say not just for the tertiary care center, but for physicians practicing in all areas of this country, what is a reasonable time that they should be expected upon being notified to come in, see a patient, and then turn around, and actually in this case, from the time they know there is a problem that requires cesarean section to have the incision made.

And so I don't think that the standard environment is the tertiary care center. That's the exception, and they have to give some language which would permit persons who were in

rural practice to practice.

Q. Now, Wooster Hospital does not have in-house staff coverage, anesthesia capabilities; true?

A. We have four hour anesthesia coverage, and once there is any institution of anesthesia, whether it be general or regional, then the anesthesiologist is in-house.

Q. Was there an in-house anesthesiologist at the time that Angel was laboring and the decision was made to perform a C-section?

A. To my knowledge, yes.

Q. Before Angel's C-section, how many VBAC's had you performed?

A. I don't know the number. But certainly many.

Q. Many, as in more than a dozen, less than a dozen?

A. Quite a few more than a dozen.

Q. I am not trying to pin you down to a specific figure, but I am not sure what your many means.

MR. JACKSON: He is trying to pin you down. Don't guess, but give it your best estimate.

A. Are we saying trial labors or actually successful VBAC's.

Q. Actually successful VBAC's.

A. This is literally going to be a guess to say four a year. My recollection for numbers are not great, but that's information that we could get.

MR. JACKSON: Don't guess. If you have a reasonable estimate, you can give it to him.

A. My estimate would be four. But as far as successfully completed VBAC's --

Q. And that would be going back how many years now?

A. I have been here for seven years.

Q. So if we multiplied four by seven, 28, it could be a few more, could be a few less. Are we basically saying somewhere in the 25 to 30 range, generally speaking?

A. Yes. The reason I have such difficulty in answering this question is because the way in which statistics were kept at our hospital are not always easy to determine that was the case.

We have looked at our numbers from our

office to the hospital and have not always had the same numbers, and so I am at odds to try to come up with a reasonable estimate. But I would say in the neighborhood of 20 is reasonable.

Q. Now, is this before Angel or is this including up to the present date?

A. This is up to the present date.

Q. So we would at least take off maybe four or eight cases to go back to January of '99?

A" That's fair.

Q. So somewhere in between ten and 15 cases before Angel, would that be a fair estimate, recognizing that we may be off by a few?

A. That's a fair estimate,

Q. Now, how many trials of labor in a previous cesarean have you been involved in all told?

Obviously, including ones that you reverted to a cesarean.

A. I would venture to double that number.

Q. Again, before January, we would be in the 20 to 30 range, give or take a few, plus or minus?

A. That's fair.

Q. And your complication rate has been what?

A. Up until Angel?

Q. Up until Angel.

A. Up until Angel, we did not have a significant complication that I could recall.

Q. Dr. Steiner assisted you at the time of Angel's delivery?

A. Yes.

Q. Tell me about Dr. Steiner's history in terms of how many attempted VBAC's he had been involved in prior to January of '99.

A. I really don't think I can answer that knowingly. I don't know what the current thinking was when he was doing obstetrics full time and how frequently they were doing VBAC's.

By the time I had come here, he was just stopping doing obstetrics, and by virtue of my coming, stopped entirely shortly thereafter.

Q. So he had zero percent obstetrical practice as of January '99?

A. No. He still saw -- for example, I think the entry that we had in her case was a situation where someone probably wasn't available, they wouldn't have been primarily

scheduled to see him, but because one of us was at the hospital, would oftentimes, as a matter of routine, fill in the gaps and see the patients in the office for us.

He attended all the same meetings that we did, and every bit of the discussion regarding any obstetrical cases he was present for, in our meetings and also at the hospital.

Q. Do you know how many emergency C-sections he had participated in, either as the attending, or as the assistant in, say, the last two to three years before January of '99?

A. I couldn't give you the number. I mean, the hospital would again have those statistics, but it's a very -- I'm sure he had more than anybody else.

Q. During that two to three year period?

A. Yes.

Q. Tell me why in this case Dr. Steiner was the assistant as opposed to someone else?

A. Dr. Steiner, as a matter of routine, when he stopped doing OB and having enjoyed it, and as kind of wanting to be a full citizen within our practice was our assistant for every surgery and every C-section unless he was

unavailable.

So when I would go into a weekend, for example, I would say, you know, Dr. Steiner, are you going to be available this weekend, and he would say, yes, and I would know that it would be him to be the first person I would call.

And it was always a great pleasure to have someone with 30 years experience be your assistant across the table.

Q. So in this particular case, when the decision was made to call a crash C-section, it was your decision that Dr. Steiner would be called in as the assistant?

A. Correct.

Q. Did you actually call him at home?

A. I believe I was the one that called him. I can't recall for sure, but I am almost certain.

Q. Do you know whether Dr. Steiner arrived before or after you to the hospital?

A. Oh, I was at the hospital before, seeing the patient the whole time.

Q. Dr. Steiner arrived. You called him when the decision was made to do the crash C-section?

A. Correct. Subsequent to the decision.
Q. You didn't contact him at any time prior to calling the crash C-section?
A. No, that would have occurred afterwards.
Q. Does Dr. Steiner live the same proximity from the hospital?
A. Closer.
Q. Back in 1999, were there any incentives that you or your practice group received with regard to suggesting or recommending a trial of labor in a patient who had had a previous cesarean section?
MR. JACKSON: Objection. You may answer.
MR. ROSSI: Objection.
A. There were no incentives.
Q. Were you aware of any suggestions by insurance companies or by the hospital to you or your practice group that encouraged the trial of labor from the standpoint of cost savings in previous cesarean deliveries?
MR. JACKSON: Objection. You may answer.
A. I would like to answer in two parts.

With regard to insurance companies, there is no doubt that our C-section rates and our vaginal birth after cesarean rates are looked at and looked at critically and expecting us to offer to our patients VBAC. And that was certainly the norm leading to and up to the time of Angel's delivery.

With regard to the hospital, the hospital, I think, gives a great deal of latitude to the physician's discretion, and although they look at those numbers, as well, if the physicians feel comfortable or uncomfortable, or specifically feel uncomfortable with something that might be in vogue, I don't think the hospital would push us.

. I have never been in a position where the hospital pushed us in that situation.

Q. Were there any issues in Angel's case that had anything to do with either financial incentives or cost cutting incentives that played a role in recommending a vaginal delivery following her cesarean?

A. Zero.

Q. Do you know who Angel's insurance carrier was?

A. Boy, I have no recollection.

MR. ROSSI: Medicaid is circled on the hospital chart.

THE WITNESS: That would be correct, because she had that consent form for tubal ligation that had to be signed.

Q. What are the common signs and symptoms of an impending uterine rupture?

A. I think there are several. One would be pain. Hypotension. A change in fetal heart rate, as nonspecific as it is.

In this particular case, there were two very obvious signs, and that was, one, all of a sudden a misshapen abdomen, and two, the head just virtually disappearing from an almost deliverable position.

Q. The pain, the hypotension and the change in the fetal heart rate are signs and symptoms of an impending uterine rupture; true?

A. They may be. They can be signs. Many other things also, but they could be symptoms.

I think that the single most important concept with regard to signs and symptoms of uterine rupture is that there is no classical presentation to this condition, which has made

it, you know, for all time very difficult to pin down.

Q. Are there additional signs and symptoms of actual uterine rupture as opposed to signs and symptoms of an impending uterine rupture that you look for?

A. Oh, yes, I guess, I am sorry. In the previous answer, I probably included things that would have been the actual uterine rupture and that would be the abdomen becoming misshapen.

Q. So pain, hypotension, change in fetal heart rate would be signs that would be consistent with other things, but also consistent with an impending uterine rupture; true?

A. Correct. And hemorrhage would be another.

Q. The misshape in the abdomen would be a symptom or sort of a classical symptom that you would see where there is an actual uterine rupture; true?

A. I can't say that I have ever read that. It is just in her case it was so obvious to have a perfectly smooth abdomen, and all of a sudden have a bilobular abdomen.

Q. Have you heard or read about

descriptions that patients have given when they have experienced an actual uterine rupture in terms of how it felt? You said pain. But have they been descriptive in any different way, either in your personal cases or from what you have read?

A" Not that I can recall specifically. You know, with regional anesthesia being as prevalent as it is, the ability to feel what is happening in the abdomen is diminished, so pain has always been, and especially in Angel's case, having had an epidural makes it difficult to surmise discomfort.

Q. Nursing personnel at Wooster Hospital back in January of '99, would you agree that they needed to be familiar with complications of a trial of labor in an anticipated vaginal delivery following a C-section in order to comply with the standard of care?

A" Yes.

Q. And nursing personnel need to be capable of watching for nonreassuring fetal heart rate patterns and inadequate progress of labor to comply with the standard of care; true?

MR. JACKSON: Objection. But you may

answer.

You are now talking about a standard of care for nurses; is that what you are asking him?

MR. MISHKIND: Right.

MR. JACKSON: Go ahead, doctor.

A. Yes. I don't know that I can comment on what is the standard of care for nurses. I don't read their literature and so I don't have a good handle on that, but I think they should be familiar with fetal monitor tracings.

Q. And also, to be aware of where there is evidence of inadequate progress of labor in order to inform the attending or the obstetrician of those developments; true?

MR. JACKSON: Objection. But go ahead, you can answer, doctor.

MR. ROSSI: Objection.

A. I think they should be watchful of the fetal monitor tracings where appropriate.

Q. And certainly where you may not be intimately familiar with the standard of care for nurses, you deal enough with obstetrical nurses that you know what is expected of them in terms of observing and assessing a mom and

communicating to you important findings and developments; true?

MR. JACKSON: Objection. You may answer.

A. That's true.

Q. Now, in a mom who has signs of an impending uterine rupture, would it be substandard for the nurse to have mom continue to push once fully dilated?

