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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Record Link - Video Tech Link Erieview Tower (130) For Ninth Street Cleveland, OH (44114) Fel (216.523.1313) Fax (216.263.7076) - 538.391.3376 (DEPO)

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APPEARANCES: 1 2 On behalf of the Plaintiffs: 3 Rubenstein, Novak, Einbund 4 & Pavlik, by 5 WILLIAM J. NOVAK, ESQ. б 270 Skylight Office Tower 7 1660 West Second Street 8 Cleveland, Ohio 44113-1498 9 (216) 781-8700 10 11 On behalf of Defendant Elyria Memorial 12 Hospital Medical Center: 13 Weston, Hurd, Fallon, Paisley & 14 Howley, by 15 JOHN W. JEFFERS, ESQ. 16 2500 Terminal Tower 17 50 Public Square 18 Cleveland, Ohio 44113-2241 19 (216) 687-3214 20 21 22 23 24 25 S)

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APPEARANCES, Continued: On behalf of Defendant Liengkong Siew, M.D.: -----Mazanec, Raskin & Ryder, by б LYNNE K. SCHOENLING, ESQ. 250 Civic Center Drive, Suite 400 Columbus, Ohio 43215 (614) 228-5931 and the second

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1	WILLIAM J. TODIA, M.D., of lawful age,
2	called for examination, as provided by the Ohio
3	Rules of Civil Procedure, being by me first
4	duly sworn, as hereinafter certified, deposed
5	and said as follows:
6	EXAMINATION OF WILLIAM J. TODIA, M.D.
7	BY MR. NOVAK:
8	2. Q. For the record, could we have your
3	name, please?
10	A. William Todia, T O D I A.
11	Q. And, Dr. Todia, I had an
12	opportunity to get your CV prior to today. In
13	1992, November to be specific, could you tell
14	me what you were doing at that time?
15	A. I was working at MetroHealth
16	Medical Center, department of obstetrics and
17	gynecology.
18	Q. And specifically, when you say you
19	were working, what was your position?
20	A. My position was well, there's
21	the position has not changed. There are two
22	positions. I have an appointment as an
23	assistant professor of reproductive gynecology
24	at Case Western, and I have an appointment to
25	the department of obstetrics and gynecology,

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1	which is as	s a generalist
2	obstetricia	an/gynecologist. So I have two
3	positions,	but my job at MetroHealth is
4	primarily a	as a general attaction
5	obstetricia	an/gynecologist.
6	Q.	When did that position commence, at
7	what date?	
8	A .	1990.
9	Q.	And your residency finished up
10	when?	
11	Α.	1990.
12	Q.	At Metro?
13	А.	No.
14	Q.	Where at?
15	Α.	Northwestern in Chicago.
16	Q.	Okay. Have you ever testified for
17-	the Weston	Hurd firm before?
18	А.	No.
19	Q.	Have you ever done any work for Mr.
20	Jeffers bef	ore?
21	Α.	No.
22	Q.	Have you ever reviewed any cases
23	for defense	lawyers on behalf of the defense of
24	litigating r	nedical malpractice cases before
25	today?	

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1	А.	Yes.
2	Q.	On how many occasions?
3	Α.	Probably 20.
4	Q.	And
5		MR. JEFFERS: You just said for the
6	defense only	у.
7	А.	Oh, I misunderstood. A total of
8	probably 20	. And of the 20, maybe 15 were for
9	the defense	, 12 for the defense. Some ratio
10	like that.	
11	Q.	And during what period of time?
12	А.	Since 1990 to the present.
13	Q.	And do you know how Mr. Jeffers got
14	your name t	o testify in this case?
15	А.	I don't.
16	Q.	And did Mr. Jeffers send you any
17	corresponde	nce before today regarding this
18	case?	
19	А.	Yes.
20	Q.	Could I see that, please?
21	А.	That looks like something
22	(handing).	
23	Q.	Thank you.
24	А.	I can give you the
25		MR. NOVAK: Would you mark this as

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1 Plaintiff's Exhibit 1? 2 (Thereupon, Plaintiff's Deposition 3 4 Exhibit 1 was marked for purposes of 5 identification.) 6 7 I think that's all I have. Α. 8 MR. JEFFERS: What's the date on 9 that one, Bill? 10 MR. NOVAK: February 27, 1998. 11 MR. JEFFERS: Twenty-seven? 12 MR. NOVAK: Uh-huh. And then marked as Plaintiff's 13 Q. Exhibit 2 --14 15 MR. NOVAK: Would you mark this? 16 This is a letter dated September 3, 1998. Contraction of the second second 17 (Thereupon, Plaintiff's Deposition 18 19 Exhibit 2 was marked for purposes of identification.) 20 21 And in this letter dated February 22 Q. 23 27, 1998, there's a statement here from Mr. 24 Jeffers' office, and it's Kathleen Mulligan, 25 RN, Legal Assistant, and the statement says,

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1	"It appears that the baby had three episodes of
2	cyanosis, hypoxia and limpness, as well as
3	seizure activity within the first 24 hours of
4	life. She was transferred to University
5	Hospitals." Would you agree in general with
6	that paragraph?
7	A. Can I read it again, please?
8	2. (Handing.)
9	A. To my knowledge, yes.
10	Q. And then there's a letter dated
11	September 3, 1998 at which time Mr. Jeffers
12	enclosed University Hospital records for you.
13	Could you read to me what the handwriting says
14	at the bottom?
15	A. It says, "11/23/98, Discussed with
16	Jeffers. I said I found no evidence in chart
17	to explain the neonatal seizures - but suggest
18	that neuro peds." What I meant by that is that
19	a neurologic pediatrician reviewer give him
20	that an opinion.
21	Q. Okay. So when you provided your
22	report on March 19, 1998, would it be fair to
23	state that you did not have any of the
24	subsequent treating records on this child?
25	A. I did not have records from

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1 University Hospital. 2 0. Right. 3 Α. Correct. 4 0. And when I say "subsequent 5 treating," that's what I mean. 6 Α. Correct. 7 0. Okay. Now, have you ever been represented in any lawsuits by the Weston Hurd 8 law firm? 9 10 Α. No. 11 Have you ever -- are you aware that 0. 12 Mr. Jeffers' law firm represents MetroHealth Medical Center in medical malpractice cases? 13 14 Α. No. 15 Q. Let me ask you, what do you 16 perceive your role as in this case? Do you 17 perceive your role as being giving an 18 independent evaluation of what occurred here and your opinions, or is your perception to be 19 one of an advocate on behalf of the defendants? 20 21 Α. My role is to review from an 22 obstetric point of view the obstetric care that 23 the patient -- the mother received and to give a fair and honest assessment of that care. 24 25 Have you ever been sued for medical 0. July Ja

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1	malpractice?
2	MR. JEFFERS: Objection. Go ahead.
3	A. Yes.
	Q. And can you tell me on how many
5	occasions?
6	MR. JEFFERS: May I just have a
7	continuing objection to this?
8	MR. NOVAK: Uh-huh.
ģ	MR. JEFFERS: Thank you.
10	A. Two times.
11	Q. And can you tell me, if you recall,
12	the names of those cases?
13	A. Nope.
14	Q. Do you know how they resolved?
15	A. Yes.
16	Q. Can you tell me?
<u> </u>	A. They were both dismissed because
18	the plaintiff's attorney could not produce an
19	expert witness to say I had done anything
20	wrong.
21	Q. Now, you've just testified a few
22	minutes ago that you were never represented by
23	the Weston Hurd law firm under oath. But,
24	Doctor, there's a case that I'm aware of filed
25	March 26, 1993 by the name of Judy Johnson

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1	versus William Todia, et al. Are you familiar
2	with that case?
3	A. Yes.
4	Q. In that case you were
5	represented
6	MR. JEFFERS: What year was that,
7	93?
8	MR. NOVAK: Ninety-three.
9	Q. You were represented by Deirdre
10	Henry, a partner of Mr. Jeffers at the law firm
11	of Weston, Hurd, Fallon. Do you recall that?
12	A. No.
13	Q. So you're telling me you don't
14	remember who your lawyer was at that time?
15	A. No. I never met a lawyer regarding
16	that case.
17 *	If I told you that the court
18	records reflect that you were represented by
19	Mr. Jeffers' law firm at that time, would you
20	have any reason to dispute the court records?
21	A. No.
22	MR. JEFFERS: What is the name of
23	that one, Bill?
24	MR. NOVAK: (Handing.)
25	MR. JEFFERS: Did you go through

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this to see if there's any -- I don't know --1 2 whether there was a subsequent representation or what happened, Bill? 3 4 MR. NOVAK: No, I did not. Rentifica and a MR. JEFFERS: It shows --5 MR. NOVAK: That's a different 6 case. 7 8 MR. JEFFERS: I was going to say, it shows Christine Reid. 9 MR. NOVAK: That's a different 10 11 case. MR. JEFFERS: Oh, it is? 12 MR. NOVAK: Yeah. 13 14 MR. JEFFERS: You have no memory of this? 15 16 THE WITNESS: I remember the case. I remember it was dismissed. I remember 17 talking to a lawyer on my behalf on the phone, 18 19 and Deirdre Henry sounds familiar, but I did 20 not know what firm she worked for. I never met 21 the person. I'm going to ask you to -- by the 2.2 Q. 23 way, do you have any notes that you prepared other than your report? 24 25 Α. No.

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1	MR. JEFFERS: Well, there's some
2	notes on that
3	A. Yeah, I read that paper to you,
4	but, I mean, not any other individual ones that
5	I have in my stack.
6	Q. I'm going to ask you if you would
7	please refer to the Elyria Memorial Hospital
8	chart, specifically the labor and delivery
9	summary.
10	A. Could you show me what page you're
11	referring to? I don't know what you're
12	speaking of.
13	Q. This would be the page here, and
14	it's got a number 4 on it. I have a couple of
15	questions about that chart.
	Under the cord blood there's a
17	circle that says "refrigerated." And according
18	to information given to us by Mr. Jeffers of ${ m R}$
19	Wednesday, it is my understanding that the
20	hospital would have discarded that blood
21	approximately three days after discharge?
22	MR. NOVAK: Is that right?
23	MR. JEFFERS: If there's no doctd $rac{F}{2}$
24	order to do anything with it, it would be
25	refrigerated for three days and/or to the time

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1	that the patient moves.
2	Q. Okay. I guess my question for you
3	is this: I'm assuming as we sit here today
4	that cord blood is no longer in existence, nor
5	was there any analysis of that cord blood.
б	Whose responsibility would it be to have any
7	analysis done of that cord blood at a hospital?
8	MR. JEFFERS: Objection. Go ahead.
9	A. What kind of analysis are you
10	referring to?
11	Q. Well, let's say, for instance, you
12	wanted to know what the cord blood pH would be.
13	Who customarily in a hospital setting would
14	issue an order to determine what cord blood pH
15	would be?
16	A. That's a test that would be ordered
17	by the attending obstetrician
18	Q. Okay. And with respect to any
19	analysis of the placenta, would your answer
20	stand the same?
21	MS. SCHOENLING: Note my objection.
22	A. The placental pathology would also
23	be done at the request of the attending
24	physician.
25	Q. Okay. Now, when I look at this

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1 labor and delivery summary and we look at the 2 column that says, "Labor summary," there's a check box for meconium; is that right? 3 4 Α. Where are you looking? 5 First column. Do you see that 0. there? б 7 Α. Uh-huh. 8 Q. You would agree with that, right? 9 Α. Yes. 10 And then under "Delivery Data," 0. 11 under the column there's a subheading for 12 "Cord," then it says, "Nuchal cord times one, 13 true knot times one," and then parenthesis 14 " (loose)." Do you see that there? 15 MR. JEFFERS: I couldn't hear the 16 last one. 17 MR. NOVAK: I'm basically reading 18 from here, John. 19 MR. JEFFERS: I didn't hear what 20 you said after "true knot." MR. NOVAK: "True knot times one 21 22 (loose)." 23 MR. JEFFERS: Oh, okay. And then it also says. "Suctioned 24 0. for meconium below cords per G. Thomas, RN." 25 333

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1	That's in the last column. Do you see that?	
2	A. Yes.	
3	Q. And then there's also a box for	
4	gross congenital anomalies. Is there any	HANNELSEN VIEW DUBTING AND
5	checkmark in that box?	
6	A. Show me where you're looking. I	
7	don't know where the	
8	Q. There's a box that says, "Gross	
9	congenital anomalies." Do you see that?	
10	MS. SCHOENLING: Which column is it	
11	in?	
12	MR. NOVAK: Last column.	
13	MR. JEFFERS: Under "Initial	
14	newborn exam."	
15	MR. NOVAK: Right.	
16	MS. SCHOENLING: Thank you.	
17	A. No, I don't see any checkmark	· · · <u></u>
18	there.	
19	Q. Okay. And if there was a gross	
20	congenital anomaly, you would certainly expect	-
21	Dr. Siew to mark that box there, wouldn't you?	
22	MR. JEFFERS: Objection.	
23	A. This was not completed by Dr. Siew.	
24	Q. Well, Dr. Siew's signature signs	¢
25	off on that, does he not?	

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	17	_
1	A. I don't see a signature of any	
2	doctor on this sheet.	
3	Q. I think we'll all agree that the	
. in construction of a sector	signature which is there	WW AAA AMMANINA IT I
5	A. Was his signature?	
6	Q is Dr. Siew's, yes,	
7	A. All right. I didn't know that was	
8	the signature.	
9	MR. JEFFERS: Lynne?	
10	MR. NOVAK: W uld you agree, Lynne,	
11	that that's Dr. Siew's signature?	
12	MS. SCHOENLING: Well, I would just	
13	preserve my objection for the record. I'm not	
14	going to agree that this is his because I don't	
15	remember what he testified to with respect to	
16	this page.	
17	Q: I want you to assume that that's	
18	Dr. Siew's signature. Would it be fair to	
19	state that either the nurse who signs it below	
20	or whoever's responsible for preparing this	•
21	labor and delivery summary, if they noticed a	
22	gross congenital anomaly, they would check that	
23	off, wouldn't they?	
24	MS. SCHOENLING: Objection.	
25	A. Probably.	

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1	Q. Okay. And then there is I'm
2	going to turn over to the infant's chart for a
3	minute, page 37. And instead of having to turn
4	over, let me just;, ask you real quick
5	MR. JEFFERS: Well, wait a minute.
6	He wants to see what you're doing.
7	Q. Tell you what I'll do, I'll pull it
8	out to save you time. Page 37 is a Lubchenco
9	chart for the weight percentiles, the length
10	percentiles and the head circumference. Do you
11	see those there?
12	A. Yes, I do.
13	Q. And would you agree with me that
14	with respect to the head circumference
15	percentiles, that is within a category that's
16	considered appropriate for gestational age; is
17	that correct?
18	MR. JEFFERS: Object.
19	A. I'm not I don't feel qualified
20	to decide. This is a pediatric record and I'm
21	not a pediatrician.
22	Q, Okay. But would you agree that
23	what you're looking at there in the boxes that
24	are marked off on the page would indicate,
25	"Appropriate for gestational age"; is that

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right? 2 I'd agree someone checked off the Α. 3 column, "Appropriate for gestational age," but I can't make an independent judgment if that's 4 5 correct or not. 6 0. I understand that. You are aware 7 that this infant was delivered under conditions of fetal distress; is that correct? 8 9 Α. That's incorrect. 10 0. Well, Doctor, I'm going to refer 11 you, while you're in the infant's chart, to the 12 initial newborn profile, page four, and I'll 13 ask you to turn to that. Which chart is this in? 14 Α. The 15 newborn chart? 16 MR. JEFFERS: It's one we had just 17 a moment ago. 18 Α. Okay. 19 Q. Do you see under "Newborn data," it indicates, "Intrapartum problems identified. 20 21 Number 1, fetal distress"? 22 MR. JEFFERS: Where are we looking? 23 THE WITNESS: (Indicating.) 24 0. Number 2, meconium fluid. Do 25 you agree what is written down there on the

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1 hospital chart prepared by Mr. Jeffers' 2 client --3 MS. SCHOENLING: Which page are we I'm sorry. 4 on? MR. NOVAK: Page four, initial 5 6 newborn profile. 7 MS. SCHOENLING: Thank you. 8 Q. Do you agree with the assessment that says, "Fetal distress"? 9 10 Α. No. 11 0. So you disagree with what someone 12 saw on 11/11/92 at 1:30 p.m. and 1:10 p.m. 13 under the "Newborn Data" box marked as "fetal 14 distress"? You disagree with that, right? That's correct. 15 Α. Ο, So you feel as you sit here today 16 17 that you are in a better position to determine whether or not there was fetal distress; is 18 that correct? 19 MR. JEFFERS: Objection; that's 20 21 argumentative now. MR. NOVAK: I'm just asking if he 22 23 feels he's in a better position. MR. JEFFERS: No, because this is 24 somebody else writing it down and we don't know 25

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who wrote that down. Maybe the nurse was 1 2 wronq. 3 MR. NOVAK: I understand. 4 0. Doctor, I'm asking you a question. Someone on November 11 wrote down "fetal 5 6 distress," and you're sitting here 7 approximately seven years later, and my 8 question for you is do you feel as you sit here today you're in a better position to evaluate 9 10 whether or not this infant had fetal distress 11 versus the person who wrote this down? 12 Α. Yes. 13 Q. Now, are you aware that this newborn had bruises on its face? 14 15 Α. Yes. 16 Are you aware that this newborn had Q. of self-second thick meconium suctioned? 17 18 Α. No. 19 Q. Looking back at that chart, do you 20 see the notation under "Detail abnormal 21 findings" the notation, "Thick meconium suctioned below the cords times 4"? 22 23 I've seen the chart marked Α. 24 "meconium," but I've not seen "thick meconium." 25 Could you show me what you're referring to? Ι **>>>**

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1	could not read the
2	Q. Right there.
3	A. Okay. Now, I see it. I never had
4	seen the I never had seen the "thick"
5	before. Okay. I believe that.
6	\mathbb{Q}_{*} But it does, in fact, say "thick
7	meconium," doesn't it?
8	A, Yes, I agree.
9	Q. You would agree with me that thick
10	meconium is certainly different than just
11	meconium fluid?
12	A. There are grades of meconium, and
13	thick is one of the grades. It can be thin
14	meconium or it can be thick meconium.
15	Q. From the standpoint of fetal
16	stress, can you tell me what your understanding
17	is of the significance of thick meconium?
18	A. Thick meconium can be an indicator
19	of fetal stress, but as an independent
20	variable, meconium alone does not correlate
21	with fetal distress.
22	Q. Right. We have to look at all of
23	the factors considered to come up with that
24	kind of an analysis; is that right?
25	A. That's correct.

