

1                   IN THE COURT OF COMMON PLEAS  
2                   OF WAYNE COUNTY, OHIO

3                   - - - - -

4   ANGEL ROBBINS, etc., et al.,  
5           Plaintiffs,

6                   vs                           Case No. 00 CV 0027  
  Judge Wiest

7   ANTHONY P. TIZZANO, M.D.,  
8           et al.,

                          Defendants.

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12                   - - - - -  
12                   DEPOSITION OF ANTHONY P. TIZZANO, M.D.

13                   MONDAY, DECEMBER 4, 2000

14                   - - - - -

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

25

1 APPEARANCES :

2 On behalf of the Plaintiff

3 Becker & Mishkind

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10 On behalf of the Defendant Wooster Clinic

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12 JOHN V. JACKSON, II, ESQ.

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17 On behalf of the Defendant Wooster Community  
18 Hospital

19 Reminger & Reminger

20 GREGORY ROSSI, ESQ.

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25 - - - -

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

1 death of Alexis Robbins.

2 You understand that, don't you?

3 A. Yes.

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

6 A. No.

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

16 A. Thank you, yes.

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

21 A. Sure.

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



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

4           A.     Absolutely.

5           Q.     Fair enough.

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

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

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

18                   MR. MISHKIND: Correct.

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

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

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

2 MR. JACKSON: Show me the February  
3 15th entry.

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

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

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

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

14 MR. JACKSON: Okay.

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

17 A. Wooster Clinic Women's Center.

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

20 A. Yes.

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

25 A. Two exceptions. Dr. Steiner is no

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

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

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

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

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

22 A. Correct.

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

1 A. No.

2 Q. I want to ask you a little bit about  
3 your educational background. That will be the  
4 first topic, and then I will talk to you about  
5 some general aspects as it relates to vaginal  
6 delivery following a cesarean, and then I want to  
7 talk to you about the labor and delivery of  
8 Alexis, just to give you sort of a road map of  
9 where I am going. Fair enough?

10 A. Yes.

11 Q. Where did you go to medical school?

12 A. Ohio State.

13 Q. Graduated what year?

14 A. '88.

15 Q. Tell me about your training after  
16 graduating from medical school.

17 A. From there I went to Bethesda Oak  
18 Hospital, Cincinnati, and spent four years there.

19 Q. And was that an OB/GYN residency?

20 A. Yes.

21 Q. That takes us up to '92?

22 A. Correct. From there I went into  
23 practice in Franklin, Pennsylvania. I was there  
24 for one year and then came here.

25 Q. What type of practice were you in in

1 Franklin, PA?

2 A. Obstetrics and gynecology practice, as  
3 well.

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

6 A. No.

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

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

12 Q. Where are you originally from?

13 A. Chesterland. East of Cleveland.

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

16 A. Yes.

17 Q. What states are you licensed in?

18 A. In Ohio.

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

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

23 Q. Have you ever practiced in Kentucky?

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

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

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

5           A.     No.

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

8           A.     No.

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

11          A.     No.

12          Q.     You are board certified?

13          A.     Yes.

14          Q.     When did you become board certified?

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

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

19          A.     Yes.

20          Q.     Do you have any teaching  
21    responsibilities?

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

1           Q.       Where?

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

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

13          Q.       How did you establish that interest?

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

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

25          A.       Only as a resident.

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

3           A.     Correct.

4           Q.     Either in the Cincinnati or the  
5     Kentucky hospitals?

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

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

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

16          Q.     At what hospital?

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

23          Q.     Doctor, what hospitals are you  
24    affiliated with?

25          A.     The Wooster Hospital, Wooster



1 Community Hospital.

2 Q. Do you have privileges at Cleveland  
3 Clinic?

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

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

12 A. Yes.

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

16 A. Yes.

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

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

21 Q. So February of 1998?

22 A. Correct.

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

25 A. The Wooster Clinic.

1           Q.     Were you an officer of the Wooster  
2     Clinic?

3           A.     I was on the board.

4           Q.     What was your position on the board?

5           A.     A board member.

6           Q.     Did you hold a title?

7           A.     No. I was newly elected for about a  
8     year before we joined The Cleveland Clinic, and  
9     then that board existed for a while during our  
10    first year and then dissolved and another board  
11    formed.

12          Q.     Do you have privileges at any other  
13    hospitals other than the Wooster Hospital or to  
14    whatever extent you had privileges at The  
15    Cleveland Clinic?

16          A.     No.

17          Q.     Have you practiced at any other  
18    hospitals or had privileges at any other  
19    hospitals since '93 up to the year 2000?

20          A.     No.

21          Q.     Have you done any writing, any  
22    publishing of any articles of any medical  
23    literature?

24          A.     Articles during medical school. An  
25    article on preeclampsia, and then during

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

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

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

7           Q.     Where was that?

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

11          Q.     Was it subsequently published --

12          A.     No.

13          Q.     -- in peer review journals?

14          A.     No.

15          Q.     Just a presentation --

16          A.     Correct.

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

19          A.     It was actually putting up our data on  
20    a series of bulletin boards at the beginning of  
21    the American College meeting in San Francisco in  
22    '90 and being there to answer questions as  
23    persons would come by.

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

1           A.     Yes.

2           Q.     What I should have done, doctor, and I  
3 will do it now, is ask whether you have a  
4 professional resume, a curriculum vitae?

5           A.     I do.

6           Q.     Is that something that you could  
7 retrieve, not necessarily right this minute, but  
8 before we leave today?

9           A.     Sure.

10          Q.     And does that set forth the  
11 publications and presentations that we have  
12 touched on?

13          A.     Yes, they are all detailed there. And  
14 the poster presentation was ready for  
15 publication, but the other supporting authors  
16 never completed it during our residency, so those  
17 are included as pending.

18          Q.     Fair enough. Do you have an area that  
19 you specialize in in the area of obstetrics and  
20 gynecology?

21          A.     It's general obstetrics and  
22 gynecology.

23          Q.     You have never had the misfortune of  
24 being named as a defendant in a medical  
25 malpractice case before this case; true?

1 MR. JACKSON: Objection. Go ahead.

2 You may answer.

3 A. Yes, there have been two other cases.

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

7 A. Correct.

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

11 A. That's correct.

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

14 A. Correct.

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

17 A. Yes.

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

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

24 Q. So you are counting the days?

25 A. Yes.

1           Q.     I take it both of those cases arose  
2 out of treatment of your patients that were in  
3 this practice here?

4           A.     Correct.

5           Q.     Tell me the names of the patients as  
6 it was set forth, so-and-so versus Dr. Tizzano.  
7 Who were the plaintiffs in those cases?

8                   MR. JACKSON: Objection, but go ahead,  
9 you may answer.

10          A.     Yes, let me just remember the names.  
11                   One was Becky Shearer.

12          Q.     Her last name is spelled how, please?

13          A.     S-H-E-A-R-E-R, I believe.

14                   But I much prefer to get the record to  
15 find out.

16                   MR. JACKSON: He can check that with  
17 the court, doctor.

18                   MR. MISHKIND: Mr. Jackson wouldn't  
19 let you get the record.

20                   MR. JACKSON: He is right about that.  
21 What's the second name, if you can  
22 recall?

23                   THE WITNESS: And the other one is --

24                   MR. JACKSON: You were personally  
25 named in both?

1 THE WITNESS: Right.

2 MR. JACKSON: There would be a record  
3 at the court. If you can't remember, tell him.

4 A. It will come to me.

5 Q. If you think of it, let me know. I  
6 don't want you to dwell on it to the point you  
7 don't listen to any of my other questions, but if  
8 you are like me, you may think, or yeah, it was  
9 Mary Jones. Let me know.

10 A. I can get those. If we have a break,  
11 I can get those easily.

12 Q. That's fine. Thank you.

13 Did either of those cases have any  
14 similarity to this case insofar as a trial of  
15 labor in a prior cesarean section, a vaginal  
16 delivery?

17 A. No.

18 Q. Did either of those cases have to do  
19 with a birthing issue?

20 A. No.

21 Q. So they were more gynecological  
22 issues?

23 A. No. The first case was a fetal demise  
24 that occurred at home.

25 Q. And the second case, the subject

1 matter of that?

2 A. An IUD placement.

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

5 MR. JACKSON: Objection. But you may  
6 answer.

7 A. No. Just in domestic violence cases.

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

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

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

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

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



1 has been approached from either side and provided  
2 opinions --

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

7 THE WITNESS: No.

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

10 A. Yes.

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

13 A. Yes.

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

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

21 Q. By Nurse Morgan?

22 A. Correct.

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

1           A.     Yes.

2           Q.     In other words, she wasn't giving it  
3     on her own. This was part of the practice that  
4     was to be followed?

5           A.     Right. We subscribe to those,  
6     purchase them and use them very liberally.

7           Q.     And do you also get the clinical  
8     management guidelines from ACOG, as well?

9           A.     Yes.

10          Q.     And do you follow those, as well?

11          A.     In terms of do I read them?

12          Q.     Yes.

13          A.     Yes.

14          Q.     Are you familiar with the ACOG  
15     practice bulletin that dealt with vaginal birth  
16     after previous cesarean delivery that was in  
17     effect prior to January of 1999?

18          A.     I am familiar with it.

19          Q.     Have you reviewed any medical  
20     literature in preparation for today's deposition?

21          A.     Other than to read through the  
22     brochure that we provide and to look up the  
23     technical bulletin that you mentioned, no.

24          Q.     Do you maintain any type of a file in  
25     your personal library on the issue of informed

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

4 A. Not specifically titled as such.

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

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

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

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

18 A. In part.

19 Q. What else would be in that?

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

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

1           A.     Correct.

2           Q.     Articles that you have read and  
3 retained for future reference?

4           A.     And the course work that I do. I  
5 don't usually tear those down, but I keep and  
6 maintain all the catalogs from the courses that I  
7 went to.

8           Q.     . But specifically, you would have a  
9 file that would be designated VBAC and would have  
10 different --

11          A.     I believe I do.

12          Q.     -- would have different sources in  
13 there, perhaps course material, perhaps medical  
14 literature; true?

15          A.     Yes.

16          Q.     Items that you consider to be  
17 reasonably reliable on the topic of VBAC?

18          A.     Yes.

19          Q.     . Is that something that's maintained in  
20 your office?

21          A.     Yes.

22                 MR. MISHKIND: Let me request on the  
23 record, John, if you have no objection, once you  
24 have taken a look at it, would you please provide  
25 me with a copy of that literature? If you have

1 an objection to it --

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

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

10 MR. JACKSON: We will consider your  
11 request.

12 MR. MISHKIND: Thanks. I know you  
13 will.

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

18 MR. JACKSON: Objection. Answer if  
19 you can.

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

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

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

4 MR. JACKSON: Objection. You may  
5 answer.

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

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

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

25 Q. Do you consider them to be reasonably

1 reliable sources of information, the ACOG  
2 technical bulletins?

3 MR. JACKSON: Objection. You may  
4 answer.

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

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

10 MR. JACKSON: Objection. You may  
11 answer.

12 A. Yes.

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

16 A. Correct.

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

21 A. If necessary.

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

1 trial of labor?

2 MR. JACKSON: Objection.

3 Q. Following cesarean section.

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

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

9 A. No.

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

17 MR. JACKSON: Objection. You may  
18 answer.

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

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

24 A. Okay.

25 Q. As I understand it, Angel was a



1 patient of this office for a prior delivery?

2 A. Correct.

3 Q. Were you at all involved in her prior  
4 obstetrical care?

5 A. I believe so. I would have to look at  
6 the record to be sure, but that was in '95, as I  
7 recall, and I would have been here then.

8 Q. This is not a memory contest, although  
9 you are doing fairly well so far. Please feel  
10 free to refer to the chart, which is to your  
11 right, when you answer those questions. I don't  
12 want you to come back later on and say I was  
13 inaccurate because I saw something.

14 A. Let me go ahead and do that then.

15 Q. Fine.

16 (Pause.)

17 A. During her prior pregnancy, when she  
18 began care here in 1994, I saw her on two  
19 occasions, three occasions during that pregnancy.

20 Q. You were not involved in the actual  
21 delivery, were you?

22 A. I did not do her C-section, and the  
23 assistant is not listed on this, so I can't tell  
24 for sure.

25 Q. You are not certain whether you were

1 the unnamed assistant?

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

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

6 A. Dr. Brown, yes.

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

9 A. Correct.

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

12 A. Yes.

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

17 A. Correct.

18 Q. And she had a baby that was 8 pounds,  
19 3 and a half ounces from her first delivery;  
20 true?

21 A. That's correct.

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

25 A. Cesarean section, yes.

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

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

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

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

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

15          A.       Low transverse uterine incision  
16 cesarean section.

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

19          A.       Correct.

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

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

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

1 the baby was fine?

2 A. Did well.

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

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

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

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

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

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

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

24 A. Yes.

25 a. Something that you prepared?

1           A.     I did.

2           Q.     When did you prepare it?

3           A.     In the last two days.

4           Q.     And why did you prepare it?

5           A.     In discussing with my attorney the  
6 case to refresh my memory and review the chart, I  
7 put this together.

8           Q.     Does this exhibit contain anything  
9 that is not otherwise reflected in the chart?

10          A.     There were items in here that I looked  
11 at, both the hospital chart and office chart, but  
12 that's it. And this was a summary of the  
13 findings at the time that she presented to labor  
14 and delivery. So it was just to refresh my  
15 memory in that regard, her history and so forth.

16          Q.     Doctor, besides reviewing the chart  
17 and the hospital chart, have you reviewed  
18 anything else as it relates to this case prior to  
19 today's deposition?

20          A.     Outside of her medical record?

21          Q.     Right.

22          A.     Other than the brochure and the  
23 technical bulletin.

24          Q.     Those would be the only items?

25          A.     The two items.

1           Q.    Those would be the two medical  
2 literature that you would review?

3           A.    Right.

4           Q.    Plus her chart and the hospital  
5 record; true?

6           A.    Right.

7           Q.    Okay. Go ahead.

8           A.    And excuse me, one other brochure that  
9 was given to you that was on postpartum tubal  
10 ligation, I looked that over, as well. Those  
11 three items and two charts.

12          Q.    The postpartum tubal ligation, was  
13 that an ACOG bulletin?

14          A.    Yes.

15          Q.    When was that given to her?

16          A.    During the course of her prenatal care  
17 in this last pregnancy.

18          Q.    Do you know the date that that was  
19 given to her?

20          A.    Not specifically.

21          Q.    Is it referenced in the chart that she  
22 was given a brochure about tubal ligation?

23          A.    Let me check. I believe so.

24                   (Pause)

25          Q.    I think I may have the reference that

1     you are looking for.

2           A.     Oh, yes, here we are. This is on the  
3     face sheet of the prenatal record on line four  
4     requests postpartum BPS, gave ACOG pamphlet,  
5     10-3-98.

6           Q.     And then it's got --

7           A.     Nancy Morgan.

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

9           A.     Yes.

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

15          A.     Yes.

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

18          A.     Yes.

19          Q.     Would that correspond with the October  
20     3, '98 date, most likely?

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

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

25          A.     No, that would be a separate

1 appointment.

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

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

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

14 Q. Yes.

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

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

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

20 Q. Is that standard procedure in the  
21 office?

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



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

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

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

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

20 MR. JACKSON: Objection. Go ahead and  
21 answer.

22 A. Yes.

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

1 A. Yes.

2 Q. The brochure on tubal ligation does  
3 not replace or dispose of the need for informed  
4 consent; true?

5 MR. JACKSON: Objection. Go ahead and  
6 answer.

7 A. Correct.

8 Q. That's sort of as a supplement to help  
9 the patient?

10 A. Yes. You know, it's something that  
11 the patient gets to take home. I think that  
12 oftentimes their questions as we are going over  
13 them may not be present in their minds at that  
14 point in time. It gives them a chance to go home  
15 and look over the information and then come  
16 back. As I often tell them, if there are any  
17 questions, you have been given the brochure,  
18 please write down any of the questions you have  
19 and we will be happy to take time to cover them  
20 with you.

21 Q. In this case, were you present when  
22 the discussion took place or any portion of the  
23 discussion took place between Nurse Morgan and  
24 Angel about the issue of tubal ligation?

25 A. No.

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

4           A.     No.

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

9           A.     Not to my knowledge.

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

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

19          A.     Not to my knowledge.

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

22                         - - - - -

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

**1**

- - - - -

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

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

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

**12** A. Yes.

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

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

**17** Q. Whose handwriting is that?

**18** A. That's mine.

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

**24** A. Yes.

**25** Q. Where in the record does it reflect

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

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

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

7           A.     From asking Nancy.

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

11          A.     Not specifically.

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

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

16          A.     Yes.

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

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

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

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

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

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

23           A.       We have not had that discussion.

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

1 MR. MISHKIND: Right.

2 MR. JACKSON: It is in the chart.

3 MR. MISHKIND: The date that it was  
4 given?

5 I see it says VBAC pamphlet, but it doesn't  
6 say the date. I think you would agree with me,  
7 would you not?

8 THE WITNESS: Right. That's what I  
9 was looking at.

10 MR. MISHKIND: As opposed to the tubal  
11 ligation, that does have the date of October 3.

12 MR. JACKSON: Okay. I thought you  
13 were suggesting there wasn't any record of the  
14 pamphlet being given.

15 MR. MISHKIND: No, the date of it.

16 MR. JACKSON: I think Nancy can  
17 address that for you.

18 MR. MISHKIND: Right, and I suspect  
19 that she will.

20 MR. JACKSON: He will ask you another  
21 question.

22 Q. Was it your office practice to provide  
23 anything else in writing to patients concerning  
24 the issue of VBAC other than the ACOG patient  
25 education document?

1           A.       No.

2           Q.       Any videotapes?

3           A.       I am not sure that we have videotapes  
4       on VBAC. We may have them on VBAC.

5           Q.       Would you make the videotapes  
6       available to patients to see?

7           A.       Right. The entire education room is  
8       available to patients any time.

9           Q.       Do you know whether that practice was  
10       followed with Angel?

11          A.       It would have been at Nancy's  
12       discretion. We typically will mention it to  
13       patients. I, generally, as a common practice,  
14       will mention to patients that we have that  
15       available to them if they would like to use it.

16          Q.       Would you suggest any other reference  
17       sources if patients want further information in  
18       order to make an informed decision?

19          A.       Not in general. I felt that all along  
20       these really provide a fairly good basis for  
21       decision-making. I think they in generalities  
22       point out most of the significant problems that  
23       one might encounter and take patients through a  
24       reasonable course of thought and then provoke  
25       questions. And it's hopefully having provided



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

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

10 Do you remember the patient from the  
11 '95 prenatal care?

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

14 Q. Seeing her and recognizing the face.

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

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

19 A. Yes.

20 Q. True?

21 A. Yes.

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

1           A.     I thought it was very good.

2           Q.     Did you find Angel to be noncompliant  
3     in any respect with regard to her obstetrical  
4     care?

5           A.     No, I think, in general, she was  
6     compliant, in terms of looking at the record and  
7     seeing there weren't any cancelled appointments.

8           Q.     There were other physicians, other  
9     obstetricians that saw Angel during the pregnancy  
10    in question; true?

11          A.     Yes.

12          Q.     When did you first see her in this  
13    pregnancy?

14          A.     September 5th.

15          Q.     It looks like she had an upper  
16    respiratory infection at that time?

17          A.     Right. She was given a prescription.

18          Q.     What was the prescription?

19          A.     For Zithromax, Z-Pack, and that is the  
20    way it's administered.

21          Q.     Anything of significance by way of  
22    your exam at that point that you were concerned  
23    about in terms of her pregnancy at that stage of  
24    the game?

25          A.     No.

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

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

7 Q. Was that before September 5?

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

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

13 A. This is my signature.

14 Q. Oh, it is, okay.

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

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

23 A. HCG's, yes.

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

1 A. Yes.

2 Q. Did this have, in your opinion, any  
3 adverse consequences on the subsequent course of  
4 her pregnancy?

5 A. No.

6 Q. If there had been an ultrasound done  
7 at that point or serial HCG's, would this have  
8 altered in any respect the manner in which you  
9 would have handled the pregnancy?

10 A. Could you ask that again?

11 Q. Sure. Had an ultrasound been done or  
12 serial labs been done, would that likely have  
13 altered the manner in which you would have  
14 handled her pregnancy?

15 A. Only to the extent that they had been  
16 abnormal.

17 Q. Do you have any reason to believe that  
18 they would have been abnormal?

19 A. No.

20 Q. So after September 5, with that one  
21 exception of some bleeding, which you have told  
22 me was not significant and certainly did not  
23 impact the pregnancy, when did you see her next,  
24 sir?

25 A. After September 5?

1 Q. Yes.

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

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

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

11 A. Yes.

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

15 A. Correct.

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

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

1 true?

2 A. In general.

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

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

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

13 A. Yes.

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

16 A. No.

17 Q. -- before January 16th?

18 A. No.

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

21 A. Dr. Wayne Bare.

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

23 A. Yes.

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

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

3 A. Yes, 37 and a half weeks. Her size  
4 was appropriate for dates. She was head down.  
5 Fetal heart rate was 150. She reported decreased  
6 fetal movement. She had normal blood pressure,  
7 112 over 74. Her weight gain was appropriate;  
8 188, a pound from her last visit, not quite, not  
9 quite a pound. And they did a nonstress test.

10 Q. Because of the decreased fetal  
11 movement?

12 A. Yes.

13 Q. Was the nonstress test reactive?

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

16 Q. Is that in a separate chart?

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

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

23 A. Yes.

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

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

5 A. The name of the other person.

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

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

10 The context of this question is  
11 recognizing that you had seen her once before and  
12 then didn't come into play until January 16th --  
13 so I recognize that you may not be able to answer  
14 some of these questions -- but as of December  
15 26th, does the record reflect or does it give you  
16 enough information to tell me whether there was a  
17 concern on your part at that point that Angel was  
18 going to have a big baby?

19 A. No. The contrary would be true. I  
20 think her size was equivalent to dates throughout  
21 her entire prenatal care from June 9 to January  
22 16th, with only one exception, and that was on  
23 her December 16, '98 visit. At 36 weeks  
24 gestation the assessment of fundal height was 37  
25 to 38 centimeters.



1           Q.     Can you tell me on December 26th what  
2     would be a reasonable estimate as to the  
3     estimated fetal weight of the baby?

4           A.     No.

5           Q.     You would be surprised then on  
6     December 26th if any such statement was made to  
7     Angel that she was likely to have a big baby?

8           MR. JACKSON: Objection. You may  
9     answer.

10          A.     Would you please restate that  
11     question?

12          Q.     Would you be surprised or would it  
13     surprise you if you learned that a statement was  
14     made -- and again, I am recognizing that you are  
15     not there, so in that context that Angel was told  
16     -- would you be surprised to learn that Angel  
17     was told that she was carrying a big baby or was  
18     going to have a big baby?

19          MR. JACKSON: Objection. You may  
20     answer.

21          A.     I would be surprised.

22          Q.     Based upon what you see in the record?

23          A.     Based upon what I see in the chart.

24          Q.     Had you seen Angel on that date, would  
25     you have had any concerns with regard to the

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

4 A. No.

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

7 A. Correct.

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

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

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

17 A. Thank you.

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

20 A. Thank you.

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

23 A. Yes.

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

1           A.     No.

2           Q.     Did you ever talk to Dr. Bare about  
3     the previous office visit?

4           A.     No.

5           Q.     The same question on that date as to  
6     whether or not, as you look at the notes, were  
7     there any concerns that a reasonable obstetrician  
8     should have had as to her ability to continue to  
9     progress toward a trial labor?

10          A.     This is on her January 2 date?

11          Q.     Yes, sir.

12          A.     No, I still think we are okay.

13          Q.     On that date, are you aware of any  
14     discussions that Dr. Brown had where Angel was  
15     told that she was going to have a large baby?

16          A.     Not directly.

17          Q.     Indirectly?

18          A.     Well, there is a phone message that  
19     makes reference to comments that Dr. Brown may  
20     have made, and that's where I have some  
21     inclination that there was conversation that took  
22     place.

23          Q.     Based upon the phone conversation,  
24     which occurred subsequently; true? That's what  
25     you are referring to?

1 A. Yes.

2 Q. We will get to that in a moment.

3 Did you ever inquire of Dr. Brown  
4 whether he had such conversation with Angel  
5 indicating that she was going to have a large  
6 baby?

7 A. No.

8 Q. Would the records support such a  
9 contention?

10 A. There is nothing here that shows that  
11 she appears to be large. In fact, her size and  
12 centimeters is 37, and there is error in  
13 measuring that for certain, but at 38 weeks, four  
14 days, she is measuring 37 centimeters, which  
15 would be perfectly compatible for a normal size  
16 infant at that gestational age.

17 Q. January 9 looks like, is that Dr.  
18 Steiner?

19 A. Yes.

20 Q. Dr. Steiner is the obstetrician that's  
21 retired now?

22 A. True.

23 Q. Angel is 39 and 4/7 weeks?

24 A. Correct.

25 Q. Again, the same question I had with

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

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

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

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

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

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

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

24          A.     Yes.

25          Q.     And we are going to talk about that.

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

6 A. Not that I can specifically recall.

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

9 A. Not that I can recall.

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

13 A. That's correct.

14 Q. Did Dr. Steiner have privileges to  
15 deliver babies at Wooster Hospital in January of  
16 1999?

17 A. I'm not certain.

18 Q. Why do you --

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

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

1           A.     Yes.

2           Q.     The response that was given to her  
3     inquiry, to her call, it appears that a physician  
4     provided that response. Was that you?

5           A.     No.

6           Q.     Who was that?

7           A.     Dr. Bellow.

8           Q.     And am I correct from what was noted  
9     on the left-hand side of this message pad, this  
10    is information that the patient is relaying to  
11    someone at your office?

12          A.     Correct.

13          Q.     Who would that someone be that she  
14    spoke to?

15          A.     The phone nurse.

16          Q.     JKW?

17          A.     Yes.

18          Q.     Can you help me out as to who that  
19    would be?

20          A.     Jennifer, and I cannot recall her last  
21    name. But it was Dr. Bellow's nurse and so --  
22    oh, no. Well, I need to take that back.

23                 JKW is who took the message. I think  
24    that is Joanie, our phone nurse. The person who  
25    talked to the patient and completed the message,

1       that was Jennifer, who was Dr. Bellow's nurse.

2                       I need to check on her last initials  
3       to know that is correct.

4           Q.       As to Joanie's last initials?

5           A.       Right.

6           Q.       Is Joanie still employed?

7           A.       Yes.

8           Q.       Is Jennifer still employed?

9           A.       No.

10          Q.       When was Jennifer last employed here?

11          A.       I'm not sure.

12          Q.       Do you know why she left?

13                   MR. JACKSON: Objection, but you may  
14       answer.

15          A.       I believe she just left to stay at  
16       home with her newborn.

17          Q.       A good reason.

18          A.       Yes.

19          Q.       This patient on January 12th was  
20       indicating some desire to be induced?

21          A.       Correct.

22          Q.       What I want to try to understand is,  
23       given the fact that the patient had been seen by  
24       a number of people, most recently by -- I guess  
25       it would have been Dr. Steiner -- yes, Dr.



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

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

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

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

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

25 A. It would be assigned to the OB doc on

1 call.

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

7 A. Correct.

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

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

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

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

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

20 A. I can.

21 Q. Would you, please.

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

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

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

7           Q.     That would have been --

8           A.     From January 9.

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

11          A.     Recommend keeping visit, her next  
12    appointment.

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

15          A.     Yes.

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

18          A.     Not according to this note.

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

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

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

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

8 A. True.

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

12 A. With the information given here, no.

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

16 A. Yes.

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

21 A. Correct.

22 Q. Do you have a recollection --

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

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

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

6           Q. Well, we can certainly agree -- I  
7 don't want to mischaracterize anything on the  
8 record -- we can agree that when you saw her on  
9 the 16th that you had the benefit of this January  
10 12th, '99 office note, as well as her prior  
11 prenatal visits; true?

12          A. Yes.

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

18          A. According to that note, yes.

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

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

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

4           A.       Four weeks and four days.

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

7           A.       True.

8           Q.       41 weeks is postdates?

9           A.       42.

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

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

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

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

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

24          A.       I have no recollection.

25          Q.       Does your record reflect that you had

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

4 A. No.

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

7 A. No. The first part, the first line,  
8 right along with the 1-16 entry, is Lisa Woods,  
9 who is my nurse, and that entry relates to the  
10 1-9 visit.

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

13 A. Yes.

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

16 A. That's me.

17 Q. That's you?

18 A. That's me from the 16th.

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

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

24 Q. And of what significance is that?

25 A. That the head has not been engaged

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

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

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

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

12          A.     Yes.

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

15          A.     I believe it says desires.

16          Q.     Oh, I'm sorry.

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

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



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

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

7 Do you follow my question?

8 A. I believe I do.

9 Q. Okay.

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

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

17 A. Yes.

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

22 MR. JACKSON: Objection. You may  
23 answer.

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

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

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

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

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

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

19                   MR. JACKSON: Objection. You may  
20     answer.

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

1 have a specific recollection of the discussion.

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

5 A. Yes.

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

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

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

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

25 A. True.

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

6                   MR. JACKSON:  Objection.

7           Q.       You can answer.

8                   MR. JACKSON:  Go ahead, you may  
9       answer.

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

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

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

1 the risks of proceeding with a VBAC?

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

5 A. Please say that to me again.

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

10 A. Yes. That would be my custom.

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

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

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

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

25 Q. Do you embellish at all what that

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

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

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

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

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

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

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

4 MR. JACKSON: Objection. You may  
5 answer.

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

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

13 A. Absolutely.

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

18 A. Absolutely.

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

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

4 MR. JACKSON: Objection. You may  
5 answer.

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

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

17 MR. JACKSON: Objection. Go ahead.

18 A. That's true.

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

22 MR. JACKSON: Objection. You may  
23 answer.

24 A. True.

25 Q. And can we agree that it would be less



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

6                     MR. JACKSON: Objection. You may  
7     answer.

8             A.     I agree.

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

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

12                     (Recess had.)

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

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

22            Q.     And this was the IUD case?

23            A.     Correct.

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

**7%**

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

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

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

12          Q.       And is Ms. Wadsworth still employed  
13      here?

14          A.       Yes.

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

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

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

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

1 building.

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

6 A. Correct.

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

10 - - - - -

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

14 - - - - -

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

17 A. Yes.

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

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

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

1           A.     No.

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

4           a.     They are doing that now.

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

9           A.     Okay.

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

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

1 evaluated.

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

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

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

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

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

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

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

10 A. I have no recollection of that  
11 conversation --

12 Q. Okay.

13 A. -- ever taking place.

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

15 A. Right.

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

18 A. It doesn't say so.

19 Q. Do you --

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

22 Q. How does one strip the membranes?

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

1     probably couldn't.

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

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

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

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

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

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

21          A.     No, sir.

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

24          A.     That's okay.

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

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

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

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

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

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

15 Q. A convention?

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

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



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

10          A.       Yes.

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

17                   , MR. JACKSON: Objection. You may  
18       answer.

19          A.       Yes.

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

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

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

7 (Pause.)

8 (Record read.)

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

11 Q. Yes.

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

20 MR. JACKSON: Is that your question?

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

23 MR. JACKSON: Rephrase your question.

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

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

4                   At the time of counseling --

5           A.     Nancy Morgan's counseling?

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

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

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

20           Q.     Do it however you feel comfortable  
21   with.

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

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

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

12                   MR. JACKSON: Objection. You may  
13          answer.

14          Q.       True?

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

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

25          A.       Yes.

1           Q.       Does the chart reflect in any way that  
2       the risks to mom and baby were discussed with  
3       Angel?

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

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

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

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

19                  MR. JACKSON: With these specific  
20       words you used?

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

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

25                  THE WITNESS: I believe so.

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

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

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

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

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

1 particular course of treatment is elected; true?

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

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

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

13 MR. JACKSON: I'll object.

14 MR. MISHKIND: That's fine.

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

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

20 a. Does giving this, in your opinion,  
21 meet the standard of care as opposed to verbally  
22 explaining the risks and complications to the  
23 patient?

24 MR. JACKSON: Objection. You may  
25 answer.

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

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

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

15                   THE WITNESS: May I answer?

16                   MR. JACKSON: Go ahead.

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

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



1     likely depending on what type of incision was  
2     used.

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

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

10          MR. MISHKIND: Or anything to that  
11     extent.

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

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

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

24          THE 'WITNESS: That completes my  
25     answer.

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

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

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

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

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

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

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

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

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

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

7 MR. JACKSON: Say that again, please.

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

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

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

15 A. Correct.

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

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

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

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

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

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

9 A. I live five minutes.

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

12 A. Right.

13 Q. I presume you live in the same place?

14 A. Yes.

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

18 A. No.

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

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

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

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

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

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

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

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

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

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

12 Q. So you have had two uterine ruptures?

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

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

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

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

25 A. No.

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

4                   MR. JACKSON:  Objection.

5           Q.       -- that's staffed --

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

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

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

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

17                  MR. JACKSON:  Objection.  You may  
18       answer.

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

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

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

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

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

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

12                  THE WITNESS: Correct. But I need to  
13    know whether to answer it today or on January  
14    17th of '99, because my answer will be different.

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

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

23                  **a.** Why?

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



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

7 Q. Any other reasons why as of January  
8 1999 any woman contemplating a VBAC would not  
9 necessarily be best advised to have labor in a  
10 tertiary Level III facility, other than what you  
11 said?

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

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

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

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

4 MR. JACKSON: Objection. You may  
5 answer.

6 MR. ROSSI: Same objection.

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

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

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

16 Go ahead, you can answer.

17 MR. JACKSON: You can answer.

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

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

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

9 A. Yes.

10 Q. What hospital?

11 A. Akron City or General.

12 Q. They are tertiary Level III  
13 facilities?

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

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

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

22 Q. Spring of 2000?

23 A. Spring of 2000, I believe.

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

1 the hospital?