MR. JACKSON: Objection.

MR. ROSSI: Objection.

MR. JACKSON: You may answer.

A. Please say that again.

Q. Sure. If there is signs of impending uterine rupture, and the nurses have the patient continue to push once the patient is fully dilated, would that be practicing below what you would consider to be reasonable practice?

MR. JACKSON: Objection. You may answer.

A. I think that it would depend on a case-by-case appraisal of what is happening.

MR. JACKSON: That's your answer.

Q. Why do you say that?

A. Because in some cases, delivery might

be so eminent that there is the possibility for immediate delivery from below and then taking care of the uterine rupture secondhand, second place.

Q. Continuing to push once fully dilated with impending uterine rupture increases the likelihood of uterine rupture; true?

A. That would be fair to say. If you were at increased pressure, you would perhaps increase likelihood if the uterine rupture was impending.

Q. I am going to ask you sort of a general statement to see if we can save some time. But was there immediate and sufficient staff available for you to proceed with the C-section when you called for the crash C-section in this case?

A. To proceed immediately?

Q. Yes.

A. No, there was not.

Q. Who was missing or what was missing such that you could not proceed with the immediate C-section?

A. The anesthesiologist was in-house, but not there. And OR personnel were on call, but

not there.

Q. Do you know where the anesthesiologist was?

A. No.

Q. Was the anesthesiologist Dr. Cooke?

A. Yes.

Q. Did you ever determine after the fact where he had been?

A. The best I can recall, the discussion we had that followed was that he was getting things down in the operating room, getting supplies to stock his cart in labor and delivery. That's my recollection, the best that I can recall.

Q. Do you know why the supplies weren't stocked and readily available at the time that the crash C-section was called?

A. I didn't say that the cart wasn't adequately stocked for a single case. He was just simply replenishing whatever number. I am sure they have enough to do more than one in a row, and so he was, you know, to my knowledge, simply bringing everything up to full, as would typically be the case on a weekend.

Q. Do you know whether there were any

obstetrical emergencies in the hospital during the early morning hours on January 17th, 1999?

A. Not to my recollection. Not in our practice.

Q. Do you know whether there were any other emergency cases demanding anesthesia during the early morning hours on January 17th, 1999?

A. Not to my knowledge, but I don't have knowledge of that. I guess I shouldn't say no. But I don't have knowledge of that.

Q. In terms of starting the case, you were dependent upon the anesthesiologist arriving; true?

A. True.

Q. And your ability to start and perform the crash C-section was delayed due to anesthesia not being present when you were ready to proceed; true?

A. In part.

Q. The other part is also the OR staff?

A. Right. Just having instruments present and so forth.

Q. Was there a delay with regard to other staff by way of nursing personnel that you needed in order to perform the C-section?

MR. ROSSI: Objection.

MR. JACKSON: You may answer.

A. Again, I don't have perfect recollection of how many staff there were there. What I can recall is that we had two persons who were available to help make phone calls, obtain the anesthesiologist, contact Dr. Steiner, make the C-section room ready.

MR. JACKSON: You answered. Did you have more to say?

THE WITNESS: I think that's all.

Q. Did you start the C-section without having all of the surgical team on board that you wanted?

A. I know for certain that there was a scrub nurse and an anesthesiologist and my assistant, and that's all I would have needed. I cannot recall if there was a circulator or not. I want to say there was a circulator. I just can't remember.

Q. Did you have to use a nurse off the floor and someone from the third floor, as well, to assist with regard to the surgery?

A. I don't know where they would have come from. I am just trying -- I can't remember

who was assisting me that was actually giving me instruments. I can't remember who that was. And I don't know if the nurse who would have otherwise been on call was working or at home. I would assume she would be at home, but I don't know.

Q. Before coming to the hospital, you had been home?

A. Yes.

Q. You said that, earlier I asked you when you first were made aware of the fact that Angel had come to the hospital, and what was it that you indicated?

A. 6:00 a.m.

Q. Prior to 6:00 a.m., you had not had any communication from the hospital?

A. That's correct, with regard to her. If I had other, it was with regard to some other patient. I don't know. Not that I can recall.

Q. I take it then prior to 6:00 a.m., you were not monitoring Angel's labor from any type of a computer at your home?

A. No.

Q. Did you have that capability to do that?

A. Not at home, no.
Q. Did you have the capability to monitor a patient in labor other than being physically at the hospital?
A. Only if I was in this office.
Q. So you have a computer set up here that will permit you to see fetal heart rate tracings if the patient is in labor and delivery?
A. Yes.
Q. Is it your testimony in this case that you were not monitoring her fetal heart rate tracings or portions thereof during the night prior to 6:00 a.m. from this office?
A. That's correct.
Q. Is it your testimony in this case, that prior to 6:00 a.m., you had no communication from the nurses with regard to any aspect of Angel's labor and delivery?
A. That's correct.
Q. Would you expect that if there were either fetal heart rate tracings pattern or any concerning assessments on vaginal exam that you or someone from this practice should be contacted by the nursing staff at the hospital?
MR. ROSSI: Objection.

MR. JACKSON: You may answer.
A. Yes.
Q. And certainly we can agree that the nurses are basically your eyes and ears in terms of monitoring a patient when they are in labor and delivery when you are not at the hospital; true?
A. That's true.
Q. And you expect them to be able to appreciate changes in examinations and changes seen on fetal heart rate tracings that would be indicative of a concerning event; true?
MR. ROSSI: Objection.
MR. JACKSON: You may answer.
A. True.
Q. And the standard of care is that the nurse, if there is something that has changed or a concern that the nurse has, they are to call you and to report that to you; correct?
MR. JACKSON: Objection.
MR. ROSSI: Objection.
MR. JACKSON: Are you talking about standard of care for a nurse?
MR. MISHKIND: Standard of care that he expects from a reasonable and prudent labor

and delivery nurse at this hospital.

MR. JACKSON: He is not going to comment because he told you before about the standard of care of a nurse. If you want to phrase that some other way, you may, but he is not going to answer about the standard of care of a nurse.

Q. Well, you recognize that nurses need to act reasonably and prudent in monitoring patients in labor and delivery; true?

A. Yes. I would say that it's our expectation, based on our understanding with our nurses, that they let us know about changes that occur in the fetal heart rate tracing.

Q. And it's your sworn testimony that prior to 6:00 a.m., you had no communication, positive or negative, from the nurses in labor and delivery about Angel; true?

A. Not that I can recall, no.

Q. And you have had a chance to look back at the hospital record and look at your office records to be able to testify to that; true?

A. Yes

(recess had.)

Q. What time did you arrive at the

hospital?

A. I believe it was -- let me check that. I want to say it would have been right around the 7:44. If I got there earlier than that to make rounds, it would be standard for me to arrive at 7:30, hear what the nurses have to say and then go examine patients.

Q. Now, your notes, doctor, show that at 6:00 a.m. you were contacted. Is that correct?

A. No, actually I called labor and delivery.

Q. At 6:00 a.m.?

A. Right.

Q. And is it your testimony that that's the first contact that you had with labor and delivery concerning this patient since her arrival at the hospital?

A. Yes.

Q. And it's the first contact that either you initiated to the hospital or that any of the labor and delivery nurses initiated to you?

A. To the best of my recollection, that's true.

Q. Now, what I want to do is I just want to clarify. It looks like there are primarily

two labor and delivery nurses that were involved from the time that she was in labor and delivery up until the time that the crash C-section was called, and then other personnel came onboard. It looks like there is a Nurse Moats?

A. Correct. Sarah Moats.

Q. And she is designated by the SCM initial on the labor flow sheet?

A. Yes.

Q. Dr. Cooke, we have talked about, is the anesthesiologist; correct?

A. Correct.

Q. It looks like he was paged at about 2:30 a.m. and an epidural was placed at about 3:00 a.m., at least according to the record; true?

A. Correct.

Q. You were not aware of any of that, were you?

A. No.

Q. And then it looks like Nurse Gwin was involved, looks like from about 7:20 a.m. up to, at least up until the time that the crash C-section was called, and perhaps beyond that. Am I correct about that, as well?

A. Yes. Change of shift at 7:00, report, and then taking over.

Q. And Nurse Gwin's first name is?

A. Mary.

Q. To your knowledge, are Nurse Moats and Nurse Gwin still in labor and delivery at the hospital?

A. Mary Gwin is.

Q. Do you know the status of Nurse Moats?

A. Sarah Moats left. I don't know if she is working in Akron. I want to say that she is. I am just not sure.

Q. After everything happened, after the baby was born and after the baby was transferred to Akron, mom was discharged from the hospital. Did you ever have any conversation with either of these nurses as to what had transpired during the early morning hours and prior to your arrival?

A. I would imagine so. I don't recall it specifically, but I imagine that we certainly discussed it.

Q. When would that discussion likely have taken place?

A. I am sure it took place right after the C-section. There had to be some discussion

there. I can't remember what it would be or what the content exactly would have been. And then this case got discussed again and again.

MR. JACKSON: He will ask another question.

Q. I take it this case was discussed in some type of a peer review setting?

MR. ROSSI: Objection.

MR. JACKSON: Objection. You may answer yes or no to that.

A. Yes.

Q. And I am not going to ask you about the subject of the peer review discussions, other than whether it was peer reviewed, and you have answered that.

And I presume that some of the discussions that you are saying it was discussed at occurred within the context of these peer review meetings; true?

MR. ROSSI: Objection.

MR. JACKSON: You mean with the nurses; is that what you are asking?

MR. MISHKIND: Yes.

MR. JACKSON: You may answer yes or no to that.

