IN THE COURT OF COMMON PLEAS

OF LORAIN COUNTY, OHIO

JASMINE MERRIWEATHER by and through her next Friend and Parent RHONDA MERRIWEATHER, etc., et al.

Plaintiffs,

vs. Case No.

ELYRIA MEMORIAL HOSPITAL, 98CV120349

and

LIENGKONG SIEW, M.D.

Defendants.

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Deposition of WILLIAM J. TODIA, M.D., called for examination under the statute, taken before me, Rebecca L. Stonerock, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at MetroHealth Medical Center, 2500 MetroHealth Drive, Room G230G, Cleveland, Ohio, on Friday, September 17, 1999, at 3:16 o'clock p.m.

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APPEARANCES:

On behalf of the Plaintiffs:

Rubenstein, Novak, Einbund
& Pavlik, by
WILLIAM J. NOVAK, ESQ.
270 Skylight Office Tower
1660 West Second Street
Cleveland, Ohio 44113-1498
(216) 781-8700

On behalf of Defendant Elyria Memorial Hospital Medical Center:

Weston, Hurd, Fallon, Paisley &
Howley, by
JOHN W. JEFFERS, ESQ.
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 44113-2241
(216) 687-3214

APPEARANCES, Continued:

On behalf of Defendant Liengkong Siew, M.D.:

Mazanec, Raskin & Ryder, by
LYNNE K. SCHOENLING, ESQ.
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Columbus, Ohio 43215
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WILLIAM J. TODIA, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF WILLIAM J. TODIA, M.D.

BY MR. NOVAK:

Q. For the record, could we have your name, please?

A. William Todia, T O D I A.

Q. And, Dr. Todia, I had an opportunity to get your CV prior to today. In 1992, November to be specific, could you tell me what you were doing at that time?

A. I was working at MetroHealth Medical Center, department of obstetrics and gynecology.

Q. And specifically, when you say you were working, what was your position?

A. My position was -- well, there's -- the position has not changed. There are two positions. I have an appointment as an assistant professor of reproductive gynecology at Case Western, and I have an appointment to the department of obstetrics and gynecology,

which is as a generalist obstetrician/gynecologist. So I have two positions, but my job at MetroHealth is primarily as a general obstetrician/gynecologist.

Q. When did that position commence, at what date?

A. 1990.

Q. And your residency finished up when?

A. 1990.

Q. At Metro?

A. No.

Q. Where at?

A. Northwestern in Chicago.

Q. Okay. Have you ever testified for the Weston Hurd firm before?

A. No.

Q. Have you ever done any work for Mr. Jeffers before?

A. No.

Q. Have you ever reviewed any cases for defense lawyers on behalf of the defense of litigating medical malpractice cases before today?

A. Yes.
Q. On how many occasions?
A. Probably 20.
Q. And --
MR. JEFFERS: You just said for the defense only.
A. Oh, I misunderstood. A total of probably 20. And of the 20, maybe 15 were for the defense, 12 for the defense. Some ratio like that.
Q. And during what period of time?
A. Since 1990 to the present.
Q. And do you know how Mr. Jeffers got your name to testify in this case?
A. I don't.
Q. And did Mr. Jeffers send you any correspondence before today regarding this case?
A. Yes.
Q. Could I see that, please?
A. That looks like something (handing).
Q. Thank you.
A. I can give you the --
MR. NOVAK: Would you mark this as

Plaintiff's Exhibit 1?

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(Thereupon, Plaintiff's Deposition Exhibit 1 was marked for purposes of identification.)

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A. I think that's all I have.

MR. JEFFERS: What's the date on that one, Bill?

MR. NOVAK: February 27, 1998.

MR. JEFFERS: Twenty-seven?

MR. NOVAK: Uh-huh.

Q. And then marked as Plaintiff's Exhibit 2 --

MR. NOVAK: Would you mark this? This is a letter dated September 3, 1998.

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(Thereupon, Plaintiff's Deposition Exhibit 2 was marked for purposes of identification.)

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Q. And in this letter dated February 27, 1998, there's a statement here from Mr. Jeffers' office, and it's Kathleen Mulligan, RN, Legal Assistant, and the statement says,

"It appears that the baby had three episodes of cyanosis, hypoxia and limpness, as well as seizure activity within the first 24 hours of life. She was transferred to University Hospitals." Would you agree in general with that paragraph?

A. Can I read it again, please?

Q. (Handing.)

A. To my knowledge, yes.

Q. And then there's a letter dated September 3, 1998 at which time Mr. Jeffers enclosed University Hospital records for you. Could you read to me what the handwriting says at the bottom?

A. It says, "11/23/98, Discussed with Jeffers. I said I found no evidence in chart to explain the neonatal seizures - but suggest that neuro peds." What I meant by that is that a neurologic pediatrician reviewer give him that -- an opinion.

Q. Okay. So when you provided your report on March 19, 1998, would it be fair to state that you did not have any of the subsequent treating records on this child?

A. I did not have records from

University Hospital.

Q. Right.

A. Correct.

Q. And when I say "subsequent treating," that's what I mean.

A. Correct.

Q. Okay. Now, have you ever been represented in any lawsuits by the Weston Hurd law firm?

A. No.

Q. Have you ever -- are you aware that Mr. Jeffers' law firm represents MetroHealth Medical Center in medical malpractice cases?

A. No.

Q. Let me ask you, what do you perceive your role as in this case? Do you perceive your role as being giving an independent evaluation of what occurred here and your opinions, or is your perception to be one of an advocate on behalf of the defendants?

A. My role is to review from an obstetric point of view the obstetric care that the patient -- the mother received and to give a fair and honest assessment of that care.

Q. Have you ever been sued for medical

malpractice?

MR. JEFFERS: Objection. Go ahead.

A. Yes.

Q. And can you tell me on how many occasions?

MR. JEFFERS: May I just have a continuing objection to this?

MR. NOVAK: Uh-huh.

MR. JEFFERS: Thank you.

A. Two times.

Q. And can you tell me, if you recall, the names of those cases?

A. Nope.

Q. Do you know how they resolved?

A. Yes.

Q. Can you tell me?

A. They were both dismissed because the plaintiff's attorney could not produce an expert witness to say I had done anything wrong.

Q. Now, you've just testified a few minutes ago that you were never represented by the Weston Hurd law firm under oath. But, Doctor, there's a case that I'm aware of filed March 26, 1993 by the name of Judy Johnson

versus William Todia, et al. Are you familiar with that case?

A. Yes.

Q. In that case you were represented --

MR. JEFFERS: What year was that, '93?

MR. NOVAK: Ninety-three.

Q. You were represented by Deirdre Henry, a partner of Mr. Jeffers at the law firm of Weston, Hurd, Fallon. Do you recall that?

A. No.

Q. So you're telling me you don't remember who your lawyer was at that time?

A. No. I never met a lawyer regarding that case.

Q. If I told you that the court records reflect that you were represented by Mr. Jeffers' law firm at that time, would you have any reason to dispute the court records?

A. No.

MR. JEFFERS: What is the name of that one, Bill?

MR. NOVAK: (Handing.)

MR. JEFFERS: Did you go through

this to see if there's any -- I don't know -- whether there was a subsequent representation or what happened, Bill?

MR. NOVAK: No, I did not.

MR. JEFFERS: It shows --

MR. NOVAK: That's a different case.

MR. JEFFERS: I was going to say, it shows Christine Reid.

MR. NOVAK: That's a different case.

MR. JEFFERS: Oh, it is?

MR. NOVAK: Yeah.

MR. JEFFERS: You have no memory of this?

THE WITNESS: I remember the case. I remember it was dismissed. I remember talking to a lawyer on my behalf on the phone, and Deirdre Henry sounds familiar, but I did not know what firm she worked for. I never met the person.

Q. I'm going to ask you to -- by the way, do you have any notes that you prepared other than your report?

A. No.

MR. JEFFERS: Well, there's some notes on that --

A. Yeah, I read that paper to you, but, I mean, not any other individual ones that I have in my stack.

Q. I'm going to ask you if you would please refer to the Elyria Memorial Hospital chart, specifically the labor and delivery summary.

A. Could you show me what page you're referring to? I don't know what you're speaking of.

Q. This would be the page here, and it's got a number 4 on it. I have a couple of questions about that chart.

Under the cord blood there's a circle that says "refrigerated." And according to information given to us by Mr. Jeffers on Wednesday, it is my understanding that the hospital would have discarded that blood approximately three days after discharge?

MR. NOVAK: Is that right?

MR. JEFFERS: If there's no doctor order to do anything with it, it would be refrigerated for three days and/or to the time

that the patient moves.

Q. Okay. I guess my question for you is this: I'm assuming as we sit here today that cord blood is no longer in existence, nor was there any analysis of that cord blood. Whose responsibility would it be to have any analysis done of that cord blood at a hospital?

MR. JEFFERS: Objection. Go ahead.

A. What kind of analysis are you referring to?

Q. Well, let's say, for instance, you wanted to know what the cord blood pH would be. Who customarily in a hospital setting would issue an order to determine what cord blood pH would be?

A. That's a test that would be ordered by the attending obstetrician.

Q. Okay. And with respect to any analysis of the placenta, would your answer stand the same?

MS. SCHOENLING: Note my objection.

A. The placental pathology would also be done at the request of the attending physician.

Q. Okay. Now, when I look at this

labor and delivery summary and we look at the column that says, "Labor summary," there's a check box for meconium; is that right?

A. Where are you looking?

Q. First column. Do you see that there?

A. Uh-huh.

Q. You would agree with that, right?

A. Yes.

Q. And then under "Delivery Data," under the column there's a subheading for "Cord," then it says, "Nuchal cord times one, true knot times one," and then parenthesis "(loose)." Do you see that there?

MR. JEFFERS: I couldn't hear the last one.

MR. NOVAK: I'm basically reading from here, John.

MR. JEFFERS: I didn't hear what you said after "true knot."

MR. NOVAK: "True knot times one (loose)."

MR. JEFFERS: Oh, okay.

Q. And then it also says. "Suctioned for meconium below cords per G. Thomas, RN."

That's in the last column. Do you see that?

A. Yes.

Q. And then there's also a box for gross congenital anomalies. Is there any checkmark in that box?

A. Show me where you're looking. I don't know where the --

Q. There's a box that says, "Gross congenital anomalies." Do you see that?

MS. SCHOENLING: Which column is it in?

MR. NOVAK: Last column.

MR. JEFFERS: Under "Initial newborn exam."

MR. NOVAK: Right.

MS. SCHOENLING: Thank you.

A. No, I don't see any checkmark there.

Q. Okay. And if there was a gross congenital anomaly, you would certainly expect Dr. Siew to mark that box there, wouldn't you?

MR. JEFFERS: Objection.

A. This was not completed by Dr. Siew.

Q. Well, Dr. Siew's signature signs off on that, does he not?

A. I don't see a signature of any doctor on this sheet.

Q. I think we'll all agree that the signature which is there --

A. Was his signature?

Q. -- is Dr. Siew's, yes,

A. All right. I didn't know that was the signature.

MR. JEFFERS: Lynne?

MR. NOVAK: Would you agree, Lynne, that that's Dr. Siew's signature?

MS. SCHOENLING: Well, I would just preserve my objection for the record. I'm not going to agree that this is his because I don't remember what he testified to with respect to this page.

Q. I want you to assume that that's Dr. Siew's signature. Would it be fair to state that either the nurse who signs it below or whoever's responsible for preparing this labor and delivery summary, if they noticed a gross congenital anomaly, they would check that off, wouldn't they?

MS. SCHOENLING: Objection.

A. Probably.

Q. Okay. And then there is -- I'm going to turn over to the infant's chart for a minute, page 37. And instead of having to turn over, let me just;, ask you real quick --

MR. JEFFERS: Well, wait a minute. He wants to see what you're doing.

Q. Tell you what I'll do, I'll pull it out to save you time. Page 37 is a Lubchenco chart for the weight percentiles, the length percentiles and the head circumference. Do you see those there?

A. Yes, I do.

Q. And would you agree with me that with respect to the head circumference percentiles, that is within a category that's considered appropriate for gestational age; is that correct?

MR. JEFFERS: Object.

A. I'm not -- I don't feel qualified to decide. This is a pediatric record and I'm not a pediatrician.

Q. Okay. But would you agree that what you're looking at there in the boxes that are marked off on the page would indicate, "Appropriate for gestational age"; is that

right?

A. I'd agree someone checked off the column, "Appropriate for gestational age," but I can't make an independent judgment if that's correct or not.

Q. I understand that. You are aware that this infant was delivered under conditions of fetal distress; is that correct?

A. That's incorrect.

Q. Well, Doctor, I'm going to refer you, while you're in the infant's chart, to the initial newborn profile, page four, and I'll ask you to turn to that.

A. Which chart is this in? The newborn chart?

MR. JEFFERS: It's one we had just a moment ago.

A. Okay.

Q. Do you see under "Newborn data," it indicates, "Intrapartum problems identified. Number 1, fetal distress"?

MR. JEFFERS: Where are we looking?

THE WITNESS: (Indicating.)

Q. Number 2, meconium fluid. Do you agree what is written down there on the

hospital chart prepared by Mr. Jeffers' client --

MS. SCHOENLING: Which page are we on? I'm sorry.

MR. NOVAK: Page four, initial newborn profile.

MS. SCHOENLING: Thank you.

Q. Do you agree with the assessment that says, "Fetal distress"?

A. No.

Q. So you disagree with what someone saw on 11/11/92 at 1:30 p.m. and 1:10 p.m. under the "Newborn Data" box marked as "fetal distress"? You disagree with that, right?

A. That's correct.

Q. So you feel as you sit here today that you are in a better position to determine whether or not there was fetal distress; is that correct?

MR. JEFFERS: Objection; that's argumentative now.

MR. NOVAK: I'm just asking if he feels he's in a better position.

MR. JEFFERS: No, because this is somebody else writing it down and we don't know

who wrote that down. Maybe the nurse was wrong.

MR. NOVAK: I understand.

Q. Doctor, I'm asking you a question. Someone on November 11 wrote down "fetal distress," and you're sitting here approximately seven years later, and my question for you is do you feel as you sit here today you're in a better position to evaluate whether or not this infant had fetal distress versus the person who wrote this down?

A. Yes.

Q. Now, are you aware that this newborn had bruises on its face?

A. Yes.

Q. Are you aware that this newborn had thick meconium suctioned?

A. No.

Q. Looking back at that chart, do you see the notation under "Detail abnormal findings" the notation, "Thick meconium suctioned below the cords times 4"?

A. I've seen the chart marked "meconium," but I've not seen "thick meconium." Could you show me what you're referring to? I

could not read the --

Q. Right there.

A. Okay. Now, I see it. I never had seen the -- I never had seen the "thick" before. Okay. I believe that.

Q. But it does, in fact, say "thick meconium," doesn't it?

A. Yes, I agree.

Q. You would agree with me that thick meconium is certainly different than just meconium fluid?

A. There are grades of meconium, and thick is one of the grades. It can be thin meconium or it can be thick meconium.

Q. From the standpoint of fetal stress, can you tell me what your understanding is of the significance of thick meconium?