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1 0. Okay. But you would agree that 2 thick meconium as has been described in this chart is an indicator; is it not? 3 4 Α. No, I didn't say that. 5 Is one of the indicators? 0. б Α. I didn't say that. I said it is 7 not correlated, it is not an independent 8 indicator. Thick meconium alone does not 9 indicate fetal distress. 10 That's not my question. Let me try 0. 11 to put it a little differently. MR. JEFFERS: You said, "Didn't you 12 13 just say," and he just said, "I did not say." 14 0. No, a factor. Can it be a factor 15 in looking at a picture of a fetus that was in 16 distress? MR JEFFERS: Objection. 17 18 Q. A factor. 19 MR. JEFFERS: That's not a complete 20 sentence. 21 Α. I'm not sure I understand the 22 question. 23 0. Well, would you agree with me that 24 thick meconium can be found in fetuses that 25 have distress?

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1	A. Yes.
2	Q. Okay. And we have to look at other
3	factors in looking at a total picture to
4	determine whether or not a fetus had distress;
5	is that right?
6	A. Yes. Meconium can be found in 99
7	percent of patients of fetuses who do not
8	have distress. So it is
9	Q. Right. But would you agree with me
10	that as this chart is written, it does indicate
11	under "Newborn Data" that this fetus had
12	distress?
13	A. No, this chart indicates that
14	someone who I'm not even familiar with the
15	signature wrote "fetal distress."
16	Q. Right. That's what I'm saying.
17	Somebody wrote down "fetal distress" here,
18	didn't they?
19	A. Right.
20	Q. Okay. Now, let's talk about Apgar
21	scores for a few minutes. Those are
22	subjective, aren't they?
23	A. Everything in medicine is
24	subjective.
25	Q. Well, pH of cord blood isn't

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1	subjective, is it?
2	A. Sure.
3	Q. Well, that's a scientific test,
4	isn't it?
5	A. It's subjective because it has to
6	be the test has to be performed by someone
7	and then interpreted, Just like every test in
8	medicine is there's no perfect test.
9	Q. Well, are you telling me, then,
10	that you can get a false positive on that's
11	the wrong word. Are you telling me that a lab
12	test that's run on cord blood has a certain
13	element of inaccuracy to it?
14	A. Yes, it does.
15	Q. Okay. Why don't you tell me what
16	the range is for cord bloods plus and minus.
17	A. I'm not a pathologist, but there
18	are ranges of accuracy of every machine that
19	performs laboratory tests. But I cannot tell
20	you off the top of my head what the range is
21	for the machine that performed the cord pH .
22	Q. Well, do you look at I'm sorry.
23	A. Go ahead.
24	Q. Do you look at cord pH's on a
25	regular basis in your practice?

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1	A. Yes.	
2	Q. Would you anticipate and expect	
3	that the results of those lab tests that you	
4	get back are accurate?	
5	A. It depends on what you mean by	
6	"accurate."	
7	Q. Well, in other words, if you get a	
8	7.Q, don't you expect that to mean what the 7.0	
9	means?	
10	A. Not always. It's taken in context	
11	with all of the data available. And there are	
12	times when 7.0 cord pH is inaccurate. There	
13	are mistakes. There are there are reasons	
14	why the test is not perfect, for a lot of	
15	reasons; how the sample was taken, how it was	
16	carried to the lab, who performed it in the	
17	lab, how the machine was calibrated.	STATISTICS CONTRACTOR
18	So there are times when you get a	
19	result to any test in medicine which is	
20	inaccurate and which you have to discard	
21	because the whole picture does not add up.	
22	Q. Okay. So I guess what you're	
23	telling me, then, is that if we had a blood gas	
24	taken on this infant at 1359 hours and it came	
25	back at 7.21, that's possible that it could	

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r	27	1
1	have been lower than that?	
2	MS. SCHOENLING: Objection.	
3	MR. JEFFERS: Object.	
4	A. Anything's possible, but I don't	
5	think that that's relevant to that pH.	1. S.
6	Q. Well, I guess my question is a few	
7	minutes ago you just told me that there can be	
8	inaccuracies based upon the way the lab data is	
9	it arrived at, and my question for you is do	
10	you have any idea as to how they arrived at the	構成でいた。 構成でいたであり のできた。
11	7.21 at 1359 hours?	
12	MS. SCHOENLING: Talking about	
13	arterial blood gases?	
14	MR, NOVAK: Right.	
15	A. That were drawn on the newborn.	
16	No, I don't have any idea. I'm not familiar	
17	with the pathology laboratory at Elyria	
18	Hospital.	
19	Q. Okay. So I guess my question is	
20	that based upon the way it's done, the way it's	
21	collected, the way it's turned over to the lab,	2.4
22	could be that the lab result for the pH could	alitati 1997 - Store Ber P
23	have been lower than the 7.21; isn't that	1
24	right?	
25	MS. SCHOENLING: Objection.	in reconstruction of the second s

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	20
1	MR. JEFFERS: Objection.
2	A. Anything's possible, but that's a
3	ridiculous question. This all started by
4	saying aren't Apgar scores subjective, and I
5	said that everything in medicine is subjective
6	to interpretation. And now we're on cord pH's
7	and whether I know whether the result of the
8	7.21 is accurate or not.
9	Q. Well, do you know whether or not
10	it's accurate?
11	A. I don't have independent
12	information about the accuracy of that. I have
13	to take it in context with everything else that
14	was going on.
15	Q. As you sit here today, do you have
16	any reason to believe that the 7.21 that's
17	recorded at 1359 hours was inaccurate?
18	A. Just as I think that I've no reason
19	that the Apgars of 6 and 8 would be inaccurate,
20	I don't have any reason to believe the 7.21 was
21	inaccurate either.
22	MR. JEFFERS: Stop. Please read
23	that back.
24	MR. NOVAK: I heard it.
25	MR. JEFFERS: I know. I think I

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1	heard it and ${\tt I}$ think you heard it, and <code>I'm</code>
2	asking her to read it back, which is my right,
3	and I'm having it read back.
4	MR, NOVAK: Okay.
5	(Record read.)
6	Q. So, Doctor, I guess my question for
7	you is, then, you don't have any reason to
8	believe the 6 or the 8 are inaccurate?
9	A. Correct.
10	Q. You don't have any reason to
11	believe that the 7.21 is inaccurate, right?
12	A. Correct.
13	Q. But you don't think that the words
14	"fetal distress" written here are accurate, do
15	you?
16	A. No, I do not.
17	Q. Did you ever talk to any of the
18	personnel at Mr. Jeffers' hospital that were
19	deposed in this case?
20	A. No.
21	Q. Did you ever speak to any
22	individuals involved in the care of Rhonda
23	Merriweather or Jasmine Merriweather?
24	No, I have not.
25	Q. So your only opinion as to whether

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1	or not these recordings are accurate or
2	inaccurate is based upon a review of the chart
3	seven years later; is that right?
4	A. That's correct
5	Q. And, in fact, as we sit here today,
б	you didn't even know that there was thick
7	meconium suctioned four times below the cords
8	until I pointed it out to you; isn't that
9	right?
10	MS. SCHOENLING: Objection.
11	A. I did know that there was meconium,
12	but I did not know that the word "thick'' was
13	included.
14	Q. Right, Now, I want to ask you a
15	little bit you've taken a look at this
16	chart. Do you see any progress notes written
17	by Dr. Siew between the time that this patient
18	enters the hospital and commences labor up
19	until the time she delivers?
20	A. No, I don't recall any. I don't
21	recall seeing any.
22	${\mathbb Q}$. Would it be fair to state that as
23	we sit here today, we have absolutely no idea
24	of what Dr. Siew's sense impressions were and
25	mental thought processes were regarding the

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1 care and treatment of this patient during her 2 labor? 3 MR. JEFFERS: From the record only? MR. NOVAK: From the record. 4 From 5 the record. MR. JEFFERS: Because he's also had 6 7 in front of him Dr. Siew's deposition. 8 MR. NOVAK: I'm talking about the record. 9 10 MR. JEFFERS: I just want to make 11 sure, because you should know that he has seen 12 Doctor -- I don't know whether he's read it 13 all, but he's seen it. 14 MS. SCHOENLING: If the question is 15 do we have any information from the totality of the record as to Dr. Siew's thought processes 16 17 from the time of labor until the delivery -- is 18 that the question? 19 MR. NOVAK: Right. 20 MS. SCHOENLING: Note my objection 21 to the question. 22 MR. JEFFERS: Also, if we're 23 getting into the realm of his evaluation of Dr. 24 Siew, he wasn't retained for that purpose, but 25 qo ahead. Just so you know.

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4 0. Okay. Now that they've made that 2 objection, is there any mention anywhere in the chart -- any writing by Dr. Siew indicative of 3 his thought processes regarding the care and 4 5 treatment of this patient during her labor? MS. SCHOENLING: Objection. 6 I don't find any notes by Dr. Siew 7 Α. 8 of the -- about the patient during labor. So that's the answer to the question. 9 You train residents in OB/GYN here, 10 0. 11 do you not? 12 Α. Yes. Q. Would you agree with the general 13 14 statement that meticulous recordkeeping by an 15 OB/GYN is very important, isn't it? It's something that I try to teach, 16 Α. 17 yes. 0. An OB who doesn't write any notes 18 19 during an entire period of labor, would you say that that comports with meticulous 20 21 recordkeeping? 22 MR. JEFFERS: Object. 23 MS. SCHOENLING: Join in the 24 objection. MR. JEFFERS: Go ahead. 25

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1 No, it's not meticulous. Α. 2 Are you familiar with Dr. O'Grady, 0. who is going to testify in this case? 3 4 Α. Only from reading his expert 5 report, but not -- I have no other personal 6 knowledge of him. 7 Did you ever know him when he was 0. here in Cleveland? 8 9 No. Α. 10 Q. Have you ever read his book on 11 Operative Obstetrics? 12 No, I have not. Α. 13 In your library, do you have 0. 14 Williams on Obstetrics? 15 Α. Yes. 16 0. Do you have Kreasy on Maternal 17 Medicine? 18 Yes. Α. 19 Let me ask you a question, because 0. 20 Dr. O'Grady is going to be an expert in this 21 I want to ask you, in a preface to the case. 22 book he wrote he has a statement here, and it 23 says --24 This is the book MR. JEFFERS: that's written subsequent to this case? 25

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1	MR. NOVAK: Right. This is the
2	immortal book.
3	MR. JEFFERS: This is in 1990 when?
4	MR. NOVAK: Right.
5	MR. JEFFERS: No, 1990 when?
6	MR. NOVAK: Five.
7	Q. "In the preparation of this text,
8	our purpose is to promote thoughtful,
9	compassionate, and technically and ethically
10	competent clinical medicine with close
11	attention to patient communication and
12	meticulous recordkeeping." You'd agree with
13	that in general, wouldn't you
14	MS. SCHOENLING: Objection.
15	Q about meticulous recordkeeping?
16	MS. SCHOENLING: Objection.
17	A. I'd like to read the paragraph in
18	context, please. Do you want to read it to me?
19	Q. Sure.
20	MR. JEFFERS: Why don't you just
21	hand it to him?
22	MR. NOVAK: Sure.
23	A. I've never seen the book, so
24	Q. It's pretty good. You ought to
25	take a look at it. Tells doctors how to stay

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1	out of trouble.
2	A. We could all use that.
r	MR. JEFFERS: Don't respond to his
4	comments · · · · · · · · · · · · · · · · · ·
5	A. Would you like me to read the rest
6	of this in the record? "It is not possible to
7	practice obstetric without complications with
8	either damaged infants or mothers. The
9	unfortunate result seems to speak very clearly
10	to this case."
11	"While the majority of these
12	problems prove to be of trivial consequence,
13	some are potentially serious. Some rarely will
14	prove fatal. These misadventures can be
15	prevented while others remain unavoidable. The
16	only certain statement is that any serious
17	injury to mother or infant could be subjected
18	to peer and usually legal review."
19	He then goes on to say, "In
20	preparation of this text, our purpose is to
21	promote thoughtful, compassionate, and
22	technically and ethically competent clinical
23	practice with close attention to patient
24	communication and recordkeeping."
25	So I would agree with the intent of

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1	this preface. It seems to be good common sense
2	for all medical practice.
3	Q. While we're on the issue of
4	meticulous medical records, is there any
5	indication in the chart between the hours of
6	9:30 and the time when Dr. Siew comes back to
7	see this patient at approximately noon that any
8	of Mr. Jeffers' nurses contacted Dr. Siew?
9	A. I'd have to look at the nursing
10	notes.
11	8:30 a.m. there's a note, "Dr. Siew
12	notified." 9:30 a.m. there's a notation that
13	says, "Dr. Siew here to check patient." I
14	can't remember the time parameters you gave me
15	in the question.
16	MR. JEFFERS: Nine-thirty and noon,
17	Bill?
18	MR. NOVAK: Uh-huh.
19	A. It appears to be the next note
20	about Dr. Siew is 12 something, maybe 12:10. I
21	can't read the "Dr. Siew here. Internal
22	monitor placed."
23	I'd also need to look at the
24	tracings because there were some notations on
25	the tracings that I don't know if there was
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	37
1	I can't remember what they said about Dr. Siew.
2	"8:30, 4 CM, vaginal exam per Dr.
3	Siew." So that means Dr. Siew was there then.
4	MR, JEFFERS: What: time?
5	THE WITNESS: Eight-thirty a.m.
6	A. I don't see any other notations
7	until the 12;10 notation that I read.
8	Q. Okay. So my question, then, is
9	between the hours of 9:30 and 12:10, at no time
10	did any of the nurses at Elyria Memorial
11	Hospital notify Dr. Siew, at least as far as
12	the record reflects, regarding this patient's
13	condition?
14	A. None that I'm aware of.
15	Q. Okay. Now, I'd like to look at the
16	fetal heart strips, if we could, and I'd like
en energiadanden 🗄 🗿	to start at the beginning <i>of</i> the strips. Now;
18	would it be fair to state that
19	MR, JEFFERS: You're starting at
20	65404?
21	MR, NOVAK: Right.
22	Q. Would it be fair to state that
23	virtually all the literature, including
24	Williams on Obstetrics, indicates that a normal
25	baseline fetal heart rate is between 120 and

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1	160?
2	A. Yes.
3	Q. Now, looking at 65404 and 05, would
4	you agree with me that that baseline is above
5	160?
6	A. Yes.
7	Q. And that baseline continues above
8	16Q for 06, 07 and 08; isn't that correct?
9	A. Yes.
10	Q. And then on 09 it continues above
11	160, doesn't it?
12	A. Yes.
13	Q. And 10 it's above 160, isn't it?
14	A. Uh-huh.
15	Q. And then we see some variability on
16	11. Do you see that there?
17	A, I see variability all the way from
18	65404. So if you want to point out what you're
19	referring to I'm not sure what you're
20	referring to.
21	Q. Well, just in general there's
22	variability on 11. Because we do have
23	periods
24	A. There's variability I don't
25	understand the question.

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	37
1	• Well, we'll get to that in a
2	minute, but what would you say the baseline is
3	on 11?
4	A. It looks like the baseline is about
5	160.
6	Q. And then at 12 we have a baseline
7	above 160 again, don't we?
8	A. Yes.
9	Q. At 13 we're above 160?
10	A. Uh-huh.
11	Q. At 14 we're above 160?
12	A. I think so.
13	Q. Now, 12 and 13 represent somewhat
14	diminished variability, don't they?
15	MR, JEFFERS: Which numbers, Bill?
16	MR. NOVAK: 12 and 13.
17	A. I would define it as minimal
18	variability in those panels. Variability is
19	taken over a period of time, so it's difficult
20	to to do variability by each minute is
21	incorrect.
22	Q. Now, 15, 16 and 17, would you agree
23	that the baseline is still above 160?
24	A. No, it looks like it's at about
25	160. Maybe we're quibbling over 160 or 162.
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1	It appears to be baseline is a mean heart
2	rate, and so it appears to be right around 160.
3	Maybe it's 162.
4	Q. Now, 18 and 19 and 20, baseline
5	above 160?
6	A. On 18, 19, 20, yes.
7	Q. Okay. Now, 21, 22, 23, right at
8	abğut 160; is that right?
9	A. Looks like that, yes.
10	Q. And then 24, 25 and 26; pretty much
11	the same at about 160?
12	A. Yes.
13	Q. And 27, 28, 29, the same?
14	A. At 27, 28, 29, yes.
15	Q. Same with 30. And then at 31 and
16	32 would you give me your impression of what
17	the baseline is there?
18	A. Could you repeat the question?
19	Q. Yeah. At 31 and 32, what's your
20	impression of what the baseline is?
21	A. Still looks like about 160 as an
22	average. Maybe 155. It's been there's a
23	moderate variability and an acceleration, so
24	it's difficult to average it out over two
25	minutes.