2 MR. ROSSI: Objection.

3 MR. JACKSON: You may answer.

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

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

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

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

19 MR. JACKSON: Objection, but go  
20 ahead.

21 A. Yes.

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

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

1 (Pause)

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

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

8 A. Three minutes.

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

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

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

1 rural practice to practice.

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

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

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

12 A. To my knowledge, yes.

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

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

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

19 A. Quite a few more than a dozen.

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

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

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

3           Q.     Actually successful VBAC's.

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

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

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

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

15          A.     I have been here for seven years.

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

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

25                     We have looked at our numbers from our

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

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

7 A. This is up to the present date.

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

10 A. That's fair.

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

15 A. That's a fair estimate,

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

19 Obviously, including ones that you  
20 reverted to a cesarean.

21 A. I would venture to double that number.

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

25 A. That's fair.



1 Q. And your complication rate has been  
2 what?

3 A. Up until Angel?

4 Q. Up until Angel.

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

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

9 A. Yes.

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

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

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

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

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

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

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

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

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

17 Q. During that two to three year period?

18 A. Yes.

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

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

1     unavailable.

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

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

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

14           A.     Correct.

15           Q.     Did you actually call him at home?

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

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

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

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

1           A.       Correct. Subsequent to the decision.

2           Q.       You didn't contact him at any time  
3 prior to calling the crash C-section?

4           A.       No, that would have occurred  
5 afterwards.

6           Q.       Does Dr. Steiner live the same  
7 proximity from the hospital?

8           A.       Closer.

9           Q.       Back in 1999, were there any  
10 incentives that you or your practice group  
11 received with regard to suggesting or  
12 recommending a trial of labor in a patient who  
13 had had a previous cesarean section?

14                   MR. JACKSON: Objection. You may  
15 answer.

16                   MR. ROSSI: Objection.

17           A.       There were no incentives.

18           Q.       Were you aware of any suggestions by  
19 insurance companies or by the hospital to you or  
20 your practice group that encouraged the trial of  
21 labor from the standpoint of cost savings in  
22 previous cesarean deliveries?

23                   MR. JACKSON: Objection. You may  
24 answer.

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

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

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

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

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

23 A. Zero.

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

1           A.       Boy, I have no recollection.

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

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

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

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

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

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

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

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

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

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

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

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

15          A.     Correct. And hemorrhage would be  
16    another.

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

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

25          Q.     Have you heard or read about

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

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

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

20 A' Yes.

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

25 MR. JACKSON: Objection. But you may



1 answer.

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

5 MR. MISHKIND: Right.

6 MR. JACKSON: Go ahead, doctor.

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

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

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

18 MR. ROSSI: Objection.

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

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

1 communicating to you important findings and  
2 developments; true?

3 MR. JACKSON: Objection. You may  
4 answer.

5 A. That's true.

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

10 MR. JACKSON: Objection.

11 MR. ROSSI: Objection.

12 MR. JACKSON: You may answer.

13 A. Please say that again.

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

19 MR. JACKSON: Objection. You may  
20 answer.

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

23 MR. JACKSON: That's your answer.

24 Q. Why do you say that?

25 A. Because in some cases, delivery might

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

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

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

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

18 A. To proceed immediately?

19 Q. Yes.

20 A. No, there was not.

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

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

1 not there.

2 Q. Do you know where the anesthesiologist  
3 was?

4 A. No.

5 Q. Was the anesthesiologist Dr. Cooke?

6 A. Yes.

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

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

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

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

25 Q. Do you know whether there were any

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

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

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

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

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

14          A.     True.

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

19          A.     In part.

20          Q.     The other part is also the OR staff?

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

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

1 MR. ROSSI: Objection.

2 MR. JACKSON: You may answer.

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

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

11 THE WITNESS: I think that's all.

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

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

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

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

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

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

9 A. Yes.

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

14 A. 6:00 a.m.

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

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

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

23 A. No.

24 Q. Did you have that capability to do  
25 that?

1           A.     Not at home, no.

2           Q.     Did you have the capability to monitor  
3 a patient in labor other than being physically at  
4 the hospital?

5           A.     Only if I was in this office.

6           Q.     So you have a computer set up here  
7 that will permit you to see fetal heart rate  
8 tracings if the patient is in labor and delivery?

9           A.     Yes.

10          Q.     Is it your testimony in this case that  
11 you were not monitoring her fetal heart rate  
12 tracings or portions thereof during the night  
13 prior to 6:00 a.m. from this office?

14          A.     That's correct.

15          Q.     Is it your testimony in this case,  
16 that prior to 6:00 a.m., you had no communication  
17 from the nurses with regard to any aspect of  
18 Angel's labor and delivery?

19          A.     That's correct.

20          Q.     Would you expect that if there were  
21 either fetal heart rate tracings pattern or any  
22 concerning assessments on vaginal exam that you  
23 or someone from this practice should be contacted  
24 by the nursing staff at the hospital?

25                 MR. ROSSI: Objection.



1 MR. JACKSON: You may answer.

2 A. Yes.

3 Q. And certainly we can agree that the  
4 nurses are basically your eyes and ears in terms  
5 of monitoring a patient when they are in labor  
6 and delivery when you are not at the hospital;  
7 true?

8 A. That's true.

9 Q. And you expect them to be able to  
10 appreciate changes in examinations and changes  
11 seen on fetal heart rate tracings that would be  
12 indicative of a concerning event; true?

13 MR. ROSSI: Objection.

14 MR. JACKSON: You may answer.

15 A. True.

16 Q. And the standard of care is that the  
17 nurse, if there is something that has changed or  
18 a concern that the nurse has, they are to call  
19 you and to report that to you; correct?

20 MR. JACKSON: Objection.

21 MR. ROSSI: Objection.

22 MR. JACKSON: Are you talking about  
23 standard of care for a nurse?

24 MR. MISHKIND: Standard of care that  
25 he expects from a reasonable and prudent labor

1 and delivery nurse at this hospital.

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

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

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

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

19 A. Not that I can recall, no.

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

23 A. Yes

24 (recess had.)

25 Q. What time did you arrive at the

1 hospital?

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

8 Q. Now, your notes, doctor, show that at  
9 6:00 a.m. you were contacted. Is that correct?

10 A. No, actually I called labor and  
11 delivery.

12 Q. At 6:00 a.m.?

13 A. Right.

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

18 A. Yes.

19 O And it's the first contact that either  
20 you initiated to the hospital or that any of the  
21 labor and delivery nurses initiated to you?

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

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

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

6 A. Correct. Sarah Moats.

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

9 A. Yes.

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

12 A. Correct.

13 Q. It looks like he was paged at about  
14 2:30 a.m. and an epidural was placed at about  
15 3:00 a.m., at least according to the record;  
16 true?

17 A. Correct.

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

20 A. No.

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

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

3           Q.     And Nurse Gwin's first name is?

4           A.     Mary.

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

8           A.     Mary Gwin is.

9           Q.     Do you know the status of Nurse Moats?

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

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

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

22          Q.     When would that discussion likely have  
23     taken place?

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

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

4                 MR. JACKSON: He will ask another  
5     question.

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

8                 MR. ROSSI: Objection.

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

11                A.     Yes.

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

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

20                MR. ROSSI: Objection.

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

23                MR. MISHKIND: Yes.

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

1           A.     Yes.

2           Q.     Were there any changes made in  
3     communication by labor and delivery nurses to  
4     attendings based upon this case?

5                     MR. ROSSI:  Objection.

6                     MR. JACKSON:  Objection.  You may  
7     answer.

8           A.     Were there changes made in  
9     communication?  You mean, how we would  
10    communicate?

11          Q.     Yes.

12          A.     With the attendings.  Yes.

13          Q.     What changes?

14                    MR. ROSSI:  Objection.

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

17          A.     Predicated on this case, we set about  
18    to look at the manner in which we communicated.  
19    And, you know, based on that, a whole series of --

20                    MR. JACKSON:  Just tell him -- the  
21    question was specifically, were changes made in  
22    the communication between the nurses and the  
23    attendings as a result of this case and that's  
24    what I would like you to answer.

25                    MR. MISHKIND:  I think he is.

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

3                   MR. MISHKIND: I think he still was.

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

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

18                   MR. ROSSI: Objection.

19                   MR. JACKSON: You may answer.

20          A.       I think those were the two things.

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



1 A. No, at 6:00 o'clock, I was.

2 Q. From the communication by the nurse?

3 A. Right. Before I arrived.

4 Q. And again, that's because you called  
5 them, or you called labor and delivery?

6 A. Correct.

7 Q. And were you surprised to learn at  
8 6:00 a.m. that Angel was there?

9 A. I was somewhat surprised to find out  
10 that there was a patient there that I didn't know  
11 about.

12 Q. And what did you say to the nurse?

13 A. For the most part, she told me that  
14 the patient was doing well; that she had a  
15 reactive tracing and so I really didn't have any  
16 cause for alarm at that point. And then I also,  
17 in just knowing the particular nurse that I was  
18 working with, I knew of her general abilities in  
19 my opinion with the interpretation of tracings  
20 and I guess I had some comfort in the fact that  
21 she was the one looking at them and in the past  
22 had read them accurately.

23 Q. But you obviously had some concern as  
24 to why you hadn't been contacted when you called  
25 labor and delivery at 6:00 a.m.; true?

1           A.     Yes.  It was not typical.

2           Q.     Did she give you any explanation at  
3     that time as to why she had not contacted you  
4     throughout the night?

5           A.     Not that I can recall.

6           Q.     Did she give you any indication as to  
7     why no one from the hospital from the time the  
8     patient arrived up until you called at 6:00 a.m.  
9     had any contact with you?

10          A.     Not that I can recall.

11          Q.     You were certainly available to be  
12     reached; true?

13          A.     Absolutely.

14          Q.     They have your number?

15          A.     Home phone and pager and a back line,  
16     so no matter what goes down, unless, you know,  
17     nothing worked, they would be able to reach me.

18          Q.     There is a note in terms of the  
19     orders, the physician orders.  It looks like, I  
20     guess, that would be 12:05 telephone order, Dr.  
21     Tizzano, and then it's got Nurse Moats, which I  
22     think is the nurse that we have been  
23     referencing.

24                     If it says telephone order -- that is  
25     what TO stands for; right?

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

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

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

25          Q.       If she did call, and you had

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

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

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

17          A'     Yes.

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

22          A.     Yes, at that time.

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

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

3                     (discussion off the record.)

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

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

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

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

1     what is noted here?

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

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

8             MR. ROSSI: Objection.

9             MR. JACKSON: You may answer.

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

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

15            A.     Yes.

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

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

1 records.

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

4 A. That's correct.

5 Q. And it should have been; true?

6 A. Yes.

7 Might I add something to that last  
8 answer?

9 Q. Go right ahead.

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

18 Q. There goes that convention.

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

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

24 A. Yes.

25 Q. When you came to the hospital at --

1 well, let's see. You saw Angel at 7:44; true?

2 A. Correct.

3 Q. Your testimony, however, is that you  
4 probably arrived at the hospital before 7:44?

5 A. Probably 7:30. I would say it would  
6 be just -- I am speculating. My convention is to  
7 wake up at 6:00 and call the hospital. I do that  
8 as a matter of routine.

9 Q. You didn't, however, go immediately  
10 when you arrived at the hospital up to see Angel,  
11 did you?

12 A. I would have went immediately to labor  
13 and delivery and got the chart out and started to  
14 look. I believe she was my only patient there  
15 that was in labor.

16 Q. But is it fair to say from the time  
17 you arrived at the hospital up until the time  
18 that you actually saw the patient, probably 10 or  
19 15 minutes went by?

20 A. . Perhaps.

21 Q. Is that a reasonable estimate?

22 A. That is reasonable.

23 Q. Again, I am not trying to put words in  
24 your mouth. **If** you immediately walked in the  
25 door and saw her in two minutes --



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

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

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

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

12                  MR. MISHKIND: To him, correct.

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

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

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

3           A.     When did the tracing become  
4 concerning?

5           Q.     To you.

6           A.     After I arrived?

7           Q.     Correct.

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

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

20           Q.     What time was the IUPC placed?

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

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

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

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

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

10          Q.       Intrauterine pressure catheter.

11          A.       I don't recall placing an IUPC.

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

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

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

23          Q.       Is it fair to say that at or around  
24       7:44 you did the artificial rupture of the  
25       membranes?

1 A. Correct.

2 Q. And I think it's at that time or  
3 shortly thereafter that the fetal heart rate  
4 tracings were of concern to you?

5 A. Yes.

6 Q. And as to whether you went back and  
7 looked at the fetal heart rate tracings before  
8 this or not, you were really looking at things  
9 prospectively at that point as opposed to  
10 retrospectively?

11 A. Correct.

12 Q. Do you recall having any discussion  
13 with Nurse Moats or perhaps Nurse Gwin when you  
14 arrived at that 7:44, 7:45 time frame?

15 A. Not that I can recall, outside of what  
16 we would have been discussing in the patient's  
17 room. But in the labor, the nurse would have  
18 been in the room almost consistently with the  
19 patient. So really any conversation I had would  
20 most likely have been with the patient and the  
21 nurse present in the room.

22 Q. And any specifics, you don't recall?

23 A. Not that I can recall.

24 Q. Do you recall any discussion with  
25 Angel at that time when you arrived concerning

1     how she was feeling?

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

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

14          A.     Of that and many other things.

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

20          A.     Possibly.

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

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

3           Q.     What were you thinking of?

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

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

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

22           A.     Under nursing notes.

23                   (Pause.)

24           Q.     I am particularly interested in the  
25 4:15 note; that is, at a point in time when a

1 vaginal exam is done; true?

2 A. 4:15, let's see.

3 MR. JACKSON: Show us the entry you  
4 are referring to.

5 Q. Do you see the 4:15?

6 A. . 4:15 a.m.

7 MR. JACKSON: What specific entry are  
8 you looking at?

9 A. Here we go, sure, yes, I see.

10 Q. All right. And just so that the  
11 record is clear, am I reading that the nurse  
12 documents dilatation complete?

13 A. Correct.

14 Q. Effacement 100 percent, minus three  
15 station and the vertex presentation, and the "I"  
16 stands for what?

17 A. . Bag of water intact.

18 Q. And so that would be a vaginal exam  
19 being performed by Nurse Moats; true?

20 A. Yes.

21 Q. When a VBAC patient reaches complete,  
22 of what significance is this?

23 A. Well, she enters at that point the  
24 second stage of labor. She has an epidural. In  
25 this case the head is very high in the pelvis and

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

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

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

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

11 A. Yes.

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

14 A. No.

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

18 A. Do you see that on the same sheet?

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

24 A. I can see SCM.

25 Q. Yours is better quality.



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

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

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

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

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

22           A.       Correct.

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

1 rupture?

2 MR. ROSSI: Objection.

3 MR. JACKSON: Objection. You may  
4 answer.

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

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

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

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

24 MR. JACKSON: Objection. You may  
25 answer.

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

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

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

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

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

21          A.     Yes.

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

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

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

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

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

16                MR. ROSSI:  I do too.

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

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

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

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

9 A. Yes.

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

13 A. Yes.

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

17 A. I see the confusion.

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

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

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

1           A.       Yes.

2           Q.       And at that time, she notes dilatation  
3       is still complete, effacement is 100 percent,  
4       station at this time now is minus four; true?

5           A.       Correct.

6           Q.       Of what significance is it in  
7       a patient that is in the trial of labor that has  
8       had a cesarean section, if they go from a minus  
9       three to a minus four station once fully dilated?

10          A.       I would prefer to see that she was  
11       progressing down instead of up. I also think  
12       that for an examiner to be able to consistently  
13       and accurately judge the centimeters in the  
14       pelvis is a tough one, and fortunately it was the  
15       same examiner, so I would rather see we were  
16       moving forward and not having the head stay high  
17       from 4:15, but this portion of labor is the  
18       deceleration phase.

19                 The change in the cervix is very slow,  
20       and you know, we were waiting for the head to now  
21       come down the pelvis, and it's at this point not  
22       happening.

23          Q.       Can we agree that at this point at  
24       6:00 a.m. that going from a minus three to a  
25       minus four station when the cervix is complete is

1 something that should be communicated to you?

2 A. I agree with that,

3 Q. And was that communicated to you when  
4 you spoke to the nurse on the phone at 6:00  
5 a.m.?

6 A. At 6:00 a.m. they told me it was minus  
7 three to minus four.

8 Q. They didn't tell you it had gone from  
9 minus three to minus four, did they?

10 A. No.

11 Q. Would you have liked to have known  
12 that?

13 A. Yes. And if I could have believed  
14 that that was measurable, I don't know how much  
15 stock I would have put into guesstimating, not  
16 guesstimating, trying to ascertain a centimeter's  
17 difference.

18 Q. We have the reliability of this being  
19 the same nurse as opposed to a different nurse?

20 A. Agreed.

21 Q. They didn't tell you if the station  
22 had regressed as opposed to progressed?

23 A. No.

24 Q. I don't know if I am using the right  
25 term.

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

3           A.       I would have preferred to have known  
4   that.

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

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

14                   MR. MISHKIND: Well, whatever. Go  
15   ahead.

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

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

24           A.       Right. That is correct.

25           Q.       And you indicated that she was at



1 minus two station?

2 A. Yes.

3 Q. Doesn't the point of engagement come  
4 at zero station?

5 A. It does, but with a little bit of  
6 fundal pressure you can easily engage her, and we  
7 needed to rupture her membranes to get on with  
8 things and that's what we did.

9 Q. So when you say the vertex was now  
10 engaged --

11 A. Oh, I see what you are saying.

12 Q. -- your statement is not consistent  
13 with --

14 A. No, I understand what you are saying.  
15 I have probably overlaid what happened after  
16 amniotomy and before amniotomy, but no, I  
17 understand your --

18 Q. The fluid was clear?

19 A. Yes.

20 Q. Do you recall who was in the room with  
21 Angel after you did the artificial rupture of  
22 membranes?

23 A. Aside from the nurse, you mean?

24 Q. Correct.

25 A. I cannot remember if her husband was

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

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

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

9 Q. Do you remember ever meeting her  
10 grandma?

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

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

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

25 Q. I take it you were not aware of the

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

5 A. Correct.

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

11 MR. ROSSI: Objection.

12 MR. JACKSON: Objection. You may  
13 answer.

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

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

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

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

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

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

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

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

1 is very difficult for me to do at this point,

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

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

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

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

1 deliver that baby vaginally.

2 Q. While looking at the fetal heart rate  
3 tracings, what do they show from 7:50 to 7:59 or  
4 8:00 o'clock when the electrode was put on?

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

10 When you have these periods where  
11 there is an actual break in the fetal heart rate  
12 tracing and you look at the top of the tracing on  
13 91038 and you look right down below the three,  
14 you can see a little point that arrives up there.

15 Q. Okay.

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

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

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

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

15          Q.    What time was oxygen started?

16          A.    8:06.

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

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

23                You know, I have seen the potential  
24   for delivering her forthwith, instruments are  
25   just outside the door in a covered cart ready to

1 be brought into the room at the very moment they  
2 are needed, and there is the time it takes to get  
3 the stuff out of the cupboard and put it on and  
4 get her breathing it, and then write it down on  
5 the tracings. So even from the time that she  
6 actually put the oxygen on, to the time she  
7 writes that, that monitor strip is continually  
8 moving.

9 Q. Would it have been preferable to have  
10 administered oxygen in light of the status of the  
11 fetal heart rate tracings and all of findings  
12 prior to 8:06?

13 A. I think it's reasonable to add the  
14 oxygen as soon as you see any permutation of the  
15 heart rate. At the same time, this is the first  
16 permutation she is seeing and the notion that  
17 this is going to resolve is a reasonable  
18 expectation.

19 Q. It would have been reasonable, would  
20 it not, at or around 8:00 o'clock to have  
21 administered oxygen?

22 A. Yes.

23 Q. And do you see any indication that  
24 oxygen could not have been administered during  
25 that five minute period or six minute period?



1           A.     Any reason that it could not have been  
2     done?

3           Q.     Correct.

4           A.     No.

5           Q.     The heart rate tracings at around 7:59  
6     or 8:00 a.m., would you agree they are suggestive  
7     of preterminal tracings?

8           A.     No.

9           Q.     Are they ominous tracings?

10          A.     Disconcerting to see that heart rate  
11     down to 60, but then in another moment, you look  
12     at one minute later and you have a heart rate at  
13     140. You-don't know that another deceleration is  
14     going to take place. Even a person standing  
15     there, hand on 02, looks over at the monitor and  
16     sees we are back up to 140, hoping, because of  
17     the rapid progress taking place, that what we are  
18     seeing is indeed the baby coming down the pelvis  
19     and compression of that head causing those  
20     changes in the heart rate to occur.

21          Q.     I think you partially answered this  
22     before in terms of why you didn't call the crash  
23     C-section at 8:00 a.m. as opposed to what, 8:12  
24     a.m.?

25          A.     Yes.

1           Q.     Was that, you, in your mind, based  
2     upon taking into account all of the information,  
3     felt that you could still safely deliver this  
4     baby vaginally?

5           A.     Correct. I thought there was a point  
6     in time that that's what we were going to be able  
7     to do.

8           Q.     And what was it at 8:12 that caused  
9     you to change that opinion that was not already  
10    known to you at 8:00 a.m.?

11          A.     At 8:12, the head ascends into the  
12    pelvis. Very atypical sort of thing to occur. I  
13    have never seen anything like that happen before  
14    in the manner in which that happened. And right  
15    then and there knew that we had something very  
16    different coming up. That was my first sense  
17    that uterine rupture was present, and at the very  
18    same time the abdomen takes on that bilobular  
19    appearance.

20          Q.     You were concerned that there was some  
21    fetal distress going on before 8:12 a.m.;  
22    correct?

23          A.     I won't say there was fetal distress,  
24    I would say there were some nonreassuring  
25    components of that fetal distress by what I

1 anticipated was the head coming down through the  
2 pelvis.

3 Q. And if those nonreassuring signs were  
4 consistent with fetal distress, you want to  
5 attempt to relieve as soon as possible any type  
6 of anoxic insult to the baby; true?

7 MR. JACKSON: Objection. Go ahead,  
8 doctor.

9 A. Just please say that one more time.

10 Q. If the fetal heart rate tracings are  
11 consistent with distress, fetal heart rate  
12 tracings were consistent with fetal distress, you  
13 want, as an obstetrician, you want to relieve the  
14 events causing that fetal distress as soon as  
15 possible to eliminate or to prevent any anoxia to  
16 the baby; true?

17 MR. JACKSON: Objection. You are  
18 distinguishing from the circumstance here or  
19 talking in general? Because he has given you his  
20 reasoning for this particular situation.

21 MR. MISHKIND: In general, then,  
22 that's fine.

23 A. In general, when I see a nonreassuring  
24 fetal heart rate tracing, certain steps I like to  
25 take to see what would happen with the tracing.

1           Q.       And the idea is you want to, if the  
2       tracings are suggestive of fetal distress, the  
3       sooner you deliver the baby, the less likelihood  
4       that there is that the baby will suffer an anoxic  
5       event; correct?

6                   MR. JACKSON:  Objection.  Go ahead.

7           A.       I want to answer that question two  
8       ways.  Yes.  If I thought that what I had coming  
9       was more nonreassuring fetal heart rate tracings,  
10      yes.  If what I had seen was a period of  
11      disconcerning fetal heart rate tracing and then  
12      return to normal, but I still knew I was going to  
13      do a cesarean section on a patient having failure  
14      to progress, I would rather allow that baby to  
15      recover in utero; that our efforts at the time of  
16      delivery, very quickly and dramatically  
17      delivering that baby would be better.

18          Q.       And as to why you didn't put the  
19      appropriate staff on notice of an impending crash  
20      C-section earlier than 8:12, for example, at 8:00  
21      o'clock or at 7:44 when you arrived, is that your  
22      thought process was you could still in the best  
23      interest of the mom and the baby deliver this  
24      child vaginally as opposed to needing to proceed  
25      to a crash C-section; true?

1           A.       Correct.

2           Q.       Were you aware of the fact that Angel  
3       questioned the nurses when the fetal heart rate  
4       tracings began to drop as to why she wasn't being  
5       moved toward a C-section?

6                   MR. ROSSI:  Objection.

7                   MR. JACKSON:  Objection.

8                   MR. ROSSI:  Can you be any more  
9       specific?

10                  MR. MISHKIND:  I really can't.

11           Q.       Let me put it to you this way.  Were  
12       you aware of the fact that Angel had questioned  
13       the nurses in the early morning hours prior to  
14       your arrival as to why she wasn't being moved  
15       toward a C-section?

16           A.       No.

17           Q.       Would you expect if such conversation  
18       occurred where the patient is questioning the  
19       nurses about why aren't we going to C-section, or  
20       I want a C-section, or something bringing up  
21       C-section, that that should be brought to your  
22       attention --

23                   MR. JACKSON:  Objection.

24           Q.       -- by the nurse?

25                   MR. ROSSI:  Objection.

1 THE WITNESS: I may answer?

2 MR. JACKSON: You may.

3 A. I think that if the patient was  
4 objecting and that the nurse did not answer by  
5 virtue of her explanation, I would appreciate  
6 being called. However, I think that also a nurse  
7 with Sarah's experience may describe to the  
8 patient what is going on, what is reasonable to  
9 expect, and if she thought that she was on solid  
10 ground, the patient perhaps would be reassured  
11 and would go forward from there.

12 Q. We are closing in on completion of the  
13 deposition. I want to talk about the surgery for  
14 a moment.

15 Anesthesia decided to use the  
16 epidural; correct?

17 A. Correct.

18 Q. Rather than a general?

19 A. Yes.

20 Q. Do you have any concerns at all as to  
21 why or as to whether it would be preferable to  
22 proceed with the general?

23 A. I think that the anesthesiologist knew  
24 that what we were doing was a crash cesarean  
25 section. Harold Cooke is very accomplished.

1 Q. What's his first name?

2 A. Harold.

3 And I would be guessing as to why he  
4 chose one over the other, knowing that my  
5 intention would be to immediately proceed.

6 Q. Do you know how long it was once the  
7 decision was made to proceed with the crash  
8 C-section until Angel was moved from her room  
9 into the OR?

10 A. There is a time. Let's see. There is  
11 a time that she is actually in the room. I am  
12 trying to remember where that time is at in the  
13 notes. I don't recall it right off. It was  
14 about three or four minutes. 8:30. I can't  
15 remember.

16 MR. JACKSON: You want to know when  
17 she was in the OR?

18 MR. MISHKIND: Basically from the time  
19 of the crash C-section until she was taken into  
20 OR.

21 (Pause.)

22 MR. JACKSON: We can't find it. If  
23 you can give us a reference somewhere.

24 THE WITNESS: I think it's in the  
25 chart. I just can't remember.

1           Q.     Let me ask you this, to try to speed  
2 things up. Angel's recollection is that from the  
3 time the crash C-section was called, she was left  
4 in the labor and delivery room for at least 10 or  
5 15 minutes prior to being taken to the OR. Does  
6 that sound consistent or inconsistent with the  
7 general flow of time in terms of what took place  
8 once you called the crash C-section?

9           A.     Are you asking do I think that her  
10 recollection is correct that she was in her room  
11 for that period of time?

12          Q.     Yes.

13          A.     I think that's probably correct.

14          Q.     Do you know what took place in the OR  
15 prior to the skin incision being made?

16          A.     They would be waiting for the crew to  
17 get there and typically we would not move the  
18 patient back to the operating room until there  
19 were staff there to take care of her, hook her up  
20 to a monitor, get her on the table, have  
21 anesthesiology present and have the nursing scrub  
22 person present, because we were disconnecting her  
23 from everything to make that move.

24          Q.     Dr. Steiner assisted with the  
25 C-section; then?



1 A. Correct.

2 Q. I asked you before as to whether or  
3 not he had privileges to perform C-sections at  
4 Wooster at that time and you are not certain  
5 whether he did?

6 A. I am not certain how his privileges  
7 read. I know he certainly had whatever it took  
8 to be assistant. I don't know if he had, if  
9 there is a difference in what the primary surgeon  
10 needs.

11 Q. Certainly his assisting an emergency  
12 C-section should be consistent with the  
13 privileges that he has at that hospital; correct?

14 A. Yes. He is absolutely qualified.

15 Q. And whether or not he was both  
16 qualified and had appropriate privileges at the  
17 hospital to perform C-sections may not  
18 necessarily be the same thing; correct?

19 MR. JACKSON: Objection. You may  
20 answer.

21 A. I am not aware of the credentialing  
22 and privileging processing and how it relates to  
23 each physician.

24 Q. Given what I understand to be a need  
25 for you to wait for anesthesia to arrive and the

1 appropriate personnel to arrive, at 8:12 when the  
2 abdomen took on this unusual shape -- and I can't  
3 remember how you described it, but I think it was  
4 an unusual shape -- why didn't you take Angel to  
5 the OR to do a limited skin prep since she had a  
6 Foley in, IV, and the epidural had been placed?

7 A. The reason I didn't do that is because  
8 I didn't think it was in her best interest. If I  
9 had done that and not had anesthesia present, not  
10 had other instruments, and I opened up an abdomen  
11 and instead of seeing the distended peritoneum, I  
12 saw blood and blood coming quickly, I would have  
13 been in a bad situation with no one to administer  
14 fluids, and so forth, that would have been needed  
15 to support her and get her through that case.

16 Q. When you opened up the abdomen, can  
17 you just describe for me in general terms what  
18 you encountered, both in the abdomen and then in  
19 the uterus.

20 A. Yes. I am going to refer back to my  
21 operative note. Once again, once we open the  
22 skin, separated the muscle, the first thing that  
23 became apparent was what would normally be the  
24 bladder, and the upper limits of the peritoneum  
25 above the uterus is this enormous bulging and

1     confluent area. So we carefully enter the  
2     peritoneal cavity and see it's very difficult to  
3     distinguish where bladder begins and ends. And  
4     knowing basically where we are and knowing if I  
5     do injure the bladder I can still go ahead and  
6     repair that, enter and discover it's not at all  
7     the bladder but a window open in the uterus which  
8     at this point in time was not hemorrhaging and  
9     that there was, I believe, arm and cord were  
10    prolapsed through the incision.

11                   It was very easy at that point without  
12    making any incision whatsoever into the uterus to  
13    simply reach in and deliver the baby.

14           Q.     The uterus itself, how badly was it  
15    torn?

16           A.     In addition to the window being  
17    opened, the lower segment of the uterus from the  
18    incision down toward the area down underneath the  
19    bladder was very contused, bruised. It had a  
20    very purplish, modeled appearance to it and the  
21    tissue, as though it had been stretched and  
22    started to split at points along the way before  
23    finally rupturing at the scar were apparent.

24           Q.     Then did the old incision from the  
25    C-section, did that rip open and rupture also?

1           A.       That, I cannot say. I'm assuming  
2       that's what happened, but I couldn't actually  
3       make out. We were right at the junction between  
4       the lower uterine segment, which is very thin,  
5       and up against the upper bladder and the thick  
6       portion of the uterus.

7           Q.       Dr. Steiner, what assistance was he  
8       providing in connection with the delivery?

9           A.       Exposure.

10          Q.       Exposure of the fascia?

11          A.       Right. Since he virtually assists  
12       with every single case that we do, his expertise  
13       as an assistant is unlike virtually anyone else  
14       that we could have.

15          Q.       Doctor, I want to ask you a couple  
16       questions relative to the delivery time, and that  
17       is, if a crash C-section had been called at 6:00  
18       a.m., hypothetically, would you agree more likely  
19       than not that the baby would have been delivered  
20       and spared the irreversible brain damage?

21                   MR. ROSSI: Objection.

22                   MR. JACKSON: Objection. You may  
23       answer.

24          A.       **If** a C-section had been called **at** 6:00  
25       a.m., I agree there would not have been a problem

1 with that baby.

2 Q. Based upon the pH at birth, do you  
3 have an opinion as to how long before the actual  
4 delivery took place that an irreversible brain  
5 damage occurred?

6 MR. JACKSON: Objection.

7 MR. ROSSI: Objection.

8 A. Can I answer?

9 Q. Sure.

10 MR. ROSSI: Unless Mr. Jackson tells  
11 you no.

12 MR. MISHKIND: He never does that.

13 (Discussion off the record.)

14 A. We are speaking of the pH of 6.4?

15 Q. Right.

16 A. I couldn't speculate as to how long it  
17 had taken. There are so many variables that  
18 amount to that.

19 Q. I guess what I am trying to get at, do  
20 you have an opinion or are you likely to express  
21 an opinion at trial as to when, prior to the  
22 actual delivery -- we have talked about the 6:00  
23 a.m. period that more likely than not the baby  
24 would have avoided irreversible brain damage,  
25 along the continuum at 6:00 a.m. and prior to

1 calling for the crash C-section at 8:12 and  
2 delivering the baby at 8:30 --

3 MR. JACKSON: I'll object to that. I  
4 think he answered.

5 Q. 8:30, whatever, do you have an opinion  
6 as to when the window of opportunity, if you  
7 will, closed on preventing irreversible brain  
8 damage?

9 MR. JACKSON: Is your answer any  
10 different than it was before?

11 MR. MISHKIND: I am not sure he  
12 answered that question.

13 MR. JACKSON: I think he did. Go  
14 ahead.

15 A. I would like to answer this in two  
16 parts. For one, I would feel relatively certain  
17 that had delivery occurred by 7:50, I would be  
18 betting that we would be on very solid ground,  
19 and that had delivery occurred even by 8:14, that  
20 this baby would have recovered from that  
21 transient period.

22 Q. So that had the actual delivery of the  
23 baby occurred at or prior to 8:14 a.m., it's your  
24 opinion, more likely than not, that Alexis would  
25 have avoided irreversible brain damage?

1 MR. ROSSI: Objection.

2 Q. Is that correct?

3 MR. JACKSON: You may answer.

4 A. I think our chances would have been  
5 good.

6 Q. More likely than not?

7 A. In my experience, yes.

8 Q. I asked you before about the  
9 intrauterine pressure catheter and whether one  
10 was or wasn't used. We sort of got hung up.  
11 What are the advantages or disadvantages of using  
12 an IUPC?