A. Yes.
Q. Were there any changes made in communication by labor and delivery nurses to attendings based upon this case?
MR. ROSSI: Objection.
MR. JACKSON: Objection. You may answer.
A. Were there changes made in communication? You mean, how we would communicate?
Q. Yes.
A. With the attendings. Yes.
Q. What changes?
MR. ROSSI: Objection.
MR. JACKSON: Objection. You may answer, doctor.
A. Predicated on this case, we set about to look at the manner in which we communicated. And, you know, based on that, a whole series of --
MR. JACKSON: Just tell him -- the question was specifically, were changes made in the communication between the nurses and the attendings as a result of this case and that's what I would like you to answer.
MR. MISHKIND: I think he is.

MR. JACKSON: I just didn't want him to go beyond that question, that's all.

MR. MISHKIND: I think he still was.

A. The answer would be yes, and the differences would be that we would be made aware of a patient's admission to the hospital, and that we would also be made aware of epidurals. Even though we may have said a patient may have an epidural, that we would be aware that the patient is getting ready to get her epidural.

Q. On admission, being notified upon admission to labor and delivery and notified of any decisions or preferences when the patient was to receive an epidural, were there any other changes made based upon this case as it relates to communication from labor and delivery to physicians?

MR. ROSSI: Objection.

MR. JACKSON: You may answer.

A. I think those were the two things.

Q. Before you came to the hospital, you were not aware of any of the fetal heart rate tracings, you were not personally aware of what the fetal heart rate tracings had indicated; true?

A. No, at 6:00 o'clock, I was.
Q. From the communication by the nurse?
A. Right. Before I arrived.
Q. And again, that's because you called them, or you called labor and delivery?
A. Correct.
Q. And were you surprised to learn at 6:00 a.m. that Angel was there?
A. I was somewhat surprised to find out that there was a patient there that I didn't know about.
Q. And what did you say to the nurse?
A. For the most part, she told me that the patient was doing well; that she had a reactive tracing and so I really didn't have any cause for alarm at that point. And then I also, in just knowing the particular nurse that I was working with, I knew of her general abilities in my opinion with the interpretation of tracings and I guess I had some comfort in the fact that she was the one looking at them and in the past had read them accurately.
Q. But you obviously had some concern as to why you hadn't been contacted when you called labor and delivery at 6:00 a.m.; true?

A. Yes. It was not typical.
Q. Did she give you any explanation at that time as to why she had not contacted you throughout the night?
A. Not that I can recall.
Q. Did she give you any indication as to why no one from the hospital from the time the patient arrived up until you called at 6:00 a.m. had any contact with you?
A. Not that I can recall.
Q. You were certainly available to be reached; true?
A. Absolutely.
Q. They have your number?
A. Home phone and pager and a back line, so no matter what goes down, unless, you know, nothing worked, they would be able to reach me.
Q. There is a note in terms of the orders, the physician orders. It looks like, I guess, that would be 12:05 telephone order, Dr. Tizzano, and then it's got Nurse Moats, which I think is the nurse that we have been referencing.
If it says telephone order -- that is what TO stands for; right?

A. I think so. I'm not sure. To be honest with you, I'm assuming so. I guess. I never looked at that, TO.

Q. Do you have any explanation for why that, at least from my reading it, would suggest that Nurse Moats is suggesting that you were called; that apparently some order was given to do a vaginal exam, to monitor her labor and to admit her, and she was admitted 12:25? That seems to be inconsistent to what you testified to.

A. Sure. And I don't have recollection of that. 'It would be very unusual for me to give an order to do an exam. I can't say that I have ever seen that before. And monitor labor and admit, you know, if they write that each time that we have someone come to the hospital, that may be the case, which I must admit, this would have come through medical records and I would have been going through and signed off on it. But I don't have recollection of this. And that's really what I can say about it. If she called, I don't remember her having called about it.

Q. If she did call, and you had

communications at or around 12:25, would you then have likely been in contact with labor and delivery at sometime between midnight and when you called at 6:00 a.m.?

A. Chances are at that time I probably still would've went to labor and delivery, because it's not typical for me to be sleeping by then. But from the time that I went to sleep, I wouldn't have set about making sure that I woke up for a certain time to call. They would call me with any type of permutation, if anything was going on with the tracing or otherwise.

Q. So they would be responsible for contacting you if there is any changes or concerns that they have during the course of the night; true?

A" Yes.

Q. But what you are telling me is that if you were contacted at or around midnight, more likely than not, you would have gone to the hospital and seen the patient?

A. Yes, at that time.

Q. So as to this note, and the suggestion that you gave a telephone order, I take it you don't concur with what is stated in this record?

A. Yes, I can't recall this having happened. This does not --

(discussion off the record.)

A. I just look at the way this is written out and this is just not my standard, go ahead, examine the patient, do a vaginal exam. You know, I expect them to have already done the vaginal exam when I am being called.

So when they call me -- I have been through this many, many times as anyone there would probably tell you -- I want to know what the nature of the tracing is and I want to know what the patient's exam is and what the pertinent points of her history are so that I can, you know, give some basis for whatever orders I might subsequently give.

But we have to have an order of admission to the hospital. And I always thought this was part of a standard written thing, but it is not. Maybe it is now and it looks different.

Q. Are there any other orders that would normally take place if Angel had come to labor and delivery, nurses in labor and delivery contact you, whether you came to the hospital or whether you gave orders over the phone, besides

what is noted here?

A. Not that I know of. Not that would routinely take place.

Q. In your discussions, doctor, with Nurse Moats, did you ever get a clarification from her as to why in your mind you were not contacted prior to 6:00 a.m.?

MR. ROSSI: Objection.

MR. JACKSON: You may answer.

A. Not to my recollection. I can't recall having had a conversation about that with her.

Q. This order does have your signature on it; true?

A. Yes.

Q. We don't know what the date was that you signed that. Presumably it would have been -- well, let me not presume anything. Presumably it would have been after the uterine rupture had taken place and the baby was delivered, but I may be presumptive in that. Is that more likely the case?

A. Yes, the more common case would be for this whole chart to have come up after the fact and I would have been doing it in medical

records.

Q. But it's not dated or timed as to when you signed, that; true?

A. That's correct.

Q. And it should have been; true?

A. Yes.

Might I add something to that last answer?

Q. Go right ahead.

A. I guess in convention what I always assumed was, I guess realizing that I am looking at the time next to the verbal order, maybe that's what they by convention do, and I always assumed that the time when I am signing this, the time of the order was put down here. I guess that's -- no, wait, she does have an RN time, okay.

Q. There goes that convention.

A. I see. It's amazing how you scrutinize things later, but that's fine.

Q. I am going to try to do this just because of the time frame, but you have had a chance to look at the fetal monitor strips?

A. Yes.

Q. When you came to the hospital at --

well, let's see. You saw Angel at 7:44; true?
A. Correct.
Q. Your testimony, however, is that you probably arrived at the hospital before 7:44?
A. Probably 7:30. I would say it would be just -- I am speculating. My convention is to wake up at 6:00 and call the hospital. I do that as a matter of routine.
Q. You didn't, however, go immediately when you arrived at the hospital up to see Angel, did you?
A. I would have went immediately to labor and delivery and got the chart out and started to look. I believe she was my only patient there that was in labor.
Q. But is it fair to say from the time you arrived at the hospital up until the time that you actually saw the patient, probably 10 or 15 minutes went by?
A. Perhaps.
Q. Is that a reasonable estimate?
A. That is reasonable.
Q. Again, I am not trying to put words in your mouth. If you immediately walked in the door and saw her in two minutes --

A. If she were the only patient there, I probably would not have changed clothes. I would probably have set my jacket down, got her chart and walked to her room.

Q. When is the first time that the fetal monitor strips became concerning to you?

A. Do we have those so I can go -- I do have those. Let's see. We have those here.

MR. JACKSON: Your question is when do the strips reflect something that would have been of concern to him?

MR. MISHKIND: To him, correct.

Q. If I can ask you another question that may save some time while looking at that, I also want to know when you arrived at the hospital, would you have gone back and looked at the strips that were available at that point as to what had transpired up to and prior to 7:44?

A. Let me answer that question first. Just recounting the best I can, the series and rapidity with which all these events began taking place, once I ruptured those membranes and things beginning to happen, I don't know that I looked at a tracing from the remainder of the night before I got there until after the fact.

Q. Fair enough. Now, you can go back to my original question.

A. When did the tracing become concerning?

Q. To you.

A. After I arrived?

Q. Correct.

A. Okay. During the period of time beginning at approximately 7:50 a.m., we have loss of the tracing, so it's hard for me to tell what is going on. An internal lead is being placed.

Once we have that internal lead on, the tracing has immediate concern. And patients from that point forward go through a series of occurrences with the fetal heart rate tracings with decelerations of various types that are concerning and more concerning and more concerning.

Q. What time was the IUPC placed?

A. Did she actually have an IUPC placed? I don't recall having -- you mean the scalp electrode?

Q. Wasn't a pressure catheter inserted? Maybe I am mistaken.

A. That normally is recorded here and I don't recall having done it. If it's in the nurse's notes, I need to go back and look.

Q. I may be mistaken, doctor, so don't assume that by my question that I am necessarily implying an answer.

MR. JACKSON: Do you have a reference to an IUPC? Your question was when was an internal monitor placed.

Q. Intrauterine pressure catheter.

A. I don't recall placing an IUPC.

Q. I think you told me that at 7:50, that's when you -- is that when you ruptured the membranes?

A. 7:44 I had examined her. Let me go back to my note here.

The operative report. I think I have it in my note. I have it 7:44 patient evaluated. Her interest in VBAC was reaffirmed, the cervix completely dilated with the vertex now engaged at a minus two station, amniotomy was performed with egressive clear fluid.