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	41
1	Q. Now, at 34 and 35 and 36
2	MR. JEFFERS: Which ones?
3	Q. At 34, 35 and 36 we are once again
4	above 160, are we not?
5	A. At 34, 35 and 36, that's hard to
6	average. It's going to be there's moderate
7	variability in this area, which makes it
8	tougher to say. It may be 165. It's 160 to
9	165. It's yeah, maybe it's 165. It's hard
10	to average in that short a time.
11	Q. We had some recordings at that time
12	that were almost as high as 180; isn't that
13	right?
14	A. It looks like it was 180 one second
15	is the only one I see.
16	Q. Okay. And then
17	A. That looks like it's part of the
18	moderate variability I'm speaking of.
19	MR. JEFFERS: And you're responding
20	to his questions not by looking at the broad
21	spectrum of the graph, but only by looking at
22	the sections he's asking for
23	A. Correct.
24	Q. Correct. If we go to 36, 37 and
25	38, it appears that we are above 160; isn't
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1 that right? 2 Α. For times -- you mean is the baseline above 160? 3 Q. 4 Yes. It looks like it averages out to 5 Α. 165. I don't see an appreciable change there. 6 0. And at about 9:30, which is panel 7 36; according to the chart, Dr. Siew was there; 8 9 is that right? 10 Panel 36, did you say? Α. 0. 11 Yes. 12 I believe that's what the note said Α. in the nurses note. Yes, "Dr. Siew here to 13 14 check patient." MS. SCHOENLING: This is at 9:30? 15 16 MR. NOVAK: Yes. At 9:30 that's what the note 17 Α. indicates. 18 Now, panels 39, 40 and 41, can you 19 0. 20 tell me what your interpretation of those is of 21 the baseline there? At 39, 40 and 41? Okay. It goes 22 Α. to -- looks like it's, again, about 160. At 23 24 160, maybe 162. Between 160 and 165. 25 Q. And then 42, 43, 44?

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	43
1	A. One sixty.
2	Q. And how about 45, 46, 47?
^	A. I'm going to say 160 again.
4	Between 160 and 165.
5	Q And how about 48, 49 and 50?
6	A Same. No appreciable change.
7	• Now, when I look at panels 51, 52,
8	53, would you agree with me that we are
9	beginning to see some change?
10	A Tell me the panel numbers again:
11	I'm sorry.
10	Q On 51, 52 and 53.
13	[™] Change in what? I don't know whaŧ
14	you're asking.
15	Well, you're talking around 160.
16	We're seeing a change now above 160; isn't that
17	right?
18	<pre>Mo, I don't agree.</pre>
19	Q. All right.
20	A. I think you're seeing moderate
	variability and accelerations. Accelerations
	are not a change in the baseline. They're a
23	sign of good fetal oxygenation. They're a
24	reassuring part of the strip. They do not
25	and that's what you're seeing in those areas is

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1 moderate variability with fetal accelerations, 2 over-15-beat-per-minute accelerations for 15 3 seconds or more. Okay. Now, when we see these 4 5 accelerations to 180 --MR. JEFFERS: Where are we talking 6 7 about? -MR. NOVAK: On 51, 52 and 53. 8 9 Α. Uh-huh. ΡO MS. SCHOENLING: Objection. Just note my objection. I don't think that we see 11 12 180 on each of those panels, but go ahead. 13 MR. JEFFERS: You mean because 14 there's none on 52? MR. NOVAK: But there is on 51. 15 16 MR. JEFFERS: Yeah, but in your 17 question you said all three. MS. SCHOENLING: You said 51, 52 18 and 53. 19 Here, my question is on 51, 52, 53 20 Q. 21 where you have accelerations to 180, do you 22 feel comfortable with those accelerations? 23 Α. Very comfortable. That's a very 24 good sign. 25 Q. Even though the baseline at this

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1	point has been generally around 160 or above?
2	A. That meets the definition for
3	acceleration. A greater-than-15-beat
4	acceleration from baseline lasting for more
5	than 15 seconds is a reassuring sign on a fetal
6	monitor strip of good fetal oxygenation.
7	Q. All right. Now, panels 54, 55, 56,
8	would you agree the baseline's above 160?
9	A. It's again about 160 with the
10	accelerations, 163, maybe 162. I don't think
11	there's appreciable change in it.
12	Q. Panels 57, 58, 59, above 160?
13	A. 57, 58, 59 was the question?
14	Q. Uh-huh.
15	A. No change.
16	Q. Above 160?
17	A. Yes, same as it was in the previous
18	panels.
19	Q. And panels 60, 61, 62, above 160?
20	A. It's 163. Looks like the same to
21	me.
22	Q. And panels 63, 64, 65, above 160?
23	A. 63, 64 and 65?
24	Q. Yes.
25	A. Baseline's still 163, 165,

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1	something in that same range, same baseline.
2	Q. Now, we're at a time period that,
3	according to the labor and progress chart,
4	would be when Nurse Lanser at 10:30 writes down
5	for baseline fetal heart rate 160's, 170's, and
6	at 11:00 writes down 160's, 170's. Given what
7	her interpretation is, 160's, 170's, do you
8	feèl that her interpretation is accurate?
9	A. I need to see the note where you're
10	speaking of her writing it down. I don't have
11	that page.
12	Q. (Indicating.)
13	A. Thank you. So this says at 10:30
14	okay, baseline, heart rate. And then at
15	11:00 was the second part of your question?
16	Q. Right. And she writes down 160's,
17	170's
18	A. Yes, I think the baseline was
19	between 160 and 170 at those two times.
20	MS. SCHOENLING: I'm sorry, your
21	answer was that it was accurate?
22	THE WITNESS: My answer was, yes,
23	that it was accurate, that the baseline was
24	between 160 and 170 at those two times.
25	Q. Now, 69, 70, 71

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1	MR. JEFFERS: We were just now
2	referring to 66, 67 and 68.
3	MR. NOVAK: Right. Now I'm on 69,
4	70, 71. we
5	Q. Baseline?
6	A. It has not changed. It's the same.
7	Q. Okay. And 72, 73, 74, baseline?
8	A. Again, I don't see an appreciable
9	change.
10	Q. So we're still over 160; is that
11	right?
12	A. 163 it looks like to me. Between
13	160 and 165, yep.
14	Q. Okay. And panels 75, 76, 77,
15	baseline?
16	A. I think it's the same. Unchanged.
17	Q. Okay. Now, at any time between the
18	time that Dr. Siew saw this patient at 9:30 and
19	up through panel 65477, which would take us up
20	to a little past 11:30, are you aware of
21	anytime when Nurse Lanser or any other nurse
22	notified Dr. Siew that this patient never came
23	below 160 as a baseline?
24	MS. SCHOENLING: From 9:30 to
25	11:30?
	and the second se

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1 MR. NOVAK: Yes. I don't see any -- I'm not aware of 2 Α. 3 any written indication in the charts that there was a conversation between the two of them. 4 5 0. And I'd like you to assume, also, that neither one of these individuals have any б 7 independent recollection of any conversations 8 that took place at that time. Do you understand that? 9 10 Α. I can't assume that. I don't know 11 that's true or not. 12 0. Well, did you read the depositions of these individuals? 13 I don't recall either of them 14 Α. 15 saying that either way. 16 I want you to assume that the 0. 17 records reflect that neither one of them have 18 any independent recollection other than what is 19 in the chart. Can you assume that? 20 Α. How can I assume something I No. 21 don't know if it's true? 22 0. I'm asking you to --23 MR. JEFFERS: Bill, he's already 24 stated he doesn't see that there was any 25 communication between 9:30 and 12:00 or 12:10,

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T	whatever that is. So why do you keep going
2	with this?
3	O And you would agree with me that
an management of the states	the text such as Williams on Obstetrics
5	MR. JEFFERS: The what?
6	MR. NOVAK: Williams on Obstetrics.
-	∩ which you use as a teaching texŧ
8	here at this hospital; isn't that right?
9	It's one of many sources of
10	information we use, yes.
11	Q It's a reliable authority, isn't
12	it?
13	It's informative. It's not
14	nothing is the authority in obstetrics.
15	C Right. But it's something that you
16	people rely on in obstetrics?
17	A. We rely we take all
18	information, not just one textbook.
19	<pre>No, I understand that.</pre>
2.0	l One is one. Williams is one of
21	the
22	Q. Right.
23	n - textbooks that I read and that 1
24	incorporate into the body of knowledge that
25	lets me practice obstetrics.

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25	MR. NOVAK: Okay. Whatever.
24	objection, I'm joining in that objection.
23	MS. SCHOENLING: Assuming that's an
22	of minutes.
21	of what has just been testified over a number
20	that's a misstatement and mischaracterization
19	it exceeded 160 from that time on. I think
18	from that time on. I'm not sure we agreed that
17	MR. JEFFERS: You said exceeded it
16	nurses notified Dr. Siew?
15	anything in there where any of Mr. Jeffers'
14	this patient up until 11:30, do you see
13	exceeded 160 from the time that Dr. Siew saw
12	question: Given that this patient's baseline
11	Q. Now I'm going to ask you this
10	and now we're doing this again.
9	fact, you already got the answer to 120 to 160,
8	MR. JEFFERS: I'm stating that, in
7	that, aren't you, John?
6	MR. NOVAK: You're stipulating
5	that is a generality.
4	MR. JEFFERS: He's already said
3	fetus is between 120 and 160?
2	that the baseline in Williams for a normal
1	Q. Okay. And you would agree with me

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1 0. Would you agree with me that there 2 is nothing in the chart to indicate that 3 whenever this patient had baselines above 160, 4 Mr. Jefferst nurses never notified Dr. Siew? 5 I cannot find any written record of Α. a conversation between any nurse and Dr. Siew 6 7 during that time, no. 8 0. Okay. Now, on panel 483 --9 MR. JEFFERS: Wait. Wait. I'm 10 skipping. At 483? 11 MR. NOVAK: Uh-huh. 12 0. There was a spontaneous rupture of 13 membranes at approximately 11:50; is that 14 right? 15 At 483. Let me find the right Α. 16 sheet. 483, 11:50, yes, the notation says, 17 "Spontaneous rupture of membranes, clear 18 liquid" -- "clear fluid, Nitrazine positive." 19 0. Okay. And then when we look at 20panels 87, 88, 89, would you agree with me that 21 the baseline stays at about 160? 22 Was it 87? Α. 23 87, 88, 89. 0. 24 Α. It looks like it's about 160 from 25 84, 85, 86, 87, 88, 89, yes.

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1 Okay. Now, when we go to panels 0. 2 90, 91 and 92, we see that Dr. Siew appears, 3 according to the fetal heart strips, on panel 91. And would you tell me what your 4 5 interpretation of the baseline is for those 6 panels? 7 MS. SCHOENLING: For 91, 92? 1 8 MR. NOVAK: For 90, 91, 92. ģ Appears again to be around 160 --Α. 10 160, maybe 165 for the same -- I don't see an 11 appreciable change from the last -- over the 12 last two hours. 13 Q. Now, one appreciable change we have 14 here is that there was meconium expelled; is 15 that right? 16 Α. Note says, "Dr. Siew here. Vaginal 17 exam, 5 centimeters. More fluid expelled, 18 meconium stained," yes. Now, panels 93, 94, 95, would you 19 Q. 20 agree with me that the baseline is above 160? 21 Α. It looks the same. It looks like it's in that 160-to-165 range. 22 23 And 96, 97, 98, would you agree 0. 24 with me now that the baseline is at about 170? 25 At 96, 97, 98, did you say? Α.

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1 Q. Yes. 2 Α. Yeah, it looks like in that --3 those three panels, yes. 4 Any recording there that any of Mr. 0. Jeffers' nurses notified Dr. Siew? 5 MR. JEFFERS: There's nothing to б 7 indicate that Dr. Siew wasn't still present at that time. 8 9 I don't -- I'm not sure what time Α. 10 this is. Let me figure out what time it is. 11 12:20, 21, 22 -- 28, 29, 30. What were the panels you were asking the question about? 12 Was 13 it 96, 97 and 98, during that time? 14 Q. Yes. Yes. Yes, 15 I have to look back at the nurses Α. 16 notes again. MR. JEFFERS: Are you indicating 17 18 that the testimony isn't that Dr. Siew was 19 basically there that entire time? 20 MR, NOVAK: Say that again? 21 MR. JEFFERS: By the way, what time 22 are those panels, 96 --23 THE WITNESS: 12:30 is the time. 24 12:30 would be right here. 12:30 would be right under 96, if I counted the minutes 25

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1	correctly. I counted from the 12:20 notation,
2	and each solid line is a minute. So I think
3	that's 12:30, but I still I can't let me
4	I'm still looking for the nurses notes.
5	MR. NOVAK: And while he's doing
6	that, John, just so the record reflects it,
7	your issue as to whether or not Dr. Siew was
8	there, apparently at 12:55 there's a note that
9	says he was notified
10	MR. JEFFERS: Notified, right.
11	MR. NOVAK: so we have to assume
12	he wasn't there.
13	MR. JEFFERS: I don't assume that.
14	MR. NOVAK: I know you don't.
15	MS. SCHOENLING: You're saying at
16	12:45 you've got a notification on the record?
17	MR. JEFFERS: 12:55.
18	MR. NOVAK: 12:55.
19	MS. SCHOENLING: Okay. I was going
20	to say, I don't see 12:45. Thanks.
21	A. I don't know if Dr. Siew was there
22	or not.
23	Q. Okay.
24	A. The nurses note there's not an
25	independent note that I can find about 12:30,

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1	so I don't know what was said at 12:30 at that	
2	time. I don't know whether there was I	
3	mean, I can't find any I can't find any note	
	about the time 12:30, so I don't have any	iciania dani
5	information in the chart.	
6	Q. I have a question for you. At this	
7	hospital, if you ordered an emergent C-section,	
^	from the time you ordered the emergent	
9	C-section up until the time of delivery, what	
10	was the average amount of time it takes?	
11	MR. JEFFERS: Objection.	
12	MS, SCHOENLING: Join in the	
13	objection.	
14	A. I don't know. I honestly don't	
15	know what the average in this hospital is.	
16	Q. Well, let me ask you in your	
17	experience, when you order an emergent	- 1.2 3 ,
18	C-section, how quickly do you want to get the	
19	delivery finished?	
20	MS. SCHOENLING: Objection.	-
21	MR, JEFFERS: Objection. This is a	
22	tertiary care institution. Go ahead.	
23	A. The standard of care is to perform	
24	a C-section within 30 minutes.	
25	Q. But there are different kinds of	
	and a set of the set o	

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C-sections, aren't there? 1 2 No, that's what -- then I misspoke. Α. 3 The standard of care is to perform an emergent 4 C-section within 30 minutes of the decision to 5 perform the C-section, to have the baby delivered. That's the national standard of 6 7 care. 8 Q. If you wanted to, you could do one 9 quicker, couldn't you? 10 MR. JEFFERS: Object. 11 Α. Depends on the circumstances. No, 12 it's not if you wanted to. Unfortunately, it depends on personnel, it depends on a lot of 13 14 things. So it's not a desire, it's limited by 15 your physical constraints. 16 0. Wouldn't it be fair to state that 17 at this institution you've -performed them within seven minutes? 18 19 MR. JEFFERS: Objection; that's not 20 relevant. 21 I don't have any independent Α. 22 recollection of that. I've not -- I mean, 23 that's possible, but I don't have an 24 independent recollection. I've not kept a 25 stopwatch on the time from when I've decided to

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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
15-0.
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.
meaning Metro.

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1 MR. NOVAK: Oh, okay. 2 I don't know how you define Α. "emergent." I'm having --3 Okay. Let's talk about C-sections. Q. 4 5 Within the realm of emergency C-sections, isn't 6 there a category called "emergent," emergent 7 being the highest priority, let's get it done 8 right now? 9 Α. Yeah, there would be a group that 10 you want to get done ASAP. Q. 11 Out of the 20 to 25 that you've 12 done --13 MR. JEFFERS: It was 20 to 25, you 14 said? MR. NOVAK: That's what I thought. 15 THE WITNESS: Uh-huh. I think so. 16 Q. Out of those, how many of those 17 were what we would call "emergent." 18 Α. I don't have an independent 19 recollection. I can only guess that it would 20 21 probably be a fifth, a fourth, if that. I mean 22 -- but -- so I can't give you an exact number. 23 That would just be my guesstimate. Q. And out of that fifth or fourth, 24 did you ever perform any of those under 30 25))))

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1 minutes? 2 7 Yes, I performed all of them within 3 30 minutes. Okay. In looking at panels 02, 03 4 \cap 5 and 04 --6 MR. JEFFERS: Going back? 7 MR. NOVAK: Uh-huh. • Δ 8 I'm sorry, 02 -- is that the ĝ beginning or the end? 10 It's 02, 03, 04. It's near the 0 11end. 12 Ζ Near the end. Sorry. Wait. Can you help me with where you're at? What's the 13 14 full number? 655022 15 0 65502, all right. I'm back to 654. 16 7 65502. Okay. It's after where we were. -----17 18 Ç 02, 03, 04. 19 А Correct. I've got the panels. 20 Would you agree with me the С 21 baseline is above 170? 22 P Yes, looks like it's about 170, 23 173, 175. 24 Now, I'm going to go up to 05 and 0. 25 06. I'm going to stop there for a minute, if I **}**

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1	could. We're almost at the end. I'm going to
2	stop at 06 for a minute. We see a notification
3	at that point that Dr. Siew was notified, and
4	then it says "FHR," and then arrow up. Let me
5	first of all ask you, what do you take FHR with
6	an arrow pointing up to mean?
7	A. FHR usually stands for fetal heart
8	rate. And that arrow up would, I assume, mean
9	up.
10	Q. Okay. Now, prior to the notation
11	here of Dr. Siew being notified because FHR up,
12	are there any other notations in the chart that
13	Dr. Siew was notified of fetal heart rates
14	being above a baseline of 160?
15	A. Just the notations I've read
16	before.
17	Q, Okay. And then when we go over to
18	07, 08 and 09, we already get to the delivery;
19	is that right?
20	MR. JEFFERS: Get to the what?
21	MR. NOVAK: Delivery.
22	A. 07, 08 and 09? Correct.
23	Q. Okay. Now, in a patient that has a
24	baseline above 160, is it your practice to use
25	an internal fetal monitor?