13 A. It is certainly the timing of  
14 contractions and the intensity. The timing I  
15 think is relatively equivalent to being able to  
16 use the external, except when there is loss of  
17 fix of the external monitor, so then it has  
18 precedence in its ability to accurately depict  
19 when a contraction begins and ends and also could  
20 depict what indeed is the true amount of pressure  
21 being exerted by that contraction.

22 Q. So during the period where we have --  
23 I think from 7:50 to 7:59 a contraction pattern  
24 -- I'm sorry, a fetal heart rate pattern  
25 somewhat difficult to interpret as we talked

1 about before, would an IUPC give you greater  
2 variability and greater assistance in  
3 appreciating the status of the baby's heart?

4 A. That would have nothing to do with the  
5 heart. In this case, seeing the baby's progress  
6 negated any reason to put in an IUPC, in my  
7 opinion.

8 Q. Do you believe, looking at this, there  
9 was no indication for an IUPC; that I may have  
10 misspoken in terms of its application?

11 A. I agree that I didn't need an IUPC at  
12 this point.

13 Q. Tell me about this meeting that you  
14 had with the family after the baby was delivered  
15 and you saw mom and dad in the office. The note  
16 reflects something about you had a conversation  
17 that lasted well over an hour. Do you recall  
18 that?

19 A " Yes.

20 Q. I am sure that this was a very  
21 heartfelt meeting that you had with the family.  
22 It wasn't easy on you and obviously not easy on  
23 the family; true?

24 A. . That's very true.

25 Q. Do the best you can, because your note



1 doesn't reflect the specifics of the  
2 conversation, but if you can give me what you  
3 recall you said and they asked, that kind of  
4 thing.

5       A.     You know, basically, there was a very  
6 brief interval of seeing how she was doing at  
7 this stage of the game and her recovery and that  
8 appeared to all be going reasonably well. And  
9 then of course how is the baby -- and that  
10 probably actually preceded any conversation --  
11 what was the status of the baby.

12             And they related to me what their  
13 feelings were. They were encouraged by a number  
14 of things, none of which sounded encouraging to  
15 me. And there was from my take on what they had  
16 said and not having seen the actual information  
17 coming from the neonatologist, I didn't know what  
18 specifically to think. But none of it sounded  
19 good.

20             At that point, there was just a hint,  
21 just a hint of anger in the father's voice as he  
22 recounted some of the things that occurred during  
23 labor and delivery. And trying to understand  
24 them -- and I fully appreciated why he would feel  
25 that way -- and simply told my nurse, I said,

1 time to tell the other patients that I am going  
2 to be tied up for an indeterminate period of time  
3 and whatever time it took to explain to them in  
4 as best a way I could what had transpired, I  
5 did.

6 And I can't remember the exact  
7 specifics of that conversation, but the father  
8 was there through every bit of that preC-section  
9 discussion. He was right outside the door up  
10 until the time, and I don't recall if he was in  
11 the room during the section. At the time I was  
12 just so focused on what was going on and getting  
13 things ready that that was the last thing I was  
14 thinking about. But then he was outside the door  
15 for the resuscitation in what I am sure was a  
16 horribly awkward position for him to be; in  
17 greens with a crew from a children's hospital  
18 that had virtually no notion that that's the  
19 father and this is not a health care professional  
20 standing there, and what was, I am sure, a very  
21 gut wrenching experience for all of us, let alone  
22 for him. And I did the best I could and  
23 described to them what happened from my  
24 perspective and that was the sum total of the  
25 conversation.

1           Q.       Sounds like a lot of questions were  
2       being asked by the dad.

3           A.       I think for the most part if Angel had  
4       questions, I don't remember them, but there was a  
5       fairly good list of questions from dad that I can  
6       recall.

7           Q.       Do you remember any of the questions,  
8       either specifically or the general nature of the  
9       questions that mom asked?

10          A.       I would be speculating and reaching to  
11       try to remember. I think most of these questions  
12       were what if, what if this, what if that.

13          Q.       Can you give me an example **of** some of  
14       the what if's that you believe were asked during  
15       that meeting?

16                 MR. JACKSON: Please don't speculate.  
17       If you can do it, a reasonable memory of it --

18          A.       I honestly can't. I would have  
19       written them down.

20          Q.       That's fine. And again, if you have  
21       reason to believe that you were asked what if A,  
22       B and C occurred, or what if such-and-such had  
23       taken place, you think that that's what occurred,  
24       tell me.

25                 If you are just speculating and you

1 are guessing at what you believe they asked, then  
2 Mr. Jackson is correct, I don't want you to go  
3 there.

4 A. I would be speculating. There is no  
5 two ways.

6 Q. Besides what you have dictated in your  
7 notes or written down in your notes -- and I  
8 think a lot of your stuff is dictated -- did you  
9 maintain any other notes concerning this meeting  
10 with the family?

11 A. No.

12 Q. Do you recall having any discussions  
13 with Angel or any family member while Angel was  
14 in the hospital where they questioned you about  
15 why the baby wasn't delivered sooner?

16 A. I don't recall them specifically.  
17 They may have occurred. I would have certainly  
18 engaged in any conversation that any family  
19 member had. I would not have shied away from  
20 that for a moment.

21 Q. Let's assume that you were asked that  
22 back in January of 1999 in the hospital before  
23 Angel is discharged, whether asked by mom, by  
24 grandma, or by dad, why didn't you deliver this  
25 baby sooner, without repeating everything you

1 have already told me, but talking to somebody as  
2 a layperson, what would have been or likely was  
3 your explanation?

4 MR. JACKSON: I'll object, because you  
5 are basically asking him what would you have said  
6 in a conversation that may or may not have  
7 occurred.

8 MR. MISHKIND: That's true. You are  
9 100 percent correct. I have reason to believe,  
10 although I can't state to a certainty, that such  
11 questions were asked, and I think the doctor has  
12 said to me that he knows if it was asked what he  
13 would have said very specifically.

14 MR. JACKSON: I agree. What this  
15 could lead to, your clients say the doctor, we  
16 asked him this question on such-and-such a date  
17 and he said a certain thing.

18 Now, the doctor has told you he  
19 doesn't have specific recollection and I don't  
20 want it to lead to a situation where your client  
21 says A, and he says B, based upon some  
22 speculation or uncertainty and you are trying to  
23 draw some distinction there.

24 If he has a memory of what he did say,  
25 in fact, if something like that was said, I will

1 let him answer that, but in terms of trying to  
2 conjure up what he may have said in a  
3 conversation that may or may not have occurred, I  
4 am not going to let him do that.

5 Q. I don't want you to conjure and I  
6 don't want you to speculate, but if you have  
7 reason to believe that a conversation occurred in  
8 the hospital where mom, grandma or dad asked you  
9 why didn't you deliver the baby sooner or why is  
10 the baby in this condition, do you know what you  
11 would have said?

12 A. Yes. I don't have recollection of  
13 them having asked me those, which I think the  
14 majority of questions occurred subsequent to  
15 delivery had to do with the baby's status, which  
16 were all directed toward the pediatricians and  
17 letting them talk to the neonatal transport crew  
18 as they got things stabilized as well as they  
19 could. That's where the propensity of questions  
20 were.

21 Q. Do you have any recollection of any  
22 specifics of any conversations with Angel, with  
23 grandma or with any family member, dad, from the  
24 time of the delivery up until the time of  
25 discharge that you have not already shared with

1 me?

2 A. No.

3 Q. Do you have any recollection of  
4 specifics or a summary of what your discussions  
5 consisted of at any time after discharge and up  
6 to this present date that we haven't already  
7 talked about?

8 A. No.

9 MR. MISHKIND: I don't believe I have  
10 any further questions at this point.

11 (Discussion off the record.)

12 Q. Doctor, we have marked as Plaintiff's  
13 Exhibit 4 --

14 - - - - -

15 (Thereupon, TIZZANO Deposition  
16 Exhibit 4 was marked for  
17 purposes of identification.)

18 - - - - -

19 Q. It's my understanding that this is a  
20 copy of the NST December 26th, 1998. Is that  
21 correct? .

22 A. Let me go back to our office record.

23 MR. JACKSON: There is the date right  
24 here.

25 A. What I am just curious about, in

1 looking at this, I have signed this. That's my  
2 only question. That's why I was curious.

3 Yes, this is the NST dated 1-1-99, I'm  
4 sorry. It's dated 12-26-98, due date is 1-1-99.

5 Q. And your interpretation of that  
6 tracing is that it was a reactive nonstress test?

7 A. Clearly reactive nonstress test.

8 MR. MISHKIND: Now I am done. Mr.  
9 Rossi may have some questions for you.

10 MR. ROSSI: I do have some follow-up  
11 questions for you.

12 EXAMINATION OF ANTHONY J. TIZZANO, M.D.

13 BY MR. ROSSI:

14 a. Mr. Mishkind asked you whether you had  
15 any knowledge that this patient during the course  
16 of the evening between January 16th and January  
17 17th of '99 requested a C-section from the  
18 nurses, Do you remember him asking you that?

19 A. Yes.

20 Q. When you arrived at the hospital that  
21 morning at 7:44 a.m., did you, in fact, discuss  
22 that very thing with this patient; that is,  
23 whether she was to have a vaginal delivery or a  
24 C-section?

25 A. Yes.



1           Q.     And in fact you documented the patient  
2     was evaluated by self and her interest in VBAC is  
3     reaffirmed; right?

4           A.     That's correct.

5           Q.     And I take it by a note like that,  
6     that you probably had a discussion with her which  
7     was just more than I want a vaginal delivery;  
8     right? I mean, you went into some detail with  
9     her about what she wanted to do?

10          A.     I can't remember what the specifics  
11     were. I just know that the traditional thing I  
12     would do was to walk into that room and seeing  
13     the patient for the first time, recognizing she  
14     has been there for the evening, is making sure  
15     that her heart and mind was in the same place and  
16     I was on the same page as we embark on whatever  
17     management was going to take place.

18          Q.     And in part and parcel to that  
19     discussion would be a discussion of whether or  
20     not she wished to have a C-section; agreed?

21          A.     That was certainly part of it. That's  
22     the one part I know for sure.

23          Q.     And as we know by your note and the  
24     actions that took place thereafter at 7:44 a.m.,  
25     she made it clear that she wanted to go forward

1 with a vaginal delivery; true?

2 A. That's correct.

3 Q. Mr. Mishkind also asked you a number  
4 of questions about the hypothetical risks of an  
5 impending uterine rupture. There were no  
6 impending risks of rupture when you evaluated  
7 this patient at 7:44 a.m.; agreed?

8 A. Agreed.

9 Q. In fact, and I believe you said this  
10 but I want to make sure I understand you, the  
11 first time it was even remotely suggested that  
12 there was a rupture in this case was at 8:12  
13 a.m.; right?

14 A. That's correct.

15 Q. And that was when the baby went from  
16 plus three back to negative two?

17 A. Correct.

18 Q. Before that time, as you looked at the  
19 heart that morning when you arrived, and as you  
20 retrospectively have reviewed this record, there  
21 are no other impending signs of a rupture; true?

22 A. No signs. It would be difficult to  
23 imagine how the baby could get pushed through the  
24 pelvis if there is a hole in the uterus.

25 Q. Would you agree with me, doctor, that

1 up until 8:12 a.m., this was proceeding as a  
2 normal vaginal delivery after a C-section?

3 A. Up to 8:12?

4 Q. Right. At 8:12 a.m. is when the event  
5 occurred that the vertex ascended up the pelvis  
6 to negative two station.

7 A. That my hopes were for a vaginal  
8 delivery.

9 Q. But as we look back at the chart,  
10 everything up and until that point was proceeding  
11 as you would hope; is that fair?

12 A. I would rather not have some parts of  
13 the tracing immediately preceding 8:12 and I  
14 needed to feel comfortable that a delivery was  
15 not only foreseen, but it was going to happen  
16 quickly. And that was my impression; that we were  
17 in short order going to deliver that baby and it  
18 was gut wrenching not to do that.

19 Q. Your concerns before 8:12 a.m. weren't  
20 for a ruptured uterus, though, were they?

21 A. No.

22 Q. Your concerns were for the condition  
23 of the fetus at that time?

24 A. Correct.

25 Q. And I guess that's what I was getting

1 at with my question.

2 A. Okay.

3 Q. There were no concerns whatsoever  
4 related to the delivery of a ruptured uterus  
5 before 8:12 a.m.; is that fair?

6 A. Well, I think from the moment that I  
7 have a patient who is in labor with a VBAC, I  
8 have a general concern that she needs to be  
9 concerned for ruptured uterus, but there was  
10 nothing at that point in time that told me that  
11 uterus was ruptured.

12 Q. Mr. Mishkind asked you if the baby had  
13 been delivered at 6:00 o'clock a.m. if there  
14 would have been a different outcome. If you had  
15 seen mom and baby, or if you had seen mom at 6:00  
16 a.m., would you have immediately proceeded to a  
17 C-section at that time based on your review of  
18 this chart?

19 A. Not from a medical indication.

20 Q. Mr. Mishkind asked you about the  
21 availability of staff at 8:12 a.m. I believe you  
22 said that there were certain OR personnel that  
23 were on call but not at the hospital at that  
24 time; is that correct?

25 A. Correct.

1           Q.    In your review of the chart,  
2    understanding how things happen, would you agree  
3    with me that the response time of the operating  
4    room personnel under these circumstances was very  
5    reasonable?

6           A.    Say that question to me again.

7           Q.    Would you agree that the response time  
8    to your request for a crash C-section at 8:12  
9    a.m. was reasonable under the circumstances?

10          A.    I think it was reasonable, as I  
11    understand what is understood reasonable to be.

12          Q.    Fair enough.

13          A.    It's not what I would have liked, but --

14          Q.    But reasonable?

15          A.    -- but reasonable.

16          Q.    Dr. Cooke was in the hospital?

17          A.    Yes.

18          Q.    And he started on the case, as I  
19    understand it, at approximately 3:00 a.m.

20                Is that your understanding, as well?

21          A.    Correct.

22          Q.    At 6:00 a.m. when you were advised of  
23    mom's status, that is, that she was 100 percent  
24    effaced, completely dilated and at negative three  
25    to negative four station, you did not immediately

1     come to the hospital, did you?

2             A.     No.

3             Q.     Would you agree with me that that  
4     information you were provided at 6:00 a.m. was  
5     very similar, if not identical, to mom's status  
6     at approximately 4:15 a.m.?

7             A.     Correct.

8             Q.     So while you said earlier you would  
9     like to have been advised at 4:15 a.m. of mom's  
10    status, would you agree with me that even if you  
11    had been contacted at 4:15 a.m. you would not  
12    have come to the hospital at that time?

13            A.     You mean at 6:00 a.m. or 4:15?

14            Q.     At 4:15 a.m.

15            A.     No, because I would have assumed that  
16    was the first time she had gotten complete.

17            Q.     I take it that you have worked with a  
18    number of these nurses in labor and delivery, in  
19    fact maybe all of them at this point in your  
20    career?

21            A.     Yes.

22            Q.     When any of them contact you to advise  
23    you that one of your patients has arrived in  
24    labor and delivery, in other words, this is the  
25    initial phone call to you to advise of the

1 arrival, do they as a matter of routine, in your  
2 experience, provide you with enough information  
3 such that over the phone you can make an  
4 assessment and give any orders that would be  
5 necessary at that time?

6 A. In general, that's usually the case.

7 Q. And I take it if that does not occur,  
8 you normally question them such that you get the  
9 information you need to provide initial orders;  
10 is that fair?

11 A. Yes.

12 Q. I know you don't remember any phone  
13 calls before 6:00 a.m.

14 Would you agree with me, however,  
15 doctor, that after having reviewed that order,  
16 that verbal order, as noted by Nurse Moats, there  
17 appears to be a telephone order provided by you  
18 at approximately 12:05 a.m. on 1-17-99?

19 A. It seems that there was a contact  
20 made. I cannot imagine having told someone to do  
21 a vaginal exam. Those are simply not orders that  
22 I give. You can go back to that so I can look at  
23 that specifically.

24 An order to do vaginal exam, I cannot  
25 imagine having given that order. An order to

1 monitor the labor of the patient, that's  
2 something I just don't ever recall having to do  
3 that. Oh, yes, and please put her on a fetal  
4 monitor, it's done. An order to admit her at 25  
5 minutes after she got there at something like,  
6 what was it, 11:23 or something of that nature,  
7 you know, and her cervix still at the time of her  
8 initial assessment -- let me go back to L&D is  
9 what that's under -- we have a patient who is one  
10 centimeter. She is 50 percent effaced. I don't  
11 know if she is in active labor yet.

12 So the notion that she would actually  
13 be admitted by me at that time, those are the  
14 things that bother me about saying that I gave  
15 these orders. It just doesn't completely cut  
16 clear the way I would typically give an order.  
17 But nonetheless there is a time there and I don't  
18 know how to account for that.

19 Q. Would you agree with me that that  
20 time, understanding how orders work, that that  
21 time reflects a telephone order by you at that  
22 time?

23 A. Yes.

24 Q. What does an epidural request mean?  
25 Does that mean the patient requesting an



1     epidural?

2           A.     Correct.

3           Q.     So at that time, as I understand it,  
4     the nurses needed to make you aware that the  
5     patient had requested an epidural; true?

6           A.     Or that I would hope they would say to  
7     me that, well, they can make me aware of that,  
8     but more often, she is ready, the patient has  
9     gotten to the point with whatever else they have  
10    done for her in terms of IV medications are no  
11    longer cutting it, ready for her epidural, and  
12    say patient is at such-and-such, can we give the  
13    epidural.

14          Q.     You agree with me that the standard  
15    orders at that time merely provided that once the  
16    nurse has made you aware that the patient  
17    requested an epidural, that the epidural was to  
18    be provided per anesthesia, when labor is  
19    established and as necessary. Would you agree?

20          A.     Where does it say that? Those were  
21    the intrapartum standing orders for patients  
22    admitted to labor and delivery. The last one on  
23    the list, number 19, that the physician would be  
24    -- the physician must be aware of an epidural  
25    request.

1           Q.       So in other words, let's assume for a  
2 moment that they knew around midnight that this  
3 woman wanted an epidural. Presumably if they had  
4 made you aware at midnight that she wanted an  
5 epidural, then it would be up to the nurses in  
6 anesthesia as to when it would be necessary for  
7 the patient; is that how it works?

8           A.       That is not usually how it works.  
9 Usually before that epidural is administered we  
10 are contacted, and I would on occasion say, if  
11 the patient would like an epidural, she can have  
12 it when she needs it.

13          Q.       And might that happen if there is  
14 indeed phone contact with you at midnight,  
15 understanding that you are going to be going to  
16 sleep soon?

17          A.       It's possible.

18          Q.       And if it happened in the way I  
19 described, would you agree with me, doctor, that  
20 that would comply with the intrapartum standing  
21 orders at that time?

22          A.       I do not want to say that the  
23 physician must be aware. The epidural request is  
24 meant to say that at the very beginning of their  
25 admission to the hospital, before it's

1 appropriate to get an epidural. And I would hope  
2 that it would mean, and I interpret that to mean,  
3 that they will call you prior to its needing to  
4 be administered so that the patient now requests  
5 her epidural.

6 Because usually before that, in the  
7 case of Mrs. Robbins, her hope was to go  
8 natural. Documented elsewhere in the chart, I  
9 believe in our office records, her hope is to  
10 pursue a natural delivery, which would imply that  
11 her hope was not to have had an epidural if at  
12 all possible. And that in her situation, you  
13 know, coming into labor and delivery early on in  
14 the course of her labor, I can't imagine that  
15 they would already know that she wants to have an  
16 epidural, and so in this situation, I would hope  
17 that I would at least have been notified that at  
18 this point in her labor at this degree of  
19 progress that the patient is now requesting her  
20 epidural and that's what I take that to mean.

21 Q. Are some women that you have treated  
22 aware before they arrive at the hospital that  
23 they want to have an epidural?

24 A. Yes.

25 Q. Did Mrs. Robbins undergo a

1 sterilization procedure at the end of the  
2 delivery?

3 A. Yes.

4 Q. I noted in the chart, it looks as  
5 though you had a discussion with her and her  
6 husband before you did the sterilization?

7 A. That's correct.

8 Q. What do you remember about that?

9 A. Well, very specifically, I knew that  
10 the baby was in trouble. There was no doubt at  
11 the time of C-section, as soon as the baby was  
12 delivered, and watching the resuscitation unfold  
13 that before we are even close to doing any kind  
14 of tubal ligation, we were closing the uterus and  
15 getting the placenta out and so on and so forth,  
16 and by this time apgar after apgar has been  
17 assigned, and so I had a bad feeling about what  
18 is going to be happening. And I felt it prudent  
19 to say to her, you know, the baby is in serious  
20 trouble, are you sure you want to go forward at  
21 this time and do a tubal ligation? Because we  
22 will have burned the bridge for having more  
23 children.

24 And there are even occasions when I  
25 wouldn't have done it regardless of what her wish

1 would have been, because all too often I have  
2 been caught in the situation later, out of the  
3 heat of the moment, I wish I hadn't done that.

4           However, in this case, this patient  
5 had adhesions of bowel to her adnexa to the  
6 fallopian tube. She had this very markedly  
7 distorted and contused lower uterine segment that  
8 I was concerned about, and my notion of seeing  
9 her in labor again at a point that was reinforced  
10 by Dr. Steiner's opinion at that point in time  
11 was to say to me, tell me, you know, this is the  
12 thing to do now, it is in her best interest  
13 regardless of desire for future child bearing;  
14 that the notion that this could end up being a  
15 disaster in the works in a future pregnancy was  
16 the reason that we went ahead and did it.

17           Q.     That sounds as though you had a very  
18 thorough discussion with them at that time about  
19 it.

20           A.     There was no question. They were  
21 absolutely adamant.

22                   MR. ROSSI: That's all I have for  
23 you.

24                   EXAMINATION OF ANTHONY P. TIZZANO, M.D.

25           BY MR. MISHKIND:

1           Q.     Doctor, I have a few more questions  
2     for you.

3                     The conversation before the tubal  
4     ligation, you consulted with Dr. Steiner; true?

5           A.     Yes.

6           Q.     And both of you felt that it was in  
7     mom's best interest, given everything that had  
8     transpired, to do the tubal ligation; true?

9           A.     Correct.

10          Q.     Given what you had found  
11     intraoperatively and the scenario that had  
12     ensued; true?

13          A.     Exactly.

14          a.     And you explained that to mom and to  
15     dad the reasons that you felt it was in their  
16     best interest to proceed with the tubal ligation;  
17     is that true?

18          A.     Well, at the time of that  
19     conversation, their questions weren't as to  
20     whether or not it would be in their best  
21     interest. They wanted it despite what my  
22     feelings were. And so then I conceded stating  
23     that the reason that I am conceding to your  
24     wishes at this point is to, you know, we will no  
25     longer have that alternative, but I think it's

1 perhaps in your best interest to not become  
2 pregnant in the future.

3 Q. From a medical standpoint, whether  
4 they were insisting upon it appropriately or  
5 inappropriately, you felt that it was in her best  
6 interest to have the procedure done; true?

7 A. Yes.

8 Q. You indicated that you would not have  
9 done a C-section at 6:00 a.m. or it wasn't  
10 medically indicated at 6:00 a.m.; true?

11 A. Correct.

12 Q. However, if the patient had expressed  
13 a preference to proceed with a C-section at 6:00  
14 a.m., you certainly would not have felt that to  
15 be ill advised; true?

16 A. Oh, absolutely true.

17 Q. You also indicated in response to Mr.  
18 Rossi that at 8:12 that it was reasonable in  
19 terms of how I think the surgical team -- I can't  
20 remember exactly how he worded it, but the  
21 surgical team, how quickly they responded, and  
22 your answer was you acknowledge that it was  
23 reasonable but not what you would have liked.  
24 Can you explain to me what you meant by that?

25 A. What I would have liked would have

1    been in residency where everyone was in house, in  
2    the hospital at the exact time, and that the  
3    average time from the time of decision to  
4    C-section was seven minutes. And that even if  
5    the heart rate went down, I would have had the  
6    baby delivered, period, and that happened over  
7    and over again. We simply are not in that kind  
8    of environment here.

9            Q.     At 7:45 had a C-section been ordered,  
10    even at this facility back in January of '99, the  
11    normal response time in terms of from decision to  
12    incision would likely have been how long?

13            A.     For a crash C-section?

14            Q.     Yes.

15            A.     I don't know that we were tracking it  
16    on any kind of -- I don't know that I could  
17    answer that with confidence. We customarily did  
18    what we needed to do. If the crew wasn't there,  
19    we had anesthesia and a nurse who wasn't on the  
20    C-section team but was qualified to go into that  
21    section room, we would do what was necessary in a  
22    crash. I mean, to have an untoward event in our  
23    hospital occur because of not getting things  
24    rolling quickly enough is very unusual.

25            Q.     Had a crash C-section been called at



1 7:44, given the physical requirements, the  
2 staffing requirements and what it takes to go  
3 from decision to incision, it's more likely than  
4 not that Alexis would have been born without  
5 irreversible brain damage; true?

6 MR. JACKSON: Objection.

7 MR. ROSSI: Objection.

8 A. If at 7:44 I was starting the  
9 C-section?

10 Q. At 7:44 you called for the C-section.  
11 At that point, given any limitations that exist  
12 or existed at the hospital, isn't it more likely  
13 than not that she would have been born without  
14 irreversible brain damage?

15 MR. JACKSON: There is an objection.

16 A. I guess I can only qualify that by  
17 saying that if, for example, we were doing the  
18 operation by within 15 to 20 minutes after the  
19 time, that there would be a reasonable chance  
20 that this baby would have done relatively well.

21 MR. JACKSON: You have answered.

22 Q. And your statement in terms of  
23 reasonable chance, that's more likely than not;  
24 true?

25 MR. JACKSON: Objection.

1           A.       From what I can see of this tracing,  
2    yes.

3                   MR. MISHKIND:  No further questions.  
4    Thank you.

5                   MR. ROSSI:  I don't have anything  
6    else.  Thanks.

7                   MR. JACKSON:  He will read it.  
8                   (Discussion off the record.)

9                   MR. MISHKIND:  It can be 28 days.

10                               - - - - -

11                               (Deposition concluded at 2:20 p.m.)

12                               (Signature not waived.)

13                               - - - - -

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1 AFFIDAVIT

2 I have read the foregoing transcript from  
3 page 1 through 206 and note the following  
4 corrections:

5 PAGE LINE REQUESTED CHANGE

6

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17

Anthony J. Tizzano, M.D.

18

19 Subscribed and sworn to before me this  
20 day of , 2000.

21

22

23 Notary Public

24

25 My commission expires .

1 CERTIFICATE

2 State of Ohio,

SS:

3 County of Cuyahoga.

4

5 I, Vivian L. Gordon, a Notary Public within  
6 and for the State of Ohio, duly commissioned and  
7 qualified, do hereby certify that the within  
8 named ANTHONY P. TIZZANO, M.D. Was by me first  
9 duly sworn to testify to the truth, the whole  
10 truth and nothing but the truth in the cause  
11 aforesaid; that the testimony as above set forth  
12 was by me reduced to stenotypy, afterwards  
13 transcribed, and that the foregoing is a true and  
14 correct transcription of the testimony.

15 I do further certify that this deposition  
16 was taken at the time and place specified and was  
17 completed without adjournment; that I am not a  
18 relative or attorney for either party or  
19 otherwise interested in the event of this action.

20 IN WITNESS WHEREOF, I have hereunto set my  
21 hand and affixed my seal of office at Cleveland,  
22 Ohio, on this 13th day of December, 2000.

23

24



Vivian L. Gordon, Notary Public

25

Within and for the State of Ohio

My commission expires June 8, 2004.

1	INDEX		
2	EXAMINATION OF ANT~ONYP. TIZZANO. M.D.		
3	BY MR. MISHKIND: .....	3	13
4	BY MR. ROSSI: .....	188	12
5	BY MR. MISHKIND: .....	201	25
6	Exhibit 1 was marked.....	3	3
7	Exhibit 2 was marked.....	39	24
8	Exhibit 3 was marked.....	79	12
9	Exhibit 4 was marked.....	187	16
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

<b>A</b>	<b>action</b> 208:12	6:22 12:24 30:10	37:20 38:5 57:20	174:9 197:18
<b>abdomen</b> 97:16,17	<b>actions</b> 189:24	<b>affixed</b> 208:13	70:8 72:8 73:3	198:6 204:19
98:14 114:14	<b>active</b> 196:11	<b>aforesaid</b> 208:7	76:17 83:25 89:5	<b>anesthesiologist</b>
115:10,17,23,24	<b>actual</b> 29:20 115:4	<b>after</b> 5:11 8:15	90:17 92:16 94:6	106:8,9 119:24
116:10 146:7	115:9,19 116:2	21:18 22:16	94:21 99:25	120:2,5 121:12
150:8 152:20,23	162:11 177:3,22	23:15 40:7 42:6	101:13 102:16	122:7,16 128:11
159:19 160:2,20	178:22 181:16	45:7 48:20,25	104:20 117:6,17	170:23
166:18 174:2,10	<b>actuality</b> 149:25	49:12 57:21 58:2	137:5 139:9	<b>anesthesiology</b>
174:16,18	<b>actually</b> 6:5 9:25	64:6 66:14 73:19	152:15 156:15	172:21
<b>abilities</b> 133:18	11:15 13:5 15:8	73:24 74:17	160:4 161:12	<b>angel</b> 1:4 6:24 7:20
<b>ability</b> 55:8 67:2	15:19 20:17	85:15 99:6,16	162:7 167:7	7:23 21:15 28:23
103:17 116:9	23:21 42:2,7	102:2 111:20	168:6 175:5	28:25 30:14 32:6
121:15 149:4	63:22 77:20	113:3 120:7	178:14 201:16	32:22 35:24
160:23 179:18	78:23 90:8 105:5	129:13,13,14,24	<b>Akron</b> 2:23 103:11	38:24 39:2,6
<b>able</b> 41:9 52:13	105:18 107:1,3	138:19,24 141:25	129:11,15	40:11 41:9,25
80:2 82:24 125:9	111:15 123:1	142:6 145:11	<b>al</b> 1:4,7	42:19,19 44:10
126:22 134:17	127:10 140:18	152:6 157:15,21	<b>alarm</b> 133:16	46:2,9 52:17 53:7
153:6,10 154:12	142:21 164:6	158:12,14,15	<b>alarmed</b> 47:20	53:15,16,24 54:15
160:25 161:15,23	171:11 176:2	180:14 187:5	<b>Alexus</b> 4:1 8:8	55:14 56:4,23
161:25 163:1	181:10 196:12	191:2 195:15	45:25 178:24	57:4,16 66:23
166:6 179:15	<b>adamant</b> 201:21	196:5 200:16	205:4	70:5 75:21 77:9
<b>abnormal</b> 48:16,18	<b>add</b> 79:19,20 139:7	205:18	<b>allow</b> 57:9 66:10	80:10 81:10 85:5
<b>above</b> 1:24 174:25	164:13	<b>afterwards</b> 112:5	168:14	85:12,20 87:6,11
208:7	<b>added</b> 89:15	208:8	<b>allowed</b> 20:22,23	89:3,18 94:15
<b>abruption</b> 31:12	<b>addition</b> 42:2 1	<b>again</b> 39:20 48:10	31:23 57:4 58:4	98:8 101:23
<b>absolute</b> 81:23	175:16	53:14 56:25	<b>almost</b> 7:15 111:17	103:4 106:10
<b>absolutely</b> 5:4	<b>additional</b> 6:6	68:18,24 69:25	114:15 144:18	108:5,12 109:3,4
75:13,18 95:2	27:18 37:23 81:9	72:18 73:5 74:24	161:13	109:5 123:12
134:13 173:14	91:5 115:3	76:8 81:22,24	<b>alone</b> 92:2 182:2 1	126:18 133:8
201:21 203:16	<b>address</b> 43:17	84:14 90:17	<b>dong</b> 32:14 44:19	137:22 140:1,10
<b>acceptable</b> 71:10	86:22 94:16	94:22 95:7 99:20	66:2 67:8 175:22	144:25 157:21
<b>accepted</b> 72:4	<b>adequate</b> 68:1	108:22 110:14	177:25	169:2,12 171:8
<b>accomplished</b>	161:19	118:13 122:3	<b>already</b> 71:17	174:4 183:3
170:25	<b>adequately</b> 120:19	130:3,3 133:4	72:11,12 76:7	184:13,13,23
<b>according</b> 31:18	151:17	140:23 148:21	79:24 88:21	186:22
63:18,19 65:18	<b>adhesions</b> 201:5	163:6 174:21	137:7 166:9	<b>Angel's</b> 30:7 50:14
84:6 128:15	<b>adjournment</b>	183:20 193:6	185:1 186:25	82:17 106:13
<b>account</b> 98:21	208:11	201:9 204:7	187:6 199:15	109:8 113:6,18,24
166:2 196:18	<b>administer</b> 174:13	<b>against</b> 17:16 176:5	<b>altered</b> 48:8,13	116:11 123:21
<b>accumulated</b> 28:12	<b>administered</b> 46:20	<b>age</b> 56:16	<b>alternative</b> 202:25	124:18 158:6,13
<b>accurate</b> 91:8	164:10,21,24	<b>agency</b> 11:10	<b>although</b> 26:13	172:2
148:17	198:9 199:4	<b>ago</b> 7:1,7 12:18	29:8 54:11	<b>anger</b> 181:21
<b>accurately</b> 133:22	<b>admission</b> 132:6,11	45:3 62:22	113:10 148:22	<b>mother</b> 11:5,6
154:13 179:18	132:12 137:18	<b>agree</b> 43:6 65:6,8	185:10	12:19 14:10 32:8
<b>acknowledge</b>	198:25	68:8 71:6,23 72:3	<b>always</b> 47:15 74:8	35:10 43:20
203:22	<b>admit</b> 135:9,16,18	76:25 77:8 85:3	80:15 81:15	93:20 115:16
<b>acknowledging</b>	196:4	85:11 90:13,18	104:15 107:23	130:4 141:13
39:17	<b>admitted</b> 135:9	91:9 99:1,21	108:1 111:7	165:11,13
<b>ACOG</b> 21:12,17	196:13 197:22	116:15 125:3	116:11 137:18	<b>innoxia</b> 167:15
22:8,14 23:20	<b>adnexa</b> 201:5	151:25 154:23	139:10,13	<b>anoxic</b> 167:6 168:4
26:10,19 27:1,13	<b>advantages</b> 179:1 1	155:2 156:8	<b>amazing</b> 139:19	<b>answer</b> 4:10,18
27:19 28:10	<b>adverse</b> 48:3	159:8 165:6	<b>American</b> 15:9,21	15:22 17:2 18:9
34:13 35:4,13	<b>advise</b> 194:22,25	176:18,25 180:11	101:5	20:6,9,16 21:3
36:4,7,12,18	<b>advised</b> 54:15	185:14 190:25	<b>amniotomy</b> 143:21	25:18 26:5 27:4
39:14 40:6,21,23	87:11 88:9 99:2	193:2,7 194:3,10	157:16,16 159:16	27:11 28:18
41:1,23 43:24	99:13,22 100:9	195:14 196:19	<b>amount</b> 177:18	29:11 37:21 38:6
90:2 104:4,12	101:9,24 102:7	197:14,19 198:19	179:20	45:1 52:13 53:9
105:9,12	193:22 194:9	<b>agreed</b> 155:20	<b>Andress</b> 2:11	53:20 60:14
<b>across</b> 96:24 111:9	203:15	189:20 190:7,8	<b>anesthesia</b> 15:2	69:23 70:9,20
<b>act</b> 126:9	<b>advising</b> 71:18	<b>agreement</b> 1:20	103:15 106:3,5,6	72:7,9 75:5 76:5
<b>acted</b> 20:17 21:4	<b>AFFIDAVIT</b> 207:1	<b>ahead</b> 17:1 18:8	116:8 121:6,16	76:23 77:7 84:23
	<b>affiliated</b> 6:18,22	23:12 29:14 34:7	170:15 173:25	85:18 87:17,18