Q. Is it fair to say that at or around 7:44 you did the artificial rupture of the membranes?

A. Correct.
Q. And I think it's at that time or shortly thereafter that the fetal heart rate tracings were of concern to you?
A. Yes.
Q. And as to whether you went back and looked at the fetal heart rate tracings before this or not, you were really looking at things prospectively at that point as opposed to retrospectively?
A. Correct.
Q. Do you recall having any discussion with Nurse Moats or perhaps Nurse Gwin when you arrived at that 7:44, 7:45 time frame?
A. Not that I can recall, outside of what we would have been discussing in the patient's room. But in the labor, the nurse would have been in the room almost consistently with the patient. So really any conversation I had would most likely have been with the patient and the nurse present in the room.
Q. And any specifics, you don't recall?
A. Not that I can recall.
Q. Do you recall any discussion with Angel at that time when you arrived concerning

how she was feeling?

A. Not specifically how she was feeling. I know that there was a period of time somewhere there that she had nausea and that we ordered some medication for that. But beyond that, my initial conversation with her had to do with just making sure that we were all still on the same page with our game plan. The ruptured membrane took place.

Q. The experiencing of nausea and vomiting after rupturing of the membranes is a sign consistent with a uterine rupture; is it not?

A. Of that and many other things.

Q. Right. But certainly, when you have a uterine rupture, patients typically will experience at or around the time of the onset of the impending uterine rupture, they will experience nausea and vomiting; true?

A. Possibly.

Q. At 7:44 when you assessed the patient, did the artificial rupture of membranes, saw her fetal heart rate tracing and experienced nausea and vomiting, did you consider at that time the possibility of a uterine rupture?

A. No. I wasn't thinking of that at that point in time.

Q. What were you thinking of?

A. Well, the baby's head, once I ruptured the membranes, was coming down the birth canal so quickly that I just assumed all those changes taking place in her abdomen would probably have been the most likely reason for her to have become nauseated at that time.

I just laid her on her back to do an examination -- laying patients on their back will frequently make them nauseated -- and then ruptured her membranes, having this egress of clear fluid, and the head coming down very easily in the pelvis once having done that.

Q. I want to ask you about a couple entries in the record that you obviously were not aware of based upon your testimony, but are charted during the night in the nursing flow sheet. If you would take a look at the labor flow sheet.

A. Under nursing notes.

(Pause.)

Q. I am particularly interested in the 4:15 note; that is, at a point in time when a

vaginal exam is done; true?
A. 4:15, let's see.
MR. JACKSON: Show us the entry you are referring to.
Q. Do you see the 4:15?
A. 4:15 a.m.
MR. JACKSON: What specific entry are you looking at?
A. Here we go, sure, yes, I see.
Q. All right. And just so that the record is clear, am I reading that the nurse documents dilatation complete?
A. Correct.
Q. Effacement 100 percent, minus three station and the vertex presentation, and the "I" stands for what?
A. Bag of water intact.
Q. And so that would be a vaginal exam being performed by Nurse Moats; true?
A. Yes.
Q. When a VBAC patient reaches complete, of what significance is this?
A. Well, she enters at that point the second stage of labor. She has an epidural. In this case the head is very high in the pelvis and

her membranes are intact and so now it's a matter of waiting for the head to settle down into the pelvis.

Q. Would you expect with a VBAC patient with those findings on vaginal exam that you should have been contacted?

A. I would like to know when the patient is complete.

Q. So your answer is yes, the nurse should have called me; true?

A. Yes.

Q. Do you have any explanation for why the nurse didn't call you?

A. No.

Q. At 4:15, the nurse's notes indicate further that she inserted a Foley. Just verify I am accurate about that.

A. Do you see that on the same sheet?

Q. If you turn to the next page, the narrative notes. Do you see 4:15, Foley cath inserted, vaginal exam as noted. And that again is Nurse Moats, although the signature line on my copy is cut off.

A. I can see SCM.

Q. Yours is better quality.

Do you have any explanation for why a Foley catheter would be inserted at 4:15?

A. Two. One is the patient has an epidural. Her ability to sense her urgency to void might not be there. I prefer once they have an epidural to have a Foley catheter.

And also she is looking at the station. This baby is still at minus three, and one of the things that can keep that head high is a distended bladder.

Q. Doctor, when I look at your operative note -- and I am trying to save some time, and I don't mean for you to jump around unnecessarily -- if you look at the second page of your operative note, the top of the page, fourth line down, that sentence started with there appeared to be a grossly distended urinary bladder.

I am not going to read the rest of it because the record is clear as to that particular point. That's when you encountered the dissected uterus; correct?

A. Correct.

Q. Is it likely that at 4:15 when she inserted the Foley that the distention that was noted was in actuality the beginning of a uterine

rupture?

MR. ROSSI: Objection.

MR. JACKSON: Objection. You may answer.

MR. ROSSI: The distention of her bladder; is that what you are asking, Howard?

MR. MISHKIND: The distention in the abdomen, excuse me.

A. The distention that I saw in the operative report is not the bladder being distended, but is indeed the uterus having ruptured. And the bladder being contiguous with the layer of tissue that covers the uterus and it had dissected underneath that labor, bulging the entire labor up, so when you initially looked at it, it appeared that the bladder was overly distended. And I don't think that at 4:15 in the morning that her uterus was ruptured.

Q. Would distention that would cause someone to insert a Foley where ultimately you have a uterine rupture that's detected some three or four hours later, would that distention be consistent with an impending uterine rupture?

MR. JACKSON: Objection. You may answer.

A. Are you saying did Sarah Moats know there was some distention and that's why she put in the Foley?

Q. No, because I am not going to ask you what her thought process was. She inserted a Foley, we know that.

I am asking you, looking at an explanation for why one would insert a Foley, one would be due to distention; true?

A. Distention, you would assume that a patient who has an epidural would not feel her bladder beginning to distend. To make sure she is completely emptying her bladder and to make sure that the head was not impeded in coming down the pelvis, you would get the bladder out of the way by making sure a catheter was in place so you knew that the bladder was adequately drained.

Q. If the Foley was inserted due to an assessment of some distention, that would be a reasonable thing to do, would it not?

A. Yes.

Q. We will talk to Nurse Moats and find out the thought process. But assuming that the Foley was inserted due to distention at that time, would you agree that more likely than not

that such distention, given what we ultimately find at 8:00 o'clock or so, that that most likely was the sign of an impending uterine rupture?

MR. ROSSI: Objection. Just so I am clear, that a distended bladder in a pregnant woman after an epidural is a sign of an impending ruptured uterus?

Q. I am saying a distention that causes one to insert the Foley, whether or not that is consistent with the subsequent diagnosis of the uterine rupture; in other words, is it a symptom or sign of an impending or approaching uterine rupture?

MR. JACKSON: Do you understand his question? I object, but go ahead.

MR. ROSSI: I do too.

A. It could be, but in this situation I know because of my initial examination on this patient at 7:44 there was no distention of her abdomen, so if it was a rupture that indeed had taken place that was causing that, you would've wanted that to be still there and that wasn't there. So her abdomen was perfectly normal in appearance when I first examined her and ruptured her membranes.

Q. Fair enough. Nurse Moats is, 1 think you told me before, is a highly qualified labor and delivery nurse?

A. I think she is very qualified, in my experience.

Q. One who you would expect to be able to do a good assessment of a patient in labor and delivery?

A. Yes.

Q. One that would be able to perform a vaginal exam on a serial basis and appreciate any changes that need to be communicated to you?

A. Yes.

Q. At 6:00 a.m. in the nursing flow sheet, Nurse Moats, I think, did the next vaginal exam. It might be 6:08.

A. I see the confusion.

Q. Is it 6:08 or maybe 6:00 o'clock. Do you see the loop is either an 8 or 10. What do you make that out to be? 6:00 o'clock?

A. I would say 6:00 o'clock, looking at the next 8.

Q. In any event, at 6:00 o'clock, she does what appears to be the next vaginal exam; correct?

A. Yes.
Q. And at that time, she notes dilatation is still complete, effacement is 100 percent, station at this time now is minus four; true?
A. Correct.
Q. Of what significance is it in a patient that is in the trial of labor that has had a cesarean section, if they go from a minus three to a minus four station once fully dilated?
A. I would prefer to see that she was progressing down instead of up. I also think that for an examiner to be able to consistently and accurately judge the centimeters in the pelvis is a tough one, and fortunately it was the same examiner, so I would rather see we were moving forward and not having the head stay high from 4:15, but this portion of labor is the deceleration phase.
The change in the cervix is very slow, and you know, we were waiting for the head to now come down the pelvis, and it's at this point not happening.
Q. Can we agree that at this point at 6:00 a.m. that going from a minus three to a minus four station when the cervix is complete is

something that should be communicated to you?
A. I agree with that,
Q. And was that communicated to you when you spoke to the nurse on the phone at 6:00 a.m.?
A. At 6:00 a.m. they told me it was minus three to minus four.
Q. They didn't tell you it had gone from minus three to minus four, did they?
A. No.
Q. Would you have liked to have known that?
A. Yes. And if I could have believed that that was measurable, I don't know how much stock I would have put into guesstimating, not guesstimating, trying to ascertain a centimeter's difference.
Q. We have the reliability of this being the same nurse as opposed to a different nurse?
A. Agreed.
Q. They didn't tell you if the station had regressed as opposed to progressed?
A. No.
Q. I don't know if I am using the right term.

That's something that should have been told to you; true?

A. I would have preferred to have known that.

Q. If you had been told that the patient was 100 percent fully effaced, cervix complete, minus three at 4:15 and minus four at 6:00 a.m., would you agree that in all likelihood you would have come to the hospital to assess this patient immediately?

MR. ROSSI: Objection. There is no evidence he wasn't told that it went from negative three to negative four on stations.

MR. MISHKIND: Well, whatever. Go ahead.

A. If I had known that between her 4:15 exam and her 6:00 a.m. exam that effectively she is not changed much at all, and in fact may have even gone up a little, I would've liked to have known and would have seen her right there.