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1	MR. JEFFERS: Object.
2	A. That's too general a question to
3	answer. The baseline is not the only thing
4	that's taken into account when I make the
5	decision to use an internal monitor.
6	Q. Okay. Was there ever an internal
7	monitor used on this patient?
8	A. I believe so, but I, again, need to
9	look back and see where I think there was an
10	indication, but maybe I misread it. One
11	second.
12	Maybe my recollection is from one
13	of the depositions, but I thought I read
14	somewhere it may have been in the deposition
15	that there was an internal monitor, but now
16	I can't find the notation to say where it was.
17	Q. I want you to assume that sometime
18	after 12:00 there was an internal fetal monitor
19	placed based on the record.
20	A. I think there was.
21	MR. JEFFERS: I'm trying to find
22	the
23	MS. SCHOENLING: I think it was
24	12:18.
25	THE WITNESS: 12:18. Thank you.

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1	Q. Now, let me ask you, in the face <i>of</i>
2	a persistent baseline heart rate above 160, do
3	you routinely use any internal fetal monitor?
4	MR. JEFFERS: I thought we just had
5	that question.
6	MR. NOVAK: I changed it a little
7	bit.
8	📜 A. I don't do anything as a routine.
9	Again, it depends. The baseline is not the
10	only criteria for evaluating a fetal monitoring
11	strip. The decision to use an internal fetal
12	monitor is based on baseline and the rest of
13	the criteria. So the answer is it's too
14	general a question for me to give you a
15	"routinely" answer.
16	Q. Okay. Now, according to the chart,
17	12:18 is the time the internal fetal monitor
18	was placed. Let me ask you, the decision to do
19	or not to do any fetal scalp sampling, whose
20	decision is that?
21	A. It would be the decision <i>of</i> the
22	attending physician.
23	${ m Q}$. And would it be fair to state that
24	as you look at this chart, there were no fetal
25	scalp samplings done?

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1	A. None that are indicated in the
2	chart that I'm aware of.
3	Q. And would you agree with me that a
4	fetal scalp sample is used generally to detect
5	whether or not there's any metabolic acidosis
б	taking place; is that right?
7	A. No, it's to detect the pH in the
8	fetal blood. It does not give an indication of
9	the reason for the pH. You get only a pH
10	reading. You cannot tell metabolic or
11	respiratory acidosis from a scalp pH sample.
12	Q. Let me ask you, what is the value
13	of the pH sample for you from a scalp sample
14	pH value from a scalp sample? What is the
15	value to you?
16	A. The value is to either it's used
17	to either reassure the physician that the baby
18	is that the pH is normal or to or to find
19	that the pH is below the normal range and
20	requires some sort of I mean, in which case
21	
22	
23	
24	there are other criteria that would make you
25	suspicious that there is that the baby might

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1	have some degree of stress or that the fetal
2	heart rate tracing is nonreassuring to you so
3	that you then need to use an additional test,
4	which scalp sampling is, to either refute your
5	suspicions or confirm them.
6	Q. Okay. Now, if you are confronted
7	with a pH of less than 7 from a fetal scalp
8	sample, would that concern you?
9	MR. JEFFERS: Object.
10	A. That would not be a normal value
11	for a fetus, no, of a scalp sample.
12	Q. Would it be a concern on your part
13	of some metabolic acidosis taking place?
14	A. As I said, you can't tell the
15	reason for the metabolic acidosis without a
16	complete blood sample without a complete
17	blood analysis of actual cord blood or arterial
18	blood.
19	Q. Right. Right.
20	A. And a scalp sample only gives the
21	pH. It doesn't give you the indication of the
22	reason why the pH is low.
23	Q. Right. Right. And Mr. Jeffers'
24	expert on Wednesday agreed with the statement
25	that the best predictor of metabolic acidosis
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1	is, in fact, the cord blood. Would you agree
2	with that?
3	A. The cord blood the cord blood
4	gives you all the parameters that make it
5	possible to judge whether acidosis is
6	respiratory, mixed or metabolic. So the cord
7	blood does give you the parameters to make that
8	assessment.
9	Q. You've read Dr. Reilly's report?
10	A. I think so, yes. His expert
11	report? Yes.
12	Q. Dr. Reilly, in his testimony on
13	Wednesday, his testimony was that the best
14	predictor of metabolic acidosis was the cord
15	blood. Would you agree with that statement in
16	general?
17	A You mean an arterial cord
18	Q. Yes
19	n a sample of the arterial cord pH
20	and complete evaluation? Yes.
21	C Okay. And unfortunately, in this
22	case we don't have it because the cord blood no
23	longer exists; is that right?
24	F Right. I wish we did have it. It
25	would settle a lot of questions.

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1	Q. And that decision not to do an
2	analysis was Dr. Siew's; is that right?
3	MS. SCHOENLING: Objection.
4	As I said before, the decision to
5	run the test is the decision of the attending
6	physician to order the test. So the fact that
7	it wasn't ordered means he didn't he decided
8	no€ to order it.
9	Q. Are you going to give any testimony
10	in this case regarding whether or not one has
11	to have cerebral edema in the case of
12	hypoxic-ischemic encephalopathy?
13	A. No, I'm not.
14	Q. And are you going to give any
15	testimony in this case regarding CT scans or
16	MRIs?
17	A. No, Immot.
18	Q. Are you going to give any testimony
19	in this case regarding any anemia that this
20	newborn had?
21	A. No.
22	Q. And by the way, there was no
23	maternal infection here, was there
24	MR. JEFFERS: No what?
25	MR. NOVAK: Maternal infection.
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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	
A. The way you'd know is if we had the placenta to evaluate. But I don't have any	
4 placenta to evaluate. But I don't have any	
5 other independent there's no information in	
6 the chart that says that there was maternal	
7 infection that I know of.	
8 Q. We went through this with Dr.	
9 Reilly on Wednesday and I asked him obviously,	
10 since we don't have any placenta, we can't	
11 determine whether or not there was any	
12 placental causes for any perinatal asphyxia in	
13 this newborn. Is that a fair statement?	
14 MR. JEFFERS: Objection. This is	
15 outside of his realm now.	
16 A. Could you repeat the question?	
17 Q. Would it be fair to state that	
18 since we don't have a placenta here, we can't	
19 determine whether or not any causes of this	
20 child's problems are related to placental	
21 problems?	
22 MR. JEFFERS: Objection.	
23 A. Not having a placenta just means	
24 that we don't have any information that it	
25 could have given us.	

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1	Q. Right. Right. And would it be
2	fair to state that the antepartum history of
3	this mother doesn't demonstrate any issues
4	relating to anything going on in her that would
5	cause a situation of hypoxic-ischemic
6	encephalopathy in this newborn?
7	A. Ask that again or read it again,
8	either one.
9	MR. JEFFERS: Why don't you read it
10	back?
11	Q. Well, here, maybe I'll ask it a
12	little better. Prior to her labor, is there
13	anything that Mrs. Merriweather demonstrated
14	that would lead you to believe that the cause
15	of this newborn's hypoxic-ischemic
16	encephalopathy is related to her?
17	A. I can't answer the question because
18	the infant did not have hypoxic-ischemic
19	encephalopathy. I don't so the question
20	doesn't make any sense in this case. It's not
21	that's not the diagnosis. That's not the
22	reason for this infant's subsequent course that
23	I'm aware of, so I don't understand what you
24	mean.
25	Q. Okay. Well, here, you are now
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1 saying it's not the reason, so obviously you're 2 going to testify with respect to cause, and I 3 want to know what you feel the cause of this 4 infant's subsequent neurolog, equelae was. 5 What I know is that the cause of Α. б the subsequent neurologic sequelae was not 7 asphyxia in the intrapartum period, meaning in the period of labor and delivery. I don't know 8 9 what the cause was. I'm not a neurologist. 10 I'm not able to tell you the -- I'm not able to 11 give you the differential diagnosis or the 12 cause of what it was, but I can tell you what 13 it was not and it was not asphyxia in the 14 intrapartum period. 15 0. Would you agree with me that cord 16 compression can cause asphyxia? Not in this case. 17 Α. 18 0. I'm asking you in general. Can 19 cord asphyxia cause compression? 20 MS. SCHOENLING: Can cord 21 compression --22 MR, JEFFERS: You've got them 23 reversed. MR. NOVAK: Cord compression. 24 Yeah, but you said 25 MR, JEFFERS:

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1	"cord asphyxia."
2	MR. NOVAK: No, I didn't.
3	MS. SCHOENLING: Yes, you did.
4	MR. NOVAK: All right. I'm sorry. 🛶
5	MR. JEFFERS: Just trying to help
6	you out and you want to fight me on that one.
7	Q. Can cord compression cause
8	asphyxia?
9	A. It would have to be cord occlusion,
10	prolonged occlusion of the cord, if that's what
11	you mean. Usually when we talk about cord
12	compression, we talk about an intermittent or
13	short-term event. So usually we don't talk
14	about cord compression and asphyxia together.
15	Asphyxia results from no flow or
16	severely decreased blood flow and oxygen to the
17	fetus. So you would have to occlude the flow
18	of blood to the fetus. And if you did that by
19	occluding the cord, then, yes, you can cause
20	asphyxia.
21	Q. If you have a true knot in the cord
22	that's not loose, you can have asphyxia, can't
23	you?
24	MR. JEFFERS: Objection.
25	MS. SCHOENLING: Objection.

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1 If the true knot occludes the cord Α. 2 and there's no blood or oxygen to the fetus, 3 then that would cause hypoxia and subsequent asphyxia. 4 5 0. Would you agree that one of the manifestations of cord compression is a fetal 6 7 heart rate above baseline? 8 Would I agree that a manifestation Α. 9 of cord compression is -- that's too general a 10 That's not -- there's -- it's -question. 11 0. Can you have elevated fetal heart 12 baseline above 160 with cord compression? 13 MR. JEFFERS: Wait. Say that one 14 again. 15 Can you have an elevated fetal 0. 16 heart rate above 160 with cord compression? 17 I'm going to object MR. JEFFERS: : 1 18 to this line of questioning that relates to all 19 these possibilities, but go ahead. 20 The opposite happens with cord Α. compression. As a rule, with cord compression 21 22 when you occlude or compress the cord and 23 decrease the flow of blood and oxygen to the 24 fetus, what you see is a decrease in heart 25 rate, a deceleration in the heart rate. And

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1	when the cord compression is relieved, because
2	it frequently is a short time-defined event,
3	then the fetal heart rate actually returns to
4	its baseline. So I disagree that cord
5	compression generally causes an increase in
6	fetal heart rate.
7	Q. So if we come to trial in this case
8	anđ I cross-examine you with standard
9	literature that one of the manifestations of
10	cord compression or a knot in the cord can be
11	an elevated baseline and the fetal heart rate
12	above 160, you're going to refute that
13	literature; is that right?
14	MR. JEFFERS: Objection to it
15	because you aren't showing him the literature.
16	A. I'd like to see the literature
17	you're referring to. You just changed the
18	wording of the question. That wasn't the
19	question that I answered, the previous
20	question.
21	Q. All right. Well, I'm going to ask
22	you
23	A. The previous question didn't say,
24	"one of the manifestations." You said cord
25	compression results in an increase in fetal
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1	heart rate above baseline.
2	Q. I didn't, but I'm going to make it
3	a little clearer if I didn't. Would you agree
4	with me that one of the manifestations of a
5	compression of a cord can be a fetal heart rate
6	above 160?
7	THE WITNESS: Read that one to me
8	again, please.
9	(Record read.)
10	MS, SCHOENLING: I'm going to
11	object to the question. We're on this path of
12	possibilities, and I'll just object on that
13	basis.
14	A. It's too general a question. I'd
15	need the specifics of where the cord how
16	much the cord's compressed, for how long, at
17	what time, where things started. It's not a
18	there's a lot of manifestations of cord
19	compression, and so it's I'm having trouble
20	giving you one of the cord compression
21	manifestations.
22	Q. Well, if Dr. Reilly testified on
23	Wednesday that one of the manifestations of
24	cord compression is an elevated fetal heart
25	rate, are you telling me that that's a lot of

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1 hogwash? 2 MR. JEFFERS: Objection. 3 MS. SCHOENLING: Objection. I'm not familiar with what Dr. 4 Α. 5 Reilly testified or the question that he answered on Wednesday. б 7 Q. Well, I'm telling you that that's 8 what the testimony was. 9 MS. SCHOENLING: Objection. Q. And if that is, in fact, the 10 11 testimony, are you telling me that that's a lot of hogwash? 12 13 MR. JEFFERS: Objection. 14 MS. SCHOENLING: Objection. 15 Α. I don't know what the testimony 16 was. I can't answer for someone else and I'm not going to tell someone else that they're --17 18 incorrect. 19 MS. SCHOENLING: Here, Bill --20 MR. NOVAK: I know what it says. Ι 21 know what it says. MR. JEFFERS: You don't want to --22 23 MS. SCHOENLING: You don't want to 24 show this --It's firmly imprinted 25 MR. NOVAK: 200

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1	in my cerebrum.
2	MR, JEFFERS: But you have a
3	defective cerebrum.
4	MR, NOVAK: Horse apples.
5	MR, JEFFERS: Like
6	MR. NOVAK: Horse apples.
7	A. Would you like me to read his
8	testimony and then comment about it?
9	MR, JEFFERS: Sure.
10	Q. My question is I want you to assume
11	that Dr. Reilly testified that a manifestation
12	of an elevated fetal heart rate is I'm
13	sorry, I want you to assume that Dr. Reilly
14	testified that a compressed cord can manifest
15	itself as an elevated fetal heart rate. Do you
16	degree or disagree with that?
se - mailing	MR, JEFFERS: A what cord?
18	MS. SCHOENLING: A compressed cord
19	manifests itself in an elevated fetal heart
20	rate. And we're asked to assume that Dr.
2 1	Reilly testified to that effect. I object to
22	the question.
23	MR, JEFFERS: I object, too.
24	I There are multiple manifestations.
25	Increased fetal heart rate can be one of them,

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1	but that's it's too it's too broad a
2	statement for me to agree with.
3	Q. I'm going to be done right away, so
4	let me just look at this.
5	MR. JEFFERS: Off the record.
6	(Discussion off the record.)
7	Q. All right. I'm going ask you if
8	yoù agree or disagree
9	MR. JEFFERS: What page?
10	MR. NOVAK: Page 88.
11	MR. JEFFERS: Okay. I'll give him
12	that in a second. Let me find it first.
13	(Handing.)
14	Q. I'm going to ask you if you agree
15	or disagree
16	MR. JEFFERS: Note the context.
17	A. *****Can I read the
18	Q. Well, I'm going to read the
19	question and answer to you, and you tell me if
20	you agree or disagree with his response. On
21	page 88 the question is, "Would you agree with
22	me that a true knot in the cord can cause cord
23	compression and can lead to perinatal
24	asphyxia?" Answer: "Yes."
25	MR. JEFFERS: What line is this?
	the transfer and the second

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1	MR. NOVAK: Line 5 to line 8.
2	Q. Do you agree with his response to
3	that question?
4	A. If the cord if the knot
5	completely occludes the cord, then yes, I
б	agree.
7	Q. And then the question is on line
8	12, "At various stages it was recorded as
9	having a true knot?" And he answers, "Yes."
10	Do you see that?
11	A. I see that. I see what you're
12	reading.
13	Q. And did you see at various portions
14	in the chart there was a recording of a true
15	knot?
16	A. I saw one place at the time of
17	delivery they recorded there was a loose true
18	knot in the cord.
19	Q. Okay. And then it says, Question:
20	"Would you agree with me that cord compression
21	can produce elevated fetal heart recordings?"
22	And his answer was, "Yes."
23	MR. JEFFERS: Where are we now?
24	MR. NOVAK: Line 15, response line
25	18.

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1	Q. Do you agree with that answer to
2	the question?
3	A. It's too short an answer. It's
4	yes, in context with a lot of things, which I
5	already described to you what happens when you
б	get cord compression, and it's not just
7	elevated fetal heart rate. It's only it's
8	that in the context of a number of other
9	things.
10	In other words, elevated fetal
11	heart rate alone does not come from cord
12	compression. That would be an incorrect answer
13	to that statement. If it's one of many things
14	if it's in a pattern of other things, as I
15	described, then the answer is yes.
16	Q. Would you agree with me that we
17	have three abnormal recordingsmin this chart
18	with respect to this newborn, and those
19	recordings were, apart from the fetal heart
20	rates, fetal distress would you agree that
21	that's an abnormal recording?
22	MR. JEFFERS: Wait a minute.
23	A. No, I don't we talked about
24	someone we're not familiar with writing the
25	words "fetal distress" after the delivery, and

1 I disagreed with that when you brought it up the first time. So I don't -- I guess I'm 2 $\overline{}$ missing your question. 4 Q. Doctor, I understand you disagree with the person who was there on November 11 of 5 1992, but would you agree with my statement 6 that someone who wrote down the words "fetal 7 distress" is indicative of less than a normal 8 newborn[°] 9 Repeat that question. 10 Α \cap Would you agree with me that the 11 words "fetal distress" -- that's not a normal 12 recording, is it? 13 14 Z You mean -- no, fetal distress is 15 not written in most initial newborn profiles 16 that I've read. Would you agree with me that thick Ο. 17 meconium suctioned four times below the cord, 18 that is not normal, is it? 19 20 MR. JEFFERS: And where are you reading from now? 21 MR. NOVAK: From the initial 22 23 newborn profile. I think that's what it is. 24 Or is it the labor and delivery sheet on page 25 four? Station St

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1 MS. SCHOENLING: I think it's the 2 L&D sheet. 3 MR. NOVAK: L&D sheet on page four. No, the vast --4 Α. 5 MR. JEFFERS: Where are you looking? 6 7 THE WITNESS: He's saying thick 8 meconium. 9 Read the question again, please. 10 I'm sorry, no, it's not. It's on 0. the initial newborn profile. And my question 11 12 for you is is thick meconium suctioned below 13 the cord times four, is that a normal finding 14 at the time of delivery? 15 MR. JEFFERS: Object. Go ahead. 16 Α. Almost always it's associated with 17 a normal neonate. 18 Q. So you're telling me that thick meconium suctioned below the cords is almost 19 20 always associated with a normal neonate? 21 Α. Normal neonatal outcome, yep. 22 Q. Didn't you tell me earlier that 23 thick meconium is of more concern to you than 24 just meconium fluid? 25 Α. Yes.