<p>88:13 89:5 90:17 91:25 92:15 93:19,25 94:6,22 99:18,25 100:1,2 100:11,13,14,18 102:5,16,17 104:3 109:13 112:15,24 112:25 115:8 117:1,17 118:4,12 118:20,23 122:2 125:1,14 126:6 130:10,24 131:7 131:16,24 132:4 132:19 138:9 139:8 141:19 143:6 148:9 150:4,25 159:13 168:7 170:1,4 173:20 176:23 177:8 178:9,15 179:3 186:1 203:22 204:17 <b>answered</b> 62:17 90:17 94:21 96:1 122:9 130:15 165:21 178:4,12 205:21 <b>answering</b> 100:6 107:21 <b>answers</b> 37:24 41:19 <b>antepartum</b> 102:24 <b>anthony</b> 1:7,12,15 3:7,12,15 188:12 201:24 207:17 208:6 209:2 <b>anticipated</b> 23:10 102:10 116:17 167:1 <b>anticipating</b> 80:14 <b>anticipation</b> 161:25 <b>anxiety</b> 65:20 <b>anybody</b> 61:20 110:16 <b>anymore</b> 102:22 <b>anyone</b> 39:5 137:10 176:13 <b>anything</b> 6:9 20:23 23:5 33:8,18 39:16 43:23 46:21 57:1 58:7 65:7 72:23 73:8 83:18 93:10 113:19 136:11 138:18 159:19 166:13 206:5 <b>apgar</b> 200:16,16 <b>apgars</b> 31:25 <b>apparent</b> 174:23 175:23 <b>apparently</b> 63:16 135:7</p>	<p><b>appear</b> 159:15,20 <b>appearance</b> 152:24 166:19 175:20 <b>APPEARANCES</b> 2:1 <b>appeared</b> 149:16 150:16 158:4 181:8 <b>appears</b> 7:19 51:2 56:11 59:3 153:24 195:17 <b>application</b> 180:10 <b>applied</b> 10:9 58:22 58:23 <b>applies</b> 105:10,10 <b>apply</b> 58:22 105:11 <b>appointment</b> 36:1 36:13 47:21 63:12 <b>appointments</b> 36:25 46:7 <b>appraisal</b> 118:22 <b>appreciate</b> 125:10 153:11 170:5 <b>appreciated</b> 181:24 <b>appreciating</b> 180:3 <b>approach</b> 75:16 89:21 <b>approached</b> 20:10 20:19,22 21:1 <b>approaching</b> 61:5 152:12 <b>appropriate</b> 51:4,7 66:19 117:20 168:19 173:16 174:1 199:1 <b>appropriately</b> 203:4 <b>approve</b> 37:12 <b>approximately</b> 7:2 142:9 193:19 194:6 195:18 <b>April</b> 32:13 40:6 <b>area</b> 10:22 16:18,19 78:22 79:3,20,21 97:3 175:1,18 <b>areas</b> 12:10 78:24 105:15 <b>arise</b> 99:16 <b>arises</b> 102:3 <b>arm</b> 175:9 <b>arose</b> 18:1 <b>around</b> 78:25 83:3 85:4 103:16 105:18 127:4 136:1,19 143:23 145:17 149:13 158:16 164:20 165:5 198:2 <b>arrival</b> 127:17 129:18 169:14 195:1</p>	<p><b>arrive</b> 41:5 126:25 127:6 173:25 174:1 199:22 <b>arrived</b> 111:20,23 133:3 134:8 140:4,10,17 141:15 142:6 144:14,25 159:4 168:21 188:20 190:19 194:23 <b>arrives</b> 162:14 <b>arriving</b> 121:13 <b>article</b> 14:25 15:1,3 <b>articles</b> 14:22,24 23:16 24:2 25:14 28:11 <b>articulate</b> 86:22 <b>artifactual</b> 162:17 <b>artificial</b> 143:24 145:22 157:21 <b>ascended</b> 191:5 <b>ascends</b> 166:11 <b>ascertain</b> 155:16 <b>Aside</b> 11:21 81:7 157:23 <b>asked</b> 11:17 41:14 41:22 42:20 45:3 90:16 94:21 123:10 173:2 179:8 181:3 183:2,9,14,21 184:1,21,23 185:11,12,16 186:8,13 188:14 190:3 192:12,20 <b>asking</b> 3:24 21:9 36:10,11 41:7 71:15 72:1 82:7 89:24 91:9 117:3 130:22 150:6 151:7 163:22 172:9 185:5 188:18 <b>aspect</b> 124:17 <b>aspects</b> 8:5 <b>assault</b> 11:20 <b>assess</b> 156:9 <b>assessed</b> 145:21 <b>assessing</b> 117:25 <b>assessment</b> 52:24 151:19 153:7 195:4 196:8 <b>assessments</b> 124:22 <b>assigned</b> 61:22,25 200:17 <b>assist</b> 122:23 <b>assistance</b> 176:7 180:2 <b>assistant</b> 29:23 30:1 98:13 110:11,20 110:24 111:9,13 122:17 173:8</p>	<p>176:13 <b>assisted</b> 109:7 172:24 <b>assisting</b> 123:1 173:11 <b>assists</b> 176:11 <b>associated</b> 70:15,16 85:6,15,25 90:15 91:12 <b>assume</b> 35:22 36:15 36:19 54:10 72:13 91:18 92:4 95:20 123:5 143:5 151:10 161:5 162:7 184:21 198:1 <b>assumed</b> 139:11,14 146:6 194:15 <b>assuming</b> 61:20 62:4 63:25 90:9 97:2 135:2 151:23 176:1 <b>assumption</b> 100:24 <b>attempt</b> 10:18 75:14 83:15 167:5 <b>attempted</b> 92:23 109:11 <b>attended</b> 110:5 <b>attending</b> 110:11 117:14 <b>attendings</b> 131:4,12 131:23 <b>attention</b> 42:8 80:17 169:22 <b>attorney</b> 20:11 33:5 40:4 208:11 <b>atypical</b> 166:12 <b>authoritative</b> 26:21 26:23 <b>authors</b> 16:15 <b>availability</b> 88:5 192:21 <b>available</b> 44:6,8,15 49:21 61:21 64:13 86:14 95:14,17 109:25 111:4 119:15 120:16 122:6 134:11 141:17 <b>average</b> 204:3 <b>avoided</b> 177:24 178:25 <b>aware</b> 30:13 55:13 72:14 75:23 112:18 117:12 123:11 128:18 132:5,7,9,22,23 146:18 158:25 169:2,12 173:21 197:4,7,16,24 198:4,23 199:22</p>	<p><b>away</b> 39:12 67:22 184:19 <b>awkward</b> 182:16 <b>a.m</b> 1:23 61:18 64:5 64:6 77:11 123:14,15,20 124:13,16 126:16 127:9,12 128:14 128:15,22 133:8 133:25 134:8 136:4 138:7 142:9 147:6 153:14 154:24 155:5,6 156:7,17 159:1 165:6,23,24 166:10,21 176:18 176:25 177:23,25 178:23 188:21 189:24 190:7,13 191:1,4,19 192:5 192:13,16,21 193:9,19,22 194:4 194:6,9,11,13,14 195:13,18 203:9 203:10,14</p>
<b>B</b>				
<p><b>B</b> 183:22 185:21 <b>babies</b> 58:15 74:6 <b>baby</b> 23:9 30:18 31:17 32:1 52:18 53:3,7,17,18 55:15 56:6 66:19 69:2 74:1 76:15 78:4 85:9,25 87:10,14 89:2,17 92:12,23 93:7 94:18 97:16,18,24 98:1 105:6 129:14,14 138:20 149:8 159:24 161:3,15 162:1 163:11 165:18 166:4 167:6,16 168:3,4,14,17,23 175:13 176:19 177:1,23 178:2,20 178:23 180:14 181:9,11 184:15 184:25 186:9,10 190:15,23 191:17 192:12,15 200:10 200:11,19 204:6 205:20 <b>baby's</b> 31:25 66:16 81:5 146:4 160:3 180:3,5 186:15 <b>back</b> 4:15 6:22 29:12 38:16 42:3 59:22 62:14 63:4 63:20 64:2 65:16 84:11 107:13</p>				

108:9 112:9 116:15 126:20 134:15 141:16 142:1 143:3,16 144:6 146:10,11 165:16 172:18 174:20 184:22 187:22 190:16 191:9 195:22 196:8 204:10 <b>background</b> 8:3 <b>bad</b> 174:13 200:17 <b>badly</b> 175:14 <b>bag</b> 97:17 147:17 <b>balance</b> 40: 14 49:7 99: 11 <b>Bare</b> 50:21 55:2 <b>based</b> 25:17 53:22 53:23 55:23 73:7 88:23 126:12 131:4,19 132:15 146:18 166:1 177:2 185:21 192:17 <b>baseline</b> 163:14 <b>basically</b> 71: 12 107:18 125:4 171:18 175:4 181:5 185:5 <b>basis</b> 44:20 137:15 153:11 <b>bearing</b> 201:13 <b>became</b> 141:6 174:23 <b>Becker</b> 2:3 <b>Becky</b> 18:11 <b>become</b> 7:18 10:14 142:3 146:9 203:1 <b>becoming</b> 10:18 115:10 <b>before</b> 1:18 3:20 4:5 5:6 7:9 13:23 14:8 16:8,25 47:7 49:20 50:11,17 52:11 69:6 79:22 80:6 83:19 84:17 84:23 87:2 90:25 95:3,8 98:10 100:20 106:13 108:5,12,22 110:12 111:20,21 123:7 126:3 132:21 133:3 135:15 140:4 141:25 144:7 153:2 157:16 162:6 163:17,20 165:22 166:13,21 173:2 175:22 177:3 178:10 179:8 180:1	184:22 190:18 191:19 192:5 195:13 198:9,25 199:6,22 200:6,13 202:3 207:19 <b>began</b> 29:18 141:21 169:4 <b>begin</b> 5:6 74:13 83:5 102:8 <b>beginning</b> 15:20 99:19 141:23 142:9 149:25 151:12 198:24 <b>begins</b> 175:3 179:19 <b>begun</b> 158:21 159:24 <b>behalf</b> 1:16 2:2,10 2:17 11:16 20:11 20:12 <b>behind</b> 66:20 104:9 <b>being</b> 3:9 15:22 16:24 43:14 57:12 64:5 83:12 84:24 90:20 91:3 98:21 105:17 116:8 121:17 124:3 132:11 137:8 142:11 147:19 150:10,12 155:18 158:7 160:7,25 161:25 163:10 169:4,14 170:6 172:5,15 175:16 179:15,21 183:2 201:14 <b>believe</b> 6:12 10:15 15:5 18:13 23:14 24:11 29:5 34:23 40:9 41:3 42:12 42:15 48:17 50:3 60:15 68:15 69:8 70:24 75:19 76:6 84:3,8 88:23 89:25 90:1 101:6 103:23 105:9 111:16 127:2 140:14 158:11,22 175:9 180:8 183:14,21 184:1 185:9 186:7 187:9 190:9 192:21 199:9 <b>believed</b> 155:13 <b>Bellow</b> 30:8,10 59:7 62:12 64:15 65:16 <b>Bellow's</b> 59:21 60:1 63:10 78:9 <b>below</b> 72:4 90:7 118:17 119:2 162:13	<b>benefit</b> 65:9 68:25 <b>benefits</b> 39:17 69:25 70:16,22 72:13,14 <b>besides</b> 32:12 33:16 39:6 137:25 184:6 <b>best</b> 23:9 31:21 99:2,13,22 101:9 101:14,24 106:24 120:9,13 127:22 141:20 168:22 174:8 180:25 182:4,22 201:12 202:7,16,20 203:1 203:5 <b>Bethesda</b> 8:17 12:7 <b>better</b> 28:14 148:25 168:17 <b>betting</b> 178:18 <b>between</b> 32:3 35:24 38:23 39:2 65:22 108:11 131:22 136:3 156:16 159:1 163:4 176:3 188:16 <b>beyond</b> 9:4 20:19 20:24 74:12 89:6 128:24 132:2 145:5 <b>bibliographies</b> 27:15,17 <b>bibliography</b> 26:17 <b>big</b> 52:18 53:7,17 53:18 <b>bilobular</b> 115:24 166:18 <b>birth</b> 21:17 22:15 30:15 40:7 70:16 81:15 92:24 113:3 146:5 177:2 <b>birthing</b> 19:19 <b>bit</b> 8:2 28:22 110:6 157:5 182:8 <b>bladder</b> 149:10,17 150:6,10,12,16 151:12,13,15,17 152:5 174:24 175:3,5,7,19 176:5 <b>blanket</b> 25:7 <b>bleeding</b> 47:6,16 48:21 93:17 <b>blood</b> 51:6 174:12 174:12 <b>board</b> 10:12,14,18 11:9,10,17 14:3,4 14:5,9,10 122:13 <b>boards</b> 15:20 <b>bob</b> 67:22 <b>born</b> 129:14 205:4	205:13 <b>both</b> 7:7 17:20 18:1 18:25 33:11 85:8 92:22 93:7,18 173:15 174:18 202:6 <b>bother</b> 196:14 <b>bottom</b> 35:17 88:6 <b>bowel</b> 201:5 <b>box</b> 90:5 <b>Boy</b> 114:1 <b>BPS</b> 35:4 <b>brain</b> 97:10 176:20 177:4,24 178:7,25 205:5,14 <b>break</b> 19:10 77:15 89:22 162:11 <b>breaks</b> 94:13 <b>breathing</b> 164:4 <b>bridge</b> 200:22 <b>brief</b> 181:6 <b>bring</b> 79: 18 <b>bringing</b> 120:23 169:20 <b>broad</b> 25:16 98:4 <b>brochure</b> 22:22 33:22 34:8,22 36:12 37:19 38:2 38:17 39:7,8,14 39:15,20 42:14,22 85:4 90:20 92:1,3 92:9,17 93:3 <b>brought</b> 42:7 164:1 169:21 <b>Brown</b> 30:5,6 54:11 54:16,24 55:14,19 56:3 61:12 <b>bruised</b> 175:19 <b>Bucholz</b> 96:21 <b>building</b> 78:16 79:1 <b>bulging</b> 150:14 174:25 <b>bulletin</b> 15:20 21:17 22:15,23 33:23 34:13 40:10 41:23,24 104:5 <b>bulletins</b> 21:12 26:10,20 27:2,13 27:20 28:11 <b>burned</b> 200:22 <b>business</b> 61:24 <b>B-A-R-E</b> 50:22  <b>C</b> <b>C</b> 183:22 <b>call</b> 47:5 58:25 59:3 61:11 62:1,13,16 63:20,22 64:2,4,7 64:9 78:6 95:22 95:25 111:6,11,15 119:25 123:4	125:18 135:25 136:10,10 137:9 140:7 148:13 158:17 159:9 160:23 165:22 192:23 194:25 199:3 <b>called</b> 1:16 3:8 6:15 10:7 62:3 64:19 65:14 68:25 80:22 111:13,16 111:23 119:16 120:17 127:10 128:4,24 133:4,5 133:24 134:8 135:7,23,23 136:4 137:8 148:10 170:6 172:3,8 176:17,24 204:25 205:10 <b>calling</b> 112:3 178:1 <b>calls</b> 61:2,2 62:6 78:8 122:6 195:13 <b>came</b> 8:24 11:14 42:16 61:16 78:20 82:14 103:25 128:4 132:21 137:24 139:25 <b>canal</b> 146:5 <b>cancelled</b> 46:7 <b>candidate</b> 62:24 63:3 102:9 <b>Canfield</b> 7:2 <b>capabilities</b> 106:3 <b>capability</b> 123:24 124:2 <b>capable</b> 99: 15 102:1 116:22 <b>care</b> 20:14 29:4,18 32:6 34:16 37:16 45:4,11 46:4 52:21 71:10 72:5 74:25 75:8 78:24 86:3 87:15 91:21 98:23 100:9,21 102:14,24 103:1 105:14,23 116:19 116:24 117:3,8,22 119:3 125:16,23 125:24 126:4,6 172:19 182:19 <b>career</b> 194:20 <b>carefully</b> 175:1 <b>carrier</b> 104:11 113:25 <b>carrying</b> 53:17 <b>cart</b> 120:12,18 163:25 <b>case</b> 1:6 5:3 11:15 16:25,25 19:14,23
--	--	--	--	---



19:25 20:4,11 21:5 33:6,18 38:21 42:10 47:18 66:14 74:19 77:16,22 81:14 84:8 95:12 97:1 100:3,6,19 101:23 104:23 105:18 107:24 109:23 110:19 111:10 113:18 114:12 115:22 116:11 119:17 120:19,24 121:11 124:10,15 130:3,6 131:4,17,23 132:15 135:18 138:22,23 147:25 174:15 176:12 180:5 190:12 193:18 195:6 199:7 201:4 <b>cases</b> 17:3,4,5,15,18 17:20 18:1,7 19:13,18 20:7 42:5,6 105:10 108:9,12 110:7 116:5 118:25 121:6 <b>case-by-case</b> 118:22 <b>catalogs</b> 24:6 <b>catastrophic</b> 86:2 87:13 88:10,17 <b>cath</b> 148:20 <b>catheter</b> 142:24 143:10 149:2,6 151:16 179:9 <b>caught</b> 201:2 <b>cause</b> 133:16 150:19 208:7 <b>caused</b> 166:8 <b>causes</b> 152:8 <b>causing</b> 152:21 165:19 167:14 <b>cavity</b> 175:2 <b>center</b> 1:22 2:13 6:17 100:21 105:14,23 <b>centimeter</b> 196:10 <b>centimeters</b> 52:25 56:12,14 66:21 154:13 <b>centimeter's</b> 155:16 <b>certain</b> 29:25 35:21 50:7 56:13 58:5 58:17 64:3 111:18 122:15 136:10 167:24 173:4,6 178:16 185:17 192:22 <b>certainly</b> 48:22	65:6 72:18 90:13 95:9 106:16 113:5 117:21 125:3 129:20 134:11 145:15 158:2 160:10 173:7,11 179:13 184:17 189:21 203:14 <b>certainty</b> 45:8 62:16 63:25 185:10 <b>CERTIFICATE</b> 208:1 <b>certified</b> 3:10 10:12 10:14,18 <b>certify</b> 208:5,10 <b>cervical</b> 68:3 <b>cervix</b> 57:13 62:23 63:5 66:13 68:6 74:20 82:23 83:4 83:12 143:19 154:19,25 156:6 196:7 <b>cesarean</b> 8:6 19:15 21:18 22:16 23:2 23:15 25:16 26:3 28:3,15 30:15,25 31:14,16,20 32:3 40:8 54:3 68:22 69:15 73:24 74:21 85:16 86:18 87:25 92:20 93:16 97:14 98:11 102:19,21 105:20 108:17,20 112:13 112:22 113:3,22 154:8 168:13 170:24 <b>cetera</b> 100:8,8 <b>chance</b> 38:14 84:19 126:20 139:23 205:19,23 <b>chances</b> 136:5 179:4 <b>change</b> 69:14 96:15 101:5 114:10,18 115:11 129:1 154:19 163:13 166:9 207:5 <b>changed</b> 58:21 100:3 125:17 141:2 156:18 <b>changes</b> 125:10,10 126:13 131:2,8,13 131:21 132:15 136:14 146:6 153:12 158:19 161:3 165:20 <b>chapters</b> 28:5 <b>chart</b> 5:24 7:19	29:10 33:6,9,11 33:11,16,17 34:4 34:21 43:2 51:16 53:23 64:14 66:19 88:18 89:1 89:8,17 90:4 114:3 138:24 140:13 141:3 171:25 191:9 192:18 193:1 199:8 200:4 <b>charted</b> 146:19 <b>charts</b> 34:11 <b>check</b> 18:16 34:23 60:2 77:15 80:2 127:2 <b>checking</b> 77:24 <b>Chesterland</b> 9:13 <b>child</b> 30:8,15 168:24 201:13 <b>children</b> 200:23 <b>children's</b> 182:17 <b>choice</b> 70:2 <b>chose</b> 171:4 <b>Cincinnati</b> 8:18 12:2,4,7 15:25 <b>circled</b> 114:2 <b>circulator</b> 122:18 122:19 <b>circumference</b> 78:25 <b>circumstance</b> 167:18 <b>circumstances</b> 97:2 193:4,9 <b>citizen</b> 110:23 <b>City</b> 103:11 <b>Civil</b> 3:9 <b>clarification</b> 138:5 <b>clarify</b> 127:25 <b>classical</b> 93:12,15 114:24 115:18 <b>classified</b> 98:22 <b>clean</b> 77:13 <b>clear</b> 143:22 146:14 147:11 149:19 152:5 157:18 189:25 196:16 <b>clearer</b> 39:21 <b>Clearly</b> 188:7 <b>Cleveland</b> 1:22 2:6 2:13,14 9:13 12:17 13:2,4,14 14:8,15 96:23 208:13 <b>client</b> 185:20 <b>clients</b> 185:15 <b>Clinic</b> 1:21 2:10 6:16,17 12:17 13:3,4,14,25 14:2 14:8,15 <b>clinical</b> 22:7	<b>clock</b> 103:16 <b>close</b> 96:7 200:13 <b>closed</b> 62:22 63:6 68:7 72:16 82:25 83:12 178:7 <b>closer</b> 57:16 112:8 <b>closing</b> 170:12 200:14 <b>clothes</b> 141:2 <b>College</b> 15:9,21 <b>Colleges</b> 101:5 <b>combination</b> 49:8 <b>come</b> 15:23 19:4 29:12 38:15 52:12 74:6 80:12 87:24 105:17 108:3 109:17 122:25 123:12 135:17,19 137:22 138:24 154:21 156:9 157:3 161:17,24 194:1 194:12 <b>comes</b> 79:3 158:12 161:13 <b>comfort</b> 133:20 <b>comfortable</b> 87:20 101:17 113:12 191:14 <b>coming</b> 42:2 80:14 90:8 109:19 123:7 146:5,14 151:14 160:15,16 161:8 163:8 165:18 166:16 167:1 168:8 174:12 181:17 199:13 <b>commencing</b> 1:23 <b>comment</b> 117:7 126:3 <b>comments</b> 55319 67:5 <b>commission</b> 207:25 208:18 <b>commissioned</b> 208:5 <b>committee</b> 11:4 104:7 <b>common</b> 1:1 44:13 114:7 138:23 <b>communicate</b> 131:10 <b>communicated</b> 131:18 153:12 155:1,3 <b>communicating</b> 118:1 <b>communication</b> 123:16 124:16 126:16 131:3,9,22 132:16 133:2	<b>communications</b> 136:1 <b>community</b> 2:17 7:25 13:1 101:18 <b>companies</b> 112:19 113:1 <b>compatible</b> 56:15 <b>compiled</b> 15:24 26:14 <b>complaining</b> 159:19 <b>complete</b> 5:10,14 93:14 97:8 147:12,21 148:8 154:3,25 156:6 194:16 <b>completed</b> 16:16 59:25 107:12 208:11 <b>completely</b> 143:20 151:13 193:24 196:15 <b>completes</b> 93:24 <b>completion</b> 170:12 <b>compliant</b> 46:6 <b>complication</b> 76:12 85:14 88:2 102:3 109:1,6 <b>complications</b> 30:23 31:2,6,9 90:15,19,25 91:11 91:17,22 94:2,24 99:16 116:16 <b>complied</b> 69:16 <b>comply</b> 37:15 74:24 75:14 116:18,24 198:20 <b>component</b> 160:24 160:24 <b>components</b> 166:25 <b>compression</b> 161:6 161:6 163:10 165:19 <b>computer</b> 123:22 124:6 <b>conceded</b> 202:22 <b>conceding</b> 202:23 <b>concept</b> 114:23 <b>concern</b> 52:17 57:2 61:4 65:21 125:18 133:23 141:11 142:14 144:4 192:8 <b>concerned</b> 46:22 65:14 69:1 166:20 192:9 201:8 <b>concerning</b> 43:23 77:16 124:22 125:12 127:16 141:6 142:4,18,18 142:19 144:25
--	---	---	---	---

158:15 159:7 184:9 <b>concerns</b> 50:24 53:25 55:7 64:19 67:1 69:14 136:15 170:20 191:19,22 192:3 <b>concert</b> 102:23 <b>concluded</b> 206:11 <b>conclusion</b> 162:25 <b>concur</b> 75:19 136:25 <b>condition</b> 114:25 186:10 191:22 <b>confidence</b> 204:17 <b>confidential</b> 20:25 <b>confinement</b> 61:5 <b>confluent</b> 175:1 <b>confused</b> 86:9 <b>confusing</b> 36:9 <b>confusion</b> 153:17 <b>conical</b> 83:4 <b>conjure</b> 186:2,5 <b>connection</b> 3:25 17:13 176:8 <b>cons</b> 26:1 <b>consent</b> 23:1 38:4 95:6,10 114:5 <b>consents</b> 39:10 <b>consequences</b> 48:3 76:14 87:14 94:18 101:22 <b>consider</b> 24:16 25:10 26:25 27:23 75:11 76:19 118:18 145:24 <b>considered</b> 101:1 161:10 <b>considering</b> 37:10 <b>consisted</b> 187:5 <b>consistent</b> 54:19 68:11 115:13,13 145:12 150:23 152:10 157:12 167:4,11,12 172:6 173:12 <b>consistently</b> 144:18 154:12 <b>consult</b> 92:19 <b>consulted</b> 202:4 <b>contact</b> 7:23 112:2 122:7 127:15,19 134:9 136:2 137:24 194:22 195:19 198:14 <b>contacted</b> 124:23 127:9 133:24 134:3 136:19 138:7 148:6 194:11 198:10 <b>contacting</b> 136:14	<b>contain</b> 33:8 91:16 <b>contained</b> 25:23 90:11 92:3 <b>contemplating</b> 99:2 99:22 100:8 101:8,24 103:6 <b>content</b> 25:7 37:18 130:2 <b>contention</b> 56:9 <b>contents</b> 72:2 90:2 <b>contest</b> 29:8 <b>context</b> 21:8 51:1 52:10 53:15 58:1 69:4 71:17 76:12 87:11 100:6 130:18 <b>contiguous</b> 150:12 <b>continually</b> 164:7 <b>continue</b> 55:8 57:4 67:2 68:19 73:18 81:17 93:4 118:8 118:16 <b>continued</b> 11:19 54:1 65:21 104:6 <b>continues</b> 74:12 <b>continuing</b> 73:16 74:14 75:1 76:1 102:13 119:5 158:23 <b>continuum</b> 177:25 <b>contraction</b> 179:19 179:21,23 <b>contractions</b> 68:1 80:16,18 97:23,25 160:21,25 162:21 179:14 <b>contraindications</b> 54:5 <b>contrary</b> 52:19 <b>contused</b> 175:19 201:7 <b>convention</b> 70:12 84:14,15,16 139:10,13,18 140:6 <b>conversation</b> 42:2 42:18 55:21,23 56:4 65:25 69:11 70:13 81:23 82:11 129:16 138:11 144:19 145:6 169:17 180:16 181:2,10 182:7,25 184:18 185:6 186:3,7 202:3,19 <b>conversations</b> 57:22 58:11 74:13 186:22 <b>conveyed</b> 65:16 <b>Cooke</b> 120:5 128:10 170:25	193:16 <b>copy</b> 5:8,14,24 6:1 6:11,13 24:25 42:15 51:21 79:8 148:23 187:20 <b>cord</b> 98:1 161:6 175:9 <b>corner</b> 35:16 <b>corrections</b> 207:4 <b>correspond</b> 35:19 <b>cost</b> 112:21 113:20 <b>counsel</b> 1:16,21 89:6 <b>counseled</b> 76:8 90:10 <b>counseling</b> 37:6 86:10,12 87:4,5 87:11 88:20 89:11 90:5 <b>counting</b> 17:24 <b>country</b> 105:15 <b>county</b> 1:29:15 11:2 17:16 208:3 <b>couple</b> 4:8 5:11 49:18 77:13 80:7 84:1 103:3 146:16 176:15 <b>course</b> 12:20,21 15:1 24:4,13 31:10 34:16 36:12 44:24 48:3 68:21 69:20 74:4 80:20 88:8 91:1 97:22 98:2 136:15 158:2,23 181:9 188:15 199:14 <b>courses</b> 24:6 <b>court</b> 1:1 18:17 19:3 <b>Courtyard</b> 2:21 <b>cover</b> 36:12 38:19 40:3 74:23 90:2 <b>coverage</b> 106:3,5 <b>covered</b> 72:11 90:11 163:25 <b>covers</b> 150:13 <b>crash</b> 99:15 102:1 111:11,24 112:3 119:16 120:17 121:16 128:3,23 158:17 159:9 165:22 168:19,25 170:24 171:7,19 172:3,8 176:17 178:1 193:8 204:13,22,25 <b>credentialing</b> 173:21 <b>crew</b> 103:15 172:16 182:17 186:17 204:18	<b>critically</b> 113:4 <b>crowning</b> 161:13 <b>cupboard</b> 164:3 <b>curious</b> 187:25 188:2 <b>current</b> 109:14 <b>Currently</b> 102:18 <b>curriculum</b> 16:4 79:16 <b>custom</b> 71:2,7,20 72:25 73:7,10 81:8 82:6 85:2 <b>customarily</b> 42:10 204:17 <b>customary</b> 74:3 <b>cut</b> 49:5 148:23 196:15 <b>cutting</b> 113:20 197:11 <b>Cuyahoga</b> 208:3 <b>CV</b> 1:6 51:25 79:8 <b>C-section</b> 29:22 85:24 87:10 95:12 98:15 99:15 102:2 106:11,13 110:25 111:11,25 112:3 113:2 116:18 119:16,16,23 120:17 121:16,25 122:8,12 128:3,24 129:25 158:12,18 159:9 165:23 168:20,25 169:5 169:15,19,20,21 171:8,19 172:3,8 172:25 173:12 175:25 176:17,24 178:1 188:17,24 189:20 191:2 192:17 193:8 200:11 203:9,13 204:4,9,13,20,25 205:9,10 <b>C-sections</b> 110:10 173:3,17 - - - - - <b>D</b> <b>D</b> 2:4 <b>dad</b> 57:23 180:15 183:2,5 184:24 186:8,23 202:15 <b>damage</b> 97:10 176:20 177:5,24 178:8,25 205:5,14 <b>danger</b> 93:18 <b>data</b> 15:19,24 <b>date</b> 1:24 26:13 34:18 35:20 41:6 41:14 43:3,6,11 43:15 53:24 55:5 55:10,13 57:3	58:5 61:5 66:23 68:24 69:3 70:6 71:22 72:3 75:25 79:18 88:22 103:20 108:6,7 138:16 185:16 187:6,23 188:4 <b>dated</b> 26:16 139:2 188:3,4 <b>dates</b> 51:4 52:20 66:19,20 <b>day</b> 1:23 61:15,19 90:2 207:20 208:14 <b>days</b> 17:24 33:3 56:14 62:22 64:20 65:13 66:4 73:12 75:22 206:9 <b>deal</b> 25:15 113:9 117:23 <b>dealt</b> 22:15 <b>death</b> 4:1 5:11 97:10 <b>deceleration</b> 154:18 160:17 165:13 <b>decelerations</b> 142:17 160:19 <b>december</b> 1:13 50:6 50:19 52:8,14,23 53:1,6 54:6 79:19 100:18 101:21 187:20 208:14 <b>decided</b> 170:15 <b>decipher</b> 62:18 <b>deciphering</b> 54:18 <b>decision</b> 23:8 44:18 70:3 85:12 88:7 103:24 104:13,22 105:4 106:11 111:11,12,24 112:1 171:7 204:3,11 205:3 <b>decisions</b> 132:13 <b>decision-making</b> 44:21 <b>declined</b> 47:18,25 <b>decreased</b> 51:5,10 <b>deem</b> 26:19 27:14 <b>defendant</b> 2:10,17 16:24 17:10 21:6 <b>Defendants</b> 1:8 <b>Define</b> 26:22 <b>definition</b> 66:5 95:16 <b>degree</b> 199:18 <b>delay</b> 121:23 <b>delayed</b> 121:16 <b>deliver</b> 58:15 87:9 97:14 100:20 161:16,16 162:1 166:3 168:3,23
---	--	---	---	---