Q. At 7:44 when you ruptured the membranes, I think you indicated in your notes that the vertex was now engaged; is that correct?

A. Right. That is correct.

Q. And you indicated that she was at

minus two station?
A. Yes.
Q. Doesn't the point of engagement come at zero station?
A. It does, but with a little bit of fundal pressure you can easily engage her, and we needed to rupture her membranes to get on with things and that's what we did.
Q. So when you say the vertex was now engaged --
A. Oh, I see what you are saying.
Q. -- your statement is not consistent with --
A. No, I understand what you are saying. I have probably overlaid what happened after amniotomy and before amniotomy, but no, I understand your --
Q. The fluid was clear?
A. Yes.
Q. Do you recall who was in the room with Angel after you did the artificial rupture of membranes?
A. Aside from the nurse, you mean?
Q. Correct.
A. I cannot remember if her husband was

in the room. I want to say that he was in the room. He certainly was there during the course of many of these events, and I don't remember when he appeared or if he was there the whole time.

Q. What about Angel's grandma, do you remember her being there?

A. I don't have a recollection of her.

Q. Do you remember ever meeting her grandma?

A. I believe so, but my recollection comes after the C-section and talking with her and Angel's husband.

Q. Fair enough. At 7:44, after rupturing the membranes, after seeing the concerning fetal heart rate tracings at or around 7:50, I think is what you said, why didn't you call for a crash C-section at that time?

A. Because very often you can see changes in fetal heart rate tracings which are transient, and this had just begun to occur. I would have more reason to believe that this would have recovered than continuing to take on the course it did.

Q. I take it you were not aware of the

fact that between 4:15 and 6:00 a.m. not only had she not progressed, but in fact she had gone from minus three to minus four station when you arrived; true?

A. Correct.

Q. Had you known that, and with the concerning findings on the fetal heart rate tracing, would you agree that there would be more reason to call a crash C-section sooner than what you did?

MR. ROSSI: Objection.

MR. JACKSON: Objection. You may answer.

A. No. I have an examination that doesn't appear unremarkable at this point in time. I performed the amniotomy, the head settles very nicely into the pelvis, at that point in time I am not hearing the patient complaining of anything differently. Her abdomen doesn't appear unusual.

We have a period then of loss of fix, which makes sense, because initially they had an external monitor. I have now ruptured membranes. The baby has begun to move down the pelvis out of range of where the original

position of where the device we use on the abdomen picks up the doppler wave form from the baby's heart rate and now we have all this loss of fix. So, okay, let's go ahead and get the scalp electrode on and see where we stand.

Q. That's put on at 7:59?

A. I remember it being 8:00 but 7:59 is -- do you know that to be --

Q. That's how I read the strips. I can certainly turn to it, but that was my understanding.

A. Okay. So scalp electrode is placed. Well, on the tracing it's not recorded, and this is typically where I expect to see t, so that what is coming out of the monitor is where something has occurred. And we are coming out of a deceleration in the 60's, the heart rate rises to the 140 and then goes into a series of variable decelerations, and you cannot by looking at the monitor that's on the fetal abdomen make any sense of where contractions are or where they are not.

So the ability to call these with a late component or without a late component by virtue of not being able to see the contractions

is very difficult for me to do at this point,

But what I do see is very sharp up and down changes in the fetal heart rate in a baby trying to recover, okay? And when I see a sharp plunk like that, I assume there is either some cord compression, perhaps some head compression, all of which in my mind is fitting with this head coming down through the pelvis.

And at 0802, taking a look at the tracing of all things considered -- let me make sure I know where I am at -- I say, let's go ahead and give a push. We give a push and the head comes almost to crowning to a plus three station.

This is a baby that I should be able to deliver, and if necessary, deliver very quickly. And a head doesn't usually come down the pelvis with that kind of grace unless there is an adequate pelvis and a fetal head of reasonable size.

I would not expect her to go from a minus three to minus four with fundal pressure, or however I was able to engage that vertex, rupture her membranes, see the head come down and not have any anticipation but being able to

deliver that baby vaginally.

Q. While looking at the fetal heart rate tracings, what do they show from 7:50 to 7:59 or 8:00 o'clock when the electrode was put on?

A. We have loss of fix throughout all of this. Let: me just look at the page before. It is so fragmented. Let's just go ahead and assume that that's fetal heart rate and not maternal heart rate.

When you have these periods where there is an actual break in the fetal heart rate tracing and you look at the top of the tracing on 91038 and you look right down below the three, you can see a little point that arrives up there.

Q. Okay.

A. Is that fetal heart rate that momentarily jumps to 170, is that artifactual? That's difficult to say. This is an external monitor. This tracing is very difficult for me to make any heads or tails out of.

You can see contractions occurring very frequently, but yet you don't see any dips and rises, you see this scattered line, and so this is a very difficult portion of tracing to draw conclusion from for me.

Q. Are you able to give any significance to what the fetal heart rate was and the significance of the status of the fetal heart rate between that 7:50 and 7:59 time frame?

A. I wouldn't place a lot of significance in this only because at this point in time, again from the time of rupture of membranes to when I am reexamining her, this head is coming down the pelvis, and I would expect by virtue of head compression being more significant than it has for this baby all through this labor up until now, because it's never been in the pelvis, that we would have some change in fetal heart rate baseline and have a difficult time picking it up.

Q. What time was oxygen started?

A. 8:06.

Q. Why wasn't oxygen started before 8:06?

A. I think probably when you look at having seen this dive and having noted that five minutes before, they were in the process. At this point in time, there are a number of things going through my mind and that I'm asking for.

You know, I have seen the potential for delivering her forthwith, instruments are just outside the door in a covered cart ready to

be brought into the room at the very moment they are needed, and there is the time it takes to get the stuff out of the cupboard and put it on and get her breathing it, and then write it down on the tracings. So even from the time that she actually put the oxygen on, to the time she writes that, that monitor strip is continually moving.

Q. Would it have been preferable to have administered oxygen in light of the status of the fetal heart rate tracings and all of findings prior to 8:06?

A. I think it's reasonable to add the oxygen as soon as you see any permutation of the heart rate. At the same time, this is the first permutation she is seeing and the notion that this is going to resolve is a reasonable expectation.

Q. It would have been reasonable, would it not, at or around 8:00 o'clock to have administered oxygen?

A. Yes.

Q. And do you see any indication that oxygen could not have been administered during that five minute period or six minute period?

A. Any reason that it could not have been done?

Q. Correct.

A. No.

Q. The heart rate tracings at around 7:59 or 8:00 a.m., would you agree they are suggestive of preterminal tracings?

A. No.

Q. Are they ominous tracings?

A. Disconcerting to see that heart rate down to 60, but then in another moment, you look at one minute later and you have a heart rate at 140. You don't know that another deceleration is going to take place. Even a person standing there, hand on 02, looks over at the monitor and sees we are back up to 140, hoping, because of the rapid progress taking place, that what we are seeing is indeed the baby coming down the pelvis and compression of that head causing those changes in the heart rate to occur.

Q. I think you partially answered this before in terms of why you didn't call the crash C-section at 8:00 a.m. as opposed to what, 8:12 a.m.?

A. Yes.

Q. Was that, you, in your mind, based upon taking into account all of the information, felt that you could still safely deliver this baby vaginally?

A. Correct. I thought there was a point in time that that's what we were going to be able to do.

Q. And what was it at 8:12 that caused you to change that opinion that was not already known to you at 8:00 a.m.?

A. At 8:12, the head ascends into the pelvis. Very atypical sort of thing to occur. I have never seen anything like that happen before in the manner in which that happened. And right then and there knew that we had something very different coming up. That was my first sense that uterine rupture was present, and at the very same time the abdomen takes on that bilobular appearance.

Q. You were concerned that there was some fetal distress going on before 8:12 a.m.; correct?

A. I won't say there was fetal distress, I would say there were some nonreassuring components of that fetal distress by what I

anticipated was the head coming down through the pelvis.

Q. And if those nonreassuring signs were consistent with fetal distress, you want to attempt to relieve as soon as possible any type of anoxic insult to the baby; true?

MR. JACKSON: Objection. Go ahead, doctor.

A. Just please say that one more time.

Q. If the fetal heart rate tracings are consistent with distress, fetal heart rate tracings were consistent with fetal distress, you want, as an obstetrician, you want to relieve the events causing that fetal distress as soon as possible to eliminate or to prevent any anoxia to the baby; true?

MR. JACKSON: Objection. You are distinguishing from the circumstance here or talking in general? Because he has given you his reasoning for this particular situation.

MR. MISHKIND: In general, then, that's fine.

A. In general, when I see a nonreassuring fetal heart rate tracing, certain steps I like to take to see what would happen with the tracing.

Q. And the idea is you want to, if the tracings are suggestive of fetal distress, the sooner you deliver the baby, the less likelihood that there is that the baby will suffer an anoxic event; correct?

MR. JACKSON: Objection. Go ahead.

A. I want to answer that question two ways. Yes. If I thought that what I had coming was more nonreassuring fetal heart rate tracings, yes. If what I had seen was a period of disconcerning fetal heart rate tracing and then return to normal, but I still knew I was going to do a cesarean section on a patient having failure to progress, I would rather allow that baby to recover in utero; that our efforts at the time of delivery, very quickly and dramatically delivering that baby would be better.

Q. And as to why you didn't put the appropriate staff on notice of an impending crash C-section earlier than 8:12, for example, at 8:00 o'clock or at 7:44 when you arrived, is that your thought process was you could still in the best interest of the mom and the baby deliver this child vaginally as opposed to needing to proceed to a crash C-section; true?