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1	MR. JEFFERS: He said 99 percent, I
2	think, or some fantastic sum like that.
3	A. Maybe I'm misunderstanding the
4	question, but meconium in all of the studies is
5	almost always associated with normal neonatal
6	outcome, meaning that after the meconium is
7	identified and is suctioned, there is a
8	completely normal baby, goes home with the
9	mother and grows up to be a healthy normal
10	person. And that's what I'm saying.
11	So most the vast, vast majority
12	of the time, meconium is associated with a
13	normal neonatal outcome. And I think that's
14	what you asked; is it normal.
15	Q. It's an abnormal finding, isn't it?
16	A. It's a finding that happens 15
17	percent of all deliveries. I mean, so it's not
18	85 percent of the time it's not there, so
19	it's not so it's more uncommon.
20	When there's meconium, it means you
21	need to be assured that there I mean, you
22	need to look at the rest of the picture and you
23	need to suction meconium at delivery. But as I
24	said, in the end, it's a normal part of labor
25	and delivery for the vast, vast majority of

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1	infants.
2	Q. Is it an abnormal finding? 'That's
3	my question. It's that simple: Is it an
4	abnormal finding?
5	MR. JEFFERS: It's not that simple,
6	and he's defined it and answered you. And he's
7	answered you twice actually. He answered your
8	eatlier
9	MR. NOVAK: Well
10	MR. JEFFERS: Wait. I'm not
11	through with my sentence. And he's now
12	answering you again.
13	MR. NOVAK: Are you done with your
14	speaking objection, which is not permitted?
15	Are you done with that?
16	MR. JEFFERS: No, I'm pointing out
17	to you that you.ace now being repetitious, and
18	that is an appropriate objection.
19	Q. Doctor, let me ask you, in this
20	chart they have a column that says, "Detail all
21	abnormal findings," and in this chart they
22	write down, "Thick meconium suctioned below the
23	cord times 4," under a column that says,
24	"Abnormal findings." Now, do you disagree with
25	the placement of "thick meconium" under a
	the second s

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1	heading that says, "Abnormal findings"?
2	A. Not in that context, no.
3	Q. And are we all on the same page on
4	this Apgar score thing? You agree with me and
5	you agree with Dr. Reilly that they're
6	subjective, aren't they?
7	A. Yeah, this is the same line of
8	questioning we had. We went through what
9	subjectivity there is in all of the
10	interpretation of tests.
11	Q. Right.
12	A. So, yes, as it's as there's
13	subjectivity in every other test that the
14	patient had, it's subjective.
15	Q. I want to talk a little bit about
16	the last four numbered comments you have in
17	your report. 🐹
18	MR, JEFFERS: Pull your report out.
19	Do you have it there?
20	THE WITNESS: Yeah. Okay, I have
21	it in front of me.
22	Q. Okay. Before the four numbered
23	comments, you have a sentence that says, "It
24	should be noted that making a diagnosis of
25	intrapartum asphyxia causing a neonatal

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1	neurologic deficit requires all of the
2	following,'' and then you go through four
3	numbers. Okay. The first question I have is
4	where and in what literature did you come up
5	with these four numbered items?
6	A. This is the criteria established by
7	The American College of Obstetrics and
8	Gynecology and The Academy of Pediatrics. It's
9	a joint statement that was established and
10	published in both literatures, and it's been
11	it was not a and it was decided after a
12	number of studies bore out the fact that this
13	was that this condensation of information
14	was necessary in order to make a diagnosis of
15	intrapartum asphyxia.
16	Q. What year did that study take
17	place?
18	A. There were multiple studies. I
19	cannot I can't give you that off the top of
20	my head. I can look them up and I can pull
2 1	them, but I can't give you the year of all the
22	studies that contributed to that statement.
23	Q. Prior to today, did you have an
24	opportunity to review any literature before
25	writing your report?
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1 Prior to today? In the last two Α. 2 years? 3 Prior to writing this report, did 0. 4 you look at any literature? 5 MR. JEFFERS: Are you asking him for the purposes of writing the report, did б 7 he --8 MR. NOVAK: Yeah. 9 MR. JEFFERS: That's not what you 10 asked him. 11 MR. NOVAK: Well, whatever. I'm 12 getting tired. 13 Okay. These are taken directly out Α. 14 of the -- they're a quotation from the American 15 College of Obstetrics and Gynecology technical 16 bulletin that discusses birth asphyxia. All right. Do you --17 Q. 18 And I don't have that with me, but Α. that's -- but I reviewed that and a number of 19 20 other studies in my file that talk about birth 21 asphyxia, cerebral palsy, fetal heart rate 22 abnormalities. 23 Q., Can you provide us with a copy of 24 that bulletin that you are referring to? 25 MR. JEFFERS: He can provide me

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with a copy of the bulletin. I will make 1 2 copies of that and I will send it to anybody 3 interested. I mean, it's open to the public. 4 MR. NOVAK: But would you please be 5 so kind as to do that? MR. JEFFERS: I will. I mean, once 6 7 I get it, I will then do that. 8 Q. Okay. Question number 1 -ģ MS. SCHOENLING: By the way, Bill, 10 it's January 1992. 11 MR. NOVAK: What is? 12 MS. SCHOENLING: When the technical bulletin was published. 13 MR. NOVAK: That depends on the one 14 15 that he used. MS. SCHOENLING: Well, I'm pretty 16 17 sure----18 (Discussion off the record.) Q. All right. Now, number 1, it says, 19 20 "Profound umbilical acidosis, metabolic or 21 mixed acidemia." Now, Doctor, the fact of the 22 matter is we can't have umbilical acidosis 23 because Mr. Jeffers' hospital discarded the 24 blood, right? 25 Yeah, the test was never ordered. Α.

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1	Q. The closest thing we have here is	
2	the arterial blood gas which has a pH of 7.21,	
3	and that took place at 1359 hours; is that	
··· ••••	right?	Periodic Disk 2017 No. 2017.
5	A. Correct.	
6	Q. Okay. And would you agree with me	
7	that this newborn was on oxygen from the time	
8	of delivery up until 1359 hours when that was	
9	done; is that right?	
10	A. I think I think that's right. I	
11	think it was there was oxygen in the hood.	
12	I think I remember reading that. I can't	
13	remember the percentage or how it was given,	
14	but I think you're right.	
15	Q. Okay. And would you agree with me	
16	that a pH of 7.21, according to the standards	
17	at Elyria Memorial Hospital, is below normal?	i meningkange
18	A. For arterial pH?	
19	Q. Uh-huh.	
20	A. Yes, it's lower than their	
21	referenced normals.	
22	Q. Okay. Now, number 2, you say,	
23	"Persistence of an Apgar score of 0 to 3 for	
24	longer than five minutes." And we're all in	
25	agreement that Apgar scores are subjective; is	

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1	that right?
2	A. As is everything else.
3	Q. Except your testimony.
4	A. Oh, it's just as subjective as
5	everyone else's.
6	Q. I see. Then on number 3, "Neonatal
7	neurologic sequelae." Now, are you telling me
8	that this newborn did not have neonatal
9	neurologic sequelae?
10	A. From my reading of the summaries, I
11	think they did have neonatal neurologic
12	sequelae. That's why we're here.
13	Q. Okay. And then you say number 4,
14	"Multiorgan system dysfunction; for example,
15	cardiovascular, gastrointestinal, hematologic,
16	pulmonary or renal." But the fact of the
17	matter is that you did net-have the University
18	Hospital records at the time you wrote your
19	report, did you?
20	A. No. I only had the neonatal
21	records from Elyria Hospital.
22	Q. Now, Dr. Reilly yesterday was
23	familiar with the studies of Perlman that
24	indicated that in 67 percent of the cases of
25	hypoxic-ischemic encephalopathy there is

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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.

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1	MR. NOVAK: No, he said he's not
2	familiar with the study. I'm asking the
3	question now in general.
4	Q. Do you agree or disagree with the
5	following statement that I'm going to make:
6	That you don't have to have multiorgan system
7	compromise in every case of hypoxic-ischemic
8	enčephalopathy?
9	A. Honestly, I don't know the I
10	can't say for sure. I can't say for sure
11	either way. I'm not familiar enough with all
12	of the neonatal literature to comment on
13	whether there's ever been a case that was
14	reported that so my I mean, my answer is
15	I can't give you I can't give you a firm
16	answer. I don't know.
17	Q. All right. And having reviewed the
18	University Hospital chart, are you aware that
19	the serum creatinine was.9?
20	A. I don't remember that. I don't
21	Q. I want you to
22	A. Again, as a I did not review the
23	charts with a view to the neonatal care because
24	I didn't I'm not an expert. I'm not a
25	pediatrician or a neonatologist. So I don't
	And Carl and A

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1	have an independent recollection of the serum
2	creatinine.
3	Q. Doctor
10 june 1 4	A. I just I remember reading the
5	summaries of the hospitalizations, but I don't
6	remember them commenting upon that.
7	Q. I'm not trying to be flip with you,
8	but you were the one who put number 4 in here,
9	and so and you said that there was
10	required all of the following, and I take that
11	to mean that you didn't find any multiorgan
12	system dysfunction or compromise; is that
13	right?
14	A. I do not think there was that
15	the definition of "multiorgan system
16	dysfunction" how do I let me say that
an the anti-testion of the anti-testing state of the	over again. The information that I'm aware of
18	there was not a diagnosis in this infant or in
19	this neonate of multiorgan system dysfunction
20	in any of the records that I reviewed.
21	Q. And at the time you had reviewed
22	this case, you did not have the UH records?
23	A. At the time I wrote the letter?
24	MR, JEFFERS: But he has had them
25	now.
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I since have had -- I since have 1 Α. 2 read the summaries of the UH records, and in no 3 summary does anyone give the diagnosis of multiorgan system dysfunction., 4 5 Q. Let me ask you this question: Did 6 you see that there were grossly bloody stools in this newborn? 7 8 I saw that there was a note that Α. 9 said that on one day, yes. 10 0. And can grossly bloody stools be a manifestation of enteritis? 11 MR. JEFFERS: Of what? 12 13 MR. NOVAK: Enteritis, 14 MR. JEFFERS: Okay. Objection. 15 Α. In a neonate? 16 Q. Uh-huh. 17 Α. Magain, I'm not sure of the complete differential of bloody stools in an intensive 18 19 care neonate. I'm not a neonatologist, so I'm 20 going to leave that up to the neonatologists to 21 say. I don't treat neonates, so I'm not -- I 22 really can't tell you. 23 0. Are you aware that from a 24 cardiovascular standpoint, this newborn had 25 tachycardia? **}**

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1	A. Yes, I remember reading that.	
2	Q. Are you aware that from a pulmonary	
3	standpoint this newborn had respiratory	
4	and istress?	
5	A. That I think they I think they	
6	quantified it. The neonatologist said that	
7	there was respiratory distress. There was	
8	transient tachypnea of the newborn was the	
9	diagnosis, yes.	
10	Q. And are you aware that from a rena	
11	standpoint, the serum creatinine was at.9?	
12	A. That one I wasn't aware of. I	
13	didn't see that.	
14	MR. NOVAK: I'm done.	
15	EXAMINATION OF WILLIAM J. TODIA, M.D.	
16	BY MS. SCHOENLING:	
17	Q. Dr. Todia, I've got some questions	manager of the second s
18	for you. I represent Dr. Siew. My name is	
19	Lynne Schoenling. I think we met for the first	
20	time this afternoon. I have a couple of	-
21	questions that I'm going to follow up from the	
22	questions that Mr. Novak had.	
23	First of all, I want to ask you	
24	about the cord blood that was discussed at	
25	length by Mr. Novak. Mr. Novak, of course,	
	to the top	

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1	pointed out to you that there was no cord pH
2	taken in this case, correct?
3	A. Correct.
4	Q. Do you have any opinions within a
5	reasonable degree of medical certainty whether,
6	if there had been a cord pH reading in this
7	case, what proposition, if any, that reading
8	would support
9	MR. NOVAK: Objection
ΡO	'Q under the records as you see
11	them in this case?
12	MR. NOVAK: conjecture and
13	speculation.
14	MR. JEFFERS: Go ahead.
15	A. The I believe that the fetal
16	heart rate tracings were reassuring and that
17	the Apgars of 6 and 8 indicated that the baby
18	that the neonate was not depressed at birth.
19	And so I would expect a cord pH at birth to be
20	in the normal range.
2 1	Q. All right. And you would expect
22	that cord pH in this case to have been in the
23	normal range based on the fact that the fetal
24	heart rate tracings were, as you say,
25	reassuring and the fact that this infant was

	not in distress at birth; is that correct?
2	A. Correct.
3	Q. Same question with respect to the
4	placenta pathology, which was also an area of
5	inquiry that Mr. Novak addressed. Do you have
6	any opinions within a reasonable degree of
7	medical certainty whether, if there had been an
8	opportunity to have a placenta pathology taken
9	in this case, whether or not that would have
10	or let me just ask it this way: If it had been
11	done, what proposition, if any, would that
12	support in this case, as you read these
13	records?
14	A. If it supported anything, I would
15	expect it to support the proposition that there
16	was that there was ongoing long-term
17	abnormalities, meaning that there were events
18	that happened sometime before the onset of
19	labor in this pregnancy.
20	But what it would show I mean, I
21	can't give you an answer what would it show
22	when, but that's the that's what I would
23	expect the information if it gave us any
24	information, that's the information I would
25	expect it would help to give.

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0. All right. And I guess my 1 2 follow-up question to that is on what basis 3 would you expect it to give that information? The basis is because I don't think Α. 4 5 that there's an explanation for the outcome for the health of this baby, and so that I think 6 7 the reason is still unknown from my reading at least of the experts' reports and of the 8 neonatologists' -- or the pediatric 9 10 neurologists' reports. So I hope it would shed 11 some light on the reason of the diagnosis of 12 the infant's condition. 0. Mr. Novak asked you a little bit 13 14 about chart notes --MR. JEFFERS: What? 15 __ chart notes recorded by Dr. Siew 16 Q. during the labor and delivery process. 17 And I know that you've reviewed the records. 18 You 19 would agree with me that there are some orders 20 written by Dr. Siew in this case in the Elyria Memorial records? 21 Yes --2.2 Α. 23 MR. NOVAK: I guess he knew how to 24 use a pen. 25 Yes, I would agree. Α. J.J.J

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1 And that these orders that you see 2 in the chart are both in the labor and delivery portion of the chart as well as the infant's 4 records? 5 There are orders that I see in the б mother's chart. I don't -- I have to look at 7 the infant's. Let me ask you to take a look at 8 the mother's orders for a minute. Do you have 9 those in front of you? 10 I'm looking at those. 11 А All right. It looks like we have 12 -- at 11/11/92 we've got a chart note at 8:30 13 a.m., 2:10 p.m., and then we've got a couple of 14 15 chart notes on 11/12 and 11/13/92. Is that what you see? 16 South States Voc 17 А. 18 MR, JEFFERS: We're looking at page 1 00 19 20 THE WITNESS: Page 16, yes. MS. SCHOENLING: Page 16, yeah. 21 And just to cater to Mr. Novak's 22 23 line of questions for a minute as to these chart notes, assuming that we had more chart 24 25 notes, in other words, additional chart notes

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1	beyond what we do have in the record, would
2	that have changed or altered the outcome in
3	this case, in your opinion?
4	ware and a NO.
5	Q. Why not?
6	A. Because I think that the notes
7	would have said that the doctor believed this
8	was a normal labor and a reassuring fetal heart
9	rate tracing and would have allowed labor to
10	progress as it had, and that the patient would
11	have progressed through labor and delivered at
12	1:10 whether there was a note saying he was
13	going to allow that or not.
14	Q. Whether or not Dr. Siew actually
15	recorded the thoughts that you just verbalized,
16	you did have an opportunity to review his
17	deposition transcript prior to today?
18	A. Yes.
19	Q. Are you aware that, in fact, in his
20	deposition testimony he did, in fact, verbalize
21	the same thoughts that you just verbalized,
22	that is that we had a reassuring chart? Are
23	you aware of that?
24	A. Yes.
25	Q. So despite the fact that we don't
	the trail the second

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1	have these detailed thoughts recorded in the
2	chart, we do know from the doctor's own
3	testimony that these were his thoughts. And
4	given the fact that we know that these were his
5	thoughts, is it your testimony that whether he
6	wrote them down or not, the outcome in this
7	case would not have been altered as a result of
8	his recording or not recording additional
9	thoughts, true?
10	A. Correct.
11	Q. All right. What do the bruises on
12	the face in this case tell you, if anything?
13	MR. JEFFERS: What?
14	MS. SCHOENLING: The bruises.
15	A. That the patient had a very rapid
16	second stage of labor.
17	Q. What does that mean?
18	A. Means she that the head
19	descended quickly from the time she was
20	complete to the time it delivered, she pushed a
21	short time and the head came through the
22	pelvis, rotated through the pelvis in that
23	short period of time,
24	Q. Is that a common occurrence in the
25	delivery of infants?