175:13 184:24 186:9 191:17 <b>deliverable</b> 114:16 <b>delivered</b> 30:7 101:1 102:8 105:6 138:21 176:19 180:14 184:15 192:13 200:12 204:6 <b>deliveries</b> 58:19 112:22 <b>delivering</b> 102:21 104:8 163:24 168:17 178:2 <b>delivery</b> 8:6,7 19:16 21:18 22:16 23:1 23:3,10 25:15 26:2 28:16 29:1 29:21 30:19,24 31:18 33:14 42:7 45:7,9,25 49:14 57:21 71:9 80:8 80:12,12,21 84:3 85:15,24 88:8,11 93:17 94:25 103:5,8 109:8 113:7,21 116:17 118:25 119:2 120:13 124:8,18 125:6 126:1,10,18 127:11,16,21 128:1,2 129:6 131:3 132:12,16 133:5,25 136:3,6 137:23,23 140:13 153:3,8 168:16 172:4 176:8,16 177:4,22 178:17 178:19,22 181:23 186:15,24 188:23 189:7 190:1 191:2,8,14 192:4 194:18,24 197:22 199:10,13 200:2 <b>demanding</b> 121:6 <b>demise</b> 19:23 74:17 <b>denied</b> 10:10 <b>departure</b> 81:3 <b>depend</b> 118:21 <b>dependent</b> 121:12 <b>depending</b> 93:1 94:8 <b>depict</b> 179:18,20 <b>deposed</b> 3:10 <b>deposition</b> 1:12,15 3:2,21 4:4 17:5,9 17:13 22:20 33:19 39:23 62:5 78:20 79:11 170:13 187:15 206:11 208:10 <b>describe</b> 45:24	170:7 174:17 <b>described</b> 98:3 174:3 182:23 198:19 <b>descriptions</b> 116:1 <b>descriptive</b> 116:4 <b>designated</b> 24:9 62:6 128:7 <b>desire</b> 60:20 68:19 69:2 70:4 82:2 201:13 <b>desired</b> 71:13 <b>desires</b> 68:15,17 69:6 70:24 81:21 82:1 <b>despite</b> 88:4 202:21 <b>detail</b> 189:8 <b>detailed</b> 16:13 <b>detected</b> 150:21 <b>determine</b> 41:9 107:23 120:7 <b>devastating</b> 98:2 <b>develop</b> 11:19 87:12 <b>development</b> 12:15 <b>developments</b> 117:15 118:2 <b>device</b> 160:1 <b>diagnoses</b> 30:23 31:2,5,8 <b>diagnosis</b> 152:10 <b>dictate</b> 103:25 <b>dictated</b> 184:6,8 <b>difference</b> 155:17 173:9 <b>differences</b> 132:5 <b>different</b> 24:10,12 94:14 100:14,18 116:4 137:20 155:19 166:16 178:10 192:14 <b>differently</b> 64:11 159:19 <b>difficult</b> 97:11 98:5 115:1 116:12 161:1 162:18,19 162:24 163:14 175:2 179:25 190:22 <b>difficulty</b> 107:21 <b>dilatation</b> 68:4 147:12 154:2 <b>dilated</b> 82:24 118:9 118:17 119:5 143:20 154:9 193:24 <b>diminished</b> 116:10 <b>Diplomate</b> 1:19 <b>dips</b> 162:22 <b>directed</b> 61:6,13 186:16 <b>directly</b> 55:16	<b>disadvantages</b> 179:11 <b>disappearing</b> 114:15 <b>disapprove</b> 37:13 <b>disaster</b> 201:15 <b>discharge</b> 186:25 187:5 <b>discharged</b> 129:15 184:23 <b>discomfort</b> 116:13 <b>disconcerting</b> 168:11 <b>Disconcerting</b> 165:10 <b>disconnecting</b> 172:22 <b>discover</b> 175:6 <b>discretion</b> 44:12 113:10 <b>discuss</b> 42:10 67:14 68:14 71:3,7,21 72:2 188:21 <b>discussed</b> 50:15 69:5 70:22,25 71:13 89:2,18 129:21 130:3,6,17 <b>discussing</b> 33:5 144:16 <b>discussion</b> 38:22,23 39:14 1:25 42:23 50:10 66:23 70:18 71:1,9,22 72:3,12 74:8,25 75:7,24 76:9,12 77:2,3 82:4 85:2 110:6 120:9 129:22,25 137:3 144:12,24 177:13 182:9 187:11 189:6,19,19 200:5 201:18 206:8 <b>discussions</b> 55:14 58:1,3 91:5 130:13,17 138:4 184:12 187:4 <b>dismissal</b> 17:22 <b>dismissed</b> 17:20 <b>dispose</b> 38:3 <b>dissected</b> 149:20 150:14 <b>dissolved</b> 14:10 <b>distance</b> 96:4 <b>distend</b> 151:12 <b>distended</b> 149:10 149:17 150:11,17 152:5 174:11 <b>distention</b> 149:24 150:5,7,9,19,22 151:2,9,10,19,24 152:1,8,19 <b>distinction</b> 185:23	<b>distinguish</b> 175:3 <b>distinguishing</b> 167:18 <b>distorted</b> 201:7 <b>distress</b> 88:3 166:21 166:23,25 167:4 167:11,12,14 168:2 <b>distribute</b> 21:19 <b>distributed</b> 21:14 78:8 84:11 85:4 <b>dive</b> 163:19 <b>divide</b> 78:17 <b>doc</b> 61:25 <b>doctor</b> 12:23 16:2 18:17 30:7 33:16 45:3 52:8 54:16 61:23 62:5 63:21 63:22 73:4 77:14 86:14 87:9,17 89:24 92:19 94:22 101:13 117:6,17 127:8 131:16 138:4 143:4 149:11 167:8 176:15 185:11,15,18 187:12 190:25 195:15 198:19 202:1 <b>doctors</b> 47:12 61:3 <b>document</b> 40:3 43:25 88:20 90:3 94:4 <b>documentation</b> 40:20 <b>documented</b> 30:23 189:1 199:8 <b>documents</b> 39:11 147:12 <b>doing</b> 29:9 58:19 80:4 87:1 103:19 109:15,16,18 110:22 133:14 138:25 170:24 181:6 200:13 205:17 <b>domestic</b> 10:23,24 10:25 11:10,22 20:7 <b>done</b> 4:17,19 14:21 16:2 20:24 48:6 48:11,12 70:12 82:21 84:18 99:7 137:7 143:2 146:15 147:1 165:2 174:9 188:8 196:4 197:10 200:25 201:3 203:6,9 205:20 <b>door</b> 86:6 140:25	163:25 182:9,14 <b>doppler</b> 160:2 <b>double</b> 108:21 <b>doubt</b> 113:2 200:10 <b>down</b> 24:5 32:18,19 38:18 42:4,15 51:4,21 69:6 83:17 89:22 96:21 106:20,24 115:2 120:11 134:16 139:15 141:3 146:5,14 148:2 149:16 151:14 154:11,21 159:24 161:3,8,17 161:24 162:13 163:8 164:4 165:11,18 167:1 175:18,18 183:19 184:7 204:5 <b>dozen</b> 106:17,18,19 <b>Dr</b> 6:25 7:2 18:6 30:5,6,8,10 50:21 54:11,16,24 55:2 55:14,19 56:3,17 56:20 58:14 59:7 59:21 60:1,25,25 61:12,12 62:12 63:4,9 64:15 65:16 78:9 109:7 109:10 110:19,21 111:3,12,19,23 112:6 120:5 122:7 128:10 134:20 172:24 176:7 193:16 201:10 202:4 <b>drained</b> 151:17 <b>dramatically</b> 168:16 <b>draw</b> 162:25 185:23 <b>driven</b> 74:9 <b>driving</b> 96:21 <b>drop</b> 169:4 <b>due</b> 30:15 121:16 151:9,18,24 188:4 <b>duly</b> 3:9 208:5,6 <b>during</b> 9:24 14:9,24 14:25 16:16 21:16 29:17,19 31:10 34:16 36:12,25 37:3,11 45:4 46:9 57:22 73:7 85:22 86:10 87:8 92:23 93:15 97:22 110:17 121:1,6 124:12 129:17 136:15 142:8 146:19 158:2 164:24 179:22 181:22
--	---	--	--	--

182:11 183:14 188:15 <b>dwelt</b> 19:6 <b>D&amp;C</b> 32:10  — — — — — <b>E</b> — — — — — <b>each</b> 4:20 49:22 135:16 173:23 <b>ear</b> 96:23 <b>earlier</b> 64:20 65:13 91:3 123:10 127:4 168:20 194:8 <b>early</b> 6:23 47:4,9,18 84:12 121:2,7 129:18 169:13 199:13 <b>ears</b> 125:4 <b>easily</b> 19:11 146:14 157:6 <b>East</b> 9:13 <b>easy</b> 26:17 107:23 175:11 180:22,22 <b>education</b> 35:12 39:15 40:7 41:1 41:23 43:25 44:7 <b>educational</b> 8:3 <b>educator</b> 7:14 36:24 <b>effaced</b> 156:6 193:24 196:10 <b>effacement</b> 68:4 147:14 154:3 <b>effect</b> 22:17 <b>effectively</b> 156:17 <b>efficacy</b> 25:17 27:25 <b>efforts</b> 168:15 <b>egress</b> 146:13 <b>egressive</b> 143:22 <b>eight</b> 108:9 <b>either</b> 7:24 10:16 12:4 17:18 19:13 19:18 20:11,13 21:1,5 25:6 61:4 62:14 110:10 113:19 116:5 124:21 127:19 129:16 153:19 161:5 183:8 208:11 <b>elect</b> 68:22 <b>elected</b> 14:7 32:16 91:1 <b>elective</b> 32:9 69:15 <b>electrode</b> 142:23 160:5,12 162:4 <b>eliminate</b> 167:15 <b>elsewhere</b> 199:8 <b>embark</b> 189:16 <b>embellish</b> 26:9 27:19 73:25	<b>embellishment</b> 92:6 <b>emergencies</b> 121:1 <b>emergency</b> 110:9 121:6 173:11 <b>eminent</b> 119:1 <b>employed</b> 60:6,8,10 78:12 <b>employee</b> 13:14,18 <b>employer</b> 13:24 <b>emptying</b> 151:13 <b>encounter</b> 44:23 <b>encountered</b> 149:20 174:18 <b>encouraged</b> 112:20 181:13 <b>encouraging</b> 181:14 <b>end</b> 90:8 200:1 201:14 <b>ends</b> 175:3 179:19 <b>engage</b> 157:6 161:23 <b>engaged</b> 67:25 83:14 143:20 156:23 157:10 184:18 <b>engagement</b> 157:3 <b>enjoyed</b> 110:22 <b>enormous</b> 174:25 <b>enough</b> 4:15,20 5:5 8:9 16:18 23:23 52:16 66:13 77:14 79:7 82:16 99:10 117:23 120:21 142:1 153:1 158:14 193:12 195:2 204:24 <b>ensued</b> 202:12 <b>ensuing</b> 49:22 <b>enter</b> 175:1,6 <b>enters</b> 147:23 <b>entertain</b> 97:12 <b>entire</b> 5:24 36:17 44:7 52:21 150:15 <b>entirely</b> 68:10 109:19 <b>entitled</b> 20:20 40:7 <b>entries</b> 5:11 146:17 <b>entry</b> 5:21 6:3,4 67:8,9 109:23 147:3,7 <b>environment</b> 105:23 204:8 <b>epidural</b> 15:2 116:12 128:14 132:9,10,14 147:24 149:4,6 151:11 152:6 170:16 174:6 196:24 197:1,5,11	197:13,17,17,24 198:3,5,9,11,23 199:1,5,11,16,20 199:23 <b>epidurals</b> 132:7 <b>equivalent</b> 52:20 179:15 <b>error</b> 56:12 <b>especially</b> 116:11 <b>ESQ</b> 2:4,12,20 <b>establish</b> 11:13 <b>established</b> 197:19 <b>estimate</b> 53:2 66:16 66:18 106:25 107:9,11 108:3,13 108:15 140:21 <b>estimated</b> 53:3 <b>et</b> 1:4,7 100:8,8 <b>etc</b> 1:4 <b>ethics</b> 11:4 <b>evaluated</b> 8:1 143:18 189:2 190:6 <b>even</b> 4:7 7:7 37:24 57:22 61:23 69:19 74:12 86:14 97:1 132:8 156:19 164:5 165:14 178:19 190:11 194:10 200:13,24 204:4 204:10 <b>evening</b> 72:21 188:16 189:14 <b>event</b> 23:23 62:12 86:15 125:12 153:23 168:5 191:4 204:22 208:12 <b>events</b> 74:4 98:3 141:21 158:3 167:14 <b>ever</b> 4:4 9:23 10:3,6 10:9 20:3,10 21:4 28:7 37:3 54:24 55:2 56:3 70:5 82:13 97:5 98:7 115:21 120:7 129:16 135:15 138:5 158:9 196:2 <b>every</b> 11:17 61:8 99:21 100:8 110:6,24,25 176:12 182:8 <b>everyone</b> 75:10 79:3 204:1 <b>everything</b> 120:23 129:13 172:23 184:25 191:10 202:7 <b>evidence</b> 117:13	156:12 <b>exact</b> 182:6 204:2 <b>exactly</b> 52:6 87:1 130:2 202:13 203:20 <b>exam</b> 46:22 49:24 67:6 68:3 124:22 135:8,14 137:6,8 137:13 147:1,18 148:5,21 153:11 153:16,24 156:17 156:17 195:21,24 <b>examination</b> 1:17 3:8,12 63:5 72:20 146:11 152:18 159:14 188:12 201:24 209:2 <b>examinations</b> 125:10 <b>examine</b> 67:21 127:7 137:6 <b>examined</b> 143:15 152:24 <b>examiner</b> 154:12 154:15 <b>example</b> 50:6 62:2 109:22 111:3 168:20 183:13 205:17 <b>except</b> 179:16 <b>Exception</b> 48:21 52:22 105:24 <b>exceptions</b> 6:25 <b>excessive</b> 62:24 <b>exchange</b> 35:24 74:9 <b>exclusively</b> 7:16 <b>excuse</b> 3:1 134:8 64:23 150:8 <b>exerted</b> 179:21 <b>exhibit</b> 3:3 32:21 33:8 39:24 40:3 79:9,12,15 84:4 85:4 90:21 187:13,16 209:6,7 209:8,9 <b>exist</b> 205:11 <b>existed</b> 14:9 205:12 <b>expect</b> 37:15 124:20 125:9 137:7 148:4 153:6 160:14 161:21 163:9 169:17 170:9 <b>expectation</b> 126:12 164:18 <b>expected</b> 61:5 75:15 105:16 117:24 <b>expecting</b> 113:4 <b>expects</b> 125:25 <b>experience</b> 47:19	76:3 97:13 111:8 145:17,19 153:5 170:7 179:7 182:21 195:2 <b>experienced</b> 98:7 116:2 145:23 <b>experiencing</b> 145:10 <b>expert</b> 20:4 21:4 <b>expertise</b> 176:12 <b>expires</b> 207:25 208:18 <b>explain</b> 36:18 67:19 70:5 73:11 100:17 102:20 182:3 203:24 <b>explained</b> 39:18 202:14 <b>explaining</b> 85:25 91:22 <b>explanation</b> 37:18 37:23 92:7,8 134:2 135:4 148:12 149:1 151:8 170:5 185:3 <b>Exposure</b> 176:9,10 <b>expound</b> 27:19 <b>express</b> 177:20 <b>expressed</b> 69:13 203:12 <b>extent</b> 14:14 48:15 93:11 <b>external</b> 159:23 162:18 179:16,17 <b>extruding</b> 97:23 <b>eyes</b> 125:4  — — — — — <b>F</b> — — — — — <b>face</b> 35:3 45:13,14 <b>facilitate</b> 37:24 <b>facilities</b> 103:13 <b>facility</b> 98:23 99:23 101:10 103:7 204:10 <b>fact</b> 42:5,17 45:7 56:11 60:23 65:14 69:14 76:21 81:21 82:24 120:7 123:11 133:20 138:24 141:25 156:18 159:1,2 169:2,12 185:25 188:21 189:1 190:9 194:19 <b>failure</b> 30:16 31:22 85:21 86:16 87:7 87:22,23 168:13 <b>fair</b> 4:15,20 5:5 8:9 13:8 16:18 23:23 37:14 82:16 88:3
---	--	---	---	---

99:10 100:5 108:10,12,15,25 119:8 140:16 142:1 143:23 153:1 158:14 191:11 192:5 193:12 195:10 <b>fairly</b> 29:9 44:20 45:16 183:5 <b>fallopian</b> 201:6 <b>familiar</b> 22:14,18 25:14 28:4 32:23 65:4 98:16,20 104:14 116:16 117:11,22 <b>family</b> 180:14,21,23 184:10,13,18 186:23 <b>far</b> 29:9 51:24 66:2 101:4 107:11 <b>fascia</b> 176:10 <b>fashion</b> 83:4 <b>father</b> 182:7,19 <b>father's</b> 181:21 <b>favorable</b> 57:7,13 66:13 72:17 <b>February</b> 5:22 6:2 7:21,24 13:19,20 13:21,23 <b>feel</b> 29:9 87:20 101:17 113:12,13 116:9 151:11 178:16 181:24 191:14 <b>feeling</b> 145:1,2 200:17 <b>feelings</b> 181:13 202:22 <b>fellowship</b> 9:5 <b>felt</b> 44:19 116:3 166:3 200:18 202:6,15 203:5,14 <b>fetal</b> 19:23 51:5,6 51:10 53:3 67:22 74:17 81:2 83:14 88:2 114:10,18 115:11 116:22 117:11,20 124:7 124:11,21 125:11 126:14 132:22,24 139:23 141:5 142:16 144:3,7 145:23 158:15,20 159:7 160:20 161:3,19 162:2,8 162:11,16 163:2,3 163:13 164:11 166:21,23,25 167:4,10,11,12,14 167:24 168:2,9,11 169:3 179:24 196:3	<b>fetus</b> 93:18 191:23 <b>few</b> 10:25 106:19 107:17,17 108:14 108:23 202:1 <b>figure</b> 106:21 <b>file</b> 22:24 23:14,14 24:9 25:7 28:13 51:19 <b>filed</b> 3:25 17:15 41:15 <b>fill</b> 110:3 <b>finally</b> 175:23 <b>financial</b> 113:19 <b>find</b> 18:15 46:2 133:9 151:22 152:2 171:22 <b>findings</b> 33:13 57:6 118:1 148:5 159:7 164:11 <b>fine</b> 19:12 29:15 31:17 32:1 91:14 97:18 139:20 167:22 183:20 <b>finest</b> 4:8 <b>finger</b> 67:23 82:23 83:3,3 <b>finish</b> 93:23 <b>first</b> 3:9 6:4 8:4 10:17 11:14 14:10 17:8 19:23 30:8,14,19,24 46:12 47:2,16 62:10,11 67:7,7 77:9 98:3 111:6 123:11 127:15,19 129:3 141:5,19 152:24 164:15 166:16 171:1 174:22 189:13 190:11 194:16 208:6 <b>fitting</b> 161:7 <b>five</b> 80:19 96:9,10 163:19 164:25 <b>fix</b> 159:21 160:4 162:5 179:17 <b>floating</b> 67:14,20 68:8,10 <b>floor</b> 2:13 122:22 122:22 <b>flow</b> 35:11 49:21 128:8 146:19,21 153:14 172:7 <b>fluid</b> 80:23 143:22 146:14 157:18 <b>fluids</b> 174:14 <b>focused</b> 182:12 <b>Foley</b> 148:16,20 149:2,6,24 150:20 151:3,6,8,18,24 152:9 174:6 <b>follow</b> 22:10 69:7	71:7 104:12 <b>followed</b> 22:4 36:6 44:10 120:10 <b>following</b> 8:6 25:16 26:2 28:3 96:20 113:22 116:18 207:3 <b>follows</b> 3:11 <b>follow-up</b> 64:4 188:10 <b>force</b> 104:9 <b>forecasting</b> 73:15 73:18 <b>foregoing</b> 207:2 208:8 <b>foreseen</b> 191:15 <b>forget</b> 52:7 <b>forgetting</b> 101:21 <b>form</b> 88:11 114:5 160:2 <b>formal</b> 39:10 <b>formally</b> 10:22 <b>formed</b> 14:11 <b>Formerly</b> 9:21 <b>forth</b> 1:24 11:8,12 16:10 18:6 33:15 121:22 174:14 200:15 208:7 <b>forthcoming</b> 84:20 <b>forthwith</b> 163:24 <b>fortunately</b> 154:14 <b>Forward</b> 142:15 154:16 170:11 189:25 200:20 <b>found</b> 202:10 <b>four</b> 8:18 35:3 56:13 64:20 65:13 66:4,4 68:7 68:10 72:17 78:17,18,18,24 79:4 106:5 107:5 107:11,16 108:9 150:22 154:4,9,25 155:7,9 156:7,13 159:3 161:22 171:14 193:25 <b>fourth</b> 149:15 <b>four-year</b> 9:5 <b>fragmented</b> 162:7 <b>frame</b> 139:22 144:14 163:4 <b>Francisco</b> 15:21 <b>Franklin</b> 8:23 9:1,8 <b>free</b> 29:10 <b>frequency</b> 80:16 <b>frequently</b> 11:11 42:5 109:16 146:12 162:22 <b>front</b> 40:13 <b>full</b> 109:15 110:23 120:23 <b>fully</b> 39:18 118:9,16	119:5 154:9 156:6 181:24 <b>fundal</b> 52:24 62:23 66:20 83:17 157:6 161:22 <b>further</b> 44:17 45:7 92:6,6 148:16 187:10 206:3 208:10 <b>future</b> 5:25 24:3 73:15 201:13,15 203:2  <b>G</b>  <b>gain</b> 51:7 <b>game</b> 46:24 145:8 181:7 <b>gaps</b> 110:3 <b>Gates</b> 7:14 <b>gathered</b> 23:17 <b>gave</b> 11:3,6 12:18 21:23 35:4,13 41:9 84:5 136:24 137:25 196:14 <b>general</b> 8:5 16:21 27:24 28:21 44:19 45:22 46:5 50:2 57:11 74:11 103:11 106:7 119:13 133:18 167:19,21,23 170:18,22 172:7 174:17 183:8 192:8 195:6 <b>generalities</b> 44:21 <b>generally</b> 26:7 44:13 58:8 80:18 107:19 <b>gestation</b> 52:24 74:18 <b>gestational</b> 56:16 84:10 <b>gets</b> 38:11 <b>getting</b> 51:25 57:16 120:10,11 132:10 182:12 191:25 200:15 204:23 <b>give</b> 4:8 8:8 10:23 12:8,10 36:25 52:15 71:16 80:10 93:22 105:24 106:24 107:9 108:23 110:13 134:2,6 135:13 137:15,16 161:12,12 163:1 171:23 180:1 181:2 183:13 195:4,22 196:16 197:12 <b>given</b> 12:13,17 21:20 34:9,15,19	34:22 36:3 38:17 39:8 40:10,22 41:2 42:8,13,25 43:4,14 46:17 54:2 57:5 59:2 60:23 64:12 72:15,24,24 81:9 81:10 83:11 88:19,22,23 90:20 116:1 135:7 152:1 167:19 173:24 195:25 202:7,10 205:1,11 <b>gives</b> 36:6 38:14 113:9 <b>giving</b> 22:2 26:11 91:20 123:1 <b>glucose</b> 84:18,21 <b>go</b> 8:11 13:7 17:1 18:8 23:11,22 26:17 29:14 34:7 36:17 37:1,20 38:5,14 49:16 57:9 58:5 61:9 66:11,12 69:24 70:8 72:8 73:3,21 74:12 76:17 89:4 90:17 92:16 94:6 94:21 99:25 101:12 102:16 104:19 108:9 111:2 117:6,16 127:7 132:2 137:5 139:9 140:9 141:7 142:1,15 143:3,15 147:9 152:15 154:8 156:14 160:4 161:11,21 162:7 167:7 168:6 170:11 175:5 178:13 184:2 187:22 189:25 195:22 196:8 199:7 200:20 204:20 205:2 <b>goes</b> 20:19 37:13 67:12 134:16 139:18 160:18 <b>going</b> 5:2 6:24 8:9 28:21 36:8 37:10 38:12 49:16 52:7 52:18 53:18 54:10 55:15 56:5 57:20,25 69:11 83:22 87:9 107:4 107:13 111:4 119:12 126:2,6 130:12 135:20 136:12 139:21 142:11 149:18
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151:4 154:24 163:22 164:17 165:14 166:6,21 168:12 169:19 170:8 174:20 181:8 182:1,12 186:4 189:17 191:15,17 198:15 198:15 200:18 <b>gone</b> 68:18 72:18 77:10 81:24 136:20 141:16 155:8 156:19 159:2 <b>good</b> 26:7 44:20 45:16 46:1 60:17 117:10 153:7 179:5 181:19 183:5 <b>Gordon</b> 1:18 208:4 208:16 <b>gotten</b> 194:16 197:9 <b>grace</b> 161:18 <b>Graduated</b> 8:13 <b>graduating</b> 8:16 <b>grand</b> 12:18 <b>grandma</b> 158:6,10 184:24 186:8,23 <b>grave</b> 76:14 <b>great</b> 9:10 37:1 80:5 107:6 111:7 113:9 <b>greater</b> 81:19 180:1 180:2 <b>greens</b> 182:17 <b>greeting</b> 78:21 <b>GREGORY</b> 2:20 <b>grew</b> 11:18 <b>grossly</b> 149:17 <b>ground</b> 170:10 178:18 <b>group</b> 6:21 11:4,12 30:11 103:25 112:10,20 <b>guess</b> 12:11 60:24 86:18 88:6 90:6,9 106:24 107:4,8 115:7 121:9 133:20 134:20 135:2 139:10,11 139:15 177:19 191:25 205:16 <b>guessing</b> 171:3 184:1 <b>guesstimating</b> 155:15,16 <b>guideline</b> 105:10,13 <b>guidelines</b> 22:8 26:11 <b>gut</b> 182:21 191:18 <b>Gwin</b> 128:21 129:6 129:8 144:13	<b>Gwin's</b> 129:3 <b>GYN</b> 7:16 <b>gynecological</b> 19:21 <b>gynecology</b> 9:2 12:10,21 16:20,22 75:17 <hr/> <b>H</b> <hr/> <b>habit</b> 47:15 75:6 81:13 <b>half</b> 30:19 51:2,3 <b>hand</b> 88:1 165:15 208:13 <b>handle</b> 61:13,21 62:6 102:10 117:10 <b>handled</b> 48:9,14 64:10,14 <b>handwriting</b> 40:15 40:17 67:6 <b>handy</b> 58:25 <b>happen</b> 71:15 88:10 141:23 166:13 167:25 191:15 193:2 198:13 <b>happened</b> 42:11 129:13 137:2 157:15 166:14 176:2 182:23 198:18 204:6 <b>happening</b> 116:10 118:22 154:22 200:18 <b>happens</b> 74:7 99:9 <b>happy</b> 38:19 102:22 <b>hard</b> 64:6 142:10 <b>harm</b> 74:6 <b>Harold</b> 170:25 171:2 <b>Hastings</b> 7:16 <b>having</b> 17:9,12 28:5 42:1 44:25 50:9 70:18,22 71:9 75:24 80:18 82:2 85:21 87:24 97:5 97:25 110:22 116:12 121:21 122:13 135:23 137:1 138:11 142:22 143:2 144:12 146:13,15 150:11 154:16 163:19,19 168:13 181:16 184:12 186:13 195:15,20 195:25 196:2 200:22 <b>HCG's</b> 47:23 48:7 <b>head</b> 51:4 67:22,25 83:3,14,17 114:14 146:4,14 147:25 148:2 149:9	151:14 154:16,20 159:16 161:6,7,13 161:17,19,24 163:8,9 165:19 166:11 167:1 <b>heads</b> 162:20 <b>health</b> 1:22 13:14 182:19 <b>hear</b> 80:21 81:5 127:6 <b>heard</b> 115:25 <b>hearing</b> 159:18 <b>heart</b> 51:5 114:10 114:18 115:12 116:22 124:7,11 124:21 125:11 126:14 132:22,24 142:16 144:3,7 145:23 158:16,20 159:7 160:3,17 161:3 162:2,8,9 162:11,16 163:2,3 163:13 164:11,15 165:5,10,12,20 167:10,11,24 168:9,11 169:3 179:24 180:3,5 189:15 190:19 204:5 <b>heartfelt</b> 180:21 <b>heat</b> 201:3 <b>height</b> 52:24 62:24 66:21 <b>help</b> 38:8 59:18 103:1 122:6 <b>hemorrhage</b> 115:15 <b>hemorrhaging</b> 175:8 <b>hereinafter</b> 3:10 <b>hereunto</b> 208:13 <b>high</b> 93:13 147:25 149:9 154:16 <b>highly</b> 153:2 <b>Hill</b> 96:22 <b>him</b> 19:3 20:22,23 21:3 86:21 93:22 107:10 110:1 111:6,15,17,23 112:2 117:4 131:20 132:1 141:11,12 182:16 182:22 185:5,16 186:1,4 188:18 <b>hint</b> 181:20,21 <b>history</b> 12:13 33:15 45:12 47:1 75:23 109:10 137:14 <b>hold</b> 14:6 83:17 <b>hole</b> 190:24 <b>home</b> 19:24 38:11 38:14 60:16 78:3 97:7 111:15	123:4,5,8,22 124:1 134:15 <b>honest</b> 135:2 <b>honestly</b> 183:18 <b>hook</b> 172:19 <b>hope</b> 66:15 191:11 197:6 199:1,7,9 199:11,16 <b>hoped</b> 9:10 <b>hopefully</b> 44:25 72:13 <b>hopes</b> 83:5 191:7 <b>hoping</b> 165:16 <b>horribly</b> 182:16 <b>hospitals</b> 9:25 12:5 12:23 14:13,18,19 <b>hospital's</b> 104:6,11 <b>hour</b> 80:20 97:2 106:5 180:17 <b>hours</b> 61:24 121:2,7 129:18 150:22 169:13 <b>house</b> 11:18 204:1 <b>housekeeping</b> 5:8 77:13 <b>howard</b> 2:4 3:21 64:23 71:11 89:6 91:3 150:6 <b>hung</b> 179:10 <b>husband</b> 157:25 158:13 200:6 <b>hypotension</b> 114:10 114:17 115:11 <b>hypothetical</b> 190:4 <b>hypothetically</b> 77:1 176:18 <hr/> <b>I</b> <hr/> <b>idea</b> 168:1 <b>identical</b> 194:5 <b>identification</b> 3:4 39:25 77:25 79:13 187:17 <b>identify</b> 25:5 32:20 40:5 <b>if's</b> 183:14 <b>II</b> 2:12 <b>III</b> 99:3,14,23 101:10,25 103:12 <b>ill</b> 203:15 <b>imagine</b> 129:19,20 190:23 195:20,25 199:14 <b>immediate</b> 119:2,14 119:23 142:14 <b>immediately</b> 103:17 119:18 140:9,12,24 156:10 171:5 191:13 192:16 193:25 <b>impact</b> 48:23	<b>impeded</b> 151:14 <b>impending</b> 114:8 114:19 115:5,14 118:7,14 119:6,11 145:18 150:23 152:3,6,12 168:19 190:5,6,21 <b>implications</b> 77:4 <b>implies</b> 81:22,24 <b>imply</b> 199:10 <b>implying</b> 143:6 <b>important</b> 4:25 73:23 114:22 118:1 <b>impression</b> 191:16 <b>improve</b> 104:18 <b>inaccurate</b> 29:13 <b>inadequate</b> 116:23 117:13 <b>inappropriately</b> 203:5 <b>incentives</b> 112:10 112:17 113:20,20 <b>incidents</b> 101:3 <b>incision</b> 3:15 92:21,25 93:1,5 93:13,16 94:4,9 94:10,11,19 104:13,22 105:3,4 105:20 172:15 175:10,12,18,24 204:12 205:3 <b>incisions</b> 94:14 <b>inclination</b> 55:21 <b>include</b> 75:2,6 <b>included</b> 16:17 70:6 115:8 <b>includes</b> 104:7 <b>including</b> 45:25 47:2 108:6,19 <b>incoming</b> 78:8 <b>inconsistent</b> 135:10 172:6 <b>increase</b> 119:10 <b>increased</b> 119:9 <b>increases</b> 119:6 <b>increasingly</b> 74:17 <b>indeed</b> 72:22 150:11 152:20 165:18 179:20 198:14 <b>indeterminate</b> 182:2 <b>INDEX</b> 209:1 <b>indicate</b> 5:7 75:25 89:17 93:4 148:15 <b>indicated</b> 4:10 63:2 71:17 72:23 73:6 77:17 123:13 132:24 156:22,25 203:8,10,17
---	---	--	--	---