A. Correct.
Q. Were you aware of the fact that Angel questioned the nurses when the fetal heart rate tracings began to drop as to why she wasn't being moved toward a C-section?
MR. ROSSI: Objection.
MR. JACKSON: Objection.
MR. ROSSI: Can you be any more specific?
MR. MISHKIND: I really can't.
Q. Let me put it to you this way. Were you aware of the fact that Angel had questioned the nurses in the early morning hours prior to your arrival as to why she wasn't being moved toward a C-section?
A. No.
Q. Would you expect if such conversation occurred where the patient is questioning the nurses about why aren't we going to C-section, or I want a C-section, or something bringing up C-section, that that should be brought to your attention --
MR. JACKSON: Objection.
Q. -- by the nurse?
MR. ROSSI: Objection.

THE WITNESS: I may answer?
MR. JACKSON: You may.
A. I think that if the patient was objecting and that the nurse did not answer by virtue of her explanation, I would appreciate being called. However, I think that also a nurse with Sarah's experience may describe to the patient what is going on, what is reasonable to expect, and if she thought that she was on solid ground, the patient perhaps would be reassured and would go forward from there.
Q. We are closing in on completion of the deposition. I want to talk about the surgery for a moment.
Anesthesia decided to use the epidural; correct?
A. Correct.
Q. Rather than a general?
A. Yes.
Q. Do you have any concerns at all as to why or as to whether it would be preferable to proceed with the general?
A. I think that the anesthesiologist knew that what we were doing was a crash cesarean section. Harold Cooke is very accomplished.

Q. What's his first name?
A. Harold.
And I would be guessing as to why he chose one over the other, knowing that my intention would be to immediately proceed.
Q. Do you know how long it was once the decision was made to proceed with the crash C-section until Angel was moved from her room into the OR?
A. There is a time. Let's see. There is a time that she is actually in the room. I am trying to remember where that time is at in the notes. I don't recall it right off. It was about three or four minutes. 8:30. I can't remember.
MR. JACKSON: You want to know when she was in the OR?
MR. MISHKIND: Basically from the time of the crash C-section until she was taken into OR.
(Pause.)
MR. JACKSON: We can't find it. If you can give us a reference somewhere.
THE WITNESS: I think it's in the chart. I just can't remember.

Q. Let me ask you this, to try to speed things up. Angel's recollection is that from the time the crash C-section was called, she was left in the labor and delivery room for at least 10 or 15 minutes prior to being taken to the OR. Does that sound consistent or inconsistent with the general flow of time in terms of what took place once you called the crash C-section?

A. Are you asking do I think that her recollection is correct that she was in her room for that period of time?

Q. Yes.

A. I think that's probably correct.

Q. Do you know what took place in the OR prior to the skin incision being made?

A. They would be waiting for the crew to get there and typically we would not move the patient back to the operating room until there were staff there to take care of her, hook her up to a monitor, get her on the table, have anesthesiology present and have the nursing scrub person present, because we were disconnecting her from everything to make that move.

Q. Dr. Steiner assisted with the C-section; then?

A. Correct.
Q. I asked you before as to whether or not he had privileges to perform C-sections at Wooster at that time and you are not certain whether he did?
A. I am not certain how his privileges read. I know he certainly had whatever it took to be assistant. I don't know if he had, if there is a difference in what the primary surgeon needs.
Q. Certainly his assisting an emergency C-section should be consistent with the privileges that he has at that hospital; correct?
A. Yes. He is absolutely qualified.
Q. And whether or not he was both qualified and had appropriate privileges at the hospital to perform C-sections may not necessarily be the same thing; correct?
MR. JACKSON: Objection. You may answer.
A. I am not aware of the credentialing and privileging processing and how it relates to each physician.
Q. Given what I understand to be a need for you to wait for anesthesia to arrive and the

appropriate personnel to arrive, at 8:12 when the abdomen took on this unusual shape -- and I can't remember how you described it, but I think it was an unusual shape -- why didn't you take Angel to the OR to do a limited skin prep since she had a Foley in, IV, and the epidural had been placed?

A. The reason I didn't do that is because I didn't think it was in her best interest. If I had done that and not had anesthesia present, not had other instruments, and I opened up an abdomen and instead of seeing the distended peritoneum, I saw blood and blood coming quickly, I would have been in a bad situation with no one to administer fluids, and so forth, that would have been needed to support her and get her through that case.

Q. When you opened up the abdomen, can you just describe for me in general terms what you encountered, both in the abdomen and then in the uterus.

A. Yes. I am going to refer back to my operative note. Once again, once we open the skin, separated the muscle, the first thing that became apparent was what would normally be the bladder, and the upper limits of the peritoneum above the uterus is this enormous bulging and

confluent area. So we carefully enter the peritoneal cavity and see it's very difficult to distinguish where bladder begins and ends. And knowing basically where we are and knowing if I do injure the bladder I can still go ahead and repair that, enter and discover it's not at all the bladder but a window open in the uterus which at this point in time was not hemorrhaging and that there was, I believe, arm and cord were prolapsed through the incision.

It was very easy at that point without making any incision whatsoever into the uterus to simply reach in and deliver the baby.

Q. The uterus itself, how badly was it torn?

A. In addition to the window being opened, the lower segment of the uterus from the incision down toward the area down underneath the bladder was very contused, bruised. It had a very purplish, modeled appearance to it and the tissue, as though it had been stretched and started to split at points along the way before finally rupturing at the scar were apparent.

Q. Then did the old incision from the C-section, did that rip open and rupture also?

A. That, I cannot say. I'm assuming that's what happened, but I couldn't actually make out. We were right at the junction between the lower uterine segment, which is very thin, and up against the upper bladder and the thick portion of the uterus.

Q. Dr. Steiner, what assistance was he providing in connection with the delivery?

A. Exposure.

Q. Exposure of the fascia?

A. Right. Since he virtually assists with every single case that we do, his expertise as an assistant is unlike virtually anyone else that we could have.

Q. Doctor, I want to ask you a couple questions relative to the delivery time, and that is, if a crash C-section had been called at 6:00 a.m., hypothetically, would you agree more likely than not that the baby would have been delivered and spared the irreversible brain damage?

MR. ROSSI: Objection.

MR. JACKSON: Objection. You may answer.

A. If a C-section had been called at 6:00 a.m., I agree there would not have been a problem

with that baby.

Q. Based upon the pH at birth, do you have an opinion as to how long before the actual delivery took place that an irreversible brain damage occurred?

MR. JACKSON: Objection.

MR. ROSSI: Objection.

A. Can I answer?

Q. Sure.

MR. ROSSI: Unless Mr. Jackson tells you no.

MR. MISHKIND: He never does that.

(Discussion off the record.)

A. We are speaking of the pH of 6.4?

Q. Right.

A. I couldn't speculate as to how long it had taken. There are so many variables that amount to that.

Q. I guess what I am trying to get at, do you have an opinion or are you likely to express an opinion at trial as to when, prior to the actual delivery -- we have talked about the 6:00 a.m. period that more likely than not the baby would have avoided irreversible brain damage, along the continuum at 6:00 a.m. and prior to

calling for the crash C-section at 8:12 and delivering the baby at 8:30 --

MR. JACKSON: I'll object to that. I think he answered.

Q. 8:30, whatever, do you have an opinion as to when the window of opportunity, if you will, closed on preventing irreversible brain damage?

MR. JACKSON: Is your answer any different than it was before?

MR. MISHKIND: I am not sure he answered that question.

MR. JACKSON: I think he did. Go ahead.

A. I would like to answer this in two parts. For one, I would feel relatively certain that had delivery occurred by 7:50, I would be betting that we would be on very solid ground, and that had delivery occurred even by 8:14, that this baby would have recovered from that transient period.

Q. So that had the actual delivery of the baby occurred at or prior to 8:14 a.m., it's your opinion, more likely than not, that Alexus would have avoided irreversible brain damage?

MR. ROSSI: Objection.
Q. Is that correct?
MR. JACKSON: You may answer.
A. I think our chances would have been good.
Q. More likely than not?
A. In my experience, yes.
Q. I asked you before about the intrauterine pressure catheter and whether one was or wasn't used. We sort of got hung up. What are the advantages or disadvantages of using an IUPC?
A. It is certainly the timing of contractions and the intensity. The timing I think is relatively equivalent to being able to use the external, except when there is loss of fix of the external monitor, so then it has precedence in its ability to accurately depict when a contraction begins and ends and also could depict what indeed is the true amount of pressure being exerted by that contraction.
Q. So during the period where we have -- I think from 7:50 to 7:59 a contraction pattern -- I'm sorry, a fetal heart rate pattern somewhat difficult to interpret as we talked

about before, would an IUPC give you greater variability and greater assistance in appreciating the status of the baby's heart?

A. That would have nothing to do with the heart. In this case, seeing the baby's progress negated any reason to put in an IUPC, in my opinion.

Q. Do you believe, looking at this, there was no indication for an IUPC; that I may have misspoken in terms of its application?

A. I agree that I didn't need an IUPC at this point.

Q. Tell me about this meeting that you had with the family after the baby was delivered and you saw mom and dad in the office. The note reflects something about you had a conversation that lasted well over an hour. Do you recall that?

A" Yes.

Q. I am sure that this was a very heartfelt meeting that you had with the family. It wasn't easy on you and obviously not easy on the family; true?

A. That's very true.

Q. Do the best you can, because your note

doesn't reflect the specifics of the conversation, but if you can give me what you recall you said and they asked, that kind of thing.

A. You know, basically, there was a very brief interval of seeing how she was doing at this stage of the game and her recovery and that appeared to all be going reasonably well. And then of course how is the baby -- and that probably actually preceded any conversation -- what was the status of the baby.

And they related to me what their feelings were. They were encouraged by a number of things, none of which sounded encouraging to me. And there was from my take on what they had said and not having seen the actual information coming from the neonatologist, I didn't know what specifically to think. But none of it sounded good.