A. Thick meconium can be an indicator of fetal stress, but as an independent variable, meconium alone does not correlate with fetal distress.

Q. Right. We have to look at all of the factors considered to come up with that kind of an analysis; is that right?

A. That's correct.

Q. Okay. But you would agree that thick meconium as has been described in this chart is an indicator; is it not?

A. No, I didn't say that.

Q. Is one of the indicators?

A. I didn't say that. I said it is not correlated, it is not an independent indicator. Thick meconium alone does not indicate fetal distress.

Q. That's not my question. Let me try to put it a little differently.

MR. JEFFERS: You said, "Didn't you just say," and he just said, "I did not say."

Q. No, a factor. Can it be a factor in looking at a picture of a fetus that was in distress?

MR. JEFFERS: Objection.

Q. A factor.

MR. JEFFERS: That's not a complete sentence.

A. I'm not sure I understand the question.

Q. Well, would you agree with me that thick meconium can be found in fetuses that have distress?

A. Yes.

Q. Okay. And we have to look at other factors in looking at a total picture to determine whether or not a fetus had distress; is that right?

A. Yes. Meconium can be found in 99 percent of patients -- of fetuses who do not have distress. So it is --

Q. Right. But would you agree with me that as this chart is written, it does indicate under "Newborn Data" that this fetus had distress?

A. No, this chart indicates that someone who I'm not even familiar with the signature wrote "fetal distress."

Q. Right. That's what I'm saying. Somebody wrote down "fetal distress" here, didn't they?

A. Right.

Q. Okay. Now, let's talk about Apgar scores for a few minutes. Those are subjective, aren't they?

A. Everything in medicine is subjective.

Q. Well, pH of cord blood isn't

subjective, is it?

A. Sure.

Q. Well, that's a scientific test, isn't it?

A. It's subjective because it has to be -- the test has to be performed by someone and then interpreted, Just like every test in medicine is -- there's no perfect test.

Q. Well, are you telling me, then, that you can get a false positive on -- that's the wrong word. Are you telling me that a lab test that's run on cord blood has a certain element of inaccuracy to it?

A. Yes, it does.

Q. Okay. Why don't you tell me what the range is for cord bloods plus and minus.

A. I'm not a pathologist, but there are ranges of accuracy of every machine that performs laboratory tests. But I cannot tell you off the top of my head what the range is for the machine that performed the cord pH.

Q. Well, do you look at -- I'm sorry.

A. Go ahead.

Q. Do you look at cord pH's on a regular basis in your practice?

A. Yes.

Q. Would you anticipate and expect that the results of those lab tests that you get back are accurate?

A. It depends on what you mean by "accurate."

Q. Well, in other words, if you get a 7.0, don't you expect that to mean what the 7.0 means?

A. Not always. It's taken in context with all of the data available. And there are times when 7.0 cord pH is inaccurate. There are mistakes. There are -- there are reasons why the test is not perfect, for a lot of reasons; how the sample was taken, how it was carried to the lab, who performed it in the lab, how the machine was calibrated.

So there are times when you get a result to any test in medicine which is inaccurate and which you have to discard because the whole picture does not add up.

Q. Okay. So I guess what you're telling me, then, is that if we had a blood gas taken on this infant at 1359 hours and it came back at 7.21, that's possible that it could

have been lower than that?

MS. SCHOENLING: Objection.

MR. JEFFERS: Object.

A. Anything's possible, but I don't think that that's relevant to that pH.

Q. Well, I guess my question is a few minutes ago you just told me that there can be inaccuracies based upon the way the lab data is it arrived at, and my question for you is do you have any idea as to how they arrived at the 7.21 at 1359 hours?

MS. SCHOENLING: Talking about arterial blood gases?

MR. NOVAK: Right.

A. That were drawn on the newborn. No, I don't have any idea. I'm not familiar with the pathology laboratory at Elyria Hospital.

Q. Okay. So I guess my question is that based upon the way it's done, the way it's collected, the way it's turned over to the lab, could be that the lab result for the pH could have been lower than the 7.21; isn't that right?

MS. SCHOENLING: Objection.

MR. JEFFERS: Objection.

A. Anything's possible, but that's a ridiculous question. This all started by saying aren't Apgar scores subjective, and I said that everything in medicine is subjective to interpretation. And now we're on cord pH's and whether I know whether the result of the 7.21 is accurate or not.

Q. Well, do you know whether or not it's accurate?

A. I don't have independent information about the accuracy of that. I have to take it in context with everything else that was going on.

Q. As you sit here today, do you have any reason to believe that the 7.21 that's recorded at 1359 hours was inaccurate?

A. Just as I think that I've no reason that the Apgars of 6 and 8 would be inaccurate, I don't have any reason to believe the 7.21 was inaccurate either.

MR. JEFFERS: Stop. Please read that back.

MR. NOVAK: I heard it.

MR. JEFFERS: I know. I think I

heard it and I think you heard it, and I'm asking her to read it back, which is my right, and I'm having it read back.

MR. NOVAK: Okay.

(Record read.)

Q. So, Doctor, I guess my question for you is, then, you don't have any reason to believe the 6 or the 8 are inaccurate?

A. Correct.

Q. You don't have any reason to believe that the 7.21 is inaccurate, right?

A. Correct.

Q. But you don't think that the words "fetal distress" written here are accurate, do you?

A. No, I do not.

Q. Did you ever talk to any of the personnel at Mr. Jeffers' hospital that were deposed in this case?

A. No.

Q. Did you ever speak to any individuals involved in the care of Rhonda Merriweather or Jasmine Merriweather?

A. No, I have not.

Q. So your only opinion as to whether

or not these recordings are accurate or inaccurate is based upon a review of the chart seven years later; is that right?

A. That's correct.

Q. And, in fact, as we sit here today, you didn't even know that there was thick meconium suctioned four times below the cords until I pointed it out to you; isn't that right?

MS. SCHOENLING: Objection.

A. I did know that there was meconium, but I did not know that the word "thick'' was included.

Q. Right, Now, I want to ask you a little bit -- you've taken a look at this chart. Do you see any progress notes written by Dr. Siew between the time that this patient enters the hospital and commences labor up until the time she delivers?

A. No, I don't recall any. I don't recall seeing any.

Q. Would it be fair to state that as we sit here today, we have absolutely no idea of what Dr. Siew's sense impressions were and mental thought processes were regarding the

care and treatment of this patient during her labor?

MR. JEFFERS: From the record only?

MR. NOVAK: From the record. From the record.

MR. JEFFERS: Because he's also had in front of him Dr. Siew's deposition.

MR. NOVAK: I'm talking about the record.

MR. JEFFERS: I just want to make sure, because you should know that he has seen Doctor -- I don't know whether he's read it all, but he's seen it.

MS. SCHOENLING: If the question is do we have any information from the totality of the record as to Dr. Siew's thought processes from the time of labor until the delivery -- is that the question?

MR. NOVAK: Right.

MS. SCHOENLING: Note my objection to the question.

MR. JEFFERS: Also, if we're getting into the realm of his evaluation of Dr. Siew, he wasn't retained for that purpose, but go ahead. Just so you know.

Q. Okay. Now that they've made that objection, is there any mention anywhere in the chart -- any writing by Dr. Siew indicative of his thought processes regarding the care and treatment of this patient during her labor?

MS. SCHOENLING: Objection.

A. I don't find any notes by Dr. Siew of the -- about the patient during labor. So that's the answer to the question.

Q. You train residents in OB/GYN here, do you not?

A. Yes.

Q. Would you agree with the general statement that meticulous recordkeeping by an OB/GYN is very important, isn't it?

A. It's something that I try to teach, yes.

Q. An OB who doesn't write any notes during an entire period of labor, would you say that that comports with meticulous recordkeeping?

MR. JEFFERS: Object.

MS. SCHOENLING: Join in the objection.

MR. JEFFERS: Go ahead.

A. No, it's not meticulous.

Q. Are you familiar with Dr. O'Grady, who is going to testify in this case?

A. Only from reading his expert report, but not -- I have no other personal knowledge of him.

Q. Did you ever know him when he was here in Cleveland?

A. No.

Q. Have you ever read his book on Operative Obstetrics?

A. No, I have not.

Q. In your library, do you have Williams on Obstetrics?

A. Yes.

Q. Do you have Kreasy on Maternal Medicine?

A. Yes.

Q. Let me ask you a question, because Dr. O'Grady is going to be an expert in this case. I want to ask you, in a preface to the book he wrote he has a statement here, and it says --

MR. JEFFERS: This is the book that's written subsequent to this case?

MR. NOVAK: Right. This is the immortal book.

MR. JEFFERS: This is in 1990 when?

MR. NOVAK: Right.

MR. JEFFERS: No, 1990 when?

MR. NOVAK: Five.

Q. "In the preparation of this text, our purpose is to promote thoughtful, compassionate, and technically and ethically competent clinical medicine with close attention to patient communication and meticulous recordkeeping." You'd agree with that in general, wouldn't you --

MS. SCHOENLING: Objection.

Q. -- about meticulous recordkeeping?

MS. SCHOENLING: Objection.

A. I'd like to read the paragraph in context, please. Do you want to read it to me?

Q. Sure.

MR. JEFFERS: Why don't you just hand it to him?

MR. NOVAK: Sure.

A. I've never seen the book, so --

Q. It's pretty good. You ought to take a look at it. Tells doctors how to stay

out of trouble.

A. We could all use that.

MR. JEFFERS: Don't respond to his comments.

A. Would you like me to read the rest of this in the record? "It is not possible to practice obstetric without complications with either damaged infants or mothers. The unfortunate result seems to speak very clearly to this case."

"While the majority of these problems prove to be of trivial consequence, some are potentially serious. Some rarely will prove fatal. These misadventures can be prevented while others remain unavoidable. The only certain statement is that any serious injury to mother or infant could be subjected to peer and usually legal review."

He then goes on to say, "In preparation of this text, our purpose is to promote thoughtful, compassionate, and technically and ethically competent clinical practice with close attention to patient communication and recordkeeping."

So I would agree with the intent of

this preface. It seems to be good common sense for all medical practice.

Q. While we're on the issue of meticulous medical records, is there any indication in the chart between the hours of 9:30 and the time when Dr. Siew comes back to see this patient at approximately noon that any of Mr. Jeffers' nurses contacted Dr. Siew?

A. I'd have to look at the nursing notes.

8:30 a.m. there's a note, "Dr. Siew notified." 9:30 a.m. there's a notation that says, "Dr. Siew here to check patient." I can't remember the time parameters you gave me in the question.

MR. JEFFERS: Nine-thirty and noon, Bill?

MR. NOVAK: Uh-huh.

A. It appears to be the next note about Dr. Siew is 12 something, maybe 12:10. I can't read the -- "Dr. Siew here. Internal monitor placed."

I'd also need to look at the tracings because there were some notations on the tracings that I don't know if there was --

I can't remember what they said about Dr. Siew.

"8:30, 4 CM, vaginal exam per Dr. Siew." So that means Dr. Siew was there then.

MR. JEFFERS: What time?

THE WITNESS: Eight-thirty a.m.

A. I don't see any other notations until the 12:10 notation that I read.

Q. Okay. So my question, then, is between the hours of 9:30 and 12:10, at no time did any of the nurses at Elyria Memorial Hospital notify Dr. Siew, at least as far as the record reflects, regarding this patient's condition?

A. None that I'm aware of.

Q. Okay. Now, I'd like to look at the fetal heart strips, if we could, and I'd like to start at the beginning of the strips. Now; would it be fair to state that --

MR. JEFFERS: You're starting at 65404?

MR. NOVAK: Right.

Q. Would it be fair to state that virtually all the literature, including Williams on Obstetrics, indicates that a normal baseline fetal heart rate is between 120 and

160?

A. Yes.

Q. Now, looking at 65404 and 05, would you agree with me that that baseline is above 160?

A. Yes.

Q. And that baseline continues above 16Q for 06, 07 and 08; isn't that correct?

A. Yes.

Q. And then on 09 it continues above 160, doesn't it?

A. Yes.

Q. And 10 it's above 160, isn't it?

A. Uh-huh.

Q. And then we see some variability on 11. Do you see that there?

A. I see variability all the way from 65404. So if you want to point out what you're referring to -- I'm not sure what you're referring to.

Q. Well, just in general there's variability on 11. Because we do have periods --

A. There's variability -- I don't understand the question.

Q. Well, we'll get to that in a minute, but what would you say the baseline is on 11?

A. It looks like the baseline is about 160.

Q. And then at 12 we have a baseline above 160 again, don't we?

A. Yes.

Q. At 13 we're above 160?

A. Uh-huh.

Q. At 14 we're above 160?

A. I think so.

Q. Now, 12 and 13 represent somewhat diminished variability, don't they?

MR. JEFFERS: Which numbers, Bill?

MR. NOVAK: 12 and 13.

A. I would define it as minimal variability in those panels. Variability is taken over a period of time, so it's difficult to -- to do variability by each minute is incorrect.

Q. Now, 15, 16 and 17, would you agree that the baseline is still above 160?

A. No, it looks like it's at about 160. Maybe we're quibbling over 160 or 162.

It appears to be -- baseline is a mean heart rate, and so it appears to be right around 160. Maybe it's 162.

Q. Now, 18 and 19 and 20, baseline above 160?

A. On 18, 19, 20, yes.

Q. Okay. Now, 21, 22, 23, right at about 160; is that right?

A. Looks like that, yes.

Q. And then 24, 25 and 26; pretty much the same at about 160?

A. Yes.

Q. And 27, 28, 29, the same?

A. At 27, 28, 29, yes.

Q. Same with 30. And then at 31 and 32 would you give me your impression of what the baseline is there?

A. Could you repeat the question?

Q. Yeah. At 31 and 32, what's your impression of what the baseline is?

A. Still looks like about 160 as an average. Maybe 155. It's been -- there's a moderate variability and an acceleration, so it's difficult to average it out over two minutes.

Q. Now, at 34 and 35 and 36 --

MR. JEFFERS: Which ones?

Q. At 34, 35 and 36 we are once again above 160, are we not?

A. At 34, 35 and 36, that's hard to average. It's going to be -- there's moderate variability in this area, which makes it tougher to say. It may be 165. It's 160 to 165. It's -- yeah, maybe it's 165. It's hard to average in that short a time.

Q. We had some recordings at that time that were almost as high as 180; isn't that right?

A. It looks like it was 180 one second is the only one I see.

Q. Okay. And then --

A. That looks like it's part of the moderate variability I'm speaking of.

MR. JEFFERS: And you're responding to his questions not by looking at the broad spectrum of the graph, but only by looking at the sections he's asking for --

A. Correct.

Q. Correct. If we go to 36, 37 and 38, it appears that we are above 160; isn't

that right?

A. For times -- you mean is the baseline above 160?

Q. Yes.

A. It looks like it averages out to 165. I don't see an appreciable change there.

Q. And at about 9:30, which is panel 36; according to the chart, Dr. Siew was there; is that right?

A. Panel 36, did you say?

Q. Yes.

A. I believe that's what the note said in the nurses note. Yes, "Dr. Siew here to check patient."

MS. SCHOENLING: This is at 9:30?

MR. NOVAK: Yes.