<p><b>indicating</b> 56:5 60:20 <b>indication</b> 75:2 134:6 164:23 180:9 192:19 <b>indicative</b> 125:12 <b>Indirectly</b> 55:17 <b>induced</b> 60:20 64:20,24 65:2,17 69:3 <b>induction</b> 57:14 62:24 63:2 66:14 72:17 <b>infant</b> 56:16 <b>infection</b> 46:16 <b>inform</b> 117:14 <b>informally</b> 20:13 <b>information</b> 23:6 25:23 26:9,14,18 27:1,8,18,25 32:22 37:4,9 38:15 42:14,20 44:17 47:10 50:5 52:1,16 57:18 59:10 62:13,15 64:12,13 65:15 82:9 84:6 104:10 107:6 166:2 181:16 194:4 195:2,9 <b>informed</b> 22:25 23:8 38:3 44:18 85:12 88:7 <b>initial</b> 35:8 128:8 145:6 152:18 194:25 195:9 196:8 <b>initially</b> 150:15 159:22 <b>initials</b> 60:2,4 77:25 <b>initiated</b> 82:5 127:20,21 <b>injure</b> 175:5 <b>inquire</b> 56:3 <b>inquiries</b> 61:14 <b>inquiry</b> 47:11 59:3 61:22 62:9 <b>insert</b> 82:23 150:20 151:8 152:9 <b>inserted</b> 142:24 148:16,21 149:2 149:24 151:5,18 151:24 <b>insisted</b> 69:19 <b>insisting</b> 203:4 <b>insofar</b> 19:14 <b>instead</b> 154:11 174:11 <b>institution</b> 102:23 103:2 106:6 <b>instruct</b> 80:15 <b>instructions</b> 4:9</p>	<p>80:10 81:7,9 <b>instruments</b> 121:21 123:2 163:24 174:10 <b>insult</b> 167:6 <b>insurance</b> 104:11 112:19 113:1,24 <b>intact</b> 147:17 148:1 <b>intelligence</b> 36:3 <b>intended</b> 45:23 <b>intensity</b> 179:14 <b>intention</b> 171:5 <b>interest</b> 11:13,22 23:9 143:19 168:23 174:8 189:2 201:12 202:7,16,21 203:1 203:6 <b>interested</b> 146:24 208:12 <b>interior</b> 79:4 <b>internal</b> 142:11,13 143:9 <b>interpret</b> 179:25 199:2 <b>interpretation</b> 133:19 188:5 <b>interrogatory</b> 41:19 <b>interrupting</b> 62:8 <b>interval</b> 181:6 <b>intimately</b> 98:16 117:22 <b>intraoperatively</b> 202:11 <b>intrapartum</b> 197:21 198:20 <b>intrauterine</b> 143:10 179:9 <b>intrinsically</b> 81:19 <b>introduce</b> 83:2 <b>introduced</b> 3:20 <b>involved</b> 29:3,20 32:5,5 35:23 108:17 109:12 128:1,22 <b>in-house</b> 103:15 106:3,8,9 119:24 <b>irreversible</b> 176:20 177:4,24 178:7,25 205:5,14 <b>issue</b> 19:19 22:25 25:15 26:1 38:24 43:24 58:4 87:25 95:4 <b>issues</b> 19:22 23:5 113:18 <b>item</b> 77:24 <b>items</b> 24:16 33:10 33:24,25 34:11 52:4 77:14 <b>IUD</b> 20:2 77:22</p>	<p><b>IUPC</b> 142:20,21 143:8,11 179:12 180:1,6,9,11 <b>IV</b> 174:6 197:10</p> <hr/> <p><b>J</b></p> <p><b>J</b> 188:12 207:17 <b>jacket</b> 141:3 <b>January</b> 22:17 49:3 49:4,12,17 50:4,5 50:6,17 52:12,21 54:8 55:10 56:17 57:8 58:15,24 60:19 61:19 63:8 63:17 64:11,17 65:9,21 67:6 70:14 75:24 80:11 81:11 83:19 100:13,16 101:7 108:9,22 109:12,21 110:12 116:15 121:2,7 184:22 188:16,16 204:10 <b>Jennifer</b> 59:20 60:1 60:8,10 62:14 78:5,10 <b>JKW</b> 59:16,23 78:1 <b>Toanie</b> 59:24 60:6 62:14 78:1,3,6 <b>Joanie's</b> 60:4 <b>job</b> 36:22 <b>John</b> 2:12 24:23 <b>join</b> 11:17 <b>joined</b> 14:8 <b>Joines</b> 19:9 <b>Jordan</b> 78:5,10 <b>jotted</b> 42:14 <b>journal</b> 23:16 28:11 <b>journals</b> 15:13 <b>judge</b> 1:6 154:13 <b>Julie</b> 7:14 <b>July</b> 7:3 79:16 101:6 <b>jump</b> 57:20 149:13 <b>jumps</b> 162:17 <b>junction</b> 176:3 <b>June</b> 52:21 208:18 <b>just</b> 4:8,19 5:7,15 5:23 7:7 8:8 9:9 11:3 15:15 18:10 20:7,8 30:2 31:7 33:14 37:16 39:21 40:5 51:1 58:11 60:15 63:20 67:22 69:20 78:24 79:2 81:17,20 86:19 89:8 94:12 105:13 109:18 114:15 115:22 120:20 121:21</p>	<p>122:19,25 127:24 129:12 131:20 132:1 133:17 137:4,5 139:21 140:6 141:20 145:6 146:6,10 147:10 148:16 152:4 158:21 162:6,7 163:25 167:9 171:25 174:17 181:20,21 182:12 183:25 187:25 189:7,11 196:2,15</p> <hr/> <p><b>K</b></p> <p><b>K</b> 78:1,6 <b>keep</b> 24:5 51:15,18 51:18 149:9 <b>keeping</b> 62:25 63:11 <b>Kentucky</b> 9:22,23 10:2 12:5 <b>kept</b> 107:22 <b>kind</b> 77:14 78:17 79:7 83:4 96:5 110:23 161:18 181:3 200:13 204:7,16 <b>lknew</b> 52:6 65:13 133:18 151:17 166:15 168:12 170:23 198:2 200:9 <b>lmock</b> 86:5 <b>knowing</b> 68:25 97:19 133:17 171:4 175:4,4 <b>ltknowingly</b> 109:14 <b>ltknowledge</b> 17:19 39:9,19 41:3 92:9 101:15 106:12 120:22 121:8,9,10 129:5 188:15 <b>known</b> 49:23 72:11 77:18 155:11 156:3,16,20 159:6 166:10 <b>knows</b> 71:21 185:12</p> <hr/> <p><b>L</b></p> <p><b>L</b> 1:18 208:4,16 <b>labor</b> 8:7 15:1 19:15 23:15 26:2 28:1 31:23 33:13 54:2 55:9 57:5 67:3 69:21 72:22 73:19,21,24 74:21 76:2 80:8,12,14 80:21 81:16,18</p>	<p>83:6,6 84:2 85:22 87:8 93:15 94:19 97:22 99:3,13,23 101:9,25 102:10 103:2 108:16 112:12,21 116:17 116:23 117:13 120:12 123:21 124:3,8,18 125:5 125:25 126:10,17 127:10,15,21 128:1,2,8 129:6 131:3 132:12,16 133:5,25 135:8,15 136:2,6 137:22,23 140:12,15 144:17 146:20 147:24 150:14,15 153:2,7 154:7,17 163:11 172:4 181:23 192:7 194:18,24 196:1,11 197:18 197:22 199:13,14 199:18 201:9 <b>laboring</b> 95:14 106:10 <b>labors</b> 107:1 <b>labs</b> 5:23 6:6 48:12 <b>lack</b> 96:15 <b>laid</b> 146:10 <b>Lake</b> 11:2 <b>language</b> 105:25 <b>large</b> 55:15 56:5,11 69:2 <b>last</b> 7:20 11:2,3 15:4 18:12 33:3 34:17 51:8 59:20 60:2,4,10 61:1 63:9 80:7 82:5,17 110:11 139:7 182:13 197:22 <b>lasted</b> 180:17 <b>late</b> 160:24,24 <b>later</b> 29:12 105:7 139:20 150:22 165:12 201:2 <b>latitude</b> 37:1 98:6 113:9 <b>latter</b> 6:23 <b>laundry</b> 51:24 <b>lawsuit</b> 3:25 32:4 41:15 <b>layer</b> 150:13 <b>laying</b> 146:11 <b>layperson</b> 185:2 <b>lead</b> 142:11,13 185:15,20 <b>leading</b> 113:6 <b>leaking</b> 80:23 <b>learn</b> 53:16 77:9 133:7 <b>learned</b> 53:13</p>
--	--	--	---	--



<b>least</b> 26:15 30:23 94:24 95:20 108:8 128:15,23 135:5 172:4 199:17 <b>leave</b> 5:1 9:7 16:8 66:2 <b>leaving</b> 73:19 <b>lecture</b> 11:4,7 12:18 12:19 28:7 <b>lectures</b> 10:24 11:21 12:8,9,13 <b>left</b> 60:12,15 67:11 80:11 92:24 96:22 129:10 172:3 <b>left-hand</b> 59:9 <b>lengthy</b> 26:15 <b>less</b> 17:22 71:10 76:25 92:25 94:8 101:1 106:17 107:17 168:3 <b>let</b> 4:8 5:7 18:10,19 19:5,9 20:8 21:3 24:22 25:2 29:14 34:23 66:2,12 71:16 72:19 86:4 93:4 103:3 126:13 127:2 138:18 141:19 143:15 161:10 162:6 169:11 172:1 182:21 186:1,4 187:22 196:8 <b>letter</b> 25:6 <b>letting</b> 186:17 <b>let's</b> 39:12 58:24 64:17 77:13 91:18 92:13 97:6 100:15 140:1 141:8 147:2 160:4 161:11 162:7 171:10 184:21 198:1 <b>level</b> 65:20 98:17,19 98:20 99:3,14,23 101:10,25 103:12 103:14 <b>liberally</b> 22:6 <b>library</b> 22:25 <b>license</b> 10:3 <b>licensed</b> 9:17,19,21 10:1 <b>ligation</b> 34:10,12,22 37:17 38:2,24 39:7,12 43:11 114:6 200:14,21 202:4,8,16 <b>light</b> 164:10 <b>like</b> 6:11 19:8 27:23 44:15 46:15	56:17 62:5 79:15 80:20,21 87:18 100:1,2 112:25 127:25 128:5,13 128:21,22 131:24 134:19 148:7 161:5 166:13 167:24 178:15 183:1 185:25 189:5 194:9 196:5 198:11 <b>liked</b> 155:11 156:19 193:13 203:23,25 <b>likelihood</b> 119:7,10 156:8 168:3 <b>likely</b> 35:20 48:12 53:7 93:1,15 94:8 94:24 129:22 136:2,20 138:22 144:20 146:8 149:23 151:25 152:2 176:18 177:20,23 178:24 179:6 185:2 204:12 205:3,12 205:23 <b>limitations</b> 205:11 <b>limited</b> 174:5 <b>limits</b> 174:24 <b>line</b> 35:3 62:10,11 63:9 67:7 88:6 89:15 134:15 148:22 149:15 162:23 207:5 <b>Lisa</b> 67:8 <b>list</b> 51:24 183:5 197:23 <b>listed</b> 29:23 <b>listen</b> 19:7 <b>lists</b> 77:20 <b>literally</b> 79:2 107:4 <b>literature</b> 14:23 22:20 24:14,25 34:2 101:2,16 117:9 <b>little</b> 8:2 28:22 30:2 36:9 49:5 66:20 156:19 157:5 162:14 <b>live</b> 95:21 96:7,9,10 96:13 112:6 <b>location</b> 80:2 <b>long</b> 7:17 13:17 62:22 63:6 68:6,6 72:16 82:25 83:12 95:18 97:9 97:19 101:15 103:18 171:6 177:3,16 204:12 <b>longer</b> 7:1 96:17 197:11 202:25 <b>longest</b> 97:3	<b>look</b> 7:11 10:16 22:22 24:24 26:10 29:5 38:15 55:6 57:7 90:3,6 92:13 101:2 104:24 113:11 115:6 126:20,21 131:18 137:4 139:23 140:14 143:3 146:20 149:11,14 161:9 162:6,12,13 163:18 165:11 191:9 195:22 <b>looked</b> 13:6 33:10 34:10 42:14 54:12 107:25 113:3,4 135:3 141:16,23 144:7 150:15 190:18 <b>looking</b> 7:19 35:1 40:19 42:24 43:9 46:6 51:14 54:6 63:4 70:17,23 81:20 93:22,23 133:21 139:11 141:14 144:8 147:8 149:7 151:7 153:21 160:19 162:2 180:8 188:1 <b>looks</b> 46:15 56:17 79:15 127:25 128:5,13,21,22 134:19 137:20 165:15 200:4 <b>loop</b> 153:19 <b>loss</b> 142:10 159:21 160:3 162:5 179:16 <b>lot</b> 36:24 96:24,25 163:5 183:1 184:8 <b>low</b> 31:13,15 94:3 94:11,18 <b>lower</b> 175:17 176:4 201:7 <b>L&amp;D</b> 196:8  — — — — — <b>M</b> — — — — — <b>made</b> 23:8 53:6,14 55:20 63:22 64:1 64:5 79:21 85:12 103:24 105:3,4,5 105:21 106:11 111:11,24 114:25 123:11 131:2,8,21 132:5,7,15 171:7 172:15 189:25 195:20 197:16 198:4 <b>magical</b> 57:17	<b>main</b> 92:22 <b>maintain</b> 22:24 24:6 184:9 <b>maintained</b> 23:24 24:19 <b>majority</b> 186:14 <b>make</b> 20:8 39:21 44:5,18 70:2 88:7 92:17 122:6,7 127:5 146:12 151:12,13 153:20 160:20 161:10 162:20 172:23 176:3 190:10 195:3 197:4,7 <b>makes</b> 55:19 116:12 159:22 <b>making</b> 4:23 96:22 136:9 145:7 151:16 175:12 189:14 <b>malpractice</b> 16:25 21:5 <b>management</b> 22:8 189:17 <b>mandatory</b> 100:22 <b>manner</b> 45:23 48:8 48:13 131:18 166:14 <b>many</b> 20:24 104:23 105:7 106:13,16 106:17,21 107:13 108:16 109:11 110:9 114:20 122:4 137:10,10 145:14 158:3 177:17 <b>map</b> 8:8 <b>mark</b> 74:13 <b>marked</b> 3:3 39:24 69:6 79:8,12 84:4 187:12,16 209:6,7 209:8,9 <b>markedly</b> 201:6 <b>Mary</b> 19:9 129:4,8 <b>material</b> 15:18 24:13 90:24 91:11 <b>materials</b> 5:16 90:11 <b>maternal</b> 28:14 162:8 <b>matter</b> 5:8 17:12 20:1 65:25 110:2 110:21 134:16 140:8 148:1 195:1 <b>may</b> 5:10,22 6:6 17:2 18:9 19:8 20:5,25 26:4,13 26:14 27:3,10 28:4,17 32:16	34:25 38:13 44:4 47:8 52:13 53:8 53:19 55:19 60:13 64:1 69:22 70:19 72:8 75:4 76:4,22 77:6 83:12 85:17 87:16 88:12 90:17 91:24 92:8 92:15,25 94:5,8 99:17 102:4 104:3 108:13 112:14,23 114:20 116:25 117:21 118:3,12,19 122:2 125:1,14 126:5 130:9,24 131:6,15 132:8,8,19 135:18 138:9,21 141:14 143:4 150:3,24 156:18 159:12 170:1,2,7 173:17 173:19 176:22 179:3 180:9 184:17 185:6,6 186:2,3,3 188:9 <b>maybe</b> 39:21 108:8 137:20 139:12 142:25 153:18 194:19 <b>McGuire</b> 77:19 <b>mean</b> 3:1 2 74:16 95:17 110:14 130:21 131:9 142:22 149:13 157:23 189:8 194:13 196:24,25 199:2,2,20 204:22 <b>means</b> 67:19,21 74:1 106:22 <b>meant</b> 68:13 72:20 198:24 203:24 <b>measurable</b> 155:14 <b>measurements</b> 49:25 <b>measuring</b> 56:13,14 <b>Medicaid</b> 114:2 <b>medical</b> 8:11,16 11:24 14:22,24 16:24 20:4 21:4 22:19 24:13 25:23 33:20 34:1 92:19 135:19 138:25 192:19 203:3 <b>medically</b> 203:10 <b>medication</b> 145:5 <b>medications</b> 197:10 <b>medicine</b> 12:14 <b>meet</b> 9:1 21 <b>meeting</b> 15:21 158:9 180:13,21
---	--	--	--	---



183:15 184:9 <b>meetings</b> 37:8,12 42:9 50:10,12 110:5,8 130:19 <b>member</b> 14:5 184:13,19 186:23 <b>membrane</b> 145:8 <b>membranes</b> 80:22 80:24 82:17,22 83:5,9,15 141:22 143:14,25 145:11 145:22 146:5,13 148:1 152:25 156:22 157:7,22 158:15 159:24 161:24 163:7 <b>memory</b> 29:8 33:6 33:15 42:2 183:17 185:24 <b>mention</b> 44:12,14 79:22 92:17 <b>mentioned</b> 22:23 94:12 98:10 <b>merely</b> 197:15 <b>message</b> 55:18 59:9 59:23,25 61:16,17 <b>met</b> 20:14 <b>midnight</b> 136:3,19 198:2,4,14 <b>midwifery</b> 12:15 <b>midwives</b> 7:5,6,8 <b>might</b> 44:23 113:14 118:25 137:15 139:7 149:5 153:16 198:13 <b>Mild</b> 31:10 <b>mind</b> 54:5 69:4 138:6 161:7 163:22 166:1 189:15 <b>minds</b> 38:13 <b>mine</b> 40:18 70:4 <b>minimum</b> 104:16 104:17 <b>minus</b> 68:7,10 72:17 108:24 143:21 147:14 149:8 154:4,8,9 154:24,25 155:6,7 155:9,9 156:7,7 157:1 159:3,3 161:22,22 <b>minute</b> 16:7 96:2 104:12 105:9 164:25,25 165:12 <b>minutes</b> 80:19 95:21 96:9,10 97:6 99:16 102:2 104:23 105:2,7,8 140:19,25 163:20 171:14 172:5 196:5 204:4	205:18 <b>mischaracterize</b> 65:7 <b>misfortune</b> 16:23 17:9 <b>mishkind</b> 2:3,4 3:13,2 15:6,18,21 6:4 18:18 20:21 24:22 25:4,12 31:4 43:1,3,10,15 43:18 65:1 71:16 86:21 89:10,21 91:7,14,18 93:10 93:21 99:6,10 100:15 117:5 125:24 130:23 131:25 132:3 141:12 150:7 156:14 167:21 169:10 171:18 177:12 178:11 185:8 187:9 188:8,14 190:3 192:12,20 201:25 206:3,9 209:3,5 <b>missed</b> 49:6 <b>misshape</b> 115:17 <b>misshapen</b> 114:14 115:10 <b>missing</b> 6:8 119:21 119:21 <b>misspoken</b> 180:10 <b>mistaken</b> 142:25 143:4 <b>Moats</b> 128:5,6 129:5,9,10 134:21 135:6 138:5 144:13 147:19 148:22 151:1,22 153:1,15 195:16 <b>mode</b> 71:9 <b>modeled</b> 175:20 <b>Molly</b> 7:16 <b>mom</b> 57:23 58:2 74:1 76:15 85:5,8 85:25 89:2,17 92:12 93:7 94:18 117:25 118:6,8 129:15 168:23 180:15 183:9 184:23 186:8 192:15,15 202:14 <b>moment</b> 45:3 56:2 65:5 73:17 84:2 164:1 165:11 170:14 184:20 192:6 198:2 201:3 <b>momentarily</b> 162:17 <b>mom's</b> 193:23 194:5,9 202:7	<b>monday</b> 1:13 62:2 <b>monitor</b> 81:17 117:11,20 124:2 135:8,15 139:23 141:6 143:9 159:23 160:15,20 162:19 164:7 165:15 172:20 179:17 196:1,4 <b>monitoring</b> 123:21 124:11 125:5 126:9 <b>month</b> 32:19 84:25 <b>more</b> 6:9 19:21 26:18 92:8,25 93:14 94:8 97:5,6 98:2 102:22 106:17,19 107:17 110:16 120:21 122:10 136:19 138:22,23 142:18 142:18 151:25 158:22 159:8 163:10 167:9 168:9 169:8 176:18 177:23 178:24 179:6 189:7 197:8 200:22 202:1 205:3,12,23 <b>Morgan</b> 7:13 21:21 21:23 35:7,24 36:22 38:23 39:2 39:6 40:16,22 41:22 42:4 84:5 88:24 90:1,24 <b>Morgan's</b> 35:8 87:5 <b>morning</b> 37:8 42:9 121:2,7 129:18 150:18 169:13 188:21 190:19 <b>Norris</b> 77:18 <b>Morris-McGuire</b> 77:21 <b>most</b> 12:21 26:8 35:20 42:6 44:22 60:24 73:23 83:16 114:22 133:13 144:20 146:8 152:2 183:3,11 <b>niother</b> 93:18 <b>niouth</b> 140:24 <b>move</b> 28:21 39:12 80:5 83:3,19,23 85:24 87:10 159:24 172:17,23 <b>moved</b> 169:5,14 171:8 <b>movement</b> 51:6,11 81:3,5 <b>moving</b> 154:16	164:8 <b>much</b> 18:14 98:2 155:14 156:18 <b>multiple</b> 61:3 <b>multiplied</b> 107:16 <b>muscle</b> 174:22 <b>must</b> 95:21,25 135:18 197:24 198:23 <b>myself</b> 3:22 83:25 <b>M.D</b> 1:7,12,15 3:7 3:12 188:12 201:24 207:17 208:6 209:2 — N — <b>name</b> 3:14,21 18:12 18:21 52:5 59:21 77:18,20 129:3 171:1 <b>named</b> 16:24 18:25 208:6 <b>names</b> 18:5,10 <b>Nancy</b> 7:13 35:7,8 36:22 40:16 41:7 41:8,12,14 42:4 42:12,17,20 43:16 84:16,23 87:5 90:1 <b>Nancy's</b> 44:11 <b>narrative</b> 148:20 <b>natural</b> 199:8,10 <b>naturally</b> 83:7 <b>nature</b> 83:11 137:12 183:8 196:6 <b>nausea</b> 145:4,10,19 145:23 <b>nauseated</b> 146:9,12 <b>necessarily</b> 16:7 101:9 143:5 173:18 <b>necessary</b> 26:12 27:21 57:10 89:22 161:16 195:5 197:19 198:6 204:21 <b>need</b> 26:18 38:3 59:22 60:2 61:9 79:19,24 80:17 83:14,25 92:19 96:3 100:12 104:24 116:21 126:8 143:3 153:12 173:24 180:11 195:9 <b>needed</b> 10:1 85:13 116:16 121:24 122:17 157:7 164:2 174:14 191:14 197:4 204:18	<b>needing</b> 168:24 199:3 <b>needs</b> 92:5,6 173:10 192:8 198:12 <b>negated</b> 180:6 <b>negative</b> 126:17 156:13,13 190:16 191:6 193:24,25 <b>negligence</b> 20:4 <b>neighborhood</b> 80:19 108:4 <b>neonatal</b> 28:14 186:17 <b>neonatologist</b> 181:17 <b>never</b> 16:16,23 70:1 113:16 135:3 163:12 166:13 177:12 <b>new</b> 7:3,7 <b>newborn</b> 60:16 <b>newly</b> 14:7 <b>newsletter</b> 23:21 <b>next</b> 21:16 48:23 49:12 54:8 63:11 89:12 139:12 148:19 153:15,22 153:24 <b>nicely</b> 159:17 <b>night</b> 124:12 134:4 136:16 141:24 146:19 <b>NM</b> 35:8 <b>noncompliant</b> 46:2 <b>none</b> 181:14,18 <b>nonetheless</b> 95:1 196:17 <b>norireassuring</b> 116:22 166:24 167:3,23 168:9 <b>nonspecific</b> 114:11 <b>nonstress</b> 51:9,13 188:6,7 <b>norm</b> 81:4 113:6 <b>normal</b> 51:6 56:15 61:23 72:25 82:6 152:23 168:12 191:2 204:11 <b>normally</b> 137:22 143:1 174:23 195:8 <b>nose</b> 96:23 <b>Notary</b> 1:19 207:23 208:4,16 <b>note</b> 47:24 63:10,18 63:19 64:2,25 65:4,10,18 78:1 81:20 134:18 136:23 143:16,18 146:25 149:12,15 174:21 180:15,25 189:5,23 207:3
---	---	--	---	--

<p><b>noted</b> 59:8 68:13 71:12,14,14 138:1 148:21 149:25 163:19 195:16 200:4 <b>notes</b> 55:6 61:8 127:8 143:3 146:22 148:15,20 154:2 156:22 171:13 184:7,7,9 <b>nothing</b> 56:1094:1 97:17 134:17 180:4 192:10 208:7 <b>notice</b> 7:4 168:19 <b>noticed</b> 11:16 <b>notified</b> 105:17 132:11,12 199:17 <b>notion</b> 26:16 101:3 164:16 182:18 196:12 201:8,14 <b>NST</b> 51:15 52:3 80:3 187:20 188:3 <b>NST's</b> 51:18 <b>number</b> 6:18 7:4 26:6 30:22 60:24 104:14 106:15 108:21 110:13 120:20 134:14 163:21 181:13 190:3 194:18 197:23 <b>numbers</b> 107:5,25 108:2 113:11 <b>nurse</b> 7:4,6,12,13 7:14,17,18 21:21 21:23 35:24 36:3 36:6,11,23 37:16 38:23 39:2,6 40:22 41:22 49:8 59:15,21,24 60:1 63:20 64:1 67:9 78:7,10 84:5 88:24 90:24 118:8 122:16,21 123:3 125:17,18 125:23 126:1,4,7 128:5,21 129:3,5 129:6,9 133:2,12 133:17 134:21,22 135:6 138:5 144:13,13,17,21 147:11,19 148:9 148:13,22 151:22 153:1,3,15 155:4 155:19,19 157:23 169:24 170:4,6 181:25 195:16 197:16 204:19 <b>nursery</b> 98:19 <b>nurses</b> 11:12 117:3</p>	<p>117:8,23,23 118:15 124:17 125:4 126:8,13,17 127:6,21 128:1 129:17 130:22 131:3,22 137:23 169:3,13,19 188:18 194:18 197:4 198:5 <b>nurse's</b> 143:3 148:15 <b>nursing</b> 78:18,21 116:14,21 121:24 124:24 146:19,22 153:14 172:21</p> <p style="text-align: center;"><b>O</b></p> <p><b>Oak</b> 8:17 96:22 <b>OB</b> 61:17,25 110:22 <b>object</b> 20:15 23:11 36:8 89:4 91:13 93:8 99:6 152:15 178:3 185:4 <b>objecting</b> 170:4 <b>objection</b> 17:1 18:8 20:5 24:23 25:1,3 25:5,8,18 26:4,22 27:3,10 28:2,17 37:20 38:5 53:8 53:19 60:13 69:22 70:8,19 71:11 72:6 73:2 75:4 76:4,17,22 77:6 85:17 86:4 87:16 88:12 90:16 91:2,24 94:5,20 99:4,9,17 99:24 101:12 102:4,6,14 104:2 104:19 112:14,16 112:23 116:25 117:16,18 118:3 118:10,11,19 122:1 124:25 125:13,20,21 130:8,9,20 131:5 131:6,14,15 132:18 138:8 150:2,3,24 152:4 156:11 159:11,12 167:7,17 168:6 169:6,7,23,25 173:19 176:21,22 177:6,7 179:1 205:6,7,15,25 <b>observing</b> 117:25 <b>obstetrical</b> 13:9 25:24 29:4 32:6 46:3 57:6 109:20 110:7 117:23 121:1 <b>obstetrician</b> 23:7</p>	<p>55:7 56:20 57:3 75:12 76:10,21 90:22 117:14 167:13 <b>obstetricians</b> 46:9 49:9 <b>obstetrician's</b> 90:23 <b>obstetrics</b> 9:2 16:19 16:21 75:16 104:6 109:15,18 <b>obtain</b> 79:7 122:6 <b>obtained</b> 5:9 <b>obvious</b> 114:13 115:22 <b>obviously</b> 49:20 64:18 108:19 133:23 146:17 180:22 <b>OB/GYN</b> 3:18 8:19 15:10 104:8 <b>OB/GYN's</b> 6:19,21 <b>occasion</b> 28:7 198:10 <b>occasions</b> 29:19,19 45:6 200:24 <b>occur</b> 74:4 76:15 77:5 86:15,16 93:15 94:18 97:10 126:14 158:21 165:20 166:12 195:7 204:23 <b>occurred</b> 19:24 32:12,16 55:24 70:14 81:11 112:4 130:18 160:16 169:18 177:5 178:17,19 178:23 181:22 183:22,23 184:17 185:7 186:3,7,14 191:5 <b>occurrences</b> 142:16 <b>occurring</b> 83:7 98:1 162:21 <b>occurs</b> 76:14 81:6 <b>October</b> 7:2 12:22 35:19 40:22 41:2 41:5,10 43:11 84:6 88:23 <b>odds</b> 108:2 <b>off</b> 5:25 28:21 49:5 108:8,13 122:21 135:20 137:3 148:23 171:13 177:13 187:11 206:8 <b>offer</b> 47:17 113:4 <b>offered</b> 47:21 63:16 <b>office</b> 2:5 5:17 6:15 7:21 21:25 24:20 29:1 32:5 33:11</p>	<p>36:21 43:22 49:10 51:20 54:8 54:25 55:3 59:11 61:3,21 64:7 65:10 73:20 79:5 80:11 82:17 84:10 90:24 108:1 110:4 124:5,13 126:21 180:15 187:22 199:9 208:13 <b>officer</b> 14:1 <b>offices</b> 1:21 78:9 <b>officially</b> 3:22 13:13 <b>often</b> 26:9 38:16 158:19 197:8 201:1 <b>oftentimes</b> 26:12 38:12 110:2 <b>oh</b> 30:4 35:2 47:14 59:22 68:16 111:21 115:7 157:11 196:3 203:16 <b>ohio</b> 1:2,20,23 2:6 2:14,23 3:8 8:12 9:18 208:2,5,14 208:17 <b>okay</b> 6:14 17:4 25:9 28:23,24 34:7 43:12 47:14 55:12 66:10 69:9 80:9 82:12 83:24 86:12 139:17 142:8 160:4,12 161:4 162:15 192:2 <b>old</b> 175:24 <b>ominous</b> 165:9 <b>omit</b> 77:3 <b>onboard</b> 128:4 <b>once</b> 24:23 52:11 57:12 68:18 69:25 81:24 84:25 106:6 118:9,16 119:5 141:22 142:13 146:4,15 149:5 154:9 171:6 172:8 174:21,21 197:15 <b>one</b> 2:13 4:7 8:24 10:22 11:2,16 15:4 18:11,23 20:17,18 21:15 25:21 30:4 34:8 42:9 44:23 47:5 48:20 52:22 57:19 58:12 61:8 61:9 62:3,17 63:13 68:20 70:1</p>	<p>74:16 75:9 76:1 78:3,22 80:16 82:22,23 83:25 98:3,9,14 101:19 103:4 104:15 110:1 111:16 114:9,13 120:21 133:21 134:7 149:3,9 151:8,8 152:9 153:6,10 154:14 165:12 167:9 171:4 174:13 178:16 179:9 189:22 194:23 196:9 197:22 <b>ones</b> 108:19 <b>one-page</b> 32:21 <b>only</b> 9:25 11:25 33:24 48:15 52:3 52:22 76:15 79:20 87:23 98:20 124:5 140:14 141:1 159:1 163:6 188:2 191:15 205:16 <b>onset</b> 145:17 <b>onto</b> 96:23 <b>open</b> 97:15 98:14 174:21 175:7,25 <b>opened</b> 174:10,16 175:17 <b>opening</b> 93:14 <b>operate</b> 13:7 <b>operating</b> 120:11 172:18 193:3 <b>operation</b> 205:18 <b>operative</b> 143:17 149:11,15 150:10 174:21 <b>opinion</b> 20:13 25:22 48:2 91:20 133:19 166:9 177:3,20,21 178:5 178:24 180:7 201:10 <b>opinions</b> 21:2 <b>opportunity</b> 93:23 178:6 <b>spposed</b> 43:10 62:8 70:15 91:21 110:20 115:4 144:9 155:19,22 165:23 168:24 <b>opposite</b> 82:7 <b>opting</b> 87:12 <b>options</b> 23:1 68:20 <b>opts</b> 88:11,15 <b>order</b> 37:15 44:18 74:24 85:11 88:7 116:18 117:14</p>
--	--	---	--	--