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1	A. Is what a common occurrence?
2	Q. This bruising that results from
3	what you just described.
4	A. Bruising from a rapid second stage
5	of labor?
б	Q. Yes. Yes.
7	A. Yes.
8	Q. Do you see that in your practice in
9	delivering infants?
10	A. Yes.
11	Q. And would you say that it's more
12	common than not?
13	A. Having such a short second stage of
14	labor as Mrs. Merriweather had would not be
15	common. It would probably be 10 or 20 percent
16	of deliveries.
17	But of those that had suchma short
18	second stage I believe from the tracings she
19	probably pushed 10 minutes at most, maybe even
20	less. There's no note that says when she
21	actually started to push. But from the time
22	she had a strong urge to push to the time the
23	baby was delivered was 10 minutes. And of that
24	time she may have only pushed five minutes.
25	But of those patients that would

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1	have pushed such a short time and delivered the
2	head so rapidly, it would be a relatively
3	common finding.
4	Q. I'm going to ask you a little bit
5	about the strips. I'm not going to belabor
6	what you've already testified to, but I do want
7	to ask you a couple of follow-up questions.
8	65412 and 65413, you were asked about the
9	variability in those two panels. And one
10	MR. JEFFERS: Do you have that yet?
11	Wait until he finds it.
12	A. 65412?
13	Q. And 65413.
14	A. Uh-huh.
15	Q. Do you have those?
16	A. 65409, 10 12 and 13.
17	Q. Right.
18	A. Uh-huh.
19	Q. Mr. Novak was asking you a question
20	about panels 12 and 13 with respect to the
21	variability, and one of the answers I heard you
22	give was that it's not proper to interpret
23	variability minute by minute. Do you remember
24	giving that response?
25	A. Yes.

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	Q. And can you explain to me what you
	mean by that?
-'	A. The reason is that you have to take
www.someenstig.fordalal.4.com	the you have to take the fetal monitor strip
5	in a you need to look at a 10- to 20-minute
6	segment of time because there the infant
7	goes through cycles.
8	The variability changes depending
9	on the fetal activity, meaning how much the
10	baby is moving around inside, whether the baby
11	is sleeping or at rest or moving. So you can't
12	look at one minute of fetal heart rate tracing
13	and say make a statement about the
14	variability and have that extend to the and
15	have that have any relation to the fetal
16	condition at that time.
17	Q. Okay.
18	A. It's usually a result of what the
19	fetus is doing. So you just need to look at a
20	longer time.
21	Q. All right.
22	A. I think what 1 said is that my
23	opinion over an appropriate length of time was
24	that there was either minimal or moderate
25	variability, depending on the time segment,

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1	with periods of accelerations, both of which	
2	are reassuring.	
3	Q. Is it also important when you're	
, 4	looking at the baseline not to interpret that	and the second
5	minute by minute, but instead, as you described	
6	the interpretation of the variability, to also	
7	interpret the baseline on the same criteria,	
8	meaning over an expanded period of time?	
9	A. Yeah, the most important thing	
10	about baseline about interpreting the	ĺ
11	baseline is putting it in context with the	
12	other criteria. Baseline's only one of the	
13	only one of the things you look at, and the	
14	variability and the accelerations are more	
15	important than the baseline in making a	
16	judgment about the overall condition of the	
17	verall interpretation of the monitor strip.	
18	Q. Okay. So in addition to the	ĺ
19	baseline, even though Mr. Novak focused quite a	
20	bit on the baseline, as I understand your	~
21	responses, it's more important to look at the	
22	variability and the accelerations, frankly,	
23	than it is to look at the baseline.	
24	A. Correct. And I would also add in	
25	the absence of decelerations.	

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1	Q. And that was my next question. If
2	you have an absence of decelerations coupled
3	with good variability and minimal accels, would
4	that be a good sign?
5	A. Well, I wouldn't answer that
6	"minimal accelerations," I would answer that
7	"and accelerations," meaning accelerations of
8	15 beats per minute over 15 seconds. Those
9	things taken together are a reassuring sign, a
10	sign of reassuring fetal status.
11	Q. And when we take all of those
12	criteria together that is the variability,
13	the accelerations, the lack of decelerations as
14	well as the baseline and we look at this
15	strip in its totality rather than panel by
16	panel, what do we see, in your opinion, Doctor,
17	in terms of whether or not this is a reassuring
18	or nonreassuring strip?
19	A. My opinion is this is a reassuring
20	fetal heart rate tracing.
21	Q. And your opinion is based on the
22	criteria that I've just referred to?
23	A. Correct.
24	Q. And in terms of the decelerations,
25	what, if anything, do you see when taking this

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1	strip in its totality?
2	" That I'm struck by the absence of
3	decelerations. There are a couple of variable
4	decelerations during second stage which go
5	along with and would be expected in a rapid
б	decent of the fetal head, as she had.
7	Otherwise, the absence of decelerations
8	throughout the rest of the fetal heart rate
9	tracing indicate to me that the baby was well
10	oxygenated during the labor.
11	O Looking at 65451, 52 and 53 for a
12	moment
13	A 65451
14	Ç 51, 52 and 53.
15	" 51 oh, 654. I'm sorry, 654
16	say it again.
17	Q. 65451, 52 and 53. 654.
18	MR. JEFFERS: 51, 52, 53.
19	I Got you. Sorry.
20	(Do you have that in front of you?
21	ł Yes, I do.
22	' Earlier in your testimony when
23	asked about this page, in looking at these
24	three panels, you indicated in your words that
25	you thought that these reflected a very good
	and the second sec

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1	sign. I believe those were your words. Do you
2	remember that testimony?
3	A. I think so.
4	Q. I guess what I'm
5	A. What I mean to say is that this is
6	a reassuring segment of fetal heart rate
7	tracing.
8	🕻 Q. And I'm taking this segment just as
9	an example because I want to make sure that I
10	understand why, in your opinion, this strip is
11	reassuring. And in looking at these three
12	panels as just a segment or an example, what do
13	we see here that, in your opinion, indicates a
14	reassuring strip?
15	A. There's moderate variability,
16	meaning that there are cycles of between five
17	and 25 beats per minute, and there are periods
18	of accelerations, meaning there are fetal heart ,
19	rate accelerations of 15 beats above the
20	baseline lasting for 15 or more seconds. Taken
21	together, both of those are have an
22	extremely strong predictive value, meaning they
23	predict that the baby is in a normal
24	oxygenated, normal pH environment.
25	Q. Okay. Now, when Mr. Novak took you

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1	through this entire strip, what I generally
2	heard were questions about the baseline. And
3	what I seem to, at least according to my notes,
4	have written down consistently, according to
5	your testimony, was that this baseline
6	throughout this strip really maintained itself
7	at about 160 to 165. True?
0	A That's correct.
9	• All right. Now, given the fact
10	that the baseline is just one of the criteria,
11	and that we have to consider variability as
12	well as accelerations, and also the absence of
13	decelerations, my question is is that 160 to
14	165 consistent baseline so I understand, in
15	and of itself, it's not necessarily indicative
16	of anything until you take into account the
17	other criteria that you've described; 'is that
18	correct?
19	' That's correct. It's the company
20	that the baseline keeps. The most important
21	criteria are absence of decels, variability,
22	accelerations.
~ ~	In that order, or equally to be
24	considered, or does it matter?
25	A. That's a good question. No, I

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1	think taken all together, because there would
2	be a lot of debate among experts about which
3	one they would put the most credence on. But I
new entrat 🦺	think there's uniform agreement that to make a
5	diagnosis of nonreassuring fetal status, that
6	there needs to be a combination of those
7	things, that you need to see decelerations
8	along with I mean, that you need to see
9	you need to take all those parameters together,
10	that one of them alone isn't is not it's
11	the sum of the parts, I guess I mean to say.
12	Q. And of those criteria, are any of
13	those criteria absent in this strip?
14	A. The only concern in this strip, as
15	we've been questioned about the whole day, is
16	the fact that the baseline runs about 165.
17	Other than that, though, we've got
18	a pretty reassuring strip with respect to
19	variability, accelerations and the lack of
20	decelerations?
21	A. Other than that, all the other
22	criteria are reassuring.
23	Q. Okay.
24	A. And the fact that the fetal heart
25	rate that the baseline that that's

with this at

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1	that baseline is the same over the period of
2	time we've seen is also a reassuring also
3	indicates that we're not looking at a period of
, in 100 (100 (100 (100 (100 (100 (100 (100	change, that nothing changed over those hours
5	that we went through the strip and kept saying
6	the baseline was 163 or 165.
7	Q. Okay. Let me skip topics here and
8	turn to emergency C-sections. What criteria,
9	in your opinion, determines whether or not an
10	emergency C-section needs to be done?
11	A. There's a lot of criteria. I can
12	give you a list, but, I mean, the short answer
13	is that there's a
14	Q. Tell you what, let me ask it a
15	different way. As you read these records and
16	these charts, do you see anything that supports
17	a decision t perform an emergency C-section?
18	^z No. An emergency C-section would
19	have in no way affected the outcome of this
20	of the neonate and would only have left the
21	mother with an unnecessary surgery.
22	Well, that was my next question;
23	whether or not even if one had been done,
24	whether the outcome would have changed. And as
° 25	I understand your answer, your answer is no, it

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1	would not have changed; is that correct?
2	A. I have no reason to believe that
3	there would be any difference in the outcome of
4	the infant.
5	Q. And what do you base that response
6	on?
7	A. The fact that there's there's no
8	evidence in this record that this baby suffered
9	from asphyxia. And so doing a C-section
10	anytime during this record would have delivered
11	a baby that was not asphyxic, just like the
12	baby that was delivered was not asphyxic.
13	Q. With respect to the fetal scalp
14	sampling that Mr. Novak asked about, I know
15	that it wasn't done in this case. Do you have
16	any opinions, Doctor, within a reasonable
17	degree of medical certainty that had a fetal
18	scalp sampling been taken, whether or not we
19	would have had, first of all, a different
20	outcome, and secondly, what proposition such a
21	scalp sampling would support if it had been
22	done?
23	A. I believe it would have been
24	reassuring and would have just reassured the
25	physician that labor could continue as it did,

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	<u></u>
1	and that the delivery would have occurred at
2	the same time in the same fashion.
3	Q. And why do you believe that?
4	A
5	because I believe that the pH would have been
6	normal because I believe the baby was had a
7	normal pH and a normal oxygenation during this
8	entire course of labor.
9	Q. Does cord compression reveal itself
10	on the strips? Not in this case, but just
11	generally. Is that something that can be
12	detected on the strips?
13	A. Yes.
14	Q. And in what form and how does it
15	manifest itself on the strips?
16	A. It manifests as well, in one of
17	two ways. Intermittent cord compression,
18	meaning cord compression that happens for some
19	period of time, 30 seconds or a minute, and
20	then resolves, would show intermittent
21	variability. Decelerations, meaning a
22	deceleration down of the heart rate from
23	whatever the baseline was down to a certain
24	level, and when the compression resolved it
25	would come back up.

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1 A cord compression that was 2 ongoing, meaning the compression was not 3 released, would show a terminal bradycardia, meaning that as the cord was compressed and the 4 5 oxygen level and the blood flow to the fetus 6 went down, you'd see the heart rate come down and come down and come down, and it would not 7 8 go back up unless you resolved the cord 9 compression. 10 Ο. We don't see either one of those on 11 this strip, do we? 12 Α. No. The only time that you could 13 postulate that that would happen was there are 14 two decelerations that I see in panel 65508, like, three minutes before delivery when the 15 16 patient's pushing. There appear to be two variable decelerations which would fit with the way 17 18 patient who had a nuchal cord, because as the 19 head descended rapidly in the pelvis and as the patient pushed to make that happen, there was 20 21 enough of a degree of cord compression to cause 22 that heart rate to go down to 90. 23 And then when the patient stopped 24 the contraction and stopped pushing, it 25 immediately returned to baseline, which would

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1 indicate to me there was probably a mild degree 2 of intermittent, meaning short-acting, 3 30-second compression at that time. 4 And other than in that minute or so 0. 5 prior to delivery that you've just described, we don't see any evidence of what you called 6 7 bradycardia or variable decels to support a cord compression finding at any time before 8 9 that point on the strip; is that true? 10 No, there's no cord compression Α. 11 pattern on this fetal monitor tracing. 12 Ο. Is cord compression on a fetal 13 monitor tracing typically seen in a pattern? 14 It has to be repetitive with Α. Yes. intermittent -- I mean, with repetitive cord 15 compression, meaning you continue to compress 16 17 the cord at intervals of time. 18 There's a very defined predictable pattern of repetitive variable decelerations 19 20 with each compression. And if the cord 21 compression is continuous, ongoing, and oxygen 22 is going down, up, and pH is changing or is 23 worsening, then you will see a bradycardia, you'll see a fetal heart rate that decelerates. 24 25 0. So not only do we not see a Pattern

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E	on this strip as you've just described, but we
2	certainly don't see any bradycardia either; is
3	that correct?
4	A That's correct.
5	Q. Okay. How about cord occlusion?
6	Is that something that's traceable on a strip?
7	A. If there's complete occlusion of
8	thẻ cord?
9	Q. Yes.
10	A. Absolutely.
11	Q. And how do we interpret that from
12	the strip?
13	A. From when you occlude the cord,
14	you'll see a deceleration of the fetal heart
15	rate that becomes a bradycardia and eventually
16	results in if you don't do something about
17	it, in fetal death. The heart rate goes down
18	until the point where the fetal heart rate
19	disappears, stops. The heart stops after a
20	long enough time of no blood to the fetus.
2 1	Q. So is that also something that we
22	see in a pattern format, or is that something
23	that is an immediate onset that's easily
24	detected from the reading of the strip?
25	A. If there's complete occlusion

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1	Q. Yes.
2	A it's not a pattern. Once it's
3	complete occlusion the minute complete
4	occlusion happens, you start to see changes
5	that just get worse and worse over the next 10
6	minutes to 15 minutes until the fetus expires.
7	Q. And that's nowhere on this strip;
8	-is that correct?
9	A. No.
10	Q. That is correct?
11	A. That's correct. It's not anywhere
12	on this strip. There's no evidence of complete
13	cord occlusion.
14	Q. All right. Have you reviewed the
15	reports of Drs. Johnston and O'Grady and of Dr.
16	Steven Donn as part of your records in the
17	file?
18	A. Yes.
19	Q. Dr. Donn is a neonatologist, Dr.
20	O'Grady is an OB/GYN and Dr. Johnston is a
21	pediatric neurologist, all three of which have
2 Ž	been retained on behalf of Dr. Siew. And I
23	guess my question to you is do you have any
24	disagreements as to the opinions that either
25	Drs. Donn, O'Grady or Johnston set forth in
-	

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1	their reports?
2	MR. JEFFERS: He
3	MS. SCHOENLING: Go ahead.
4	MR. JEFFERS: Some of this is not
5	in his area of expertise,
6	MS. SCHOENLING: I understand that.
7	A. Right.
8	🕻 🗘 Well, let's talk about Dr.
9	O'Grady's report. Can we do that?
ΡO	A. Yeah. I'd like to I haven't
11	read it recently enough to remember the exact
12	details of the report. I've read all of them,
13	but it hasn't been within the last two days. I
14	thought I had it I must not have them all
15	with me. If I do I have a pile of it
16	must be with all the other depositions. I'm
17	sorry. Or is that no, there they are.
18	There they are. Okay. Which one do you want
19	to talk about?
20	Q. Dr. O'Grady.
21	A. Dr. O'Grady, okay. I do remember
22	reading
23	Q. I guess I really just have a very
24	general question with respect to his report,
25	and that is

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1	A. Yeah, I didn't I mean, I didn't
2	have any I do remember it now because I
3	as I see the format, I can remember having
4	which one I read recently. But no, I did not
5	have any disagreements that I recall from
6	reading this report.
7	Q. Now, as far as your opinions that
8	you're going to be rendering in this case, it's
9	my understanding that you have not or do not
10	intend to offer any opinions with respect to
11	Dr. Siew's care and treatment either during
12	labor and delivery or during the prenatal
13	phase. Is that correct?
14	A. That's correct.
15	Q. Let me check my notes here, Doctor:
16	I may be done.
17	You stated that had we had the cord
18	pH, you would be able to definitively determin@
19	whether or not metabolic acidosis was present
20	in this case? Did I understand that from your
21	testimony?
22	A. I think it would have been another
23	piece of information that I think would have
24	corroborated, would have agreed with the
25	interpretation of the fetal monitor that the
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1	baby was normally oxygenated at birth.
2	Q. Okay. So in other words, we do not
3	have to have the cord pH in and of itself in
and all tribule tribules when an a 🖧	order to reach that conclusion; is that
5	correct?
6	A. No. It's just it would just be
7	another piece of information that would be
8	it would just add to what we already have, in
9	my opinion.
1 0	Q. In fact, support what we already
11	have?
12	A. Correct.
1 3	MS. SCHOENLING: I don't think I
14	have any other questions. Thank you.
15	EXAMINATION OF WILLIAM J. TODIA, M.D.
16	BY MR. NOVAK:
<u>1</u> -1-7	Q. While we're kind of rolling on this
18	pH thing, would you agree with me that the only
19	scientific demonstration of metabolic acidosis
20	would have been the cord blood?
2 1	MR. JEFFERS: Metabolic acidosis?
22	MR. NOVAK: That's what I said.
23	MR. JEFFERS: Okay. I'm just
24	making sure.
25	A. The only way I know of to make a

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25	demonstration of metabolic acidosis would have
24	Thomas Reilly, agreed that the only scientific
23	Q. If Mr. Jeffers' other expert, Dr.
22	characterize the exact number.
21	patient. But that's the only way to
20	based on a number of other by examining a
19	can make a determination about severe acidosis
18	In the absence of that test, you
~ 17	the only scientific test.
16	acidosis that you can find, also. So it's not
15	are signs and symptoms of various degrees of
14	the degree of metabolic acidosis. But there
13	only test I know of that you can characterize
12	that yeah, that's the only that's the
11	A. The only scientific the only way
10	been the cord blood; is that correct?
9	demonstration of metabolic acidosis would have
8	pH. My question was the only scientific
7	Q. My question wasn't related to the
6	think that's yes.
5	but if we had that complete study, yeah, I
·site/ - 4	I mean, the pH alone wouldn't have made it,
3	I think that's what you mean by "cord pH," but
2	pH, PCO2, bicarbonate and base excess analysis.
1	diagnosis of metabolic acidosis is to have a

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1	been the cord blood, and he agreed that that
2	was correct, would you agree or disagree with
3	his statement?
4	MS. SCHOENLING: Objection. First
5	of all
6	MR. JEFFERS: What page are you on?
7	MR. NOVAK: Page 67, line 6. And
8	he went through that, and it goes from line 6
9	to line 16.
10	MS. SCHOENLING: I'm going to
11	object. It's a mischaracterization. He quotes
12	his question accurately, but it's a
13	mischaracterization of Dr. Reilly's response to
14	that question.
15	Q. Let me read it here. "So the only
16	scientific demonstration of metabolic acidosis
17	would have been the cord blood?" "Answer:
18	That's correct. But it's simply not a standard
19	of care for cord blood to have studies done
20	when the Apgars are 6 and 8."
21	But with respect to the issue of
22	whether or not the only scientific
23	demonstration of metabolic acidosis would be
24	the cord blood, would you agree with his
25	statement when he says, "That's correct"?