A. At 9:30 that's what the note indicates.

Q. Now, panels 39, 40 and 41, can you tell me what your interpretation of those is of the baseline there?

A. At 39, 40 and 41? Okay. It goes to -- looks like it's, again, about 160. At 160, maybe 162. Between 160 and 165.

Q. And then 42, 43, 44?

A. One sixty.

Q. And how about 45, 46, 47?

A. I'm going to say 160 again. Between 160 and 165.

Q And how about 48, 49 and 50?

A Same. No appreciable change.

Q Now, when I look at panels 51, 52, 53, would you agree with me that we are beginning to see some change?

A Tell me the panel numbers again. I'm sorry.

Q On 51, 52 and 53.

A Change in what? I don't know what you're asking.

Q Well, you're talking around 160. We're seeing a change now above 160; isn't that right?

A No, I don't agree.

Q. All right.

A. I think you're seeing moderate variability and accelerations. Accelerations are not a change in the baseline. They're a sign of good fetal oxygenation. They're a reassuring part of the strip. They do not -- and that's what you're seeing in those areas is

moderate variability with fetal accelerations, over-15-beat-per-minute accelerations for 15 seconds or more.

Q. Okay. Now, when we see these accelerations to 180 --

MR. JEFFERS: Where are we talking about?

MR. NOVAK: On 51, 52 and 53.

A. Uh-huh.

MS. SCHOENLING: Objection. Just note my objection. I don't think that we see 180 on each of those panels, but go ahead.

MR. JEFFERS: You mean because there's none on 52?

MR. NOVAK: But there is on 51.

MR. JEFFERS: Yeah, but in your question you said all three.

MS. SCHOENLING: You said 51, 52 and 53.

Q. Here, my question is on 51, 52, 53 where you have accelerations to 180, do you feel comfortable with those accelerations?

A. Very comfortable. That's a very good sign.

Q. Even though the baseline at this

point has been generally around 160 or above?

A. That meets the definition for acceleration. A greater-than-15-beat acceleration from baseline lasting for more than 15 seconds is a reassuring sign on a fetal monitor strip of good fetal oxygenation.

Q. All right. Now, panels 54, 55, 56, would you agree the baseline's above 160?

A. It's again about 160 with the accelerations, 163, maybe 162. I don't think there's appreciable change in it.

Q. Panels 57, 58, 59, above 160?

A. 57, 58, 59 was the question?

Q. Uh-huh.

A. No change.

Q. Above 160?

A. Yes, same as it was in the previous panels.

Q. And panels 60, 61, 62, above 160?

A. It's 163. Looks like the same to me.

Q. And panels 63, 64, 65, above 160?

A. 63, 64 and 65?

Q. Yes.

A. Baseline's still 163, 165,

something in that same range, same baseline.

Q. Now, we're at a time period that, according to the labor and progress chart, would be when Nurse Lanser at 10:30 writes down for baseline fetal heart rate 160's, 170's, and at 11:00 writes down 160's, 170's. Given what her interpretation is, 160's, 170's, do you feel that her interpretation is accurate?

A. I need to see the note where you're speaking of her writing it down. I don't have that page.

Q. (Indicating.)

A. Thank you. So this says at 10:30 -- okay, baseline, heart rate. And then at 11:00 was the second part of your question?

Q. Right. And she writes down 160's, 170's.

A. Yes, I think the baseline was between 160 and 170 at those two times.

MS. SCHOENLING: I'm sorry, your answer was that it was accurate?

THE WITNESS: My answer was, yes, that it was accurate, that the baseline was between 160 and 170 at those two times.

Q. Now, 69, 70, 71 --

MR. JEFFERS: We were just now referring to 66, 67 and 68.

MR. NOVAK: Right. Now I'm on 69, 70, 71.

Q. Baseline?

A. It has not changed. It's the same.

Q. Okay. And 72, 73, 74, baseline?

A. Again, I don't see an appreciable change.

Q. So we're still over 160; is that right?

A. 163 it looks like to me. Between 160 and 165, yep.

Q. Okay. And panels 75, 76, 77, baseline?

A. I think it's the same. Unchanged.

Q. Okay. Now, at any time between the time that Dr. Siew saw this patient at 9:30 and up through panel 65477, which would take us up to a little past 11:30, are you aware of anytime when Nurse Lanser or any other nurse notified Dr. Siew that this patient never came below 160 as a baseline?

MS. SCHOENLING: From 9:30 to 11:30?

MR. NOVAK: Yes.

A. I don't see any -- I'm not aware of any written indication in the charts that there was a conversation between the two of them.

Q. And I'd like you to assume, also, that neither one of these individuals have any independent recollection of any conversations that took place at that time. Do you understand that?

A. I can't assume that. I don't know that's true or not.

Q. Well, did you read the depositions of these individuals?

A. I don't recall either of them saying that either way.

Q. I want you to assume that the records reflect that neither one of them have any independent recollection other than what is in the chart. Can you assume that?

A. No. How can I assume something I don't know if it's true?

Q. I'm asking you to --

MR. JEFFERS: Bill, he's already stated he doesn't see that there was any communication between 9:30 and 12:00 or 12:10,

whatever that is. So why do you keep going with this?

Q. And you would agree with me that the text such as Williams on Obstetrics --

MR. JEFFERS: The what?

MR. NOVAK: Williams on Obstetrics.

Q -- which you use as a teaching text here at this hospital; isn't that right?

A It's one of many sources of information we use, yes.

Q It's a reliable authority, isn't it?

A It's informative. It's not -- nothing is the authority in obstetrics.

Q Right. But it's something that you people rely on in obstetrics?

A. Q. We rely -- we take all information, not just one textbook.

Q No, I understand that.

A One is one. Williams is one of the --

Q. Right.

A - textbooks that I read and that I incorporate into the body of knowledge that lets me practice obstetrics.

Q. Okay. And you would agree with me that the baseline in Williams for a normal fetus is between 120 and 160?

MR. JEFFERS: He's already said that is a generality.

MR. NOVAK: You're stipulating that, aren't you, John?

MR. JEFFERS: I'm stating that, in fact, you already got the answer to 120 to 160, and now we're doing this again.

Q. Now I'm going to ask you this question: Given that this patient's baseline exceeded 160 from the time that Dr. Siew saw this patient up until 11:30, do you see anything in there where any of Mr. Jeffers' nurses notified Dr. Siew?

MR. JEFFERS: You said exceeded it from that time on. I'm not sure we agreed that it exceeded 160 from that time on. I think that's a misstatement and mischaracterization of what has just been testified over a number of minutes.

MS. SCHOENLING: Assuming that's an objection, I'm joining in that objection.

MR. NOVAK: Okay. Whatever.

Q. Would you agree with me that there is nothing in the chart to indicate that whenever this patient had baselines above 160, Mr. Jeffers' nurses never notified Dr. Siew?

A. I cannot find any written record of a conversation between any nurse and Dr. Siew during that time, no.

Q. Okay. Now, on panel 483 --

MR. JEFFERS: Wait. Wait. I'm skipping. At 483?

MR. NOVAK: Uh-huh.

Q. There was a spontaneous rupture of membranes at approximately 11:50; is that right?

A. At 483. Let me find the right sheet. 483, 11:50, yes, the notation says, "Spontaneous rupture of membranes, clear liquid" -- "clear fluid, Nitrazine positive."

Q. Okay. And then when we look at panels 87, 88, 89, would you agree with me that the baseline stays at about 160?

A. Was it 87?

Q. 87, 88, 89.

A. It looks like it's about 160 from 84, 85, 86, 87, 88, 89, yes.

Q. Okay. Now, when we go to panels 90, 91 and 92, we see that Dr. Siew appears, according to the fetal heart strips, on panel 91. And would you tell me what your interpretation of the baseline is for those panels?

MS. SCHOENLING: For 91, 92?

MR. NOVAK: For 90, 91, 92.

A. Appears again to be around 160 -- 160, maybe 165 for the same -- I don't see an appreciable change from the last -- over the last two hours.

Q. Now, one appreciable change we have here is that there was meconium expelled; is that right?

A. Note says, "Dr. Siew here. Vaginal exam, 5 centimeters. More fluid expelled, meconium stained," yes.

Q. Now, panels 93, 94, 95, would you agree with me that the baseline is above 160?

A. It looks the same. It looks like it's in that 160-to-165 range.

Q. And 96, 97, 98, would you agree with me now that the baseline is at about 170?

A. At 96, 97, 98, did you say?

Q. Yes.

A. Yeah, it looks like in that -- those three panels, yes.

Q. Any recording there that any of Mr. Jeffers' nurses notified Dr. Siew?

MR. JEFFERS: There's nothing to indicate that Dr. Siew wasn't still present at that time.

A. I don't -- I'm not sure what time this is. Let me figure out what time it is. 12:20, 21, 22 -- 28, 29, 30. What were the panels you were asking the question about? Was it 96, 97 and 98, during that time?

Q. Yes. Yes. Yes,

A. I have to look back at the nurses notes again.

MR. JEFFERS: Are you indicating that the testimony isn't that Dr. Siew was basically there that entire time?

MR. NOVAK: Say that again?

MR. JEFFERS: By the way, what time are those panels, 96 --

THE WITNESS: 12:30 is the time. 12:30 would be right here. 12:30 would be right under 96, if I counted the minutes

correctly. I counted from the 12:20 notation, and each solid line is a minute. So I think that's 12:30, but I still -- I can't -- let me -- I'm still looking for the nurses notes.

MR. NOVAK: And while he's doing that, John, just so the record reflects it, your issue as to whether or not Dr. Siew was there, apparently at 12:55 there's a note that says he was notified --

MR. JEFFERS: Notified, right.

MR. NOVAK: -- so we have to assume he wasn't there.

MR. JEFFERS: I don't assume that.

MR. NOVAK: I know you don't.

MS. SCHOENLING: You're saying at 12:45 you've got a notification on the record?

MR. JEFFERS: 12:55.

MR. NOVAK: 12:55.

MS. SCHOENLING: Okay. I was going to say, I don't see 12:45. Thanks.

A. I don't know if Dr. Siew was there or not.

Q. Okay.

A. The nurses note -- there's not an independent note that I can find about 12:30,

so I don't know what was said at 12:30 at that time. I don't know whether there was -- I mean, I can't find any -- I can't find any note about the time 12:30, so I don't have any information in the chart.

Q. I have a question for you. At this hospital, if you ordered an emergent C-section, from the time you ordered the emergent C-section up until the time of delivery, what was the average amount of time it takes?

MR. JEFFERS: Objection.

MS. SCHOENLING: Join in the objection.

A. I don't know. I honestly don't know what the average in this hospital is.

Q. Well, let me ask you in your experience, when you order an emergent C-section, how quickly do you want to get the delivery finished?

MS. SCHOENLING: Objection.

MR. JEFFERS: Objection. This is a tertiary care institution. Go ahead.

A. The standard of care is to perform a C-section within 30 minutes.

Q. But there are different kinds of

C-sections, aren't there?

A. No, that's what -- then I misspoke. The standard of care is to perform an emergent C-section within 30 minutes of the decision to perform the C-section, to have the baby delivered. That's the national standard of care.

Q. If you wanted to, you could do one quicker, couldn't you?

MR. JEFFERS: Object.

A. Depends on the circumstances. No, it's not if you wanted to. Unfortunately, it depends on personnel, it depends on a lot of things. So it's not a desire, it's limited by your physical constraints.

Q. Wouldn't it be fair to state that at this institution you've performed them within seven minutes?

MR. JEFFERS: Objection; that's not relevant.

A. I don't have any independent recollection of that. I've not -- I mean, that's possible, but I don't have an independent recollection. I've not kept a stopwatch on the time from when I've decided to

perform one and when the baby's been out. So I can't honestly answer you -- I can't give you an honest time of my best time ever performing a C-section.

Q. How many babies do you deliver a year?

A. About 100. Maybe between 100 and 150.

Q. And out of those 100 to 150, how many of those are C-sections?

A. Twenty to twenty-five.

Q. And out of that --

A. It's about 15 percent, yeah.

Q. And out of that 20 to 25, how many of those are emergent C-sections?

MR. JEFFERS: Object to what his experience is.

MR. NOVAK: Are you telling me he doesn't have any, John?

MR. JEFFERS: No, I'm just saying --

MS. SCHOENLING: He didn't say --

MR. JEFFERS: -- I'm objecting to this line of questioning at this hospital, meaning Metro.

MR. NOVAK: Oh, okay.

A. I don't know how you define "emergent." I'm having --

Q. Okay. Let's talk about C-sections. Within the realm of emergency C-sections, isn't there a category called "emergent," emergent being the highest priority, let's get it done right now?

A. Yeah, there would be a group that you want to get done ASAP.

Q. Out of the 20 to 25 that you've done --

MR. JEFFERS: It was 20 to 25, you said?

MR. NOVAK: That's what I thought.

THE WITNESS: Uh-huh. I think so.

Q. Out of those, how many of those were what we would call "emergent."

A. I don't have an independent recollection. I can only guess that it would probably be a fifth, a fourth, if that. I mean -- but -- so I can't give you an exact number. That would just be my guesstimate.

Q. And out of that fifth or fourth, did you ever perform any of those under 30

minutes?

A Yes, I performed all of them within 30 minutes.

Q Okay. In looking at panels 02, 03 and 04 --

MR. JEFFERS: Going back?

MR. NOVAK: Uh-huh.

A I'm sorry, 02 -- is that the beginning or the end?

Q It's 02, 03, 04. It's near the end.

A Near the end. Sorry. Wait. Can you help me with where you're at? What's the full number?

Q 655022

A 65502, all right. I'm back to 654. 65502. Okay. It's after where we were.

Q 02, 03, 04.

A Correct. I've got the panels.

Q Would you agree with me the baseline is above 170?

A Yes, looks like it's about 170, 173, 175.

Q. Now, I'm going to go up to 05 and 06. I'm going to stop there for a minute, if I

could. We're almost at the end. I'm going to stop at 06 for a minute. We see a notification at that point that Dr. Siew was notified, and then it says "FHR," and then arrow up. Let me first of all ask you, what do you take FHR with an arrow pointing up to mean?

A. FHR usually stands for fetal heart rate. And that arrow up would, I assume, mean up.

Q. Okay. Now, prior to the notation here of Dr. Siew being notified because FHR up, are there any other notations in the chart that Dr. Siew was notified of fetal heart rates being above a baseline of 160?

A. Just the notations I've read before.

Q. Okay. And then when we go over to 07, 08 and 09, we already get to the delivery; is that right?

MR. JEFFERS: Get to the what?

MR. NOVAK: Delivery.

A. 07, 08 and 09? Correct.

Q. Okay. Now, in a patient that has a baseline above 160, is it your practice to use an internal fetal monitor?

MR. JEFFERS: Object.

A. That's too general a question to answer. The baseline is not the only thing that's taken into account when I make the decision to use an internal monitor.

Q. Okay. Was there ever an internal monitor used on this patient?

A. I believe so, but I, again, need to look back and see where -- I think there was an indication, but maybe I misread it. One second.

Maybe my recollection is from one of the depositions, but I thought I read somewhere -- it may have been in the deposition -- that there was an internal monitor, but now I can't find the notation to say where it was.