121:25 134:20,24 135:7,14 136:24 137:17 138:13 139:12,15 191:17 195:15,16,17,24 195:25,25 196:4 196:16,21 <b>ordered</b> 145:4 204:9 <b>orders</b> 134:19,19 137:15,21,25 195:4,9,21 196:15 196:20 197:15,21 198:21 <b>original</b> 142:2 159:25 <b>originally</b> 9:12 <b>other</b> 4:20 7:8 9:24 11:23 12:8 14:12 14:13,17,18 16:15 17:3,4,4,15 18:23 19:7 22:2,21 30:22 33:22 34:8 36:5 43:24 44:16 46:8,8 49:9 52:5 57:19 58:12 64:5 77:15,24 88:1,2 94:11 98:5,8,9 101:7,10 104:8 114:21 115:13 121:6,20,23 123:18,18 124:3 126:5 128:4 130:13 132:14 137:21 145:14 152:11 171:4 174:10 182:1 184:9 190:21 194:24 198:1 <b>others</b> 11:7 25:25 75:15 79:23 <b>otherwise</b> 33:9 123:4 136:12 208:12 <b>ounces</b> 30:19 <b>out</b> 18:2,15 44:22 59:18 72:21 133:9 137:5 140:13 151:15,23 153:20 159:25 160:15,16 162:20 164:3 176:3 200:15 201:2 <b>outcome</b> 92:12 101:22 192:14 <b>outcomes</b> 28:14 85:8 <b>outgrowth</b> 104:4,5 <b>outline</b> 92:10 <b>outside</b> 26:8 33:20 144:15 163:25 182:9,14	<b>outstanding</b> 28:6 <b>outweighs</b> 70:4 <b>over</b> 23:17,24 26:15 34:10 37:1 38:12 38:15 51:7 68:18 72:18 80:19 81:24 129:2 137:25 165:15 171:4 180:17 195:3 204:6,7 <b>overlaid</b> 157:15 <b>overlapping</b> 4:20 <b>overly</b> 47:20 150:16 <b>own</b> 22:3 <b>oxygen</b> 163:15,17 164:6,10,14,21,24 <b>o'clock</b> 1:23 133:1 152:2 153:18,20 153:21,23 162:4 164:20 168:21 192:13  <b>P</b> <b>P</b> 1:7,12,15 3:7,12 3:15 201:24 208:6 209:2 <b>PA</b> 9:1,8 <b>pad</b> 59:9 <b>page</b> 49:5 145:8 148:19 149:14,15 162:6 189:16 207:3,5 <b>paged</b> 96:2 128:13 <b>pager</b> 134:15 <b>pain</b> 114:10,17 115:11 116:3,10 <b>pamphlet</b> 35:4,13 36:5,7,18 37:17 40:7,21,23 41:1 43:5,14 84:2,4,11 88:19 89:13,14 90:3,6,10,12 <b>paper</b> 75:9 <b>parcel</b> 189:18 <b>parking</b> 96:24,25 <b>part</b> 6:23,23 12:20 21:23 22:3 23:18 26:8 52:17 67:7 69:19 74:25 81:8 82:6 83:16 121:19,20 133:13 137:19 183:3 189:18,21,22 <b>partial</b> 31:11 <b>partially</b> 89:10 165:21 <b>participate</b> 45:6,9 <b>participated</b> 110:10 <b>particular</b> 61:6,23 68:24 73:13 84:9 91:1 103:7 111:10 114:12	133:17 149:19 167:20 <b>particularly</b> 146:24 <b>parts</b> 87:19 112:25 178:16 191:12 <b>party</b> 208:11 <b>passed</b> 104:23 <b>past</b> 13:20 58:5 61:4 66:11,12 103:21 133:21 <b>path</b> 96:19 <b>patients</b> 11:16 13:7 13:9 18:2,5 37:11 43:23 44:6,8,13 44:14,17,23 62:3 84:17 101:20 102:11,15,21 110:3 113:5 116:1 126:10 127:7 142:14 145:16 146:11 182:1 194:23 197:21 <b>patient's</b> 72:10 77:18 132:6 137:13 144:16 <b>patient-to-patient</b> 98:5 <b>pattern</b> 76:21 124:21 179:23,24 <b>patterns</b> 116:23 <b>Pause</b> 29:16 34:24 86:7 105:1 146:23 171:21 <b>pay</b> 80:17 <b>pediatricians</b> 186:16 <b>peer</b> 15:13 130:7,13 130:14,18 <b>peers</b> 75:15 <b>pelvic</b> 12:14 <b>pelvis</b> 68:1 146:15 147:25 148:3 151:15 154:14,21 159:17,25 161:8 161:18,19 163:9 163:12 165:18 166:12 167:2 190:24 191:5 <b>pen</b> 54:12 <b>pending</b> 16:17 17:19 <b>penmanship</b> 54:18 <b>Pennsylvania</b> 8:23 9:20,22 <b>people</b> 39:6 60:24 102:25 <b>per</b> 197:18 <b>perceive</b> 81:4 <b>perceived</b> 69:2 <b>percent</b> 31:11 101:19 109:20	147:14 154:3 156:6 185:9 193:23 196:10 <b>perfect</b> 122:3 <b>perfectly</b> 56:15 97:18 115:23 152:23 <b>perform</b> 106:11 121:15,25 153:10 173:3,17 <b>performed</b> 106:14 143:21 147:19 159:16 <b>performing</b> 99:15 102:1 <b>perhaps</b> 23:20 24:13,13 37:24 45:2 66:20 97:22 119:9 128:24 140:20 144:13 161:6 170:10 203:1 <b>period</b> 17:21 26:15 57:23 68:17 81:16 84:10 95:23 96:2 110:17 142:8 145:3 159:21 164:25,25 168:10 172:11 177:23 178:21 179:22 182:2 204:6 <b>periods</b> 162:10 <b>peritoneal</b> 175:2 <b>peritoneum</b> 174:11 174:24 <b>permit</b> 105:25 124:7 <b>permutation</b> 136:11 164:14,16 <b>person</b> 52:5 59:24 61:7 62:13 111:6 165:14 172:22 <b>personal</b> 22:25 116:5 <b>personally</b> 18:24 21:19 132:23 <b>personnel</b> 99:14 102:1 116:14,21 119:25 121:24 128:4 174:1 192:22 193:4 <b>persons</b> 15:23 105:25 122:5 <b>perspective</b> 182:24 <b>pertains</b> 72:25 <b>pertinent</b> 6:6 137:13 <b>peruse</b> 93:4 <b>pH</b> 177:2,14 <b>phase</b> 21:17 154:18 <b>phone</b> 47:5 55:18	55:23 59:15,24 61:8 78:1,7 122:6 134:15 137:25 155:4 194:25 195:3,12 198:14 <b>phrase</b> 126:5 <b>physical</b> 205:1 <b>physically</b> 124:3 <b>physician</b> 3:16 20:12 59:3 61:9 61:15,16 75:21 78:19 88:5 95:20 95:25 96:1 134:19 173:23 197:23,24 198:23 <b>physicians</b> 11:5 46:8 101:17 104:8 105:14 113:11 132:17 <b>physician's</b> 10:24 113:10 <b>picking</b> 163:14 <b>picks</b> 160:2 <b>pin</b> 106:20,23 115:1 <b>place</b> 37:8 38:22,23 39:2 55:22 58:11 68:2 77:2 82:13 87:8 96:13,16 97:23 119:4 129:23,24 137:22 138:3,20 141:22 145:9 146:7 151:16 152:21 163:5 165:14,17 172:7,14 177:4 183:23 189:15,17 189:24 208:10 <b>placed</b> 128:14 142:12,20,21 143:9 160:12 174:6 <b>placement</b> 20:2 <b>placenta</b> 31:12 200:15 <b>placing</b> 143:11 <b>plaintiff</b> 1:17 2:2 21:5 <b>plaintiffs</b> 1:5 18:7 <b>Plaintiff's</b> 32:21 40:3 90:21 187:12 <b>plan</b> 57:9,11 145:8 <b>planned</b> 31:20 <b>planning</b> 102:11 <b>plans</b> 35:11 <b>play</b> 6:9 52:12 <b>played</b> 113:20 <b>PLEAS</b> 1:1 <b>please</b> 3:14 18:12 24:24 29:9 38:18 53:10 62:21 73:5 95:7 118:13
---	--	---	---	--

167:9 183:16 196:3 <b>pleasure</b> 111:7 <b>plunk</b> 161:5 <b>plus</b> 34:4 108:23 161:13 190:16 <b>point</b> 19:6 21:15 31:24 32:20 37:12 38:14 44:22 46:22 48:7 52:17 57:8 58:20 64:14 69:13 80:13,15 84:24 95:12 133:16 141:17 142:15 144:9 146:2,25 147:23 149:20 154:21,23 157:3 159:15,18 161:1 162:14 163:6,21 166:5 175:8,11 180:12 181:20 187:10 191:10 192:10 194:19 197:9 199:18 201:9,10 202:24 205:11 <b>points</b> 137:14 175:22 <b>policies</b> 21:24 <b>poor</b> 62:24 63:2 85:8 92:12 <b>portion</b> 35:17 38:22 154:17 162:24 176:6 <b>portions</b> 124:12 <b>pose</b> 93:18 <b>poses</b> 93:6 <b>position</b> 14:4 113:16 114:16 160:1 182:16 <b>positive</b> 126:17 <b>possibility</b> 119:1 145:25 <b>possible</b> 41:20 167:5,15 198:17 199:12 <b>Possibly</b> 145:20 <b>post</b> 66:1,1 <b>postdates</b> 57:10,12 66:6,8 <b>poster</b> 15:9 16:14 <b>posterior</b> 62:23 <b>postgraduate</b> 12:20 <b>postpartum</b> 34:9,12 35:4 57:23 <b>potential</b> 76:11 85:8,14 86:1 87:13 92:12 163:23 <b>potentially</b> 94:17 <b>pound</b> 51:8,9	<b>pounds</b> 30:18 <b>practice</b> 8:23,25 9:2 9:7,10,14 18:3 21:11,12,24 22:3 22:15 27:6,9 43:22 44:9,13 71:3,7,20 72:25 73:8 75:16 81:8 82:6 85:2 103:24 106:1,1 109:21 110:24 112:10,20 118:18 121:4 124:23 <b>practiced</b> 9:23 14:17 <b>practicing</b> 105:15 118:17 <b>practitioner</b> 7:15 7:18 <b>practitioners</b> 7:5,13 49:9 <b>precautionary</b> 4:9 <b>preceded</b> 181:10 <b>precedence</b> 179:18 <b>preceding</b> 191:13 <b>preC-section</b> 182:8 <b>Predicated</b> 131:17 <b>preeclampsia</b> 14:25 31:10 <b>preface</b> 81:15 <b>prefer</b> 18:14 81:16 149:5 154:10 <b>preferable</b> 164:9 170:21 <b>preference</b> 69:14 203:13 <b>preferences</b> 132:13 <b>preferred</b> 65:15 156:3 <b>prefers</b> 65:1,2 <b>pregnancy</b> 6:24 29:17,19 30:14 31:11 32:4,8,10 32:13 34:17 45:4 45:18 46:9,13,23 47:4,9,20 48:4,9 48:14,23 50:15,25 54:1 67:1 68:22 74:14 81:10 84:20 201:15 <b>Pregnant</b> 152:5 203:2 <b>prenatal</b> 34:16 35:3 45:4,11 47:2 49:7 52:21 65:11 75:23 <b>prep</b> 174:5 <b>preparation</b> 22:20 <b>prepare</b> 33:2,4 <b>prepared</b> 32:25 <b>prescription</b> 46:17 46:18	<b>present</b> 37:3 38:13 38:21 39:1,5 108:6,7 110:7 121:17,22 144:21 166:17 172:21,22 174:9 187:6 <b>presentation</b> 15:9 15:15 16:14 114:25 147:15 <b>presentations</b> 16:11 79:21 <b>presented</b> 15:17 33:13 <b>presents</b> 105:12 <b>pressure</b> 51:6 83:17 119:9 142:24 143:10 157:6 161:22 179:9,20 <b>presuit</b> 5:9 <b>Presumably</b> 138:17 138:19 198:3 <b>presume</b> 96:13 130:16 138:18 <b>presumptive</b> 138:21 <b>preterminal</b> 165:7 <b>prevalent</b> 74:17 116:9 <b>prevent</b> 167:15 <b>preventing</b> 178:7 <b>previous</b> 22:16 23:2 45:4 55:3 57:1 92:20 93:16 102:19 108:17 112:13,22 115:8 <b>previoud</b> 94:16 98:9 103:5 <b>primarily</b> 7:15 109:25 127:25 <b>primary</b> 104:9 173:9 <b>primigravida</b> 15:2 <b>printed</b> 89:12 <b>prior</b> 11:5 19:15 22:17 29:1,3,17 33:18 47:20 49:17 54:2 65:10 74:21 102:21 109:12 112:3 123:15,20 124:13 124:16 126:16 129:18 138:7 141:18 164:12 169:13 172:5,15 177:21,25 178:23 199:3 <b>privileges</b> 10:6,9 13:2,5 14:12,14 14:18 58:14,20,23 173:3,6,13,16 <b>privileging</b> 173:22 <b>probably</b> 35:11	41:17 45:6 83:1,8 101:4 109:24 115:8 136:5 137:11 140:4,5,18 141:2,3 146:7 157:15 163:18 172:13 181:10 189:6 <b>problem</b> 85:22 86:25 87:8,23 105:19 176:25 <b>problems</b> 44:22 <b>procedure</b> 3:9 36:20 200:1 203:6 <b>proceed</b> 57:14 67:2 73:19 119:15,18 119:22 121:17 168:24 170:22 171:5,7 202:16 203:13 <b>proceeded</b> 192:16 <b>proceeding</b> 50:25 71:4,8,19 73:1,9 73:13 85:13 191:1,10 <b>process</b> 57:17 151:5 151:23 163:20 168:22 <b>processing</b> 173:22 <b>producing</b> 52:1 <b>professional</b> 16:4 182:19 <b>professionally</b> 7:24 <b>program</b> 11:20 <b>progress</b> 30:16 31:23 54:1 55:9 57:5 85:21 86:16 87:7,22,23 116:23 117:13 165:17 168:14 180:5 199:19 <b>progressed</b> 155:22 159:2 <b>progressing</b> 154:11 <b>prolapsed</b> 175:10 <b>prompted</b> 70:25 82:2 <b>propensity</b> 186:19 <b>proper</b> 71:17 <b>proposition</b> 95:5 <b>pros</b> 26:1 <b>prospectively</b> 144:9 <b>protocol</b> 21:24 36:6 84:9,14 <b>prove</b> 28:13 <b>provide</b> 5:14 20:12 22:22 23:7 24:24 37:10,16,23 43:22 44:20 51:21 90:24 91:10 102:23 195:2,9	<b>provided</b> 3:8 15:17 21:1 39:15 40:4 40:13,15 42:13,21 44:25 47:10 59:4 62:13,15 82:8 84:7 194:4 195:17 197:15,18 <b>providing</b> 25:9 42:21 176:8 <b>provoke</b> 44:24 83:6 <b>proximity</b> 112:7 <b>prudent</b> 23:6 75:12 75:20 76:7,10,20 77:1 125:25 126:9 200:18 <b>Public</b> 1:19 207:23 208:4,16 <b>publication</b> 16:15 <b>publications</b> 16:11 79:21 <b>published</b> 15:11 <b>publishing</b> 14:22 26:13 <b>purchase</b> 22:6 <b>purplish</b> 175:20 <b>purpose</b> 36:23 <b>purposes</b> 3:4 5:3 6:1 39:25 79:13 100:16 103:8 187:17 <b>pursuant</b> 1:20 21:24 <b>pursue</b> 68:19 103:2 199:10 <b>pursuing</b> 73:23 88:8 101:18 <b>push</b> 113:15 118:9 118:16 119:5 161:12,12 <b>pushed</b> 113:17 190:23 <b>put</b> 32:18,19 33:7 75:9 139:15 140:23 151:2 155:15 160:6 162:4 164:3,6 168:18 169:11 180:6 196:3 <b>putting</b> 15:19 <b>p.m</b> 206:11  <hr/> <b>a</b> <hr/> <b>qualified</b> 153:2,4 173:14,16 204:20 208:5 <b>qualify</b> 205:16 <b>quality</b> 148:25 <b>quarter</b> 62:3 <b>question</b> 4:19 7:10 10:7 20:16 42:3 43:21 45:22 46:10 52:10
--	---	---	--	---

53:11 55:5 56:25 62:11 69:7 73:3 86:9,20,23 87:3 89:16 93:20,20 97:11 99:7,11,20 100:2,7,10 107:21 130:5 131:21 132:2 141:9,13,19 142:2 143:5,8 152:15 168:7 178:12 185:16 188:2 192:1 193:6 195:8 201:20 <b>questioned</b> 169:3 169:12 184:14 <b>questioning</b> 5:7 21:16 169:18 <b>questions</b> 3:24 4:11 15:22 19:7 29:11 37:25 38:12,17,18 41:18 42:19 44:25 45:1 49:18 52:14 80:7 82:8 84:1,24 91:6 102:14 176:16 183:1,4,5,7,9,11 185:11 186:14,19 187:10 188:9,11 190:4 202:1,19 206:3 <b>quickly</b> 11:15 146:6 161:17 168:16 174:12 191:16 203:21 204:24 <b>quite</b> 51:8,9 106:19 <b>quote</b> 25:20 <b>quoted</b> 101:19	<b>rather</b> 6:9 154:15 168:14 170:18 191:12 <b>reach</b> 134:17 175:13 <b>reached</b> 57:12 134:12 <b>reaches</b> 147:21 <b>reaching</b> 183:10 <b>reactive</b> 51:13 133:15 188:6,7 <b>read</b> 4:15 22:11,21 24:2 28:5 31:7 40:14 86:8 91:4 92:4 115:21,25 116:6 117:9 133:22 149:18 160:9 173:7 206:7 207:2 <b>readily</b> 95:13,17 120:16 <b>reading</b> 28:10 135:5 147:11 <b>ready</b> 16:14 121:17 122:8 132:10 163:25 182:13 197:8,11 <b>reaffirmed</b> 143:19 189:3 <b>realizing</b> 139:11 <b>really</b> 44:20 98:20 109:13 133:15 135:22 144:8,19 169:10 <b>reason</b> 4:22 17:5 25:8 40:9 48:17 50:3 54:12 60:17 88:22 93:21 101:5 107:20 146:8 158:22 159:9 165:1 174:7 180:6 183:21 185:9 186:7 201:16 202:23 <b>reasonable</b> 23:6 26:11 37:15 44:24 45:8 53:2 55:7 57:3 69:24 75:12,20 76:6,9 76:20 77:1 100:20 105:16 107:9 108:3,4 118:18 125:25 140:21,22 151:20 161:20 164:13,17 164:19 170:8 183:17 193:5,9,10 193:11,14,15 203:18,23 205:19 205:23 <b>reasonably</b> 24:17	26:20,25 27:14,24 126:9 181:8 <b>reasoning</b> 167:20 <b>reasons</b> 101:7 202:15 <b>reassured</b> 170:10 <b>recall</b> 18:22 29:7 42:1 58:6,7,9 59:20 71:18 83:20 97:5 109:6 111:17 116:7 120:9,14 122:5,18 123:19 126:19 129:19 134:5,10 137:1 138:11 142:22 143:2,11 144:12,15,22,23 144:24 157:20 171:13 180:17 181:3 182:10 183:6 184:12,16 196:2 <b>recalled</b> 41:12 <b>receive</b> 21:11 132:14 <b>received</b> 64:10 112:11 <b>recently</b> 12:21 60:24 <b>reception</b> 79:3 <b>recess</b> 77:12 126:24 <b>recognize</b> 52:13 126:8 <b>recognizing</b> 45:13 45:14 52:11 53:14 108:13 189:13 <b>recollection</b> 41:25 45:17 50:9 54:15 54:19 64:22 65:19,24 66:22,24 69:5,10 70:10,18 70:21 71:1 81:12 81:23 82:10 107:5 114:1 120:13 121:3 122:4 127:22 135:12,21 138:10 158:8,11 172:2,10 185:19 186:12,21 187:3 <b>recommend</b> 62:25 63:11 103:7 <b>recommending</b> 112:12 113:21 <b>record</b> 3:23 4:25 5:13,17 18:14,19 19:2 24:23 25:6 29:6 30:3,24 31:7 31:18 33:20 34:5 35:3 39:21 40:4 40:19,25 43:13	46:6 50:24 52:15 53:22 54:6 65:8 66:25 70:23 86:5 86:8 100:17 101:15 104:25 126:21 128:15 136:25 137:3 146:17 147:11 149:19 177:13 187:11,22 190:20 206:8 <b>recorded</b> 49:22 143:1 160:13 <b>records</b> 5:8,14 32:15 56:8 92:19 126:22 135:19 139:1 199:9 <b>recounted</b> 181:22 <b>recounting</b> 141:20 <b>recover</b> 161:4 168:15 <b>recovered</b> 158:23 178:20 <b>recovery</b> 181:7 <b>reduced</b> 208:8 <b>reexamining</b> 163:8 <b>refer</b> 29:10 174:20 <b>reference</b> 24:3 34:25 35:11 42:25 44:16 55:19 68:9 79:24 89:7 143:7 171:23 <b>referenced</b> 31:5 34:21 <b>referencing</b> 94:1 134:23 <b>referred</b> 27:7 98:21 <b>referring</b> 55:25 62:23 147:4 <b>refers</b> 90:4 <b>refine</b> 20:8 <b>reflect</b> 32:15 40:25 50:24 52:15 66:25 86:5 88:21 89:1 141:10 181:1 <b>reflected</b> 33:9 68:4 <b>reflecting</b> 81:21 <b>reflection</b> 45:7 <b>reflects</b> 88:18 101:16 180:16 196:21 <b>refresh</b> 33:6,14 <b>regard</b> 11:24 33:15 37:5 42:3 46:3 53:25 57:1,11 70:3 77:15 81:2 87:22 90:10 93:12 100:4 112:11 113:1,8 114:23 121:23	122:23 123:17,18 124:17 <b>regarding</b> 110:6 <b>regardless</b> 74:18 200:25 201:13 <b>region</b> 75:10 <b>regional</b> 106:7 116:8 <b>Registered</b> 1:18 <b>regressed</b> 155:22 <b>reinforced</b> 201:9 <b>reintroduce</b> 3:22 <b>related</b> 47:6 181:12 192:4 <b>relates</b> 8:5 12:14 23:1,10 27:25 33:18 36:4 39:3 67:9 132:15 173:22 <b>relationship</b> 45:24 <b>relative</b> 176:16 208:11 <b>relatively</b> 178:16 179:15 205:20 <b>relayed</b> 63:21 <b>relaying</b> 59:10 <b>reliability</b> 155:18 <b>reliable</b> 24:17 25:23 26:20 27:1 27:14,24 <b>relied</b> 27:8 <b>relieve</b> 167:5,13 <b>rely</b> 5:1,2 <b>remainder</b> 84:20 98:22 141:24 <b>remains</b> 72:14,16 <b>remember</b> 7:9 18:10 19:3 41:20 45:10,12 58:12 99:11 122:20,25 123:2 130:1 135:23 157:25 158:3,7,9 160:7 171:12,15,25 174:3 182:6 183:4,7,11 188:18 189:10 195:12 200:8 203:20 <b>remembers</b> 42:18 <b>Reminger</b> 2:19,19 <b>remotely</b> 190:11 <b>rendered</b> 102:15 <b>repair</b> 175:6 <b>repeat</b> 4:12 28:15 67:11 76:8 <b>repeated</b> 68:23 <b>repeating</b> 184:25 <b>rephrase</b> 4:14 86:23,24 <b>replace</b> 38:3 90:21 91:10 <b>replenishing</b>
---	--	--	---	---

120:20 <b>report</b> 125:19 129:1 143:17 150:10 <b>reported</b> 51:5 <b>Reporter</b> 1:19 <b>represent</b> 54:14 <b>representatives</b> 90:23 <b>represented</b> 4:7 <b>request</b> 5:13 24:22 25:11 193:8 196:24 197:25 198:23 <b>requested</b> 12:10 188:17 197:5,17 207:5 <b>requesting</b> 196:25 199:19 <b>requests</b> 35:4 199:4 <b>require</b> 92:8 <b>requirement</b> 91:10 <b>requirements</b> 96:5 96:5 205:1,2 <b>requires</b> 105:20 <b>residency</b> 8:19 9:5 9:24 15:1 16:16 204:1 <b>resident</b> 11:25 <b>residents</b> 11:24 12:11 103:16 <b>resolve</b> 164:17 <b>respect</b> 46:3 48:8 81:4 <b>respiratory</b> 46:16 <b>respond</b> 47:11 95:22 96:3 103:17 <b>responded</b> 81:25 203:21 <b>responding</b> 41:17 <b>response</b> 59:2,4 82:3,9 193:3,7 203:17 204:11 <b>responsibilities</b> 10:21 11:23 <b>responsibility</b> 90:22 <b>responsible</b> 136:13 <b>rest</b> 149:18 <b>restate</b> 53:10 <b>result</b> 93:17 94:24 131:23 <b>resulted</b> 30:14 <b>results</b> 52:3 80:3 86:2 88:10,16 <b>resume</b> 16:4 <b>resuscitation</b> 182:15 200:12 <b>retained</b> 24:3 <b>retired</b> 7:1 56:21 <b>retirement</b> 12:20	<b>retrieve</b> 16:7 <b>retrospectively</b> 144:10 190:20 <b>return</b> 168:12 <b>returned</b> 78:6 <b>reverted</b> 108:20 <b>review</b> 15:13 20:11 33:6 34:2 37:11 42:6 52:2 84:19 104:6 130:7,13,19 192:17 193:1 <b>reviewed</b> 5:15 22:19 33:17 130:14 190:20 195:15 <b>reviewing</b> 33:16 47:1 66:18 <b>revoked</b> 10:4,7 <b>right</b> 16:7 18:20 19:1 20:18 22:5 23:13 29:11 30:2 33:21 34:3,6 43:1 43:8,18 44:7 46:17 60:5 62:15 67:5,8 77:20 82:15 87:6 89:12 95:5,9,11 96:12 96:22 117:5 121:21 127:3,13 129:24 133:3 134:25 139:9 145:15 147:10 155:24 156:20,24 162:13 166:14 171:13 176:3,11 177:15 182:9 187:23 189:3,8 190:13 191:4 <b>right-hand</b> 35:16 <b>rip</b> 175:25 <b>rises</b> 160:17 162:23 <b>risk</b> 70:6 73:12,16 73:16,22,23 74:14 81:19 85:7 88:4,9 92:10,11,18,22 93:7 94:1 100:24 <b>risks</b> 39:17 69:25 70:15,17,22 71:3 71:8,19,21 72:2 72:12,14 73:1,9 74:16 75:1 76:1 85:25 89:2,17 90:14,19,25 91:11 91:17,22 190:4,6 RN 139:16 <b>road</b> 1:22 8:8 96:23 <b>Robbins</b> 1:44:1 32:22 39:7 40:11 101:23 199:7,25 <b>Roetzel</b> 2:11 <b>role</b> 10:25 113:21 <b>rolling</b> 204:24	<b>room</b> 44:7 120:11 122:8 141:4 144:17,18,21 157:20 158:1,2 164:1 171:8,11 172:4,10,18 182:11 189:12 193:4 204:21 <b>rossi</b> 2:20 6:1,11,13 102:6,13 104:2 112:16 114:2 117:18 118:11 122:1 124:25 125:13,21 130:8 130:20 131:5,14 132:18 138:8 150:2,5 152:4,16 156:11 159:11 169:6,8,25 176:21 177:7,10 179:1 188:9,10,13 201:22 203:18 205:7 206:5 209:4 <b>round</b> 95:4 <b>rounds</b> 12:18 127:5 <b>routine</b> 110:3,21 140:8 195:1 <b>routinely</b> 138:3 <b>row</b> 120:22 <b>rule</b> 104:13 105:10 <b>Rules</b> 3:9 <b>rupture</b> 57:22 58:3 70:7 73:22 74:2,5 75:2,7 76:3,11,14 77:4,4 80:22 85:7 85:14 86:1 87:13 88:3,9 92:11,18 92:24,25 93:5,6 93:14 94:2,3,7,17 97:8,13,19,21 98:8 100:25 101:3,19 114:8,19 114:24 115:4,6,9 115:14,20 116:2 118:7,15 119:3,6 119:7,10 138:20 143:24 145:12,16 145:18,22,25 150:1,21,23 152:3 152:11,13,20 157:7,21 161:24 163:7 166:17 175:25 190:5,6,12 190:21 <b>ruptured</b> 80:24 97:16 141:22 143:13 145:8 146:4,13 150:12 150:18 152:7,24 156:21 159:23 191:20 192:4,9,11	<b>ruptures</b> 98:12 <b>rupturing</b> 145:11 158:14 175:23 <b>rural</b> 106:1 <b>rush</b> 97:2  S S 90:8 <b>safe</b> 6:10 95:2 <b>safely</b> 166:3 <b>safer</b> 95:1 <b>same</b> 5:25 6:21 55:5 56:25 64:15 96:13,16 97:21 99:24 101:17 102:6 108:2 110:5 112:6 145:7 148:18 154:15 155:19 164:15 166:18 173:18 189:15,16 <b>San</b> 15:21 <b>Sarah</b> 128:6 129:10 151:1 <b>Sarah's</b> 170:7 <b>satisfied</b> 47:3 <b>save</b> 119:13 141:14 149:12 <b>savings</b> 112:21 <b>saw</b> 29:13,18 45:5 46:9 49:2 50:4,19 63:13 65:8,22 109:22 140:1,18 140:25 145:22 150:9 174:12 180:15 <b>saying</b> 63:21 70:23 71:14 86:13 91:16 92:18 94:23 107:1,18 130:17 151:1 152:8 157:11,14 196:14 205:17 <b>says</b> 35:12 36:18 40:13 43:5 47:24 64:25 65:2 67:11 67:14 68:15 71:12 88:19 89:6 89:8,11,12,14 90:4 93:12 134:24 185:21,21 <b>icalp</b> 142:22 160:5 160:12 <b>icar</b> 92:24 93:14 102:20 175:23 <b>icattered</b> 162:23 <b>icenario</b> 202:11 <b>icheduled</b> 85:23 110:1 <b>ichool</b> 8:11,16 14:24 <b>ichools</b> 11:7,24	<b>SCM</b> 128:7 148:24 <b>scrub</b> 122:16 172:21 <b>scrutinize</b> 139:20 <b>seal</b> 208:13 <b>search</b> 51:21 <b>second</b> 18:21 19:25 30:4 39:13 119:3 147:24 149:14 <b>secondary</b> 31:5,8 <b>secondhand</b> 119:3 <b>section</b> 19:15 25:16 26:3 28:3 30:15 30:25 31:14,16 40:8 54:3 68:23 73:24 74:22 86:18 87:25 92:20 97:14 98:11 102:19,21 105:20 112:13 154:8 168:13 170:25 182:11 204:21 <b>see</b> 5:10 13:7 35:13 40:19 43:5 44:6 46:12 47:17 48:23 51:15 53:22,23 64:18 69:11 72:24 80:20,25 81:16 84:17 99:9,11 105:17 110:1,3 115:19 119:13 124:7 139:19 140:1,10 141:8 147:2,5,9 148:18 148:20,24 153:17 153:19 154:10,15 157:11 158:19 160:5,14,25 161:2 161:4,24 162:14 162:21,22,23 164:14,23 165:10 167:23,25 171:10 175:2 206:1 <b>ieeing</b> 45:13,14 46:7 111:22 158:15 164:16 165:18 174:11 180:5 181:6 189:12 201:8 <b>seems</b> 135:10 195:19 <b>ieen</b> 7:20 13:10 32:12 47:19 49:13 52:11 53:24 60:23 61:3 84:24 125:11 135:15 136:21 156:20 163:19,23 166:13 168:10 181:16 192:15,15
--	--	--	--	--