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1	Would you agree with his answer to that?
2	MS. SCHOENLING: Objection.
3	A. I think so. I just answered the
4	question when I answered
5	what scientific demonstration of metabolic
<u>^</u>	acidosis was. I think I said the pH and cord
7	bloods is a scientific demonstration, but that
8	there are other things or other signs and
9	symptoms in a person in a neonate that would
10	also indicate severe metabolic acidosis.
11	So I don't understand why I have to
12	answer the question over again. I answered
13	that. And what you're trying to do is get me
14	to interpret his answer and say he's wrong, but
15	I answered the question already.
16	C No, my question is pretty simple.
17	You don't agree wi ^{th him} because he says the
18	only scientific
19	MR, NOVAK: Let me finish my
20	question. Okay?
21	MR, JEFFERS: Don't raise your
22	voice to me.
23	MR, NOVAK: Don't start butting
24	into my question right in the middle of it.
25	You started to butt into my question right in

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1	the middle. So back off.
2	MR. JEFFERS: Don't raise your
3	voice to me, Sonny.
4	MR. NOVAK: Don't.get smart, John.
5	MR. JEFFERS: You just got smart
6	with me. You raised your voice. You pointed
7	your finger
8	MR. NOVAK: I'm going to point my
9	finger and I'm going to keep pointing my
10	finger. Back off.
11	MR. JEFFERS: I'm not doing
12	anything. So just cool it. Things aren't
13	going well for you and you're upset.
14	MR. NOVAK: Things aren't going
15	well for me? I just don't like you to butt in
16	when you're off the wall. Okay?
17	MR. JEFFERS: The record will
18	demonstrate I didn't butt in.
19	Q. My question for you is the only
20	scientific demonstration of metabolic acidosis
21	is the cord blood, isn't it?
22	A. That wasn't no, I didn't answer
23	that that was the only scientific
24	demonstration.
25	Q. So you don't agree with that?

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1 I said the cord blood is one of the Α. 2 scientific demonstrations of metabolic 3 acidosis. 0. All right. 4 P (75 5 And that, yes, it is one of, but I Α. 6 didn't say it was the only scientific 7 demonstration of metabolic acidosis. 8 0. Okay. So we'll let your answer 9 stand and we'll let Dr. Reilly's answer stand 10 and we'll let a jury decide --11 MS. SCHOENLING: Is that a 12 question? 13 -- we'll let the jury decide who's 0. 14 telling the truth on that. 15 MS. SCHOENLING: Are you asking a 16 question? 17 MR. JEFFERS: No, this is Bill 18 giving a final argument. 19 You gave a statement to this line 0. 20 of questioning by your codefendant's lawyer, 21 Doctor. 22 MR. JEFFERS: Wait a minute. This 23 is not his codefendant's --24 MS. SCHOENLING: Excuse me? 25 MR. NOVAK: Well, the codefendant.

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11		
12		
13		
14		
15	normal, I'm going to change my statement	
16	because what I said at least what I said one	
17	of the times, but the questions keep getting	to the second
18	re-asked, is that the pH would have reassured	
19	me. It would have been reassuring that I	
20	said the fetal monitor strips would have been	
21	reassuring and that the pH would have gone	
22	along with the fetal monitor strips. They	
23	would have reassured me that the labor would	
24	continue as it was allowed to continue.	
25	MR. NOVAK: Would you go back to	
	the second se	

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		1
1	the initial line of questioning that counsel	
2	for Dr. Siew asked and it's at the very	
3	beginning, about the question of the cord	
encos ass <mark>A</mark> To	blood. And I want you to find the doctor's	Martin Martin Martin
5	answer where he said the pH would be in the	+
6	normal range. Would you find that for me,	
7	please.	~
8	- A Even if you can find it, it's my	
9	right to explain what I meant. And I'm	
10	explaining to you that whether I said "normal"	
11	once or not, what I'm explaining to you is that	
12	because I'm not going to get into an	
13	argument about what you say is normal and what	
14	I say is normal.	-
15	What I'm saying is that I would	
16	have expected the pH to be reassuring, that the	
17	pH would have gone along with the fetal	anna 1990 - Carlon, a sherra ann
18	monitoring tracing and would have a	
19	MS, SCHOENLING: Bill, are you	
20	saying he doesn't have a right to respond?	-
21	MR, NOVAK: I'm saying he's under	
22	oath and just because I asked the question	
23	instead of you I'd like to hear the response	
24	to the question.	
25	Would you please go back to the	

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1	statement he made that said it would be a
2	normal range pH? I have the right to have that
3	read back.
4	MRJEFFERS: Do whatever you want.
5	Let the record show Mr. Novak is
6	again raising his voice. And let the record
7	also show that during the doctor's response,
8	Mr Novak said something to the effect of
9	"uh-huh" seven times during his response.
10	MR. NOVAK: Are you done?
11	MR. JEFFERS: I'm done now.
12	MR. NOVAK: Okay. Would you please
13	go back? We can wait here.
14	(Record read.)
15	(Discussion off the record.)
16	Q. Doctor, we've just had your
17	testimony reread and you've indicated that
18	based upon the Apgar scores and based upon what
19	you believe were reassuring fetal heart strips,
20	you believe that the cord blood would have had
21	a pH in the normal range. Am I characterizing
22	that answer correctly?
23	MR. JEFFERS: Did you add fetal
24	heart rate tracings?
25	MR. NOVAK: Yes, I did.

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1	Q. Am I characterizing that answer as
2	correct?
3	A. That's the answer I gave. And I
4	think I'm sure that when you asked it
5	another time, that I used the word
6	"reassuring." And we must have been talking
7	about scalp pH rather than cord blood. But I
8	would expect that the what I mean by
9	"normal" is in the normal range. What I mean
10	by that, because you bring it up, is that the
11	that it would not show that the baby had
12	metabolic acidosis at the time of delivery.
13	Q. Based upon the cord pH?
14	A. Right, the cord pH and the
15	attendant measurement, PCO2, bicarbonate, base
16	excess, could have indicated that the infant
17	did not suffer from metabolic acidosis.
18	Q. I didn't ask you these questions,
19	she did.
20	A. I know. I'm just clarifying the
21	question.
22	Q. But her question, she asked you
23	based upon a reasonable medical probability
24	would the cord pH be within the normal range,
25	and your response to that question would be

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1	yes; is that right?
2	A. No, that would be what I've just
3	clarified. It would be that it would be it
<u> 4</u>	would indicate that there was not metabolic
5	acidosis. PHs vary for a number of reasons by
6	what we were just the question was and the
7	whole point of the discussion is does this baby
8	have asphyxia, was there metabolic acidosis and
9	hypoxia at the time of birth. And I said and
10	my belief is that the pH would not indicate
11	that there was hypoxia and metabolic acidosis
12	at birth.
13	Q. Would you agree with me that you
14	stated that you believed that there would be a
15	pH in the normal range? You did say that?
16	A. Sure. And I've now explained
to an and the second	exactly what I mean by pH in the normal range
18	in answer to that question. So, I mean, I'm
19	not going to sit here
20	Q. so
21	MR. JEFFERS: Let him finish. Let
22	him finish. Let him finish.
23	MR. NOVAK: Now you're raising your
24	voice and you're turning red and the top of
25	your head is turning red, Mr. Jeffers.

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1MR. JEFFERS: Absolutely. And2you're very irritating.3(Discussion off the record.)4Q. Would you describe for me what5normal pH range is? What are those values?6A. What are the values for normal pH?7Q. Uh-huh.8A. In what circumstance?9Q. Well, you10A. Here's what I would the it11depends on which time we're talking about. The12 if the infant had a scalp pH during the time13of labor, then I would expect it to be above147.20. That would be reassuring and that would15be normal for this fetal heart rate tracing.16Q cord pH?19A. A cord pH?20Q. Uh-huh.21A. Then the pH depends on the PCO2,22bicarbonate and base excess, because a pH a23corrected pH would be meaning corrected for24respiratory for PCO2 I would expect to be25normal in this infant. You're talking		129
 (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. Uh-huh. 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 PCO2 I would expect to be 	1	MR. JEFFERS: Absolutely. And
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 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. Uh-huh. 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 PCO2 I would expect to be 	3	(Discussion off the record.)
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 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 PCO2 I would expect to be 	5	normal pH range is? What are those values?
 A. In what circumstance? 9 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? 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 PCO2 I would expect to be 	6	A. What are the values for normal pH?
 9 Q. Well, you A. Here's what I would the it 11 depends on which time we're talking about. The 12 if the infant had a scalp pH during the time 13 of labor, then I would expect it to be above 14 7.20. That would be reassuring and that would 15 be normal for this fetal heart rate tracing. 16 Q. How about a cord 17 A. Now, when the baby is born, then -=' 18 Q cord pH? 19 A. A cord pH? 20 Q. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PCO2 I would expect to be 	7	Q. Uh-huh.
 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 14 7.20. That would be reassuring and that would 15 be normal for this fetal heart rate tracing. 16 Q. How about a cord 17 A. Now, when the baby is born, then -=' 18 Q cord pH? 19 A. A cord pH? 20 Q. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PCO2 I would expect to be 	я	A. In what circumstance?
11 depends on which time we're talking about. The 12 if the infant had a scalp pH during the time 13 of labor, then I would expect it to be above 14 7.20. That would be reassuring and that would 15 be normal for this fetal heart rate tracing. 16 Q. How about a cord 17 A. Now, when the baby is born, then -='- 18 Q cord pH? 19 A. A cord pH? 20 Q. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PCO2 I would expect to be	9	Q. Well, you
 12 if the infant had a scalp pH during the time 13 of labor, then I would expect it to be above 14 7.20. That would be reassuring and that would 15 be normal for this fetal heart rate tracing. 16 0. How about a cord 17 A. Now, when the baby is born, then -='- 18 0 cord pH? 19 A. A cord pH? 20 0. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PC02 I would expect to be 	10	A. Here's what I would the it
 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 Q. How about a cord A. Now, when the baby is born, then -='- Q cord pH? Q. Q. Uh-huh. 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 	11	depends on which time we're talking about. The
 14 7.20. That would be reassuring and that would 15 be normal for this fetal heart rate tracing. 16 Q. How about a cord 17 A. Now, when the baby is born, then -='- 18 Q cord pH? 19 A. A cord pH? 20 Q. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PCO2 I would expect to be 	12	if the infant had a scalp pH during the time
 be normal for this fetal heart rate tracing. Q. How about a cord A. Now, when the baby is born, then -='- Q cord pH? 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 PCO2 I would expect to be 	13	of labor, then I would expect it to be above
 16 Q. How about a cord 17 A. Now, when the baby is born, then -='- 18 Q cord pH? 19 A. A cord pH? 20 Q. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PCO2 I would expect to be 	14	7.20. That would be reassuring and that would
 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 PCO2 I would expect to be 	15	be normal for this fetal heart rate tracing.
 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 PCO2 I would expect to be 	16	Q. How about a cord
 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 PCO2 I would expect to be 	m1 7	A. Now, when the baby is born, then $-='$ —
20 Q. Uh-huh. 21 A. Then the pH depends on the PCO2, 22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PCO2 I would expect to be	18	Q cord pH?
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 PCO2 I would expect to be	19	A. A cord pH?
22 bicarbonate and base excess, because a pH a 23 corrected pH would be meaning corrected for 24 respiratory for PC02 I would expect to be	20	Q. Uh-huh.
<pre>23 corrected pH would be meaning corrected for 24 respiratory for PC02 I would expect to be</pre>	21	A. Then the pH depends on the PCO2,
24 respiratory for PC02 I would expect to be	22	bicarbonate and base excess, because a pH a
	23	corrected pH would be meaning corrected for
25 normal in this infant. You're talking	24	respiratory for PC02 I would expect to be
	25	normal in this infant. You're talking

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1	arterial, right?
2	Q. Yes. So give me a number that you
3	would expect it at.
4	A. I would expect it to be above
5	corrected for PCO2, above 7.20.
6	Q. Okay. Now, we do know that the
7	arterial blood gas taken at 1359 was 7.21; is
8	that right?
9	A. That was just the pH. That's not
10	the corrected pH for the respiratory component.
11	Q. I'm just talking about the pH.
12	A. That's what I said. That's what I
13	said, right.
14	Q. Now, the pH that you would expect
15	from the cord, what would you expect, 7.20?
16	A. I said the corrected pH and the
17	cord corrected for PCO2, because what we're
18	interested in at the time of delivery is the
19	metabolic acidosis. That's what we're trying
20	to get at. Which means that the PC02 level has
21	to be taken into account in order to decide
22	whether the pH is coming from respiratory,
23	meaning the amount of PCO2, or from metabolic.
24	So I said the corrected pH would I would
25	expect to be above 7.20 at the time of

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1	delivery.	
2	0. What's the corrected pH from the	
3	arterial blood gas?	
4	The one that was 7-21?	مەم مەم بىلىمى
5	Q. Uh-huh.	
6	A. I need to see all the measurements	
7	to the pH was 7.21. The PC02 was 63.	
8	Normal PC02 would be 40. In order to correct	
9	in order to correct the pH, you have to use	
10	a factor of .08 pH, meaning you raise the pH.08	
11	for every 10 millimeters of mercury for PC02,	
12	So I can't do the math exactly, but it would	
13	corrected it would be 7.21 plus .16. It would	
14	be 7.37 at 1359.	
15	MS. SCHOENLING: Is that the	
16	corrected ABG or corrected	
17	THE WITNESS: Corrected ABG pH.	
18	MS. SCHOENLING: Thank you.	
19	A. The one that we're looking on at	
20	1359. And what that means is that this pH , the	
21	reason this pH was 7.21 was because of the	
22	PC02, It was not there was not metabolic	
23	acidosis at 1359. If there was metabolic	
24	acidosis, this pH would still be low after you	
25	corrected the PC02.	

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1	This says that this abnormal pH is
2	solely because of respiratory component, solely
3	because the PCO2, which is blown off at the
4	lungs when you breathe, was not happening as
5	much as it should have. There wasn't as much
6	PC02 being blown off as there should have been.
7	Q. So you're saying the 7.21 is not
8	acidotic, right?
9	A. I didn't say that. I said the
10	corrected pH is not acidotic. And I said 7.21
11	is respiratory acidosis alone. There is no
12	metabolic acidosis. I should say there's no
13	significant metabolic acidosis because there's
14	never no anything in medicine.
15	Q. And you are aware that by the time
16	that this blood gas was done, this infant was
17	on oxygen, right?
18	A. Uh-huh. That's correct.
19	Q. Okay. Now, this pH that you feel
20	is in the normal range, the cord blood, that is
21	a guess on your part, isn't it?
22	A. No, it's not a guess. That's an
23	educated opinion based on all of the other
24	information I've reviewed.
25	Q. By the way

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1 Α. It's not a guess at all. 2 -- did Mr. Jeffers talk to you 0. 3 about this line of inquiry that Ms. Schoenling was going to ask you about the cord blood? 4 5 Α. No. 6 Did she --0. 7 MS. SCHOENLING: Came up with it 8 all on my own, Bill. MR. NOVAK: Let me finish. 9 10 By the way, let's get on to the 0. 11 placenta. You said that you expected to see a 12 normal placenta? 13 Α. No, I didn't expect to see a normal 14 placenta. 15 Q. You expected to see a placenta that demonstrated something that would have shown a 16 long-standing problem; is that right? 17 18 Α. Right, which would not -- which 19 would be the opposite of a normal placenta. 20 Q. Would you do me a favor, then, and 21 tell me on a gross examination what color 22 placenta would you expect? 23 What color placenta? Α. 24 Yes. Q. 25 Α. I don't know, I'm not a

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1	pathologist.
2	Q. Would you tell me what the cord
3	would look like on gross examination?
4	A. Again, I'm not a pathologist,
5	Q. Would you tell me what the chorion
6	would look like?
7	A. I'm not going to testify about the
8	pathologic exam of the placenta. I was not
9	trained in the pathologic exam of the placenta.
10	I rely on a placental pathologist who I send my
11	placentas to to interpret the findings of the
12	placenta and give me a report about that
13	placenta.
14	Q. But you're testifying here today
15	that you would expect a placenta in this case
16	to look like something long-term was going on;
17	isn't that right?
18	A. I said I expected the placental
19	pathology, which is a microscopic and
20	macroscopic exam by a placental pathologist, to
21	give us more information about the cause of
22	that infant's long-term deficit.
23	Q. Doctor, the fact of the matter is
24	that as you sit here, you would have no idea as
25	to what the color, the composition, the

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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.	11
Q. Well, I guess ${f I}$ 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	
	<pre>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?</pre>

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1	would expect the placental pathology to reveal.
2	I didn't say I would do the placental
3	pathology. I didn't say I could tell you all
4	of the findings of the placental pathologist.
5	I said that if you take the
6	placenta and send it to a placental
7	pathologist, that the placental pathologist, in
8	thèir expertise, would be able to give me
9	information'that would help or potentially help
10	explain why the baby has the disease that the
11	baby has. That's all that I intended to say.
12	Q. Doctor, are you aware of all the
13	literature out there with respect to placental
14	pathology and hypoxic-ischemic encephalopathy?
15	Are you aware of a lot of literature that's out
16	there?
17	MR. JEFFERS: You said all of it.
18	Q. Let's say all of it. Are you aware
19	of the literature that's out there on placental
20	pathology as it relates to hypoxic-ischemic
21	encephalopathy?
22	A. I'm aware there's literature out
23	there.
24	Q. Are you aware that placental
25	pathologists even disagree on what they see in
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1	a placenta and whether or not the timing of the
2	event antedates or occurs during labor and
3	delivery based upon what they see in a
4	placenta?
5	MR. JEFFERS: Objection. Go ahead.
6	A. I'm aware that doctors disagree
7	about most every subject. So it wouldn't
8	surprise me at all if there is pathologists
9	that have disagreements on reading the
10	placental pathology.
11	Q. Now, I'm a little confused about
12	this issue about the orders in the chart.
13	You're not telling us, are you, that the orders
14	in the chart reflect Dr. Siew's ongoing thought
15	processes as it relates to the labor and
16	delivery of this patient, are you?
17	A. No.
18	Q. And you would agree with me that as
19	this Elyria Memorial Hospital chart is
20	composed, we don't see anything in there about
21	congenital microcephaly, do we?
22	A. I don't recall seeing that written
23	anywhere in the chart.
24	Q. And if there was something abnormal
25	with respect to a gross congenital anomaly, one

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1	would expect that a nurse or Dr. Siew would
2	appropriately note that; isn't that correct?
3	A. I wouldn't expect Dr. Siew would,
4	but because usually that a pediatric
5	function, not the function of the obstetrician.
6	But if there was a congenital abnormality that
7	the pediatrician or the pediatric nurse
8	recognized, then you may find it documented in
9	the chart, sure.
10	Q. Would you agree with me that a
11	baseline fetal heart rate above 160 represents
12	some form of tachycardia?
13	A. It's defined as tachycardia if it's
14	above 160. That's the definition of fetal
15	tachycardia, yes.
16	Q. Okay. Let me ask you if you agree
17	with any of these clinical associations with
18	baseline heart rate tachycardia. How about
19	maternal thyrotoxicosis?
20	MS. SCHOENLING: I'm sorry, what
21	was the question?
22	MR. NOVAK: Maternal
23	thyrotoxicosis.
24	MS. SCHOENLING: What's the
25	question, though?