Q. I want you to assume that sometime after 12:00 there was an internal fetal monitor placed based on the record.

A. I think there was.

MR. JEFFERS: I'm trying to find the --

MS. SCHOENLING: I think it was 12:18.

THE WITNESS: 12:18. Thank you.

Q. Now, let me ask you, in the face of a persistent baseline heart rate above 160, do you routinely use any internal fetal monitor?

MR. JEFFERS: I thought we just had that question.

MR. NOVAK: I changed it a little bit.

A. I don't do anything as a routine. Again, it depends. The baseline is not the only criteria for evaluating a fetal monitoring strip. The decision to use an internal fetal monitor is based on baseline and the rest of the criteria. So the answer is it's too general a question for me to give you a "routine1y" answer.

Q. Okay. Now, according to the chart, 12:18 is the time the internal fetal monitor was placed. Let me ask you, the decision to do or not to do any fetal scalp sampling, whose decision is that?

A. It would be the decision of the attending physician.

Q. And would it be fair to state that as you look at this chart, there were no fetal scalp samplings done?

A. None that are indicated in the chart that I'm aware of.

Q. And would you agree with me that a fetal scalp sample is used generally to detect whether or not there's any metabolic acidosis taking place; is that right?

A. No, it's to detect the pH in the fetal blood. It does not give an indication of the reason for the pH. You get only a pH reading. You cannot tell metabolic or respiratory acidosis from a scalp pH sample.

Q. Let me ask you, what is the value of the pH sample for you from a scalp sample -- pH value from a scalp sample? What is the value to you?

A. The value is to either -- it's used to either reassure the physician that the baby is -- that the pH is normal or to -- or to find that the pH is below the normal range and requires some sort of -- I mean, in which case there are other criteria that would make you suspicious that there is -- that the baby might

have some degree of stress or that the fetal heart rate tracing is nonreassuring to you so that you then need to use an additional test, which scalp sampling is, to either refute your suspicions or confirm them.

Q. Okay. Now, if you are confronted with a pH of less than 7 from a fetal scalp sample, would that concern you?

MR. JEFFERS: Object.

A. That would not be a normal value for a fetus, no, of a scalp sample.

Q. Would it be a concern on your part of some metabolic acidosis taking place?

A. As I said, you can't tell the reason for the metabolic acidosis without a complete blood sample -- without a complete blood analysis of actual cord blood or arterial blood.

Q. Right. Right.

A. And a scalp sample only gives the pH. It doesn't give you the indication of the reason why the pH is low.

Q. Right. Right. And Mr. Jeffers' expert on Wednesday agreed with the statement that the best predictor of metabolic acidosis

is, in fact, the cord blood. Would you agree with that?

A. The cord blood -- the cord blood gives you all the parameters that make it possible to judge whether acidosis is respiratory, mixed or metabolic. So the cord blood does give you the parameters to make that assessment.

Q. You've read Dr. Reilly's report?

A. I think so, yes. His expert report? Yes.

Q. Dr. Reilly, in his testimony on Wednesday, his testimony was that the best predictor of metabolic acidosis was the cord blood. Would you agree with that statement in general?

A You mean an arterial cord --

Q Yes

A -- a sample of the arterial cord pH and complete evaluation? Yes.

Q Okay. And unfortunately, in this case we don't have it because the cord blood no longer exists; is that right?

A Right. I wish we did have it. It would settle a lot of questions.

Q. And that decision not to do an analysis was Dr. Siew's; is that right?

MS. SCHOENLING: Objection.

A. As I said before, the decision to run the test is the decision of the attending physician to order the test. So the fact that it wasn't ordered means he didn't -- he decided no€ to order it.

Q. Are you going to give any testimony in this case regarding whether or not one has to have cerebral edema in the case of hypoxic-ischemic encephalopathy?

A. No, I'm not.

Q. And are you going to give any testimony in this case regarding CT scans or MRIs?

A. No, I'm not.

Q. Are you going to give any testimony in this case regarding any anemia that this newborn had?

A. No.

Q. And by the way, there was no maternal infection here, was there --

MR. JEFFERS: No what?

MR. NOVAK: Maternal infection.

MR. JEFFERS: Okay.

Q. -- as far as you could see?

A. The way you'd know is if we had the placenta to evaluate. But I don't have any other independent -- there's no information in the chart that says that there was maternal infection that I know of.

Q. We went through this with Dr. Reilly on Wednesday and I asked him obviously, since we don't have any placenta, we can't determine whether or not there was any placental causes for any perinatal asphyxia in this newborn. Is that a fair statement?

MR. JEFFERS: Objection. This is outside of his realm now.

A. Could you repeat the question?

Q. Would it be fair to state that since we don't have a placenta here, we can't determine whether or not any causes of this child's problems are related to placental problems?

MR. JEFFERS: Objection.

A. Not having a placenta just means that we don't have any information that it could have given us.

Q. Right. Right. And would it be fair to state that the antepartum history of this mother doesn't demonstrate any issues relating to anything going on in her that would cause a situation of hypoxic-ischemic encephalopathy in this newborn?

A. Ask that again or read it again, either one.

MR. JEFFERS: Why don't you read it back?

Q. Well, here, maybe I'll ask it a little better. Prior to her labor, is there anything that Mrs. Merriweather demonstrated that would lead you to believe that the cause of this newborn's hypoxic-ischemic encephalopathy is related to her?

A. I can't answer the question because the infant did not have hypoxic-ischemic encephalopathy. I don't -- so the question doesn't make any sense in this case. It's not -- that's not the diagnosis. That's not the reason for this infant's subsequent course that I'm aware of, so I don't understand what you mean.

Q. Okay. Well, here, you are now

saying it's not the reason, so obviously you're going to testify with respect to cause, and I want to know what you feel the cause of this infant's subsequent neurologic sequelae was.

A. What I know is that the cause of the subsequent neurologic sequelae was not asphyxia in the intrapartum period, meaning in the period of labor and delivery. I don't know what the cause was. I'm not a neurologist. I'm not able to tell you the -- I'm not able to give you the differential diagnosis or the cause of what it was, but I can tell you what it was not and it was not asphyxia in the intrapartum period.

Q. Would you agree with me that cord compression can cause asphyxia?

A. Not in this case.

Q. I'm asking you in general. Can cord asphyxia cause compression?

MS. SCHOENLING: Can cord compression --

MR. JEFFERS: You've got them reversed.

MR. NOVAK: Cord compression.

MR. JEFFERS: Yeah, but you said

"cord asphyxia."

MR. NOVAK: No, I didn't.

MS. SCHOENLING: Yes, you did.

MR. NOVAK: All right. I'm sorry.

MR. JEFFERS: Just trying to help you out and you want to fight me on that one.

Q. Can cord compression cause asphyxia?

A. It would have to be cord occlusion, prolonged occlusion of the cord, if that's what you mean. Usually when we talk about cord compression, we talk about an intermittent or short-term event. So usually we don't talk about cord compression and asphyxia together.

Asphyxia results from no flow or severely decreased blood flow and oxygen to the fetus. So you would have to occlude the flow of blood to the fetus. And if you did that by occluding the cord, then, yes, you can cause asphyxia.

Q. If you have a true knot in the cord that's not loose, you can have asphyxia, can't you?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

A. If the true knot occludes the cord and there's no blood or oxygen to the fetus, then that would cause hypoxia and subsequent asphyxia.

Q. Would you agree that one of the manifestations of cord compression is a fetal heart rate above baseline?

A. Would I agree that a manifestation of cord compression is -- that's too general a question. That's not -- there's -- it's --

Q. Can you have elevated fetal heart baseline above 160 with cord compression?

MR. JEFFERS: Wait. Say that one again.

Q. Can you have an elevated fetal heart rate above 160 with cord compression?

MR. JEFFERS: I'm going to object to this line of questioning that relates to all these possibilities, but go ahead.

A. The opposite happens with cord compression. As a rule, with cord compression when you occlude or compress the cord and decrease the flow of blood and oxygen to the fetus, what you see is a decrease in heart rate, a deceleration in the heart rate. And

when the cord compression is relieved, because it frequently is a short time-defined event, then the fetal heart rate actually returns to its baseline. So I disagree that cord compression generally causes an increase in fetal heart rate.

Q. So if we come to trial in this case and I cross-examine you with standard literature that one of the manifestations of cord compression or a knot in the cord can be an elevated baseline and the fetal heart rate above 160, you're going to refute that literature; is that right?

MR. JEFFERS: Objection to it because you aren't showing him the literature.

A. I'd like to see the literature you're referring to. You just changed the wording of the question. That wasn't the question that I answered, the previous question.

Q. All right. Well, I'm going to ask you --

A. The previous question didn't say, "one of the manifestations." You said cord compression results in an increase in fetal

heart rate above baseline.

Q. I didn't, but I'm going to make it a little clearer if I didn't. Would you agree with me that one of the manifestations of a compression of a cord can be a fetal heart rate above 160?

THE WITNESS: Read that one to me again, please.

(Record read.)

MS. SCHOENLING: I'm going to object to the question. We're on this path of possibilities, and I'll just object on that basis.

A. It's too general a question. I'd need the specifics of where the cord -- how much the cord's compressed, for how long, at what time, where things started. It's not a -- there's a lot of manifestations of cord compression, and so it's -- I'm having trouble giving you one of the cord compression manifestations.

Q. Well, if Dr. Reilly testified on Wednesday that one of the manifestations of cord compression is an elevated fetal heart rate, are you telling me that that's a lot of

hogwash?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

A. I'm not familiar with what Dr. Reilly testified or the question that he answered on Wednesday.

Q. Well, I'm telling you that that's what the testimony was.

MS. SCHOENLING: Objection.

Q. And if that is, in fact, the testimony, are you telling me that that's a lot of hogwash?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

A. I don't know what the testimony was. I can't answer for someone else and I'm not going to tell someone else that they're -- incorrect.

MS. SCHOENLING: Here, Bill --

MR. NOVAK: I know what it says. I know what it says.

MR. JEFFERS: You don't want to --

MS. SCHOENLING: You don't want to show this --

MR. NOVAK: It's firmly imprinted

in my cerebrum.

MR. JEFFERS: But you have a defective cerebrum.

MR. NOVAK: Horse apples.

MR. JEFFERS: Like --

MR. NOVAK: Horse apples.

A. Would you like me to read his testimony and then comment about it?

MR. JEFFERS: Sure.

Q. My question is I want you to assume that Dr. Reilly testified that a manifestation of an elevated fetal heart rate is -- I'm sorry, I want you to assume that Dr. Reilly testified that a compressed cord can manifest itself as an elevated fetal heart rate. Do you degree or disagree with that?

MR. JEFFERS: A what cord?

MS. SCHOENLING: A compressed cord manifests itself in an elevated fetal heart rate. And we're asked to assume that Dr. Reilly testified to that effect. I object to the question.

MR. JEFFERS: I object, too.

A. There are multiple manifestations. Increased fetal heart rate can be one of them,

but that's -- it's too -- it's too broad a statement for me to agree with.

Q. I'm going to be done right away, so let me just look at this.

MR. JEFFERS: Off the record.

(Discussion off the record.)

Q. All right. I'm going ask you if you agree or disagree --

MR. JEFFERS: What page?

MR. NOVAK: Page 88.

MR. JEFFERS: Okay. I'll give him that in a second. Let me find it first.

(Handing.)

Q. I'm going to ask you if you agree or disagree --

MR. JEFFERS: Note the context.

A. Can I read the --

Q. Well, I'm going to read the question and answer to you, and you tell me if you agree or disagree with his response. On page 88 the question is, "Would you agree with me that a true knot in the cord can cause cord compression and can lead to perinatal asphyxia?" Answer: "Yes."

MR. JEFFERS: What line is this?

MR. NOVAK: Line 5 to line 8.

Q. Do you agree with his response to that question?

A. If the cord -- if the knot completely occludes the cord, then yes, I agree.

Q. And then the question is on line 12, "At various stages it was recorded as having a true knot?" And he answers, "Yes." Do you see that?

A. I see that. I see what you're reading.

Q. And did you see at various portions in the chart there was a recording of a true knot?

A. I saw one place at the time of delivery they recorded there was a loose true knot in the cord.

Q. Okay. And then it says, Question: "Would you agree with me that cord compression can produce elevated fetal heart recordings?" And his answer was, "Yes."

MR. JEFFERS: Where are we now?

MR. NOVAK: Line 15, response line 18.

Q. Do you agree with that answer to the question?

A. It's too short an answer. It's yes, in context with a lot of things, which I already described to you what happens when you get cord compression, and it's not just elevated fetal heart rate. It's only -- it's that in the context of a number of other things.

In other words, elevated fetal heart rate alone does not come from cord compression. That would be an incorrect answer to that statement. If it's one of many things -- if it's in a pattern of other things, as I described, then the answer is yes.

Q. Would you agree with me that we have three abnormal recordings in this chart with respect to this newborn, and those recordings were, apart from the fetal heart rates, fetal distress -- would you agree that that's an abnormal recording?

MR. JEFFERS: Wait a minute.

A. No, I don't -- we talked about someone we're not familiar with writing the words "fetal distress" after the delivery, and

I disagreed with that when you brought it up the first time. So I don't -- I guess I'm missing your question.

Q. Doctor, I understand you disagree with the person who was there on November 11 of 1992, but would you agree with my statement that someone who wrote down the words "fetal distress" is indicative of less than a normal newborn?

A Repeat that question.

Q Would you agree with me that the words "fetal distress" -- that's not a normal recording, is it?

A You mean -- no, fetal distress is not written in most initial newborn profiles that I've read.

Q. Would you agree with me that thick meconium suctioned four times below the cord, that is not normal, is it?

MR. JEFFERS: And where are you reading from now?

MR. NOVAK: From the initial newborn profile. I think that's what it is. Or is it the labor and delivery sheet on page four?

MS. SCHOENLING: I think it's the L&D sheet.

MR. NOVAK: L&D sheet on page four.

A. No, the vast --

MR. JEFFERS: Where are you looking?

THE WITNESS: He's saying thick meconium.

Read the question again, please.

Q. I'm sorry, no, it's not. It's on the initial newborn profile. And my question for you is is thick meconium suctioned below the cord times four, is that a normal finding at the time of delivery?

MR. JEFFERS: Object. Go ahead.

A. Almost always it's associated with a normal neonate.

Q. So you're telling me that thick meconium suctioned below the cords is almost always associated with a normal neonate?

A. Normal neonatal outcome, yep.

Q. Didn't you tell me earlier that thick meconium is of more concern to you than just meconium fluid?

A. Yes.

MR. JEFFERS: He said 99 percent, I think, or some fantastic sum like that.

A. Maybe I'm misunderstanding the question, but meconium in all of the studies is almost always associated with normal neonatal outcome, meaning that after the meconium is identified and is suctioned, there is a completely normal baby, goes home with the mother and grows up to be a healthy normal person. And that's what I'm saying.

So most -- the vast, vast majority of the time, meconium is associated with a normal neonatal outcome. And I think that's what you asked; is it normal.

Q. It's an abnormal finding, isn't it?

A. It's a finding that happens 15 percent of all deliveries. I mean, so it's not -- 85 percent of the time it's not there, so it's not -- so it's more uncommon.