At that point, there was just a hint, just a hint of anger in the father's voice as he recounted some of the things that occurred during labor and delivery. And trying to understand them -- and I fully appreciated why he would feel that way -- and simply told my nurse, I said,

time to tell the other patients that I am going to be tied up for an indeterminate period of time and whatever time it took to explain to them in as best a way I could what had transpired, I did.

And I can't remember the exact specifics of that conversation, but the father was there through every bit of that preC-section discussion. He was right outside the door up until the time, and I don't recall if he was in the room during the section. At the time I was just so focused on what was going on and getting things ready that that was the last thing I was thinking about. But then he was outside the door for the resuscitation in what 1 am sure was a horribly awkward position for him to be; in greens with a crew from a children's hospital that had virtually no notion that that's the father and this is not a health care professional standing there, and what was, I am sure, a very gut wrenching experience for all of us, let alone for him. And I did the best I could and described to them what happened from my perspective and that was the sum total of the conversation.

Q. Sounds like a lot of questions were being asked by the dad.

A. I think for the most part if Angel had questions, I don't remember them, but there was a fairly good list of questions from dad that I can recall.

Q. Do you remember any of the questions, either specifically or the general nature of the questions that mom asked?

A. I would be speculating and reaching to try to remember. I think most of these questions were what if, what if this, what if that.

Q. Can you give me an example **of** some of the what if's that you believe were asked during that meeting?

MR. JACKSON: Please don't speculate. If you can do it, a reasonable memory of it --

A. I honestly can't. I would have written them down.

Q. That's fine. And again, if you have reason to believe that you were asked what if A, B and C occurred, or what if such-and-such had taken place, you think that that's what occurred, tell me.

If you are just speculating and you

are guessing at what you believe they asked, then Mr. Jackson is correct, I don't want you to go there.

A. I would be speculating. There is no two ways.

Q. Besides what you have dictated in your notes or written down in your notes -- and I think a lot of your stuff is dictated -- did you maintain any other notes concerning this meeting with the family?

A. No.

Q. Do you recall having any discussions with Angel or any family member while Angel was in the hospital where they questioned you about why the baby wasn't delivered sooner?

A. I don't recall them specifically. They may have occurred. I would have certainly engaged in any conversation that any family member had. I would not have shied away from that for a moment.

Q. Let's assume that you were asked that back in January of 1999 in the hospital before Angel is discharged, whether asked by mom, by grandma, or by dad, why didn't you deliver this baby sooner, without repeating everything you

have already told me, but talking to somebody as a layperson, what would have been or likely was your explanation?

MR. JACKSON: I'll object, because you are basically asking him what would you have said in a conversation that may or may not have occurred.

MR. MISHKIND: That's true. You are 100 percent correct. I have reason to believe, although I can't state to a certainty, that such questions were asked, and I think the doctor has said to me that he knows if it was asked what he would have said very specifically.

MR. JACKSON: I agree. What this could lead to, your clients say the doctor, we asked him this question on such-and-such a date and he said a certain thing.

Now, the doctor has told you he doesn't have specific recollection and I don't want it to lead to a situation where your client says A, and he says B, based upon some speculation or uncertainty and you are trying to draw some distinction there.

If he has a memory of what he did say, in fact, if something like that was said, I will

let him answer that, but in terms of trying to conjure up what he may have said in a conversation that may or may not have occurred, I am not going to let him do that.

Q. I don't want you to conjure and I don't want you to speculate, but if you have reason to believe that a conversation occurred in the hospital where mom, grandma or dad asked you why didn't you deliver the baby sooner or why is the baby in this condition, do you know what you would have said?

A. Yes. I don't have recollection of them having asked me those, which I think the majority of questions occurred subsequent to delivery had to do with the baby's status, which were all directed toward the pediatricians and letting them talk to the neonatal transport crew as they got things stabilized as well as they could. That's where the propensity of questions were.

Q. Do you have any recollection of any specifics of any conversations with Angel, with grandma or with any family member, dad, from the time of the delivery up until the time of discharge that you have not already shared with

me?

A. No.

Q. Do you have any recollection of specifics or a summary of what your discussions consisted of at any time after discharge and up to this present date that we haven't already talked about?

A. No.

MR. MISHKIND: I don't believe I have any further questions at this point.

(Discussion off the record.)

Q. Doctor, we have marked as Plaintiff's Exhibit 4 --

- - - - -

(Thereupon, TIZZANO Deposition Exhibit 4 was marked for purposes of identification.)

- - - - -

Q. It's my understanding that this is a copy of the NST December 26th, 1998. Is that correct? .

A. Let me go back to our office record.

MR. JACKSON: There is the date right here.

A. What I am just curious about, in

looking at this, I have signed this. That's my only question. That's why I was curious.

Yes, this is the NST dated 1-1-99, I'm sorry. It's dated 12-26-98, due date is 1-1-99.

Q. And your interpretation of that tracing is that it was a reactive nonstress test?

A. Clearly reactive nonstress test.

MR. MISHKIND: Now I am done. Mr. Rossi may have some questions for you.

MR. ROSSI: I do have some follow-up questions for you.

EXAMINATION OF ANTHONY J. TIZZANO, M.D.

BY MR. ROSSI:

a. Mr. Mishkind asked you whether you had any knowledge that this patient during the course of the evening between January 16th and January 17th of '99 requested a C-section from the nurses, Do you remember him asking you that?

A. Yes.

Q. When you arrived at the hospital that morning at 7:44 a.m., did you, in fact, discuss that very thing with this patient; that is, whether she was to have a vaginal delivery or a C-section?

A. Yes.

Q. And in fact you documented the patient was evaluated by self and her interest in VBAC is reaffirmed; right?

A. That's correct.

Q. And I take it by a note like that, that you probably had a discussion with her which was just more than I want a vaginal delivery; right? I mean, you went into some detail with her about what she wanted to do?

A. I can't remember what the specifics were. I just know that the traditional thing I would do was to walk into that room and seeing the patient for the first time, recognizing she has been there for the evening, is making sure that her heart and mind was in the same place and I was on the same page as we embark on whatever management was going to take place.

Q. And in part and parcel to that discussion would be a discussion of whether or not she wished to have a C-section; agreed?

A. That was certainly part of it. That's the one part I know for sure.

Q. And as we know by your note and the actions that took place thereafter at 7:44 a.m., she made it clear that she wanted to go forward

with a vaginal delivery; true?
A. That's correct.
Q. Mr. Mishkind also asked you a number of questions about the hypothetical risks of an impending uterine rupture. There were no impending risks of rupture when you evaluated this patient at 7:44 a.m.; agreed?
A. Agreed.
Q. In fact, and I believe you said this but I want to make sure I understand you, the first time it was even remotely suggested that there was a rupture in this case was at 8:12 a.m.; right?
A. That's correct.
Q. And that was when the baby went from plus three back to negative two?
A. Correct.
Q. Before that time, as you looked at the heart that morning when you arrived, and as you retrospectively have reviewed this record, there are no other impending signs of a rupture; true?
A. No signs. It would be difficult to imagine how the baby could get pushed through the pelvis if there is a hole in the uterus.
Q. Would you agree with me, doctor, that

up until 8:12 a.m., this was proceeding as a normal vaginal delivery after a C-section?

A. Up to 8:12?

Q. Right. At 8:12 a.m. is when the event occurred that the vertex ascended up the pelvis to negative two station.

A, That my hopes were for a vaginal delivery.

Q. But as we look back at the chart, everything up and until that point was proceeding as you would hope; is that fair?

A. I would rather not have some parts of the tracing immediately preceding 8:12 and I needed to feel comfortable that a delivery was not only foreseen, but it was going to happen quickly. And that was my impression; that we were in short order going to deliver that baby and it was gut wrenching not to do that.

Q. Your concerns before 8:12 a.m. weren't for a ruptured uterus, though, were they?

A. No.

Q. Your concerns were for the condition of the fetus at that time?

A. Correct.

Q. And I guess that's what I was getting

at with my question.
A. Okay.
Q. There were no concerns whatsoever related to the delivery of a ruptured uterus before 8:12 a.m.; is that fair?
A. Well, I think from the moment that I have a patient who is in labor with a VBAC, I have a general concern that she needs to be concerned for ruptured uterus, but there was nothing at that point in time that told me that uterus was ruptured.
Q. Mr. Mishkind asked you if the baby had been delivered at 6:00 o'clock a.m. if there would have been a different outcome. If you had seen mom and baby, or if you had seen mom at 6:00 a.m., would you have immediately proceeded to a C-section at that time based on your review of this chart?
A. Not from a medical indication.
Q. Mr. Mishkind asked you about the availability of staff at 8:12 a.m. I believe you said that there were certain OR personnel that were on call but not at the hospital at that time; is that correct?
A. Correct.

Q. In your review of the chart, understanding how things happen, would you agree with me that the response time of the operating room personnel under these circumstances was very reasonable?

A. Say that question to me again.

Q. Would you agree that the response time to your request for a crash C-section at 8:12 a.m. was reasonable under the circumstances?

A. I think it was reasonable, as I understand what is understood reasonable to be.

Q. Fair enough.

A. It's not what I would have liked, but --

Q. But reasonable?

A. -- but reasonable.

Q. Dr. Cooke was in the hospital?

A. Yes.

Q. And he started on the case, as I understand it, at approximately 3:00 a.m.

Is that your understanding, as well?

A. Correct.

Q. At 6:00 a.m. when you were advised of mom's status, that is, that she was 100 percent effaced, completely dilated and at negative three to negative four station, you did not immediately

come to the hospital, did you?
A. No.
Q. Would you agree with me that that information you were provided at 6:00 a.m. was very similar, if not identical, to mom's status at approximately 4:15 a.m.?
A. Correct.
Q. So while you said earlier you would like to have been advised at 4:15 a.m. of mom's status, would you agree with me that even if you had been contacted at 4:15 a.m. you would not have come to the hospital at that time?
A. You mean at 6:00 a.m. or 4:15?
Q. At 4:15 a.m.
A. No, because I would have assumed that was the first time she had gotten complete.
Q. I take it that you have worked with a number of these nurses in labor and delivery, in fact maybe all of them at this point in your career?
A. Yes.
Q. When any of them contact you to advise you that one of your patients has arrived in labor and delivery, in other words, this is the initial phone call to you to advise of the

arrival, do they as a matter of routine, in your experience, provide you with enough information such that over the phone you can make an assessment and give any orders that would be necessary at that time?