<p><b>segment</b> 175:17 176:4 201:7</p> <p><b>self</b> 189:2</p> <p><b>sense</b> 63:1 149:4 159:22 160:21 166:16</p> <p><b>sent</b> 41:18</p> <p><b>sentence</b> 149:16</p> <p><b>sentiment</b> 57:15</p> <p><b>separate</b> 35:25 51:16,19</p> <p><b>separated</b> 174:22</p> <p><b>separating</b> 83:4</p> <p><b>separation</b> 92:24</p> <p><b>September</b> 46:14 47:3,7 48:20,25</p> <p><b>serial</b> 47:22 48:7,12 153:11</p> <p><b>series</b> 15:20 131:19 141:20 142:15 160:18</p> <p><b>serious</b> 74:6 93:17 94:17 99:16 102:2 200:19</p> <p><b>serve</b> 11:9</p> <p><b>served</b> 11:9 20:3</p> <p><b>serving</b> 101:20</p> <p><b>sessions</b> 37:4</p> <p><b>set</b> 1:24 16:10 18:6 87:24 124:6 131:17 136:9 141:3 208:7,13</p> <p><b>setting</b> 101:18 130:7</p> <p><b>settle</b> 148:2</p> <p><b>settles</b> 159:17</p> <p><b>seven</b> 107:15,16 204:4</p> <p><b>several</b> 45:5 114:9</p> <p><b>sexual</b> 11:19</p> <p><b>shape</b> 174:2,4</p> <p><b>shared</b> 57:16 186:25</p> <p><b>sharp</b> 161:2,4</p> <p><b>Shearer</b> 18:11</p> <p><b>sheet</b> 32:22 35:3,11 49:21 128:8 146:20,21 148:18 153:15</p> <p><b>shied</b> 184:19</p> <p><b>shift</b> 129:1</p> <p><b>short</b> 191:17</p> <p><b>shortly</b> 109:19 144:3</p> <p><b>show</b> 6:2 102:13 127:8 147:3 162:3</p> <p><b>showed</b> 49:24</p> <p><b>shows</b> 56:10</p> <p><b>shrinking</b> 9:11</p> <p><b>side</b> 21:1 59:9 67:11</p> <p><b>sides</b> 4:25</p>	<p><b>sign</b> 39:11 145:12 152:3,6,12</p> <p><b>signature</b> 47:13 54:13 64:1 138:13 148:22 206:12</p> <p><b>signed</b> 39:16 114:6 135:20 138:17 139:3 188:1</p> <p><b>significance</b> 46:21 67:24 72:19 147:22 154:6 163:1,3,5</p> <p><b>significant</b> 44:22 48:22 85:7 92:10 92:11 109:6 163:10</p> <p><b>signing</b> 139:14</p> <p><b>signs</b> 49:25 114:7 114:13,18,20,23 115:3,5,12 118:6 118:14 167:3 190:21,22</p> <p><b>similar</b> 194:5</p> <p><b>similarity</b> 19:14</p> <p><b>simply</b> 120:20,23 175:13 181:25 195:21 204:7</p> <p><b>since</b> 7:24 9:15 14:19 40:2 41:15 81:18 103:18 127:16 174:5 176:11</p> <p><b>single</b> 73:23 114:22 120:19 176:12</p> <p><b>sir</b> 4:5 48:24 55:11 83:21</p> <p><b>situation</b> 70:1 72:10 81:18 109:24 113:17 152:17 167:20 174:13 185:20 199:12,16 201:2</p> <p><b>six</b> 32:13 97:6 164:25</p> <p><b>size</b> 5:1,3 52:20 56:11,15 66:20 161:20</p> <p><b>skin</b> 172:15 174:5 174:22</p> <p><b>Skylight</b> 2:5</p> <p><b>slash</b> 89:13 90:7</p> <p><b>sleep</b> 136:8 198:16</p> <p><b>sleeping</b> 136:7</p> <p><b>slip</b> 51:15</p> <p><b>slow</b> 154:19</p> <p><b>small</b> 85:6 92:10</p> <p><b>smooth</b> 115:23</p> <p><b>solid</b> 170:9 178:18</p> <p><b>some</b> 3:24 5:23 6:6 7:12 8:515:18 26:16 27:22 31:8</p>	<p>31:23 37:18 48:21 49:18 52:14 55:20 60:20 73:12 75:22 79:22 105:24 118:25 119:13 123:18 126:5 129:25 130:7,16 133:20 133:23 135:7 137:15 141:14 145:5 149:12 150:21 151:2,19 161:5,6 163:13 166:20,24 181:22 183:13 185:21,23 188:9,10 189:8 191:12 199:21</p> <p><b>somebody</b> 185:1</p> <p><b>someone</b> 51:20 59:11,13 74:11 81:14 92:2 109:24 110:20 111:8 122:22 124:23 135:17 150:20 195:20</p> <p><b>something</b> 4:13 16:6 23:21,24 24:19 29:13 32:23,25 38:10 45:1 49:6 52:6 74:22 75:9 88:2 104:17 113:13 125:17 139:7 141:10 155:1 156:1 160:16 166:15 169:20 180:16 185:25 196:2,5,6</p> <p><b>sometime</b> 4:15 136:3</p> <p><b>Sometimes</b> 83:16</p> <p><b>somewhat</b> 133:9 179:25</p> <p><b>somewhere</b> 32:12 84:17 107:18 108:11 145:3 171:23</p> <p><b>soon</b> 5:24 81:6 164:14 167:5,14 198:16 200:11</p> <p><b>sooner</b> 159:9 168:3 184:15,25 186:9</p> <p><b>sorry</b> 15:3,8 49:2 63:9 68:16 86:15 105:3 115:7 179:24 188:4</p> <p><b>sort</b> 8:8 23:21 38:8 57:20 102:19 115:18 119:12 166:12 179:10</p> <p><b>sound</b> 172:6</p>	<p><b>sounded</b> 181:14,18</p> <p><b>sounds</b> 183:1 201:17</p> <p><b>source</b> 27:18,24</p> <p><b>sources</b> 24:12 27:1 44:17</p> <p><b>South</b> 2:22</p> <p><b>so-and-so</b> 18:6</p> <p><b>space</b> 79:5</p> <p><b>spared</b> 176:20</p> <p><b>speak</b> 11:11 61:12 61:12</p> <p><b>speaking</b> 77:2 107:19 177:14</p> <p><b>specialist</b> 96:24</p> <p><b>specialize</b> 16:19</p> <p><b>specific</b> 28:20 70:10 71:1 84:13 89:7 89:16,19 106:21 147:7 169:9 185:19</p> <p><b>specifically</b> 12:11 23:4 24:8 25:20 34:20 41:11 58:6 71:18 94:16 113:13 116:7 129:20 131:21 145:2 181:18 183:8 184:16 185:13 195:23 200:9</p> <p><b>specifics</b> 42:18 144:22 181:1 182:7 186:22 187:4 189:10</p> <p><b>specified</b> 208:10</p> <p><b>speculate</b> 177:16 183:16 186:6</p> <p><b>speculating</b> 140:6 183:10,25 184:4</p> <p><b>speculation</b> 185:22</p> <p><b>speed</b> 172:1</p> <p><b>spelled</b> 18:12</p> <p><b>spend</b> 10:22 36:25</p> <p><b>spent</b> 8:18</p> <p><b>split</b> 175:22</p> <p><b>spoke</b> 59:14 155:4</p> <p><b>spring</b> 12:19 103:21,22,23</p> <p><b>Square</b> 2:21</p> <p><b>squeezing</b> 97:25</p> <p><b>SS</b> 208:2</p> <p><b>stabilized</b> 186:18</p> <p><b>staff</b> 13:4 106:3 119:15 121:20,24 122:4 124:24 168:19 172:19 192:21</p> <p><b>staffed</b> 99:5,14 101:25</p> <p><b>staffing</b> 205:2</p> <p><b>stage</b> 46:23 147:24</p>	<p>181:7</p> <p><b>stages</b> 102:12</p> <p><b>stand</b> 92:1 160:5</p> <p><b>standard</b> 20:14 25:24 27:22 36:2 36:5,20 74:25 75:8 86:3 87:15 91:21 104:16,17 105:22 116:19,24 117:2,8,22 125:16 125:23,24 126:4,6 127:5 137:5,19 197:14</p> <p><b>standards</b> 72:4</p> <p><b>standing</b> 165:14 182:20 197:21 198:20</p> <p><b>standpoint</b> 112:21 203:3</p> <p><b>stands</b> 134:25 147:16</p> <p><b>start</b> 28:22 121:15 122:12</p> <p><b>started</b> 3:21 80:5 140:13 149:16 163:15,17 175:22 193:18</p> <p><b>starting</b> 121:11 205:8</p> <p><b>state</b> 1:20 3:14 8:12 81:10 94:23 99:19 185:10 208:2,5,17</p> <p><b>stated</b> 136:25</p> <p><b>statement</b> 53:6,13 119:13 157:12 205:22</p> <p><b>states</b> 9:17 47:19</p> <p><b>stating</b> 202:22</p> <p><b>station</b> 68:4,8,10 72:17 78:21 143:21 147:15 149:8 154:4,9,25 155:21 157:1,4 159:3 161:14 191:6 193:25</p> <p><b>stations</b> 78:18,19 78:22,25 79:4 156:13</p> <p><b>statistics</b> 107:22 110:15</p> <p><b>status</b> 67:1 129:9 163:3 164:10 180:3 181:11 186:15 193:23 194:5,10</p> <p><b>statute</b> 1:17</p> <p><b>stay</b> 60:15 69:20 154:16</p> <p><b>Steiner</b> 6:25 56:18 56:20 58:14 60:25 61:1,13</p>
--	---	---	---	---



109:7 110:19,21 111:3,12,19,23 112:6 122:7 172:24 176:7 202:4 Steiner's 63:5 109:10 201:10 stenotypy 208:8 step 83:25 Stephanie 77:18,19 steps 76:20 167:24 sterilization 35:13 36:7 37:5 40:23 200:1,6 still 17:18,23 20:9 30:10 55:12 57:7 60:6,8 69:6 70:24 72:14 78:12 96:16 109:22 129:6 132:3 136:6 145:7 149:8 152:22 154:3 166:3 168:12,22 175:5 196:7 stock 120:12 155:15 stocked 120:16,19 stopped 58:19 103:19 109:19 110:22 stopping 109:18 Street 2:22 streets 96:20 stretched 175:21 strike 41:13 52:9 strip 82:16,22 83:9 83:15 164:7 strips 139:23 141:6 141:10,16 160:9 strong-arm 70:1 studies 25:17 28:20 97:9 study 97:12 stuff 164:3 184:8 subject 19:25 32:4 130:13 subscribe 22:5 Subscribed 207:19 subsequent 48:3 94:25 112:1 152:10 186:14 subsequently 15:11 55:24 137:16 substandard 118:8 substantial 93:7 successful 10:17 101:16 107:2,3 successfully 107:12 such-and-such 26:14 183:22 185:16 197:12	sudden 114:14 115:24 suffer 168:4 sufficient 119:14 suggest 44:16 135:5 suggested 69:19 190:11 suggesting 6:8 43:13 91:7 112:11 135:6 suggestion 136:23 suggestions 112:18 suggestive 165:6 168:2 suite 2:5 78:10,15 suites 78:18 sum 182:24 summary 33:12 187:4 Summit 2:22 supplant 90:22 supplement 38:8 supplies 120:12,15 support 56:8 174:15 supporting 16:15 102:24 sure 4:9,21,23 5:9 6:5 13:6 16:9 20:8,23 29:6,24 32:7 36:9 44:3 48:11 49:6 51:17 54:13 58:20 60:11 61:18 64:24 73:6 80:23 103:20 106:21 110:15 111:17 118:14 120:21 129:12,24 135:1 135:12 136:9 145:7 147:9 151:12,14,16 161:11 177:9 178:11 180:20 182:15,20 189:14 189:22 190:10 200:20 surgeon 98:14 173:9 surgery 12:14 94:15 110:25 122:23 170:13 surgical 122:13 203:19,21 surmise 116:13 surprise 53:13 72:21 surprised 53:5,12 53:16,21 82:1 133:7,9 suspect 43:18 suspended 10:4,6	sworn 3:10 126:15 207:19 208:6 symposium 11:6 symptom 115:18,18 152:11 symptoms 114:7,19 114:21,23 115:4,5 Systems 13:15 <b>S-H-E-A-R-E-R</b> 18:13  <b>T</b> t 160:14 table 111:9 172:20 tails 162:20 take 9:19 18:1 21:11 37:7 38:11 38:19 41:14 44:23 45:16 58:11 59:22 92:13 95:4 96:16 97:9 100:15 108:8,23 123:20 130:6 136:24 137:22 138:3 146:20 158:23,25 165:14 167:25 172:19 174:4 181:15 189:5,17 194:17 195:7 199:20 taken 1:18 4:5 17:6 17:10,13 24:24 68:2 78:7 97:3,5 129:23 138:20 152:21 171:19 172:5 177:17 183:23 208:10 takes 8:21 164:2 166:18 205:2 taking 37:1 82:13 97:23 103:1 119:2 129:2 141:21 146:7 161:9 165:17 166:2 talk 8:4,7 21:15 39:13 54:24 55:2 57:25 58:24 64:17 151:22 170:13 186:17 talked 40:20 50:11 59:25 77:16 79:24 85:1 88:21 91:2 95:3,8 128:10 177:22 179:25 187:7 talking 23:12 28:22 51:25,25 52:2 65:19 117:2 125:22 158:12 167:19 185:1	talks 94:10 teaching 10:20 11:23 12:11,12 team 87:24 122:13 203:19,21 204:20 tear 24:5 technical 22:23 26:10,19 27:2,13 28:11 33:23 104:5 telephone 47:11 58:25 61:14,22 64:9 134:20,24 136:24 195:17 196:21 tell 4:13,22 8:15 18:5 19:3 29:23 31:21,21 38:16 52:16 53:1 57:19 63:24 64:6 68:13 73:22 76:10 109:10 110:19 131:20 137:11 142:10 155:8,21 180:13 182:1 183:24 201:11 telling 136:18 tells 177:10 ten 31:25,25 80:19 108:11 Tenth 2:13 term 26:23 47:4 80:14 155:25 termination 32:9 32:16 terms 4:23 22:11 25:16 40:21 42:19 45:12 46:6 46:23 68:3 70:14 85:1 102:11 109:11 116:3 117:24 121:11 125:4 134:18 165:22 172:7 174:17 180:10 186:1 197:10 203:19 204:11 205:22 tertiary 98:23 99:3 99:14,23 100:9,21 101:10,25 103:12 105:14,23 test 51:9,13 84:21 188:6,7 testified 84:5 135:10 testify 126:22 208:6 testimony 5:1 71:2 83:8,10 124:10,15 126:15 127:14 140:3 146:18 208:7,9	tests 84:18 text 25:24 28:6 textbook 26:12 textbooks 26:7,8 texts 27:22 Thank 4:16 19:12 20:3 54:17,20 206:4 Thanks 25:12 206:6 their 26:17 38:12 38:13 42:7 61:5 84:18 95:6,9 96:24 117:9 146:11 181:12 198:24 202:15,19 202:20 thereof 124:12 Theresa 7:2 thereto 82:9 thick 68:7 72:16 82:25 83:12 176:5 thin 176:4 thing 5:25 36:18 137:19 151:20 166:12 173:18 174:22 181:4 182:13 185:17 188:22 189:11 201:12 things 4:22 5:19 28:12 57:7 71:23 80:16 84:19 92:7 103:4 114:21 115:8,13 120:11 132:20 139:20 141:22 144:8 145:14 149:9 157:8 161:10 163:21 172:2 181:14,22 182:13 186:18 193:2 196:14 204:23 think 6:1 17:21 19:5,8 20:17,19 20:22 26:6 27:5 34:25 35:10 38:11 43:6,16 44:2 146:5 50:11 51:18 52:3,20 55:12 59:23 70:2 70:3 71:12 81:14 83:11 90:7 92:1,7 94:20,23 97:11 98:2,4 100:19 105:11,11,22 109:13,23 113:9 113:14 114:9,22 117:10,19 118:21 122:11 131:25 132:3,20 134:22 135:1 143:12,17
---	--	--	---	--



144:2 150:17 153:1,4,15 154:11 156:22 158:16 163:18 164:13 165:21 170:3,6,23 171:24 172:9,13 174:3,8 178:4,13 179:4,15,23 181:18 183:3,11 183:23 184:8 185:11 186:13 192:6 193:10 202:25 203:19 <b>thinking</b> 65:5 82:25 100:3 109:15 146:1,3 182:14 <b>third</b> 122:22 <b>thorough</b> 36:22 201:18 <b>though</b> 4:7 17:21 49:20 61:23 132:8 175:21 191:20 200:5 201:17 <b>thought</b> 43:12 44:24 46:1 57:17 137:18 151:5,23 166:5 168:8,22 170:9 <b>three</b> 29:19 34:11 62:22 94:13 95:1 105:8 110:12,17 147:14 149:8 150:21 154:9,24 155:7,9 156:7,13 159:3 161:13,22 162:13 171:14 190:16 193:24 <b>threshold</b> 83:6 <b>throat</b> 96:24 <b>through</b> 6:24 22:21 23:22 36:17 44:23 47:2 49:16 69:24 97:24,24 135:19,20 137:10 142:15 161:8 163:11,22 167:1 174:15 175:10 182:8 190:23 207:3 <b>throughout</b> 52:20 68:21 134:4 162:5 <b>Thursday</b> 11:3 <b>tied</b> 62:4 182:2 <b>timed</b> 139:2 <b>times</b> 10:25 20:24 137:10 <b>timing</b> 179:13,14 <b>tissue</b> 150:13 175:21 <b>title</b> 14:6	<b>titled</b> 23:4 <b>tizzano</b> 1:7,12,15 3:2,7,12,15 18:6 39:23 79:11 134:21 187:15 188:12 201:24 207:17 208:6 209:2 <b>today</b> 5:2 16:8 62:2 72:20 100:13 102:8 <b>today's</b> 22:20 33:19 <b>together</b> 33:7 70:3 <b>told</b> 5:3 48:21 53:15 53:17 55:15 71:20 85:5,13,20 87:6 88:24 90:14 90:18 108:18 126:3 133:13 143:12 153:2 155:6 156:2,5,12 181:25 185:1,18 192:10 195:20 <b>tolerance</b> 84:18,21 <b>top</b> 149:15 162:12 <b>topic</b> 8:4 23:25 24:17 28:8,22 39:3 40:2 50:14 <b>torn</b> 175:15 <b>total</b> 182:24 <b>touch</b> 67:22 73:8 <b>touched</b> 16:12 58:4 58:8 <b>touches</b> 23:5 25:25 <b>tough</b> 154:14 <b>toward</b> 54:1 55:9 57:5 67:2 69:20 76:2 80:5 169:5 169:15 175:18 186:16 <b>Tower</b> 2:5 <b>town</b> 9:9,11 11:14 <b>tracing</b> 126:14 133:15 136:12 137:12 141:24 142:3,10,14 145:23 159:8 160:13 161:10 162:12,12,19,24 167:24,25 168:11 188:6 191:13 206:1 <b>tracings</b> 117:11,20 124:8,12,21 125:11 132:23,24 133:19 142:16 144:4,7 158:16,20 162:3 164:5,11 165:5,7,9 167:10 167:12 168:2,9 169:4 <b>track</b> 101:15	<b>tracking</b> 204:15 <b>traditional</b> 189:11 <b>traditionally</b> 96:6 <b>training</b> 8:15 9:4 <b>transcribed</b> 208:8 <b>transcript</b> 207:2 <b>transcription</b> 208:9 <b>transferred</b> 129:14 <b>transient</b> 158:20 178:21 <b>transpired</b> 129:17 141:18 182:4 202:8 <b>transport</b> 186:17 <b>transverse</b> 31:14,15 94:4,11,19 <b>treated</b> 13:9,10 199:21 <b>treating</b> 75:21 <b>treatment</b> 18:2 91:1 102:15 <b>tremendous</b> 98:6 <b>trial</b> 19:14 23:15 26:2 28:1 54:2 55:9 57:5 67:3 69:21 73:19,24 76:2 94:19 102:10 107:1 112:12,20 116:17 154:7 177:21 <b>trials</b> 28:13 108:16 <b>tried</b> 83:9,13 104:15 <b>tries</b> 84:17 <b>trimester</b> 47:17 <b>trouble</b> 200:10,20 <b>truth</b> 208:6,7,7 <b>try</b> 51:21 60:22 82:16 84:22 103:3 104:18 108:2 139:21 172:1 183:11 <b>trying</b> 106:20,23 122:25 140:23 149:12 155:16 161:4 171:12 177:19 181:23 185:22 186:1 <b>tubal</b> 34:9,12,22 35:12 36:6 37:5 37:17 38:2,24 39:7,12 43:10 114:5 200:14,21 202:3,8,16 <b>tube</b> 201:6 <b>turn</b> 72:21 105:18 148:19 160:10 <b>two</b> 6:25 7:6,8 13:19,19 17:3,4 17:15 29:18 33:3 33:25 34:1,11 39:6 80:16 87:18	96:4 98:12 110:12,17 112:25 114:13,14 122:5 128:1 132:20 140:25 143:21 149:3 157:1 168:7 178:15 184:5 190:16 191:6 <b>type</b> 8:25 22:24 36:2 92:21 93:1 94:8,15 102:20 123:21 130:7 136:11 167:5 <b>typed</b> 32:21 <b>types</b> 94:14 95:1 142:17 <b>typical</b> 54:11 82:21 134:1 136:7 <b>typically</b> 44:12 84:17 120:24 145:16 160:14 172:17 196:16  <b>U</b> <b>ultimately</b> 103:1 150:20 152:1 <b>ultrasound</b> 47:22 48:6,11 <b>umbilical</b> 98:1 <b>unavailable</b> 111:1 <b>unbeknownst</b> 97:15 <b>uncertainty</b> 185:22 <b>uncomfortable</b> 113:12,13 <b>under</b> 1:17 35:11 97:1 146:22 193:4,9 196:9 <b>undergo</b> 199:25 <b>underneath</b> 150:14 175:18 <b>underreported</b> 101:4 <b>understand</b> 4:2,11 4:12,14,23 5:2 13:13 21:8 28:25 31:13 45:2 60:22 73:3 76:13 87:2 88:16 89:5,23 91:15 92:2,5 95:16 103:3 152:14 157:14,17 173:24 181:23 190:10 193:11,19 197:3 <b>understanding</b> 17:23 95:19,24 102:25 126:12 160:11 187:19 193:2,20 196:20 198:15 <b>understood</b> 26:24	193:11 <b>uneventful</b> 47:4 <b>unfavorable</b> 74:20 <b>unfold</b> 200:12 <b>unfortunately</b> 93:13 <b>unless</b> 4:11 110:25 134:16 161:18 177:10 <b>unlike</b> 176:13 <b>unnamed</b> 30:1 <b>unnecessarily</b> 149:13 <b>unpredictable</b> 74:5 <b>unreasonable</b> 69:18 <b>unremarkable</b> 159:15 <b>until</b> 4:17,18 52:12 65:15 105:3,4 109:3,4,5 128:3 128:23 134:8 140:17 141:25 163:11 171:8,19 172:18 182:10 186:24 191:1,10 <b>untoward</b> 86:15 204:22 <b>unusual</b> 135:13 159:20 174:2,4 204:24 <b>updated</b> 26:11 <b>upper</b> 35:16 46:15 174:24 176:5 <b>urgency</b> 149:4 <b>urinary</b> 149:17 <b>use</b> 22:6 26:9 44:15 122:21 160:1 170:15 179:16 <b>used</b> 89:20 92:21 93:2,16 94:9 179:10 <b>using</b> 89:8 155:24 179:11 <b>usually</b> 12:9 24:5 26:9 161:17 195:6 198:8,9 199:6 <b>uterine</b> 31:15 57:21 58:2 70:6 73:22 74:2,5 75:2,7 76:3,11,13 77:3,4 85:7,14 86:1 87:13 88:3,9 92:11,21 93:6 94:2,3,17 97:8,13 97:19 98:7,12 100:25 101:3 114:8,19,24 115:4 115:5,9,14,19 116:2 118:7,15 119:3,6,7,10 138:19 145:12,16
--	---	---	---	---

145:18,25 149:25 150:21,23 152:3 152:11,12 166:17 176:4 190:5 201:7 <b>utero</b> 168:15 <b>uterus</b> 92:18 97:16 97:24 149:21 150:11,13,18 152:7 174:19,25 175:7,12,14,17 176:6 190:24 191:20 192:4,9,11 200:14	192:7 <b>VBAC's</b> 25:17 101:16,18 103:19 106:14 107:2,3,12 109:11,16 <b>VBAC/pamphlet</b> 88:20 <b>vehicle</b> 91:4 <b>venture</b> 108:21 <b>verbal</b> 37:18 139:12 195:16 <b>verbally</b> 91:21 <b>verify</b> 92:20 148:16 <b>versus</b> 18:6 <b>vertex</b> 67:14,20 68:7,9 72:16 143:20 147:15 156:23 157:9 161:23 191:5 <b>vertical</b> 93:13 <b>very</b> 6:4 22:6 26:17 36:22 42:4 46:1 47:9,18 74:5 97:11 98:4 110:15 114:13 115:1 135:13 146:14 147:25 153:4 154:19 158:19 159:17 161:1,2,16 162:19 162:22,24 164:1 166:12,15,17 168:16 170:25 175:2,11,19,20 176:4 178:18 180:20,24 181:5 182:20 185:13 188:22 193:4 194:5 198:24 200:9 201:6,17 204:24 <b>videotapes</b> 44:2,3,5 <b>view</b> 101:6 104:15 <b>violation</b> 86:2 87:15 <b>violence</b> 10:23,24 10:25 11:10,22 20:7 <b>virtually</b> 114:15 176:11,13 182:18 <b>virtue</b> 11:11 109:18 160:25 163:9 170:5 <b>visit</b> 47:2 51:8 52:23 54:8,25 55:3 61:1 62:25 63:11,17 64:18 66:17 67:10 72:15 73:7 77:3 80:7 82:5,17 83:19 <b>visits</b> 49:7,17,22	57:1 65:11 <b>vitae</b> 16:4 79:16 <b>vital</b> 49:25 <b>Vivian</b> 1:18 4:15 208:4,16 <b>vogue</b> 113:14 <b>voice</b> 181:21 <b>void</b> 149:5 <b>vomiting</b> 145:11,19 145:24 <b>vs</b> 1:6  ----- W ----- <b>Wadsworth</b> 78:2,6 78:12 <b>wait</b> 4:17,18,24 30:4 139:16 173:25 <b>waiting</b> 4:24 86:21 93:21 148:2 154:20 172:16 <b>waived</b> 206:12 <b>wake</b> 140:7 <b>walk</b> 189:12 <b>walked</b> 140:24 141:4 <b>wall</b> 97:24 <b>want</b> 4:25 8:2,6 19:6 26:23 29:12 44:17 49:18 60:22 61:11,12 65:7 80:6,25 81:5 89:7 91:15 93:8 93:22 103:20 122:19 126:4 127:3,24,24 129:11 132:1 137:11,12 141:15 146:16 158:1 167:4,13,13 168:1 168:7 169:20 170:13 171:16 176:15 184:2 185:20 186:5,6 189:7 190:10 198:22 199:23 200:20 <b>wanted</b> 6:1 64:24 65:15,17 122:14 152:22 189:9,25 198:3,4 202:21 <b>wanting</b> 64:19 110:23 <b>wants</b> 65:2 199:15 <b>wasn't</b> 22:2 43:13 49:6 54:13 66:13 109:24 120:18 142:24 146:1 152:22 156:12 163:17 169:4,14 179:10 180:22 184:15 203:9	204:18,19 <b>watchful</b> 117:19 <b>watching</b> 116:22 200:12 <b>water</b> 97:17 147:17 <b>wave</b> 160:2 <b>way</b> 7:25 31:3 46:20,21 57:19 58:12 64:15 82:14 89:1,22 95:4 97:18 107:22 116:4 121:24 126:5 137:4 151:16 169:11 175:22 181:25 182:4 196:16 198:18 <b>wayne</b> 1:29:14 17:16 50:21 96:22 <b>ways</b> 168:8 184:5 <b>Wednesday</b> 42:9 50:11 <b>Wednesdays</b> 37:9 <b>week</b> 57:17 61:19 74:12 <b>weekday</b> 61:20 <b>weekend</b> 111:2,4 120:24 <b>weeks</b> 32:14 51:2,3 52:23 54:22 56:13,23 57:13 66:4,8,11,12 73:12 74:18 75:22 84:22 <b>weight</b> 51:7 53:3 66:17 <b>well</b> 5:23 6:11 7:18 9:3 10:2 11:19 12:14 22:8,10 27:5,15 29:9 32:2 34:10 36:19 55:18 58:19 59:22 65:6,10 66:2 74:23 76:15 91:18 101:20 104:7 113:11 122:22 126:8 128:25 133:14 138:18 140:1 146:4 147:23 156:14 160:13 180:17 181:8 186:18 192:6 193:20 197:7 200:9 202:18 205:20 <b>went</b> 8:17,22 10:1 11:15 24:7 67:21 78:9 136:6,8 140:12,19 144:6 156:12 189:8	190:15 201:16 204:5 <b>weren't</b> 35:23 46:7 62:4 120:15 191:19 202:19 <b>West</b> 11:2 <b>whatsoever</b> 175:12 192:3 <b>WHEREOF</b> 208:13 <b>while</b> 14:9 15:24 58:2 141:14 162:2 184:13 194:8 <b>whole</b> 111:22 131:19 138:24 158:4 208:6 <b>Wiest</b> 1:6 <b>Williams</b> 25:25 27:23,23 28:5,6 <b>window</b> 175:7,16 178:6 <b>wish</b> 200:25 201:3 <b>wished</b> 189:20 <b>wishes</b> 202:24 <b>withdraw</b> 95:6,9 99:8 <b>witness</b> 1:16 3:7 18:23 19:1 20:4 21:7 43:8 89:25 92:15 93:24 100:1,12 114:4 122:11 170:1 171:24 208:13 <b>woke</b> 136:9 <b>woman</b> 94:3 99:21 100:8 101:8 152:6 198:3 <b>Woman's</b> 11:18 <b>women</b> 99:1 199:21 <b>Women's</b> 1:21 6:17 <b>Woods</b> 67:8 <b>Wooster</b> 1:21,22 2:10,17 6:15,17 12:25,25 13:11,25 14:1,13 58:15 98:17,18 103:19 106:2 116:14 173:4 <b>word</b> 90:7 <b>worded</b> 203:20 <b>words</b> 22:2 36:5 89:9,20 93:9 140:23 152:11 194:24 198:1 <b>work</b> 24:4 102:23 196:20 <b>worked</b> 13:5 27:5 95:19 134:17 194:17 <b>working</b> 5:25 123:4 129:11 133:18 <b>works</b> 198:7,8
---	--	---	--	--

201:15 <b>worry</b> 85:20 86:13 86:17 87:6 <b>worse</b> 97:1 <b>wouldn't</b> 18:18 37:16 50:5 57:18 102:8 109:25 136:9 163:5 200:25 <b>would've</b> 136:6 152:21 156:19 <b>wrenching</b> 182:21 191:18 <b>write</b> 38:18 81:21 135:16 164:4 <b>writes</b> 164:7 <b>writing</b> 14:21 20:13 43:23 <b>written</b> 15:18 39:11 41:18 42:4 62:19 69:12 137:4,19 183:19 184:7 <b>wrote</b> 41:21	10 140:18 153:19 172:4 <b>10-140</b> :16 <b>10-3-98</b> 35:5 <b>100</b> 147:14 154:3 156:6 185:9 193:23 <b>11</b> 62:3 <b>11:23</b> 196:6 <b>112</b> 51:7 <b>12</b> 209:4,8 <b>12th</b> 58:24 60:19 61:19 63:17 64:11 65:10,21,22 <b>12-26-98</b> 188:4 <b>12:05</b> 134:20 195:18 <b>12:25</b> 135:9 136:1 <b>13</b> 209:3 <b>13th</b> 208:14 <b>140</b> 160:18 165:13 165:16 <b>15</b> 5:22 108:11 140:19 172:5 205:18 <b>15th</b> 6:3 <b>150</b> 51:5 <b>16</b> 52:23 209:9 <b>16th</b> 49:2,3,4,12,17 50:4,17 52:12,22 64:17 65:9,20,23 67:6,18 68:5 70:14 72:15,24 75:24 80:11 81:11 83:19 188:16 <b>17th</b> 77:11 100:14 100:16 121:2,7 188:17 <b>170</b> 162:17 <b>1739</b> 1:22 <b>187</b> 209:9 <b>188</b> 51:8 209:4 <b>19</b> 197:23 <b>19th</b> 47:8 <b>1990</b> 15:8 40:6 <b>1993</b> 9:15 <b>1994</b> 29:18 <b>1998</b> 13:21,23 45:17 187:20 <b>1999</b> 22:17 45:17 58:16 95:13 100:16 101:8 112:9 121:2,7 184:22	20 31:11 95:21 96:2 108:4,23 205:18 <b>200</b> 2:21 <b>2000</b> 1:13 14:19 79:19 100:18 101:21 103:22,23 207:20 208:14 <b>2004</b> 208:18 <b>201</b> 209:5 <b>206</b> 207:3 <b>216-241-2600</b> 2:7 <b>216-623-0150</b> 2:15 <b>22</b> 105:2 <b>23</b> 79:16 <b>24</b> 84:21 209:7 <b>25</b> 107:18 196:4 209:5 <b>26</b> 84:22 <b>26th</b> 50:6,19 52:8 52:15 53:1,6 54:6 187:20 <b>28</b> 107:16 206:9	6 <b>6.4</b> 177:14 <b>6:00</b> 77:11 123:14 123:15,20 124:13 124:16 126:16 127:9,12 133:1,8 133:25 134:8 136:4 138:7 140:7 153:14,18 153:20,21,23 154:24 155:4,6 156:7,17 159:1 176:17,24 177:22 177:25 192:13,15 193:22 194:4,13 195:13 203:9,10 203:13 <b>6:08</b> 153:16,18 <b>60</b> 165:11 <b>60's</b> 160:17 <b>660</b> 2:5	8:14 178:19,23 <b>8:30</b> 171:14 178:2,5 <b>80</b> 2:22 88 8:14
<b>X</b> <b>X</b> 89:13 <b>X'd</b> 90:5	<b>X</b> <b>Y</b> <b>yeah</b> 19:8 <b>year</b> 7:1,7 8:13,24 10:25 11:5 12:18 12:22 14:8,10,19 17:22 107:5 110:17 <b>sears</b> 8:18 13:19,19 23:24 107:14,15 110:12 111:8	- -3-- 3 30:19 35:20 40:22 43:11 79:9,12,15 209:3,6,6,8 <b>3:00</b> 128:15 193:19 <b>30</b> 104:12 105:9 107:18 108:23 111:8 <b>330-375-1311</b> 2:24 <b>36</b> 52:23 <b>37</b> 51:2,3 52:24 56:12,14 <b>38</b> 52:25 54:21 56:13 66:21 <b>39</b> 56:23 209:7	7 <b>7:00</b> 129:1 <b>7:20</b> 128:22 <b>7:30</b> 127:6 140:5 <b>7:44</b> 127:4 140:1,4 141:18 143:15,18 143:24 144:14 145:21 152:19 156:21 158:14 168:21 188:21 189:24 190:7 205:1,8,10 <b>7:45</b> 144:14 204:9 <b>7:50</b> 142:9 143:12 158:16 162:3 163:4 178:17 179:23 <b>7:59</b> 160:6,7 162:3 163:4 165:5 179:23 <b>74</b> 51:7 <b>79</b> 209:8	<b>9</b> <b>9</b> 50:5 52:21 56:17 57:8 63:8 <b>9:00</b> 1:23 <b>9:56</b> 61:18 64:6 <b>90</b> 15:22 <b>91</b> 15:6 <b>91038</b> 162:13 <b>92</b> 8:21 15:6 <b>93</b> 14:19 <b>94</b> 10:15,16 <b>95</b> 10:16 29:6 32:3 45:11 <b>96</b> 32:13,17,18,19 <b>98</b> 6:23 35:20 40:22 41:2,10 47:8 52:23 84:11 <b>99</b> 5:22 6:23 7:3,21 7:24 65:10 79:16 84:12 96:7 100:14 101:6 108:9 109:12,21 110:12 116:15 188:17 204:10
<b>Z</b> <b>zero</b> 109:20 113:23 157:4 <b>Zithromax</b> 46:19 <b>Z-Pack</b> 46:19	<b>Z</b> <b>0</b> <b>00</b> 1:6 <b>0027</b> 1:6 <b>02</b> 165:15 <b>0802</b> 161:9	4 4 1:13 187:13,16 209:9 4/7 54:21 56:23 <b>4:15</b> 146:25 147:2,5 147:6 148:15,20 149:2,23 150:17 154:17 156:7,16 159:1 194:6,9,11 194:13,14 <b>40</b> 57:17 73:12 74:12,17 75:22 <b>41</b> 57:12 66:8,11,12 <b>42</b> 66:9,10 <b>44113</b> 2:6 <b>44115</b> 2:14 <b>44308</b> 2:23	8 8 30:18 153:19,22 208:18 <b>8:00</b> 152:2 160:7 162:4 164:20 165:6,23 166:10 168:20 <b>8:06</b> 163:16,17 164:12 <b>8:12</b> 165:23 166:8 166:11,21 168:20 174:1 178:1 190:12 191:1,3,4 191:13,19 192:5 192:21 193:8 203:18	
<b>1</b> 3:3 32:21 41:2,5 41:10 84:6 85:4 88:23 207:3 209:6 <b>1st</b> 69:1 <b>1-1-99</b> 188:3,4 <b>1-16</b> 67:8 <b>1-17-99</b> 195:18 <b>1-9</b> 67:10,12	<b>2</b> 2 39:24 40:3 55:10 84:4 90:21 209:7 <b>2nd</b> 50:6 54:8 <b>2:20</b> 206:11 <b>2:30</b> 128:14	<b>5</b> 5 47:3,7 48:20,25 <b>5th</b> 46:14 <b>50</b> 196:10		