When there's meconium, it means you need to be assured that there -- I mean, you need to look at the rest of the picture and you need to suction meconium at delivery. But as I said, in the end, it's a normal part of labor and delivery for the vast, vast majority of

infants.

Q. Is it an abnormal finding? That's my question. It's that simple: Is it an abnormal finding?

MR. JEFFERS: It's not that simple, and he's defined it and answered you. And he's answered you twice actually. He answered your earlier --

MR. NOVAK: Well --

MR. JEFFERS: Wait. I'm not through with my sentence. And he's now answering you again.

MR. NOVAK: Are you done with your speaking objection, which is not permitted? Are you done with that?

MR. JEFFERS: No, I'm pointing out to you that you. ace now being repetitious, and that is an appropriate objection.

Q. Doctor, let me ask you, in this chart they have a column that says, "Detail all abnormal findings," and in this chart they write down, "Thick meconium suctioned below the cord times 4," under a column that says, "Abnormal findings." Now, do you disagree with the placement of "thick meconium" under a

heading that says, "Abnormal findings"?

A. Not in that context, no.

Q. And are we all on the same page on this Apgar score thing? You agree with me and you agree with Dr. Reilly that they're subjective, aren't they?

A. Yeah, this is the same line of questioning we had. We went through what subjectivity there is in all of the interpretation of tests.

Q. Right.

A. So, yes, as it's -- as there's subjectivity in every other test that the patient had, it's subjective.

Q. I want to talk a little bit about the last four numbered comments you have in your report.

MR. JEFFERS: Pull your report out. Do you have it there?

THE WITNESS: Yeah. Okay, I have it in front of me.

Q. Okay. Before the four numbered comments, you have a sentence that says, "It should be noted that making a diagnosis of intrapartum asphyxia causing a neonatal

neurologic deficit requires all of the following,'' and then you go through four numbers. Okay. The first question I have is where and in what literature did you come up with these four numbered items?

A. This is the criteria established by The American College of Obstetrics and Gynecology and The Academy of Pediatrics. It's a joint statement that was established and published in both literatures, and it's been -- it was not a -- and it was decided after a number of studies bore out the fact that this was -- that this condensation of information was necessary in order to make a diagnosis of intrapartum asphyxia.

Q. What year did that study take place?

A. There were multiple studies. I cannot -- I can't give you that off the top of my head. I can look them up and I can pull them, but I can't give you the year of all the studies that contributed to that statement.

Q. Prior to today, did you have an opportunity to review any literature before writing your report?

A. Prior to today? In the last two years?

Q. Prior to writing this report, did you look at any literature?

MR. JEFFERS: Are you asking him for the purposes of writing the report, did he --

MR. NOVAK: Yeah.

MR. JEFFERS: That's not what you asked him.

MR. NOVAK: Well, whatever. I'm getting tired.

A. Okay. These are taken directly out of the -- they're a quotation from the American College of Obstetrics and Gynecology technical bulletin that discusses birth asphyxia.

Q. All right. Do you --

A. And I don't have that with me, but that's -- but I reviewed that and a number of other studies in my file that talk about birth asphyxia, cerebral palsy, fetal heart rate abnormalities.

Q. Can you provide us with a copy of that bulletin that you are referring to?

MR. JEFFERS: He can provide me

with a copy of the bulletin. I will make copies of that and I will send it to anybody interested. I mean, it's open to the public.

MR. NOVAK: But would you please be so kind as to do that?

MR. JEFFERS: I will. I mean, once I get it, I will then do that.

Q. Okay. Question number 1 --

MS. SCHOENLING: By the way, Bill, it's January 1992.

MR. NOVAK: What is?

MS. SCHOENLING: When the technical bulletin was published.

MR. NOVAK: That depends on the one that he used.

MS. SCHOENLING: Well, I'm pretty sure--

(Discussion off the record.)

Q. All right. Now, number 1, it says, "Profound umbilical acidosis, metabolic or mixed acidemia." Now, Doctor, the fact of the matter is we can't have umbilical acidosis because Mr. Jeffers' hospital discarded the blood, right?

A. Yeah, the test was never ordered.

Q. The closest thing we have here is the arterial blood gas which has a pH of 7.21, and that took place at 1359 hours; is that right?

A. Correct.

Q. Okay. And would you agree with me that this newborn was on oxygen from the time of delivery up until 1359 hours when that was done; is that right?

A. I think -- I think that's right. I think it was -- there was oxygen in the hood. I think I remember reading that. I can't remember the percentage or how it was given, but I think you're right.

Q. Okay. And would you agree with me that a pH of 7.21, according to the standards at Elyria Memorial Hospital, is below normal?

A. For arterial pH?

Q. Uh-huh.

A. Yes, it's lower than their referenced normals.

Q. Okay. Now, number 2, you say, "Persistence of an Apgar score of 0 to 3 for longer than five minutes." And we're all in agreement that Apgar scores are subjective; is

that right?

A. As is everything else.

Q. Except your testimony.

A. Oh, it's just as subjective as everyone else's.

Q. I see. Then on number 3, "Neonatal neurologic sequelae." Now, are you telling me that this newborn did not have neonatal neurologic sequelae?

A. From my reading of the summaries, I think they did have neonatal neurologic sequelae. That's why we're here.

Q. Okay. And then you say number 4, "Multiorgan system dysfunction; for example, cardiovascular, gastrointestinal, hematologic, pulmonary or renal." But the fact of the matter is that you did not have the University Hospital records at the time you wrote your report, did you?

A. No. I only had the neonatal records from Elyria Hospital.

Q. Now, Dr. Reilly yesterday was familiar with the studies of Perlman that indicated that in 67 percent of the cases of hypoxic-ischemic encephalopathy there is

multiorgan compromise, and out of that 67 percent, 70 percent is limited to only one organ. Are you familiar with that study?

MR. JEFFERS: Objection. Go ahead.

MS. SCHOENLING: I'm going to object to that as well.

A. I don't have an independent recollection of reading it. I haven't read it recently enough to know the -- I'd need to reread it to comment on it.

Q. Would you have any disagreement with the notion that you don't have to have multiorgan system compromise in every case of hypoxic-ischemic encephalopathy?

MR. JEFFERS: Objection.

A. No, I won't -- I can't agree with that because I'm not -- I'm not familiar with the study you're quoting, so I can't --

Q. I'm just asking you a general question.

MR. JEFFERS: He answered.

MS. SCHOENLING: He answered it.

MR. NOVAK: No, he didn't.

MS. SCHOENLING: He said, no, he wouldn't agree with it.

MR. NOVAK: No, he said he's not familiar with the study. I'm asking the question now in general.

Q. Do you agree or disagree with the following statement that I'm going to make: That you don't have to have multiorgan system compromise in every case of hypoxic-ischemic encephalopathy?

A. Honestly, I don't know the -- I can't say for sure. I can't say for sure either way. I'm not familiar enough with all of the neonatal literature to comment on whether there's ever been a case that was reported that -- so my -- I mean, my answer is I can't give you -- I can't give you a firm answer. I don't know.

Q. All right. And having reviewed the University Hospital chart, are you aware that the serum creatinine was.9?

A. I don't remember that. I don't --

Q. I want you to --

A. Again, as a -- I did not review the charts with a view to the neonatal care because I didn't -- I'm not an expert. I'm not a pediatrician or a neonatologist. So I don't

have an independent recollection of the serum creatinine.

Q. Doctor --

A. I just -- I remember reading the summaries of the hospitalizations, but I don't remember them commenting upon that.

Q. I'm not trying to be flip with you, but you were the one who put number 4 in here, and so -- and you said that there was -- required all of the following, and I take that to mean that you didn't find any multiorgan system dysfunction or compromise; is that right?

A. I do not think there was -- that the definition of "multiorgan system dysfunction" -- how do I -- let me say that over again. The information that I'm aware of there was not a diagnosis in this infant or in this neonate of multiorgan system dysfunction in any of the records that I reviewed.

Q. And at the time you had reviewed this case, you did not have the UH records?

A. At the time I wrote the letter?

MR. JEFFERS: But he has had them now.

A. I since have had -- I since have read the summaries of the UH records, and in no summary does anyone give the diagnosis of multiorgan system dysfunction.,

Q. Let me ask you this question: Did you see that there were grossly bloody stools in this newborn?

A. I saw that there was a note that said that on one day, yes.

Q. And can grossly bloody stools be a manifestation of enteritis?

MR. JEFFERS: Of what?

MR. NOVAK: Enteritis,

MR. JEFFERS: Okay. Objection.

A. In a neonate?

Q. Uh-huh.

A. Again, I'm not sure of the complete differential of bloody stools in an intensive care neonate. I'm not a neonatologist, so I'm going to leave that up to the neonatologists to say. I don't treat neonates, so I'm not -- I really can't tell you.

Q. Are you aware that from a cardiovascular standpoint, this newborn had tachycardia?

A. Yes, I remember reading that.

Q. Are you aware that from a pulmonary standpoint this newborn had respiratory distress?

A. That I think they -- I think they quantified it. The neonatologist said that there was respiratory distress. There was transient tachypnea of the newborn was the diagnosis, yes.

Q. And are you aware that from a rena standpoint, the serum creatinine was at.9?

A. That one I wasn't aware of. I didn't see that.

MR. NOVAK: I'm done.

EXAMINATION OF WILLIAM J. TODIA, M.D.

BY MS. SCHOENLING:

Q. Dr. Todia, I've got some questions for you. I represent Dr. Siew. My name is Lynne Schoenling. I think we met for the first time this afternoon. I have a couple of questions that I'm going to follow up from the questions that Mr. Novak had.

First of all, I want to ask you about the cord blood that was discussed at length by Mr. Novak. Mr. Novak, of course,

pointed out to you that there was no cord pH taken in this case, correct?

A. Correct.

Q. Do you have any opinions within a reasonable degree of medical certainty whether, if there had been a cord pH reading in this case, what proposition, if any, that reading would support --

MR. NOVAK: Objection --

Q. -- under the records as you see them in this case?

MR. NOVAK: -- conjecture and speculation.

MR. JEFFERS: Go ahead.

A. The -- I believe that the fetal heart rate tracings were reassuring and that the Apgars of 6 and 8 indicated that the baby -- that the neonate was not depressed at birth. And so I would expect a cord pH at birth to be in the normal range.

Q. All right. And you would expect that cord pH in this case to have been in the normal range based on the fact that the fetal heart rate tracings were, as you say, reassuring and the fact that this infant was

not in distress at birth; is that correct?

A. Correct.

Q. Same question with respect to the placenta pathology, which was also an area of inquiry that Mr. Novak addressed. Do you have any opinions within a reasonable degree of medical certainty whether, if there had been an opportunity to have a placenta pathology taken in this case, whether or not that would have -- or let me just ask it this way: If it had been done, what proposition, if any, would that support in this case, as you read these records?

A. If it supported anything, I would expect it to support the proposition that there was -- that there was ongoing long-term abnormalities, meaning that there were events that happened sometime before the onset of labor in this pregnancy.

But what it would show -- I mean, I can't give you an answer what would it show when, but that's the -- that's what I would expect the information -- if it gave us any information, that's the information I would expect it would help to give.

Q. All right. And I guess my follow-up question to that is on what basis would you expect it to give that information?

A. The basis is because I don't think that there's an explanation for the outcome for the health of this baby, and so that I think the reason is still unknown from my reading at least of the experts' reports and of the neonatologists' -- or the pediatric neurologists' reports. So I hope it would shed some light on the reason of the diagnosis of the infant's condition.

Q. Mr. Novak asked you a little bit about chart notes --

MR. JEFFERS: What?

Q. -- chart notes recorded by Dr. Siew during the labor and delivery process. And I know that you've reviewed the records. You would agree with me that there are some orders written by Dr. Siew in this case in the Elyria Memorial records?

A. Yes --

MR. NOVAK: I guess he knew how to use a pen.

A. Yes, I would agree.

Q And that these orders that you see in the chart are both in the labor and delivery portion of the chart as well as the infant's records?

A There are orders that I see in the mother's chart. I don't -- I have to look at the infant's.

Q Let me ask you to take a look at the mother's orders for a minute. Do you have those in front of you?

A I'm looking at those.

Q All right. It looks like we have -- at 11/11/92 we've got a chart note at 8:30 a.m., 2:10 p.m., and then we've got a couple of chart notes on 11/12 and 11/13/92. Is that what you see?

A. Yes.

MR. JEFFERS: We're looking at page 16.

THE WITNESS: Page 16, yes.

MS. SCHOENLING: Page 16, yeah.

Q And just to cater to Mr. Novak's line of questions for a minute as to these chart notes, assuming that we had more chart notes, in other words, additional chart notes

beyond what we do have in the record, would that have changed or altered the outcome in this case, in your opinion?

A. No.

Q. Why not?

A. Because I think that the notes would have said that the doctor believed this was a normal labor and a reassuring fetal heart rate tracing and would have allowed labor to progress as it had, and that the patient would have progressed through labor and delivered at 1:10 whether there was a note saying he was going to allow that or not.

Q. Whether or not Dr. Siew actually recorded the thoughts that you just verbalized, you did have an opportunity to review his deposition transcript prior to today?

A. Yes.

Q. Are you aware that, in fact, in his deposition testimony he did, in fact, verbalize the same thoughts that you just verbalized, that is that we had a reassuring chart? Are you aware of that?

A. Yes.

Q. So despite the fact that **we** don't

have these detailed thoughts recorded in the chart, we do know from the doctor's own testimony that these were his thoughts. And given the fact that we know that these were his thoughts, is it your testimony that whether he wrote them down or not, the outcome in this case would not have been altered as a result of his recording or not recording additional thoughts, true?

A. Correct.

Q. All right. What do the bruises on the face in this case tell you, if anything?

MR. JEFFERS: What?

MS. SCHOENLING: The bruises.

A. That the patient had a very rapid second stage of labor.

Q. What does that mean?

A. Means she -- that the head descended quickly from the time she was complete to the time it delivered, she pushed a short time and the head came through the pelvis, rotated through the pelvis in that short period of time,

Q. Is that a common occurrence in the delivery of infants?

A. Is what a common occurrence?

Q. This bruising that results from what you just described.

A. Bruising from a rapid second stage of labor?

Q. Yes. Yes.

A. Yes.

Q. Do you see that in your practice in delivering infants?

A. Yes.

Q. And would you say that it's more common than not?

A. Having such a short second stage of labor as Mrs. Merriweather had would not be common. It would probably be 10 or 20 percent of deliveries.

But of those that had such a short second stage -- I believe from the tracings she probably pushed 10 minutes at most, maybe even less. There's no note that says when she actually started to push. But from the time she had a strong urge to push to the time the baby was delivered was 10 minutes. And of that time she may have only pushed five minutes.

But of those patients that would

have pushed such a short time and delivered the head so rapidly, it would be a relatively common finding.

Q. I'm going to ask you a little bit about the strips. I'm not going to belabor what you've already testified to, but I do want to ask you a couple of follow-up questions. 65412 and 65413, you were asked about the variability in those two panels. And one --

MR. JEFFERS: Do you have that yet? Wait until he finds it.