A. In general, that's usually the case.

Q. And I take it if that does not occur, you normally question them such that you get the information you need to provide initial orders; is that fair?

A. Yes.

Q. I know you don't remember any phone calls before 6:00 a.m.

Would you agree with me, however, doctor, that after having reviewed that order, that verbal order, as noted by Nurse Moats, there appears to be a telephone order provided by you at approximately 12:05 a.m. on 1-17-99?

A. It seems that there was a contact made. I cannot imagine having told someone to do a vaginal exam. Those are simply not orders that I give. You can go back to that so I can look at that specifically.

An order to do vaginal exam, I cannot imagine having given that order. An order to

monitor the labor of the patient, that's something I just don't ever recall having to do that. Oh, yes, and please put her on a fetal monitor, it's done. An order to admit her at 25 minutes after she got there at something like, what was it, 11:23 or something of that nature, you know, and her cervix still at the time of her initial assessment -- let me go back to L&D is what that's under -- we have a patient who is one centimeter. She is 50 percent effaced. I don't know if she is in active labor yet.

So the notion that she would actually be admitted by me at that time, those are the things that bother me about saying that I gave these orders. It just doesn't completely cut clear the way I would typically give an order. But nonetheless there is a time there and I don't know how to account for that.

Q. Would you agree with me that that time, understanding how orders work, that that time reflects a telephone order by you at that time?

A. Yes.

Q. What does an epidural request mean? Does that mean the patient requesting an

epidural?

A. Correct.

Q. So at that time, as I understand it, the nurses needed to make you aware that the patient had requested an epidural; true?

A. Or that I would hope they would say to me that, well, they can make me aware of that, but more often, she is ready, the patient has gotten to the point with whatever else they have done for her in terms of IV medications are no longer cutting it, ready for her epidural, and say patient is at such-and-such, can we give the epidural.

Q. You agree with me that the standard orders at that time merely provided that once the nurse has made you aware that the patient requested an epidural, that the epidural was to be provided per anesthesia, when labor is established and as necessary. Would you agree?

A. Where does it say that? Those were the intrapartum standing orders for patients admitted to labor and delivery. The last one on the list, number 19, that the physician would be -- the physician must be aware of an epidural request.

Q. So in other words, let's assume for a moment that they knew around midnight that this woman wanted an epidural. Presumably if they had made you aware at midnight that she wanted an epidural, then it would be up to the nurses in anesthesia as to when it would be necessary for the patient; is that how it works?

A. That is not usually how it works. Usually before that epidural is administered we are contacted, and I would on occasion say, if the patient would like an epidural, she can have it when she needs it.

Q. And might that happen if there is indeed phone contact with you at midnight, understanding that you are going to be going to sleep soon?

A. It's possible.

Q. And if it happened in the way I described, would you agree with me, doctor, that that would comply with the intrapartum standing orders at that time?

A. I do not want to say that the physician must be aware. The epidural request is meant to say that at the very beginning of their admission to the hospital, before it's

appropriate to get an epidural. And I would hope that it would mean, and I interpret that to mean, that they will call you prior to its needing to be administered so that the patient now requests her epidural.

Because usually before that, in the case of Mrs. Robbins, her hope was to go natural. Documented elsewhere in the chart, I believe in our office records, her hope is to pursue a natural delivery, which would imply that her hope was not to have had an epidural if at all possible. And that in her situation, you know, coming into labor and delivery early on in the course of her labor, I can't imagine that they would already know that she wants to have an epidural, and so in this situation, I would hope that I would at least have been notified that at this point in her labor at this degree of progress that the patient is now requesting her epidural and that's what I take that to mean.

Q. Are some women that you have treated aware before they arrive at the hospital that they want to have an epidural?

A. Yes.

Q. Did Mrs. Robbins undergo a

sterilization procedure at the end of the delivery?

A. Yes.

Q. I noted in the chart, it looks as though you had a discussion with her and her husband before you did the sterilization?

A. That's correct.

Q. What do you remember about that?

A. Well, very specifically, I knew that the baby was in trouble. There was no doubt at the time of C-section, as soon as the baby was delivered, and watching the resuscitation unfold that before we are even close to doing any kind of tubal ligation, we were closing the uterus and getting the placenta out and so on and so forth, and by this time apgar after apgar has been assigned, and so I had a bad feeling about what is going to be happening. And I felt it prudent to say to her, you know, the baby is in serious trouble, are you sure you want to go forward at this time and do a tubal ligation? Because we will have burned the bridge for having more children.

And there are even occasions when I wouldn't have done it regardless of what her wish

would have been, because all too often I have been caught in the situation later, out of the heat of the moment, I wish I hadn't done that.

However, in this case, this patient had adhesions of bowel to her adnexa to the fallopian tube. She had this very markedly distorted and contused lower uterine segment that I was concerned about, and my notion of seeing her in labor again at a point that was reinforced by Dr. Steiner's opinion at that point in time was to say to me, tell me, you know, this is the thing to do now, it is in her best interest regardless of desire for future child bearing; that the notion that this could end up being a disaster in the works in a future pregnancy was the reason that we went ahead and did it.

Q. That sounds as though you had a very thorough discussion with them at that time about it.

A. There was no question. They were absolutely adamant.

MR. ROSSI: That's all I have for you.

EXAMINATION OF ANTHONY P. TIZZANO, M.D.

BY MR. MISHKIND:

Q. Doctor, I have a few more questions for you.

The conversation before the tubal ligation, you consulted with Dr. Steiner; true?

A. Yes.

Q. And both of you felt that it was in mom's best interest, given everything that had transpired, to do the tubal ligation; true?

A. Correct.

Q. Given what you had found intraoperatively and the scenario that had ensued; true?

A. Exactly.

Q. And you explained that to mom and to dad the reasons that you felt it was in their best interest to proceed with the tubal ligation; is that true?

A. Well, at the time of that conversation, their questions weren't as to whether or not it would be in their best interest. They wanted it despite what my feelings were. And so then I conceded stating that the reason that I am conceding to your wishes at this point is to, you know, we will no longer have that alternative, but I think it's

perhaps in your best interest to not become pregnant in the future.

Q. From a medical standpoint, whether they were insisting upon it appropriately or inappropriately, you felt that it was in her best interest to have the procedure done; true?

A. Yes.

Q. You indicated that you would not have done a C-section at 6:00 a.m. or it wasn't medically indicated at 6:00 a.m.; true?

A. Correct.

Q. However, if the patient had expressed a preference to proceed with a C-section at 6:00 a.m., you certainly would not have felt that to be ill advised; true?

A. Oh, absolutely true.

Q. You also indicated in response to Mr. Rossi that at 8:12 that it was reasonable in terms of how I think the surgical team -- I can't remember exactly how he worded it, but the surgical team, how quickly they responded, and your answer was you acknowledge that it was reasonable but not what you would have liked. Can you explain to me what you meant by that?

A. What I would have liked would have

been in residency where everyone was in house, in the hospital at the exact time, and that the average time from the time of decision to C-section was seven minutes. And that even if the heart rate went down, I would have had the baby delivered, period, and that happened over and over again. We simply are not in that kind of environment here.

Q. At 7:45 had a C-section been ordered, even at this facility back in January of '99, the normal response time in terms of from decision to incision would likely have been how long?

A. For a crash C-section?

Q. Yes.

A. I don't know that we were tracking it on any kind of -- I don't know that I could answer that with confidence. We customarily did what we needed to do. If the crew wasn't there, we had anesthesia and a nurse who wasn't on the C-section team but was qualified to go into that section room, we would do what was necessary in a crash. I mean, to have an untoward event in our hospital occur because of not getting things rolling quickly enough is very unusual.

Q. Had a crash C-section been called at

7:44, given the physical requirements, the staffing requirements and what it takes to go from decision to incision, it's more likely than not that Alexus would have been born without irreversible brain damage; true?

MR. JACKSON: Objection.

MR. ROSSI: Objection.

A. If at 7:44 I was starting the C-section?

Q. At 7:44 you called for the C-section. At that point, given any limitations that exist or existed at the hospital, isn't it more likely than not that she would have been born without irreversible brain damage?

MR. JACKSON: There is an objection.

A. . I guess I can only qualify that by saying that if, for example, we were doing the operation by within 15 to 20 minutes after the time, that there would be a reasonable chance that this baby would have done relatively well.

MR. JACKSON: You have answered.

Q. And your statement in terms of reasonable chance, that's more likely than not; true?

MR. JACKSON: Objection.

A. From what I can see of this tracing, yes.

MR. MISHKIND: No further questions. Thank you.

MR. ROSSI: I don't have anything else. Thanks.

MR. JACKSON: He will read it.

(Discussion off the record.)

MR. MISHKIND: It can be 28 days.

- - - - -

(Deposition concluded at 2:20 p.m.)

(Signature not waived.)

- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 206 and note the following corrections:

PAGE LINE REQUESTED CHANGE

Anthony J. Tizzano, M.D.

Subscribed and sworn to before me this day of , 2000.

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named ANTHONY P. TIZZANO, M.D. Was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that **I** am not a relative or attorney for 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 13th day of December, 2000.

Vivian L. Gordoh, Notary Public
Within and for the State of Ohio
My commission expires June 8, 2004.

INDEX

EXAMINATION OF ANT~ONYP. TIZZANO. M.D.