A. 65412?

Q. And 65413.

A. Uh-huh.

Q. Do you have those?

A. 65409, 10 -- 12 and 13.

Q. Right.

A. Uh-huh.

Q. Mr. Novak was asking you a question about panels 12 and 13 with respect to the variability, and one of the answers I heard you give was that it's not proper to interpret variability minute by minute. Do you remember giving that response?

A. Yes.

Q. And can you explain to me what you mean by that?

A. The reason is that you have to take the -- you have to take the fetal monitor strip in a -- you need to look at a 10- to 20-minute segment of time because there -- the infant goes through cycles.

The variability changes depending on the fetal activity, meaning how much the baby is moving around inside, whether the baby is sleeping or at rest or moving. So you can't look at one minute of fetal heart rate tracing and say -- make a statement about the variability and have that extend to the -- and have that have any relation to the fetal condition at that time.

Q. Okay.

A. It's usually a result of what the fetus is doing. So you just need to look at a longer time.

Q. All right.

A. I think what 1 said is that my opinion over an appropriate length of time was that there was either minimal or moderate variability, depending on the time segment,

with periods of accelerations, both of which are reassuring.

Q. Is it also important when you're looking at the baseline not to interpret that minute by minute, but instead, as you described the interpretation of the variability, to also interpret the baseline on the same criteria, meaning over an expanded period of time?

A. Yeah, the most important thing about baseline -- about interpreting the baseline is putting it in context with the other criteria. Baseline's only one of the -- only one of the things you look at, and the variability and the accelerations are more important than the baseline in making a judgment about the overall condition of -- the overall interpretation of the monitor strip.

Q. Okay. So in addition to the baseline, even though Mr. Novak focused quite a bit on the baseline, as I understand your responses, it's more important to look at the variability and the accelerations, frankly, than it is to look at the baseline.

A. Correct. And I would also add in the absence of decelerations.

Q. And that was my next question. If you have an absence of decelerations coupled with good variability and minimal accels, would that be a good sign?

A. Well, I wouldn't answer that "minimal accelerations," I would answer that "and accelerations," meaning accelerations of 15 beats per minute over 15 seconds. Those things taken together are a reassuring sign, a sign of reassuring fetal status.

Q. And when we take all of those criteria together -- that is the variability, the accelerations, the lack of decelerations as well as the baseline -- and we look at this strip in its totality rather than panel by panel, what do we see, in your opinion, Doctor, in terms of whether or not this is a reassuring or nonreassuring strip?

A. My opinion is this is a reassuring fetal heart rate tracing.

Q. And your opinion is based on the criteria that I've just referred to?

A. Correct.

Q. And in terms of the decelerations, what, if anything, do you see when taking this

strip in its totality?

A That I'm struck by the absence of decelerations. There are a couple of variable decelerations during second stage which go along with and would be expected in a rapid decent of the fetal head, as she had. Otherwise, the absence of decelerations throughout the rest of the fetal heart rate tracing indicate to me that the baby was well oxygenated during the labor.

Q Looking at 65451, 52 and 53 for a moment --

A 65451 --

Q 51, 52 and 53.

A 51 -- oh, 654. I'm sorry, 654 -- say it again.

Q. 65451, 52 and 53. 654.

MR. JEFFERS: 51, 52, 53.

A Got you. Sorry.

Q Do you have that in front of you?

A Yes, I do.

Q Earlier in your testimony when asked about this page, in looking at these three panels, you indicated in your words that you thought that these reflected a very good

sign. I believe those were your words. Do you remember that testimony?

A. I think so.

Q. I guess what I'm --

A. What I mean to say is that this is a reassuring segment of fetal heart rate tracing.

Q. And I'm taking this segment just as an example because I want to make sure that I understand why, in your opinion, this strip is reassuring. And in looking at these three panels as just a segment or an example, what do we see here that, in your opinion, indicates a reassuring strip?

A. There's moderate variability, meaning that there are cycles of between five and 25 beats per minute, and there are periods of accelerations, meaning there are fetal heart rate accelerations of 15 beats above the baseline lasting for 15 or more seconds. Taken together, both of those are -- have an extremely strong predictive value, meaning they predict that the baby is in a normal oxygenated, normal pH environment.

Q. Okay. Now, when Mr. Novak took you

through this entire strip, what I generally heard were questions about the baseline. And what I seem to, at least according to my notes, have written down consistently, according to your testimony, was that this baseline throughout this strip really maintained itself at about 160 to 165. True?

A That's correct.

Q All right. Now, given the fact that the baseline is just one of the criteria, and that we have to consider variability as well as accelerations, and also the absence of decelerations, my question is is that 160 to 165 consistent baseline -- so I understand, in and of itself, it's not necessarily indicative of anything until you take into account the other criteria that you've described; is that correct?

A That's correct. It's the company that the baseline keeps. The most important criteria are absence of decels, variability, accelerations.

Q In that order, or equally to be considered, or does it matter?

A. That's a good question. No, I

think taken all together, because there would be a lot of debate among experts about which one they would put the most credence on. But I think there's uniform agreement that to make a diagnosis of nonreassuring fetal status, that there needs to be a combination of those things, that you need to see decelerations along with -- I mean, that you need to see -- you need to take all those parameters together, that one of them alone isn't -- is not -- it's the sum of the parts, I guess I mean to say.

Q. And of those criteria, are any of those criteria absent in this strip?

A. The only concern in this strip, as we've been questioned about the whole day, is the fact that the baseline runs about 165.

Q. Other than that, though, we've got a pretty reassuring strip with respect to variability, accelerations and the lack of decelerations?

A. Other than that, all the other criteria are reassuring.

Q. Okay.

A. And the fact that the fetal heart rate -- that the baseline -- that that's --

that baseline is the same over the period of time we've seen is also a reassuring -- also indicates that we're not looking at a period of change, that nothing changed over those hours that we went through the strip and kept saying the baseline was 163 or 165.

Q. Okay. Let me skip topics here and turn to emergency C-sections. What criteria, in your opinion, determines whether or not an emergency C-section needs to be done?

A. There's a lot of criteria. I can give you a list, but, I mean, the short answer is that there's a --

Q. Tell you what, let me ask it a different way. As you read these records and these charts, do you see anything that supports a decision t perform an emergency C-section?

A. No. An emergency C-section would have in no way affected the outcome of this -- of the neonate and would only have left the mother with an unnecessary surgery.

Q. Well, that was my next question; whether or not -- even if one had been done, whether the outcome would have changed. And as I understand your answer, your answer is no, it

would not have changed; is that correct?

A. I have no reason to believe that there would be any difference in the outcome of the infant.

Q. And what do you base that response on?

A. The fact that there's -- there's no evidence in this record that this baby suffered from asphyxia. And so doing a C-section anytime during this record would have delivered a baby that was not asphyxic, just like the baby that was delivered was not asphyxic.

Q. With respect to the fetal scalp sampling that Mr. Novak asked about, I know that it wasn't done in this case. Do you have any opinions, Doctor, within a reasonable degree of medical certainty that had a fetal scalp sampling been taken, whether or not we would have had, first of all, a different outcome, and secondly, what proposition such a scalp sampling would support if it had been done?

A. I believe it would have been reassuring and would have just reassured the physician that labor could continue as it did,

and that the delivery would have occurred at the same time in the same fashion.

Q. And why do you believe that?

A. Because I don't believe that -- because I believe that the pH would have been normal because I believe the baby was -- had a normal pH and a normal oxygenation during this entire course of labor.

Q. Does cord compression reveal itself on the strips? Not in this case, but just generally. Is that something that can be detected on the strips?

A. Yes.

Q. And in what form and how does it manifest itself on the strips?

A. It manifests as -- well, in one of two ways. Intermittent cord compression, meaning cord compression that happens for some period of time, 30 seconds or a minute, and then resolves, would show intermittent variability. Decelerations, meaning a deceleration down of the heart rate from whatever the baseline was down to a certain level, and when the compression resolved it would come back up.

A cord compression that was ongoing, meaning the compression was not released, would show a terminal bradycardia, meaning that as the cord was compressed and the oxygen level and the blood flow to the fetus went down, you'd see the heart rate come down and come down and come down, and it would not go back up unless you resolved the cord compression.

Q. We don't see either one of those on this strip, do we?

A. No. The only time that you could postulate that that would happen was there are two decelerations that I see in panel 65508, like, three minutes before delivery when the patient's pushing. There appear to be two variable decelerations which would fit with the patient who had a nuchal cord, because as the head descended rapidly in the pelvis and as the patient pushed to make that happen, there was enough of a degree of cord compression to cause that heart rate to go down to 90.

And then when the patient stopped the contraction and stopped pushing, it immediately returned to baseline, which would

indicate to me there was probably a mild degree of intermittent, meaning short-acting, 30-second compression at that time.

Q. And other than in that minute or so prior to delivery that you've just described, we don't see any evidence of what you called bradycardia or variable decels to support a cord compression finding at any time before that point on the strip; is that true?

A. No, there's no cord compression pattern on this fetal monitor tracing.

Q. Is cord compression on a fetal monitor tracing typically seen in a pattern?

A. Yes. It has to be repetitive with intermittent -- I mean, with repetitive cord compression, meaning you continue to compress the cord at intervals of time.

There's a very defined predictable pattern of repetitive variable decelerations with each compression. And if the cord compression is continuous, ongoing, and oxygen is going down, up, and pH is changing or is worsening, then you will see a bradycardia, you'll see a fetal heart rate that decelerates.

Q. So not only do we not see a Pattern

on this strip as you've just described, but we certainly don't see any bradycardia either; is that correct?

A. That's correct.

Q. Okay. How about cord occlusion? Is that something that's traceable on a strip?

A. If there's complete occlusion of the cord?

Q. Yes.

A. Absolutely.

Q. And how do we interpret that from the strip?

A. From when you occlude the cord, you'll see a deceleration of the fetal heart rate that becomes a bradycardia and eventually results in -- if you don't do something about it, in fetal death. The heart rate goes down until the point where the fetal heart rate disappears, stops. The heart stops after a long enough time of no blood to the fetus.

Q. So is that also something that we see in a pattern format, or is that something that is an immediate onset that's easily detected from the reading of the strip?

A. If there's complete occlusion --

Q. Yes.

A. -- it's not a pattern. Once it's complete occlusion -- the minute complete occlusion happens, you start to see changes that just get worse and worse over the next 10 minutes to 15 minutes until the fetus expires.

Q. And that's nowhere on this strip; is that correct?

A. No.

Q. That is correct?

A. That's correct. It's not anywhere on this strip. There's no evidence of complete cord occlusion.

Q. All right. Have you reviewed the reports of Drs. Johnston and O'Grady and of Dr. Steven Donn as part of your records in the file?

A. Yes.

Q. Dr. Donn is a neonatologist, Dr. O'Grady is an OB/GYN and Dr. Johnston is a pediatric neurologist, all three of which have been retained on behalf of Dr. Siew. And I guess my question to you is do you have any disagreements as to the opinions that either Drs. Donn, O'Grady or Johnston set forth in

their reports?

MR. JEFFERS: He --

MS. SCHOENLING: Go ahead.

MR. JEFFERS: Some of this is not in his area of expertise,

MS. SCHOENLING: I understand that.

A. Right.

Q. Well, let's talk about Dr. O'Grady's report. Can we do that?

A. Yeah. I'd like to -- I haven't read it recently enough to remember the exact details of the report. I've read all of them, but it hasn't been within the last two days. I thought I had it -- I must not have them all with me. If I do -- I have a pile of -- it must be with all the other depositions. I'm sorry. Or is that -- no, there they are. There they are. Okay. Which one do you want to talk about?

Q. Dr. O'Grady.

A. Dr. O'Grady, okay. I do remember reading --

Q. I guess I really just have a very general question with respect to his report, and that is --

A. Yeah, I didn't -- I mean, I didn't have any -- I do remember it now because I -- as I see the format, I can remember having -- which one I read recently. But no, I did not have any disagreements that I recall from reading this report.

Q. Now, as far as your opinions that you're going to be rendering in this case, it's my understanding that you have not -- or do not intend to offer any opinions with respect to Dr. Siew's care and treatment either during labor and delivery or during the prenatal phase. Is that correct?

A. That's correct.

Q. Let me check my notes here, Doctor, I may be done.

You stated that had we had the cord pH, you would be able to definitively determine whether or not metabolic acidosis was present in this case? Did I understand that from your testimony?

A. I think it would have been another piece *of* information that I think would have corroborated, would have agreed with the interpretation of the fetal monitor that the

baby was normally oxygenated at birth.

Q. Okay. So in other words, we do not have to have the cord pH in and of itself in order to reach that conclusion; is that correct?

A. No. It's just -- it would just be another piece of information that would be -- it would just add to what we already have, in my opinion.

Q. In fact, support what we already have?

A. Correct.

MS. SCHOENLING: I don't think I have any other questions. Thank you.

EXAMINATION OF WILLIAM J. TODIA, M.D.

BY MR. NOVAK:

Q. While we're kind of rolling on this pH thing, would you agree with me that the only scientific demonstration of metabolic acidosis would have been the cord blood?

MR. JEFFERS: Metabolic acidosis?

MR. NOVAK: That's what I said.

MR. JEFFERS: Okay. I'm just making sure.

A. The only way I know of to make a

diagnosis of metabolic acidosis is to have a pH, PCO2, bicarbonate and base excess analysis. I think that's what you mean by "cord pH," but -- I mean, the pH alone wouldn't have made it, but if we had that complete study, yeah, I think that's -- yes.

Q. My question wasn't related to the pH. My question was the only scientific demonstration of metabolic acidosis would have been the cord blood; is that correct?

A. The only scientific -- the only way that -- yeah, that's the only -- that's the only test I know of that you can characterize the degree of metabolic acidosis. But there are signs and symptoms of various degrees of acidosis that you can find, also. So it's not the only scientific test.

In the absence of that test, you can make a determination about severe acidosis based on a number of other -- by examining a patient. But that's the only way to characterize the exact number.

Q. If Mr. Jeffers' other expert, Dr. Thomas Reilly, agreed that the only scientific demonstration of metabolic acidosis would have

been the cord blood, and he agreed that that was correct, would you agree or disagree with his statement?

MS. SCHOENLING: Objection. First of all --

MR. JEFFERS: What page are you on?

MR. NOVAK: Page 67, line 6. And he went through that, and it goes from line 6 to line 16.

MS. SCHOENLING: I'm going to object. It's a mischaracterization. He quotes his question accurately, but it's a mischaracterization of Dr. Reilly's response to that question.

Q. Let me read it here. "So the only scientific demonstration of metabolic acidosis would have been the cord blood?" "Answer: That's correct. But it's simply not a standard of care for cord blood to have studies done when the Apgars are 6 and 8."

But with respect to the issue of whether or not the only scientific demonstration of metabolic acidosis would be the cord blood, would you agree with his statement when he says, "That's correct"?

Would you agree with his answer to that?

MS. SCHOENLING: Objection.

A. I think so. I just answered the question when I explained -- when I answered what scientific demonstration of metabolic acidosis was. I think I said the pH and cord bloods is a scientific demonstration, but that there are other things or other signs and symptoms in a person -- in a neonate that would also indicate severe metabolic acidosis.

So I don't understand why I have to answer the question over again. I answered that. And what you're trying to do is get me to interpret his answer and say he's wrong, but I answered the question already.

C. No, my question is pretty simple. You don't agree with him because he says the only scientific --

MR. NOVAK: Let me finish my question. Okay?

MR. JEFFERS: Don't raise your voice to me.

MR. NOVAK: Don't start butting into my question right in the middle of it. You started to butt in -- you started to butt into my question right in

the middle. So back off.

MR. JEFFERS: Don't raise your voice to me, Sonny.

MR. NOVAK: Don't. get smart, John.

MR. JEFFERS: You just got smart with me. You raised your voice. You pointed your finger --

MR. NOVAK: I'm going to point my finger and I'm going to keep pointing my finger. Back off.

MR. JEFFERS: I'm not doing anything. So just cool it. Things aren't going well for you and you're upset.

MR. NOVAK: Things aren't going well for me? I just don't like you to butt in when you're off the wall. Okay?

MR. JEFFERS: The record will demonstrate I didn't butt in.

Q. My question for you is the only scientific demonstration of metabolic acidosis is the cord blood, isn't it?

A. That wasn't -- no, I didn't answer that that was the only scientific demonstration.

Q. So you don't agree with that?

A. I said the cord blood is one of the scientific demonstrations of metabolic acidosis.

Q. All right.

A. And that, yes, it is one of, but I didn't say it was the only scientific demonstration of metabolic acidosis.

Q. Okay. So we'll let your answer stand and we'll let Dr. Reilly's answer stand and we'll let a jury decide --

MS. SCHOENLING: Is that a question?

Q. -- we'll let the jury decide who's telling the truth on that.

MS. SCHOENLING: Are you asking a question?

MR. JEFFERS: No, this is Bill [redacted] giving a final argument.

Q. You gave a statement to this line of questioning by your codefendant's lawyer, Doctor.

MR. JEFFERS: Wait a minute. This is not his codefendant's --

MS. SCHOENLING: Excuse me?

MR. NOVAK: Well, the codefendant.

normal, I'm going to change my statement because what I said -- at least what I said one of the times, but the questions keep getting re-asked, is that the pH would have reassured me. It would have been reassuring that -- I said the fetal monitor strips would have been reassuring and that the pH would have gone along with the fetal monitor strips. They would have reassured me that the labor would continue as it was allowed to continue.

MR. NOVAK: Would you go back to

the initial line of questioning that counsel for Dr. Siew asked and -- it's at the very beginning, about the question of the cord blood. And I want you to find the doctor's answer where he said the pH would be in the normal range. Would you find that for me, please.

A. Even if you can find it, it's my right to explain what I meant. And I'm explaining to you that whether I said "normal" once or not, what I'm explaining to you is that -- because I'm not going to get into an argument about what you say is normal and what I say is normal.

What I'm saying is that I would have expected the pH to be reassuring, that the pH would have gone along with the fetal monitoring tracing and would have a --

MS. SCHOENLING: Bill, are you saying he doesn't have a right to respond?

MR. NOVAK: I'm saying he's under oath and -- just because I asked the question instead of you -- I'd like to hear the response to the question.

Would you please go back to the

statement he made that said it would be a normal range pH? I have the right to have that read back.

MR. JEFFERS: Do whatever you want.

Let the record show Mr. Novak is again raising his voice. And let the record also show that during the doctor's response, Mr. Novak said something to the effect of "uh-huh" seven times during his response.

MR. NOVAK: Are you done?

MR. JEFFERS: I'm done now.

MR. NOVAK: Okay. Would you please go back? We can wait here.

(Record read.)

(Discussion off the record.)

Q. Doctor, we've just had your testimony reread and you've indicated that based upon the Apgar scores and based upon what you believe were reassuring fetal heart strips, you believe that the cord blood would have had a pH in the normal range. Am I characterizing that answer correctly?

MR. JEFFERS: Did you add fetal heart rate tracings?

MR. NOVAK: Yes, I did.

Q. Am I characterizing that answer as correct?

A. That's the answer I gave. And I think -- I'm sure that when you asked it another time, that I used the word "reassuring." And we must have been talking about scalp pH rather than cord blood. But I would expect that the -- what I mean by "normal" is in the normal range. What I mean by that, because you bring it up, is that the -- that it would not show that the baby had metabolic acidosis at the time of delivery.

Q. Based upon the cord pH?

A. Right, the cord pH and the attendant measurement, PCO2, bicarbonate, base excess, could have indicated that the infant did not suffer from metabolic acidosis.

Q. I didn't ask you these questions, she did.

A. I know. I'm just clarifying the question.

Q. But her question, she asked you based upon a reasonable medical probability would the cord pH be within the normal range, and your response to that question would be

yes; is that right?

A. No, that would be what I've just clarified. It would be that it would be -- it would indicate that there was not metabolic acidosis. PHs vary for a number of reasons by what we were -- just the question was and the whole point of the discussion is does this baby have asphyxia, was there metabolic acidosis and hypoxia at the time of birth. And I said and my belief is that the pH would not indicate that there was hypoxia and metabolic acidosis at birth.

Q. Would you agree with me that you stated that you believed that there would be a pH in the normal range? You did say that?

A. Sure. And I've now explained exactly what I mean by pH in the normal range in answer to that question. So, I mean, I'm not going to sit here --

Q. so --

MR. JEFFERS: Let him finish. Let him finish. Let him finish.

MR. NOVAK: Now you're raising your voice and you're turning red and the top of your head is turning red, Mr. Jeffers.

MR. JEFFERS: Absolutely. And you're very irritating.

(Discussion off the record.)

Q. Would you describe for me what normal pH range is? What are those values?

A. What are the values for normal pH?

Q. Uh-huh.

A. In what circumstance?

Q. Well, you --

A. Here's what I would -- the -- it depends on which time we're talking about. The -- if the infant had a scalp pH during the time of labor, then I would expect it to be above 7.20. That would be reassuring and that would be normal for this fetal heart rate tracing.

Q. How about a cord --

A. Now, when the baby is born, then --

Q. -- cord pH?

A. A cord pH?

Q. Uh-huh.

A. Then the pH depends on the PCO2, bicarbonate and base excess, because a pH -- a corrected pH would be -- meaning corrected for respiratory -- for PC02 I would expect to be normal in this infant. You're talking

arterial, right?

Q. Yes. So give me a number that you would expect it at.

A. I would expect it to be above -- corrected for PCO2, above 7.20.

Q. Okay. Now, we do know that the arterial blood gas taken at 1359 was 7.21; is that right?

A. That was just the pH. That's not the corrected pH for the respiratory component.

Q. I'm just talking about the pH.

A. That's what I said. That's what I said, right.

Q. Now, the pH that you would expect from the cord, what would you expect, 7.20?

A. I said the corrected pH and the cord corrected for PCO2, because what we're interested in at the time of delivery is the metabolic acidosis. That's what we're trying to get at. Which means that the PC02 level has to be taken into account in order to decide whether the pH is coming from respiratory, meaning the amount of PCO2, or from metabolic. So I said the corrected pH would -- I would expect to be above 7.20 at the time of

delivery.

Q. What's the corrected pH from the arterial blood gas?

A. The one that was 7-21?

Q. Uh-huh.

A. I need to see all the measurements to -- the pH was 7.21. The PC02 was 63. Normal PC02 would be 40. In order to correct -- in order to correct the pH, you have to use a factor of .08 pH, meaning you raise the pH.08 for every 10 millimeters of mercury for PCO2. So I can't do the math exactly, but it would -- corrected it would be 7.21 plus .16. It would be 7.37 at 1359.

MS. SCHOENLING: Is that the corrected ABG or corrected --

THE WITNESS: Corrected ABG pH.

MS. SCHOENLING: Thank you.

A. The one that we're looking on at 1359. And what that means is that this pH, the reason this pH was 7.21 was because of the PCO2. It was not -- there was not metabolic acidosis at 1359. If there was metabolic acidosis, this pH would still be low after you corrected the PCO2.

This says that this abnormal pH is solely because of respiratory component, solely because the PCO2, which is blown off at the lungs when you breathe, was not happening as much as it should have. There wasn't as much PC02 being blown off as there should have been.

Q. So you're saying the 7.21 is not acidotic, right?

A. I didn't say that. I said the corrected pH is not acidotic. And I said 7.21 is respiratory acidosis alone. There is no metabolic acidosis. I should say there's no significant metabolic acidosis because there's never no anything in medicine.

Q. And you are aware that by the time that this blood gas was done, this infant was on oxygen, right?

A. Uh-huh. That's correct.

Q. Okay. Now, this pH that you feel is in the normal range, the cord blood, that is a guess on your part, isn't it?

A. No, it's not a guess. That's an educated opinion based on all of the other information I've reviewed.

Q. By the way --

A. It's not a guess at all.

Q. -- did Mr. Jeffers talk to you about this line of inquiry that Ms. Schoenling was going to ask you about the cord blood?

A. No.

Q. Did she --

MS. SCHOENLING: Came up with it all on my own, Bill.

MR. NOVAK: Let me finish.

Q. By the way, let's get on to the placenta. You said that you expected to see a normal placenta?

A. No, I didn't expect to see a normal placenta.

Q. You expected to see a placenta that demonstrated something that would have shown a long-standing problem; is that right?

A. Right, which would not -- which would be the opposite of a normal placenta.

Q. Would you do me a favor, then, and tell me on a gross examination what color placenta would you expect?

A. What color placenta?

Q. Yes.

A. I don't know, I'm not a

pathologist.

Q. Would you tell me what the cord would look like on gross examination?

A. Again, I'm not a pathologist,

Q. Would you tell me what the chorion would look like?

A. I'm not going to testify about the pathologic exam of the placenta. I was not trained in the pathologic exam of the placenta. I rely on a placental pathologist who I send my placentas to to interpret the findings of the placenta and give me a report about that placenta.

Q. But you're testifying here today that you would expect a placenta in this case to look like something long-term was going on; isn't that right?

A. I said **I** expected the placental pathology, which is a microscopic and macroscopic exam by a placental pathologist, to give us more information about the cause of that infant's long-term deficit.

Q. Doctor, the fact of the matter is that as you sit here, you would have no idea as to what the color, the composition, the

chorion, the villi, the cord or anything else would look like on this infant based upon a reasonable medical probability; isn't that right?

A. That's not what I said.

Q. That's my question. You wouldn't really know what any of those components would look like, would you?

A. That's incorrect.

Q. But you're not a placental pathologist, are you?

A. That's correct. I'm not a placental pathologist, so I'm not going to claim to be an expert in placental pathology. That does not mean that I have no idea what a placenta looks like. That's an incorrect characterization of what I said.

Q. Well, I guess I want to know that if you're going to testify that you expected the placenta to look like there was an issue which antedated labor and delivery, then I want you to tell me what this placenta should look like in terms of its gross color. Can you do that for me?

A. No, I didn't say that. I said I

would expect the placental pathology to reveal. I didn't say I would do the placental pathology. I didn't say I could tell you all of the findings of the placental pathologist.

I said that if you take the placenta and send it to a placental pathologist, that the placental pathologist, in their expertise, would be able to give me information that would help or potentially help explain why the baby has the disease that the baby has. That's all that I intended to say.

Q. Doctor, are you aware of all the literature out there with respect to placental pathology and hypoxic-ischemic encephalopathy? Are you aware of a lot of literature that's out there?

MR. JEFFERS: You said all of it.

Q. Let's say all of it. Are you aware of the literature that's out there on placental pathology as it relates to hypoxic-ischemic encephalopathy?

A. I'm aware there's literature out there.

Q. Are you aware that placental pathologists even disagree on what they see in

a placenta and whether or not the timing of the event antedates or occurs during labor and delivery based upon what they see in a placenta?

MR. JEFFERS: Objection. Go ahead.

A. I'm aware that doctors disagree about most every subject. So it wouldn't surprise me at all if there is pathologists that have disagreements on reading the placental pathology.

Q. Now, I'm a little confused about this issue about the orders in the chart. You're not telling us, are you, that the orders in the chart reflect Dr. Siew's ongoing thought processes as it relates to the labor and delivery of this patient, are you?

A. No.

Q. And you would agree with me that as this Elyria Memorial Hospital chart is composed, we don't see anything in there about congenital microcephaly, do we?

A. I don't recall seeing that written anywhere in the chart.

Q. And if there was something abnormal with respect to a gross congenital anomaly, one

would expect that a nurse or Dr. Siew would appropriately note that; isn't that correct?

A. I wouldn't expect Dr. Siew would, but -- because usually that's a pediatric function, not the function of the obstetrician. But if there was a congenital abnormality that the pediatrician or the pediatric nurse recognized, then you may find it documented in the chart, sure.

Q. Would you agree with me that a baseline fetal heart rate above 160 represents some form of tachycardia?

A. It's defined as tachycardia if it's above 160. That's the definition of fetal tachycardia, yes.

Q. Okay. Let me ask you if you agree with any of these clinical associations with baseline heart rate tachycardia. How about maternal thyrotoxicosis?

MS. SCHOENLING: I'm sorry, what was the question?

MR. NOVAK: Maternal thyrotoxicosis.

MS. SCHOENLING: What's the question, though?

MR. NOVAK: Would you read back the question?

(Record read.)

MS. SCHOENLING: Thank you.

Q. How about maternal --

A. Do you mean the disease maternal thyrotoxicosis --

Q. Yes.

A. -- can be associated with fetal tachycardia?

Q. Right.

A. Yes, I agree that's an association.

Q. How about tachyarrythmia? Can that be associated --

A. Yes, it could be associated with fetal tachycardia.

Q. How about prematurity?

A. Prematurity? It's possible.

Q. How about drugs such as beta agonists?

A. It's possible, yes.

Q. How about fetal infection?

A. It's possible.

Q. How about maternal fever?

A. It's possible, too.

Q. Now do we have any maternal fever here?

A. Not that I recall.

Q. Do we have any fetal infection?

A. Don't know the answer to that question. The infant was treated with antibiotics after delivery, but I don't remember whether there was any -- I don't remember whether there was documentation of infection or if the antibiotic treatment was a precaution for infection. So I can't answer whether there was infection.

Q. How about beta agonists?

A. I don't believe the mother received beta agonist medicines in labor.

Q. We don't have any prematurity, do we?

A. She's 37 weeks?

Q. Thirty-nine weeks.

A. No, there is not prematurity.

Q. How about tachyarrythmia?

A. Tachyarrythmia means that the -- that there was an intrinsic fetal tachycardia. That's certainly possible, especially since the summary from University Hospital talks about

persistent fetal tachycardia with a negative workup.

Q. Okay. How about maternal thyrotoxicosis?

A. It's possible, but I'm not aware of the patient having a thyrotoxicosis in the chart.

Q. Would you agree with me that a clinical association with tachycardia can be hypoxia?

A. That -- say that again? That a --

Q. Clinical association with tachycardia can be hypoxia.

A. Would a clinical association -- it's possible just like all the other things are possible.

MS. SCHOENLING: Excuse me, noting that the last 10 or 12 questions have been referencing Dr. O'Grady's text, I would just ask you to identify the page numbers that you're referencing.

MR. NOVAK: I really don't have to because I'm not quoting anything.

MS. SCHOENLING: I believe that you are --

MR. NOVAK: No, I'm not. If I have this on the floor --

MS. SCHOENLING: For the record, Mr. Novak is reading from the text --

MR. NOVAK: Page 322 entitled Table 13.2 Baseline Heart Rate Abnormalities, and for tachycardia as an abnormality -- by the way, Dr. O'Grady, your wonderful expert, here in his book edited by him, lists at the top of the list the clinical association of hypoxia.

MS. SCHOENLING: Thank you.

Q. You would agree that that's a possibility, isn't it?

A, I would.

MR. JEFFERS: That what's a possibility?

MR. NOVAK: That hypoxia can be a clinical association with tachycardia.

MS. SCHOENLING: Note my objections to all the possibilities that we're referencing here.

Q. But the fact of the matter is that other than the tachyarrythmia which you said may have been present here, none of the other causes that I just gave to you appear to be in

this case; isn't that correct?

A. The tachyarrythmia seems to be the only cause that there's any just indication for --

Q. Right.

A. -- because that's the only thing that persists into the neonatal period and that there's any documentation.

Q. Would you disagree with me that this newborn had hypoxia?

A. Yes.

Q. So, then, would you disagree with Dr. Dominguez at --

MR. JEFFERS: University Hospital.

Q. -- University Hospital who wrote down on 11/12/92 by actually seeing the infant that -- he says, "The infant **may** have suffered from asphyxia. Although Apgar scores were fairly good, this is the most likely cause.'' Would you agree or disagree with him?

A. **I** would disagree with that.

Q. And would you agree or disagree with this statement on 11/13/92: "Most likely cause ischemia with anemia secondary to true knot in cord"?

MS. SCHOENLING: Whose statement are you reading, Bill?

MR. NOVAK: Looks like a Dr. Walla.

MS. SCHOENLING: At UH?

MR. NOVAK: Yes.

MR. JEFFERS: Do you want to read that once more?

Q. Question, "Etiology most likely is ischemia with" -- "secondary to true knot in cord." Would you agree or disagree with that?

A, I'd disagree.

Q. On 11/13/92 there's another note here, "Neurology consulted," and then it says, "Etiology," question mark. "Hypoxic event/ischemia secondary to nuchal cord." Would you agree or disagree with that?

A. Disagree with that.

Q. And on 11/14/92 there's an assessment that says, "Number 1, Seizures on day of life number 1 probably due to a hypoxic episode from a nuchal cord with a true knot." Do you agree or disagree with that?

A. Disagree.

Q. And continuing on, on 11/15/92 a note that says, "Seizures probably secondary to

hypoxia." Do you agree or disagree with that?

A. Disagree.

MR. JEFFERS: What day was that, Bill, the last one?

MR. NOVAK: Fifteenth.

MR. JEFFERS: Pardon me?

MR. NOVAK: The fifteenth.

MR. JEFFERS: Thank you.

Q And then on November 17, 1992, the note says, "Seizures probably secondary to hypoxia (tight nuchal cord)." Do you agree or disagree with that?

A Disagree.

Q And then on 11/17/92, a note, "Birth asphyxia with seizures." Do you agree or disagree with that?

A I disagree.

Q And on 11/18/92 there's a note here that says, "Seizures probably secondary to hypoxia (tight nuchal cord)." Do you agree or disagree with that?

A. Disagree.

Q And also on that same page it says, "Six-day-old 39 weeks with seizures, probably hypoxic." Would you agree or disagree with

that?

A. Disagree.

MR. JEFFERS: Pardon me?

THE WITNESS: I disagree.

Q. And then on 11/19 it says, "Seizures secondary to hypoxia presumed." Would you agree or disagree with that?

A. Disagree.

Q. And on 11/20/92 it says, "Seizures probably hypoxic in etiology." Would you agree or disagree with that?

A. Disagree.

Q. And also on 11/19/92, would you agree or disagree with the note that says, "HIE seizures"? Would you agree or disagree?

A. What's HIE?

Q. Hypoxic-ischemic encephalopathy.

A. Disagree.

Q. And on 11/21/92, "Seizures secondary to birth asphyxia," question mark. Would you agree or disagree?

A. I agree with the question mark. I disagree with the proposition that it was birth asphyxia.

Q. And on 8/3/93 in a consult, do you

agree or disagree --

MR. JEFFERS: Consult by whom, please?

Q. The consultant's note has the patient was being observed for constipation and hepatomegalia and a consult's note has, "Nine months old with history of birth asphyxia." Do you agree with the note "birth asphyxia"?

A. No, I don't.

Q. And on 8/10/93, pediatric clinical pharmacology consulting, it says, "Admission at birth for neonatal seizures thought to be secondary to a hypoxic-ischemic event." Do you agree or disagree with that?

A. Disagree.

Q. And under the EEG summary at the Cleveland Clinic on 3/31/93 --

MR. JEFFERS: The date again was?

MR. NOVAK: 3/31/93.

Q. "Etiology perinatal asphyxia." Do you agree or disagree with that?

A. Disagree.

Q. And under Conclusions of Recommendations on that EEG summary it says, "Jasmine Merriweather was a 16-month-old girl

who had perinatal asphyxia with meconium and a nuchal cord." Do you agree or disagree with that?

A. Disagree with perinatal asphyxia.

Q. And also under Etiology for Perinatal Complications it says, "Asphyxia." Do you agree or disagree with that?

A. Disagree.

Q. And on a note that was done for the Ohio Department for Hearing, the notation indicates that this infant had seizures related secondary to birth. Do you agree or disagree with that?

A. Seizures related --

Q. Related to birth.

A. -- to birth. The seizures were around birth, I don't know what it means by "seizures related to birth." If you mean seizures related to birth asphyxia, I disagree with it just like all of the above.

MR. JEFFERS: What department was that, Bill?

MR. NOVAK: I'll find it.

Q. The Infant Hearing Assessment reporting form that goes to the Ohio Department

of Health says, "Seizure disorder secondary to birth asphyxia." Do you agree or disagree with that?

A. Disagree.

Q. Do you agree or disagree with the patient progress note on 11/15/92 when it says, "Seizures and hypoxic episode at birth." Do you agree or disagree with that?

A. Disagree.

MR. JEFFERS: That's 11/15/92?

MR. NOVAK: Yeah.

Q. My last question, then, is as you sit here today having never seen this patient, having never met any of the nurses in this case, having never met Dr. Siew, having never seen this patient face to face, it's your opinion today that you're disagreeing with all of what I've just read you as respects the notations in the chart as to the cause of this event; is that right?

MS. SCHOENLING: Objection.

A. All of the people you just read me never reviewed the fetal heart rate tracing and never saw the course of labor. So their opinion about birth asphyxia is less founded

than the opinion I've given you today based on all of the information I've reviewed with you.

Q. Whoa, whoa, whoa, whoa, Doctor. Here we go.

A. I want you to show me one of those notes you read that was done by a perinatologist or obstetrician or anyone who reviewed the fetal heart rate tracing in the labor course.

Q. Are you telling me --

A. Those are all pediatric notes. They're notes from the neonatologist who read a summary from a nurse from Elyria when the patient was transferred.

Q. Are you --

A. Go ahead.

Q. Are you telling me that -- so you're telling me that --

A. You've just read for me the notes in -- the notes by pediatricians, all of which you said have question marks after the diagnosis. You didn't read the body of the whole report. These are not anyone who viewed the labor, who saw the tracing, who saw the infant at birth, who assessed the Apgars and

who made any assessment of the baby except for the fact that the baby had seizures two days later.

Q. Are you telling me University Hospital didn't have the EMH records when this patient was seen?

MS. SCHOENLING: Objection. That's not --

A. Didn't have the fetal monitor tracings.

Q. How do you know?

A. Because there's not any indication in anything you just read to me because none of them commented on the fetal monitor tracings.

Q. How do you know they didn't have it?

MR. JEFFERS: Objection --

(Discussion off the record.)

Q. Well, there's a note here on 11/12/92 at 4:15 p.m. and it says, "Source medical records from Elyria Memorial Hospital." Are you telling me that they just got part of the records, but not all of them? Is that what you're telling me?

A. I'm telling you when an infant is

transferred to another neonatal intensive care unit, the record that's sent is the neonatal record. That's an independent patient. The patient that goes is the baby, and the record that's transferred is the baby's. The mother's record is not part -- is not the baby's record. The mother's record doesn't go to the intensive care unit.

They don't make any independent assessment of what happened during labor. They write down what it says on the neonatal sheet from the pediatrician at the previous hospital and then they make a judgment.

Q. So you're telling me --

A. So they base everything on that sheet that we already reviewed that I disagreed with where someone who we can't even find their name wrote "fetal distress."

Q. Are you telling me that the fact that this newborn had seizure activity within the first 24 hours is irrelevant as represents its connection to hypoxic-ischemic encephalopathy?

A. I'm saying that hypoxic-ischemic encephalopathy did not cause this infant's

seizure disorder in the first 24 hours.

Q. My question for you is do you feel, or not, that the fact that the seizure activity started within 24 hours of birth is significant?

A. Significant to this baby, of course.

Q. Do you feel that it's significant as respects the timing of the event?

A. Timing of what event?

Q. The hypoxic-ischemic event.

A. Baby didn't have a hypoxic-ischemic event, not in the time of -- not in the time of labor. My comments are about the patient's labor course and her delivery. There is no evidence from the record that this baby suffered a hypoxic-ischemic event from the time the baby went into labor that I have a record of to the time the baby was delivered. That's what I'm commenting upon.

I can't tell you if it suffered a hypoxic-ischemic event at 18 weeks or 22 weeks or 32 weeks, and I can't tell you if it suffered the event at three hours of age. I can't comment on that part. I can comment on

what happened during labor.

Q. So all you're concerned with is labor. But from a standpoint of looking at this from a perspective of a pediatric neurologist or a pediatrician, you don't care about those factors, do you?

A. What I -- I don't care about those factors?

MS. SCHOENLING: Objection.

MR. JEFFERS:: If you don't understand the question --

MR. NOVAK: I understand it.

MR. JEFFERS: You can understand whatever you say, but --

A. Can you repeat it, please?

MR. JEFFERS: -- others have to understand it.

A. I don't understand your question. You can reread it if you like and I'll try --

Q. Here's my question: Are you telling me that the people who wrote down -- those physicians at University Hospital, are you telling me that the opinions they wrote down and the assessments they wrote down are totally invalid?

A. I'm telling you that this infant did not sustain neurologic damage from hypoxic encephalopathy during her course of labor and delivery.

Q. Based upon your review seven years later?

A. Based upon all the information contained in her labor and delivery course, that's what I'm telling you.

Q. Including the true knot in the cord, right?

A. Including the loose true knot in the cord which we've reviewed already, yes.

Q. And including issues relating to the cord around the neck, right?

A. Yes.

Q. And including the fetal distress that's marked down in the chart, right?

A. The incorrect fetal distress that's written in the initial newborn profile, but is never written in the maternal record, yes.

Q. I just want to make sure before I leave here that you and I are on the same page on one thing: That you're going to tell the jury that Mr. Jeffers' client was wrong when it

wrote down "fetal distress" on 11/11/92. Is that what you're going to tell this jury? I want to know that.

A. What I'm going to say is that that. is an incorrect characterization of the labor course. Yes, I'm going to say that.

MR. NOVAK: Okay. All righty. I am done.

(Deposition concluded at 6:15 p.m.)

CERTIFICATE

The State of Ohio,)

ss:

County of Cuyahoga.)

I, Rebecca L. Stonerock, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, WILLIAM J. TODIA, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 22nd day of September 1999.

Rebecca L. Stonerock

Rebecca L. Stonerock, Notary Public within and for the State of Ohio

My commission expires March 17, 2002.

I N D E X

The deposition of WILLIAM J. TODIA, M.D., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

AFFIDAVIT

The State **of Ohio,**)

) **SS:**

County of Cuyahoga)

Before me, a Notary Public in and for said County and State, personally appeared **WILLIAM J. TODIA, M.D.,** who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.

In the TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at this_____ day of_____ A.D 1999:

_____

Notary Public

_____

My Commission Expires:

DEPOSITION ERRATA SHEET

RE: JASMINE MERRIWEATHER, ETC., ET AL.

VS. ELYRIA MEMORIAL HOSPITAL, ET AL.

RRS File No.: 836

Deponent: WILLIAM J. TODIA, M.D.

Deposition Date: SEPTEMBER 17, 1999

To the Reporter:

I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

_____

DEPOSITION ERRATA SHEET

PAGE LINE

SIGNATURE: _____ DATE: _____

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216/687-3330
KM2500@MCIMAIL.COM

3/17 2

February 27, 1998

William Todia, M.D.
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, Ohio 44109

Re: **MERRIWEATHER vs. EMH, et al.**
Our File #16082-20157

Dear Dr. Todia:

I am currently working with John Jeffers relative to the captioned matter. In that regard, we are requesting your review of the records herein as they relate **only** to the standard of care provided by the health care providers at EMH. All other Co-Defendants have other counsel.

Rhonda Met-riweather was admitted to **EMH** on 11/11/92 in active labor and delivered a female infant at 1:10PM. There was meconium fluid noted, and aggressive pulmonary toilet was done for Jasmine Merriweather, whose APGAR's were 6 and 8 at 1 and 5 minutes.

It appears that the baby had three episodes of cyanosis, hypoxia and limpness, as well as seizure activity within the first 24 hours of life. She was transferred to University Hospitals.

The case is in early discovery, and the Complaint alleges brain damage.

I am currently attempting to secure the records from University Hospitals as well as those of current health care providers. We would appreciate your initial review and communication with us by April 30, 1998.

At this time, I am enclosing the following for your review:

- Copy of the Complaint;
- EMH records for Rhonda Merriweather;
- EMH records for Jasmine Merriweather; and
- Copies of the fetal monitoring strips.

PLAINTIFFS EXHIBIT
TODIA 1

If you need any additional material, please feel free to give me a call.

Thank you for your cooperation and assistance in the above regard.

Veiy truly yours,

KATHLEEN MULLIGAN, R.N.
Legal Assistant

KM:lmw
Encs.

WESTON HURD
FALLON PAISLEY & HOWLEY L.L.P.
COUNSELLORS AT LAW

Kathleen Mulligan, R N
2161687-3330
KM2500@MCIMAIL COM

September 3, 1998

William Todia, M.D.
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, Ohio 44109

Re: **MERRIWEATHER vs. EMH, et al.**
Our File #16082-20157

Dear Dr. Todia:

Enclosed are additional records received relevant to the captioned matter

- University Hospital records of 11/12/92 - 11/23/92;
- University Hospital records of 1/2/93 - 2/3/93; and
- University Hospital records of 8/2/93 - 8/9/93.

Please review these records and call John Jeffers to discuss any additional thoughts you might have by 10/1/98. Mr. Jeffers can be reached at 216/687-3214.

Thank you for your continued cooperation and assistance in this matter.

Veiy truly yours,

KATHLEEN MULLIGAN, R.N.
Legal Assistant

KM:lmw

PLAINTIFFS
EXHIBIT
TODIA

11/23/98

[illegible]

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