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3 ₫ ± 3

1 MR. NOVAK: Would you read back the 2 question? 3 (Record read.) 4 MS. SCHOENLING: Thank you. 5 How about maternal --0. 6 Do you mean the disease maternal Α. 7 thyrotoxicosis --8 Q. Yes. 9 -- can be associated with fetal Α. 10 tachycardia? 11 0. Right. 12 Yes, I agree that's an association. Α. 13 How about tachyarrythmia? Can that Q. 14 be associated --15 Yes, it could be associated with Α. 16 fetal tachycardia. 17 How about prematurity? Q. We set 18 Α. Prematurity? It's possible. 19 Q. How about drugs such as beta 20 agonists? 21 Α. It's possible, yes. 22 How about fetal infection? Q. 23 Α. It's possible. 24 0. How about maternal fever? 25 It's possible, too. Α.

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1 0. Now do we have any maternal fever 2 here? 3 Α. Not that I recall. 4 Q. Do we have any fetal infection? Don't know the answer to that 5 Α. 6 question. The infant was treated with 7 antibiotics after delivery, but I don't remember whether there was any -- I don't 8 remember whether there was documentation of 9 10 infection or if the antibiotic treatment was a precaution for infection. So I can't answer 11 12 whether there was infection. How about beta agonists? 13 Q, 14 Α. I don't believe the mother received beta agonist medicines in labor. 15 16 Q. We don't have any prematurity, do 17 we? 18 She's 37 weeks? Α. Q. Thirty-nine weeks. 19 20 Α. No, there is not prematurity. 21 0. How about tachyarrythmia? 22 Tachyarrythmia means that the --Α. that there was an intrinsic fetal tachycardia. 23 That's certainly possible, especially since the 24 25 summary from University Hospital talks about

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	141	1
1	persistent fetal tachycardia with a negative	
2	workup.	
3	Q. Okay. How about maternal	
4	thyrotoxicosis?	nikalisi silin ami'n sin sosis
5	A. It's possible, but I'm not aware of	
6	the patient having a thyrotoxicosis in the	
7	chart.	
8	Q. Would you agree with me that a	
9	clinical association with tachycardia can be	1. J. C.
10	hypoxia?	
11	A. That say that again? That a	
12	Q. Clinical association with	
13	tachycardia can be hypoxia.	
14	A. Would a clinical association	
15	it's possible just like all the other things	
16	are possible.	
17	MS: SCHOENLING: Excuse me, noting	· · · · · · · · · · · · · · · · · · ·
18	that the last 10 or 12 questions have been	
19	referencing Dr. O'Grady's text, I would just	
20	ask you to identify the page numbers that	-
21	you're referencing.	
22	MR, NOVAK: I really don't have to	
23	because I'm not quoting anything.	
24	MS, SCHOENLING: I believe that you	
25	are	
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1	MR. NOVAK: No, I'm not. If I have
2	this on the floor
3	MS. SCHOENLING: For the record,
4	Mr. Novak is reading from the text
5	MR. NOVAK: Page 322 entitled Table
6	13.2 Baseline Heart Rate Abnormalities, and for
7	tachycardia as an abnormality by the way,
8	Dr: O'Grady, your wonderful expert, here in his
9	book edited by him, lists at the top of the
10	list the clinical association of hypoxia.
11	MS. SCHOENLING: Thank you.
12	Q. You would agree that that's a
13	possibility, isn't it?
14	A, I would.
15	MR. JEFFERS: That what's a
16	possibility?
17	MR. NOVAK: That hypoxia can be a
18	clinical association with tachycardia.
19	MS. SCHOENLING: Note my objections
20	to all the possibilities that we're referencing
21	here.
22	Q. But the fact of the matter is that
23	other than the tachyarrythmia which you said
24	may have been present here, none of the other
25	causes that I just gave to you appear to be in
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1 this case; isn't that correct? 2 The tachyarrythmia seems to be Α. 3 the only cause that there's any just indication for --4 5 0. Right. 6 -- because that's the only thing Α. 7 that persists into the neonatal period and that there's any documentation. 8 9 0. Would you disagree with me that this newborn had hypoxia? 10 11 Α. Yes. 12 So, then, would you disagree with Q. 13 Dr. Dominguez at --14 MR, JEFFERS: University Hospital. 15 0. -- University Hospital who wrote 16 down on 11/12/92 by actually seeing the infant 17 that -- he says, "The infant may have suffered 18 from asphyxia. Although Apgar scores were 19 fairly good, this is the most likely cause.'' 20 Would you agree or disagree with him? 21 I would disagree with that. Α. 22 And would you agree or disagree 0. with this statement on 11/13/92: "Most likely 23 24 cause ischemia with anemia secondary to true knot in cord"? 25

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1	MS. SCHOENLING: Whose statement
2	are you reading, Bill?
3	MR. NOVAK: Looks like a Dr. Walla.
4	MS. SCHOENLING: At UH?
5	MR. NOVAK: Yes.
6	MR. JEFFERS: Do you want to read
7	that once more?
8	Q. Question, "Etiology most likely is
9	ischemia with" "secondary to true knot in
10	cord." Would you agree or disagree with that?
11	A, I'd disagree.
12	Q. On $11/13/92$ there's another note
13	here, "Neurology consulted," and then it says,
14	"Etiology," question mark. "Hypoxic
15	event/ischemia secondary to nuchal cord."
16	Would you agree or disagree with that?
17	A. Disagree with that.
18	Q. And on 11/14/92 there's an
19	assessment that says, "Number 1, Seizures on
20	day of life number 1 probably due to a hypoxic
21	episode from a nuchal cord with a true knot."
22	Do you agree or disagree with that?
23	A. Disagree.
24	Q. And continuing on, on 11/15/92 a
25	note that says, "Seizures probably secondary to
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	145
1	hypoxia." Do you agree or disagree with that?
2	A. Disagree.
3	MR, JEFFERS: What day was that,
4	Bill, the last one?
5	MR. NOVAK: Fifteenth.
б	MR, JEFFERS: Pardon me?
7	MR. NOVAK: The fifteenth.
8	MR. JEFFERS: Thank you.
9	• And then on November 17, 1992, the
10	note says, "Seizures probably secondary to
11	hypoxia (tight nuchal cord)." Do you agree or
12	disagree with that?
13	A Disagree.
14	And then on 11/17/92, a note,
15	"Birth asphyxia with seizures." Do you agree
16	or disagree with that?
17	I disagree.
18	And on 11/18/92 there's a note here
19	that says, "Seizures probably secondary to
20	hypoxia (tight nuchal cord)." Do you agree or
21	disagree with that?
22	A. Disagree.
23	And also on that same page it says,
24	"Six-day-old 39 weeks with seizures, probably
25	hypoxic." Would you agree or disagree with

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1 that? 2 Α. Disagree. Pardon me? MR. JEFFERS: 3 THE WITNESS: I disagree. 4 5 0. And then on 11/19 it says, 6 "Seizures secondary to hypoxia presumed." 7 Would you agree or disagree with that? Α. Disagree. 8 Q. And on 11/20/92 it says, "Seizures 9 probably hypoxic in etiology." Would you agree 10 or disagree with that? 11 12 Α. Disagree. And also on 11/19/92, would you Q. 13 agree or disagree with the note that says, "HIE 14 Would you agree or disagree? 15 seizures"? Α. What's HIE? 16 17 0. ____Hypoxic-ischemic encephalopathy. Α. Disagree. 18 Q. And on 11/21/92, "Seizures 19 20 secondary to birth asphyxia, " question mark. 21 Would you agree or disagree? 22 Α. I agree with the question mark. Ι 23 disagree with the proposition that it was birth 24 asphyxia. Q. And on 8/3/93 in a consult, do you 25 **}**

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	147
1	agree or disagree
2	MR. JEFFERS: Consult by whom,
3	please?
4	Q. The consultant's note has the
5	patient was being observed for constipation and
6	hepatomegalia and a consult's note has, "Nine
7	months old with history of birth asphyxia." Do
8	yoù agree with the note "birth asphyxia"?
9	A. No, I don't.
10	Q. And on 8/10/93, pediatric clinical
11	pharmacology consulting, it says, "Admission at
12	birth for neonatal seizures thought to be
13	secondary to a hypoxic-ischemic event." Do you
14	agree or disagree with that?
15	A. Disagree.
16	Q. And under the EEG summary at the
17	Cleveland Clinic on 3/31/93
18	MR, JEFFERS: The date again was?
19	MR, NOVAK: 3/31/93.
20	Q. "Etiology perinatal asphyxia." Do
21	you agree or disagree with that?
22	A. Disagree.
23	Q. And under Conclusions of
24	Recommendations on that EEG summary it says,
25	"Jasmine Merriweather was a 16-month-old girl

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1	who had perinatal asphyxia with meconium and a
2	nuchal cord." Do you agree or disagree with
3	that?
4	A. Disagree with perinatal asphyxia.
5	Q. And also under Etiology for
6	Perinatal Complications it says, "Asphyxia."
7	Do you agree or disagree with that?
8	A. Disagree.
9	Q. And on a note that was done for the
10	Ohio Department for Hearing, the notation
11	indicates that this infant had seizures related
12	secondary to birth. Do you agree or disagree
13	with that?
14	A. Seizures related
15	Q. Related to birth.
16	A to birth. The seizures were
17	around birth, I don't know what it means by
18	"seizures related to birth." If you mean
19	seizures related to birth asphyxia, I disagree
20	with it just like all of the above.
21	MR. JEFFERS: What department was
22	that, Bill?
23	MR. NOVAK: I'll find it.
24	Q. The Infant Hearing Assessment
25	reporting form that goes to the Ohio Department

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	149
1	of Health says, "Seizure disorder secondary to
2	birth asphyxia." Do you agree or disagree with
3	that?
4	A. Disagree.
5	Q. Do you agree or disagree with the
6	patient progress note on 11/15/92 when it says,
7	"Seizures and hypoxic episode at birth." Do
8	you agree or disagree with that?
9	A. Disagree.
10	MR. JEFFERS: That's 11/15/92?
11	MR. NOVAK: Yeah.
12	Q. My last question, then, is as you
13	sit here today having never seen this patient,
14	having never met any of the nurses in this
15	case, having never met Dr. Siew, having never
16	seen this patient face to face, it's your
17	opinion today that you're disagreeing with all
18	of what I've just read you as respects the
19	notations in the chart as to the cause of this
20	event; is that right?
21	MS. SCHOENLING: Objection.
22	A. All of the people you just read me
23	never reviewed the fetal heart rate tracing and
24	never saw the course of labor. So their
25	opinion about birth asphyxia is less founded
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	UC 1
1	than the opinion I've given you today based on
2	all of the information I've reviewed with you.
3	Q. Whoa, whoa, whoa, whoa, Doctor.
4	Here we go.
5	A. I want you to show me one of those
6	notes you read that was done by a
7	perinatologist or obstetrician or anyone who
8	reviewed the fetal heart rate tracing in the
9	labor course.
10	Q. Are you telling me
11	A. Those are all pediatric notes.
12	They're notes from the neonatologist who read a
13	summary from a nurse from Elyria when the
14	patient was transferred.
15	Q. Are you
16	A. Go ahead.
17	Q. Are you telling me that so
18	you're telling me that
19	A. You've just read for me the notes
20	in the notes by pediatricians, all of which
21	you said have question marks after the
22	diagnosis. You didn't read the body of the
23	whole report. These are not anyone who viewed
24	the labor, who saw the tracing, who saw the
25	infant at birth, who assessed the Apgars and

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1	who made any assessment of the baby except for
2	the fact that the baby had seizures two days
3	later.
uuuuuuuuu	Q. Are you telling me University
5	Hospital didn't have the EMH records when this
6	patient was seen?
-	MS, SCHOENLING: Objection. That's
8	not
9	A. Didn't have the fetal monitor
10	tracings.
11	Q. How do you know?
12	A. Because there's not any indication
13	in anything you just read to me because none of
14	them commented on the fetal monitor tracings.
15	Q. How do you know they didn't have
16	it?
<u>1</u> 7	MR. JEFFERS: Objection
18	(Discussion off the record.)
19	Q. Well, there's a note here on
20	11/12/92 at 4:15 p.m. and it says, "Source
21	medical records from Elyria Memorial Hospital."
22	Are you telling me that they just got part of
23	the records, but not all of them? Is that what
24	you're telling me?
25	A. I'm telling you when an infant is

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1	transferred to another neonatal intensive care
2	unit, the record that's sent is the neonatal
3	record. That's an independent patient. The
4	patient that goes is the baby, and the record
5	that's transferred is the baby's. The mother's
6	record is not part is not the baby's record.
7	The mother's record doesn't go to the intensive
8	care unit.
9	They don't make any independent
10	assessment of what happened during labor. They
11	write down what it says on the neonatal sheet
12	from the pediatrician at the previous hospital
13	and then they make a judgment.
14	Q. So you're telling me
15	A. So they base everything on that
16	sheet that we already reviewed that I disagreed
17	with where someone who we can't even find their
18	name wrote "fetal distress."
19	Q. Are you telling me that the fact
20	that this newborn had seizure activity within
21	the first 24 hours is irrelevant as represents
22	its connection to hypoxic-ischemic
23	encephalopathy?
24	A. I'm saying that hypoxic-ischemic
25	encephalopathy did not cause this infant's

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	153
1	seizure disorder in the first 24 hours.
2	Q. My question for you is do you feel,
3	or not, that the fact that the seizure activity
4	started within 24 hours of birth is
5	significant?
6	A. Significant to this baby, of
7	course.
8	• Q. Do you feel that it's significant
9	as respects the timing of the event?
10	A. Timing of what event?
11	Q. The hypoxic-ischemic event.
12	A. Baby didn't have a hypoxic-ischemic
13	event, not in the time of not in the time of
14	labor. My comments are about the patient's
15	labor course and her delivery. There is no
16	evidence from the record that this baby
17	suffered a hypoxic-ischemic event from the time
18	the baby went into labor that I have a record
19	of to the time the baby was delivered. That's
20	what I'm commenting upon.
21	I can't tell you if it suffered a
22	hypoxic-ischemic event at 18 weeks or 22 weeks
23	or 32 weeks, and I can't tell you if it
24	suffered the event at three hours of age. I
25	can't comment on that part. I can comment on

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what happened during labor. 1 2 0. So all you're concerned with is 3 labor. But from a standpoint of looking at this from a perspective of a pediatric 4 neurologist or a pediatrician, you don't care 5 about those factors, do you? б 7 What I -- I don't care about those Α. factors? 8 9 MS. SCHOENLING: Objection. 10 MR. JEFFERS:: If you don't 11 understand the question --12 MR. NOVAK: I understand it. 13 MR. JEFFERS: You can understand 14 whatever you say, but --15 Α. Can you repeat it, please? 16 MR. JEFFERS: -- others have to 17 understand it. I don't understand your question. 18 Α. You can reread it if you like and I'll try --19 20 Here's my question: Are you 0. 21 telling me that the people who wrote down --22 those physicians at University Hospital, are 23 you telling me that the opinions they wrote 24 down and the assessments they wrote down are 25 totally invalid?

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	155
1	A. I'm telling you that this infant
2	did not sustain neurologic damage from hypoxic
3	encephalopathy during her course of labor and
4	delivery.
5	Q. Based upon your review seven years
6	later?
7	A. Based upon all the information
8	contained in her labor and delivery course,
9	that's what I'm telling you.
10	Q. Including the true knot in the
11	cord, right?
12	A. Including the loose true knot in
13	the cord which we've reviewed already, yes.
14	Q. And including issues relating to
15	the cord around the neck, right?
16	A. Yes.
17	Q. And including the fetal distress
18	that's marked down in the chart, right?
19	A. The incorrect fetal distress that's
20	written in the initial newborn profile, but is
21	never written in the maternal record, yes.
22	Q. I just want to make sure before I
23	leave here that you and ${\tt I}$ are on the same page
24	on one thing: That you're going to tell the
25	jury that Mr. Jeffers' client was wrong when it

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1	wrote down "fetal distress" on 11/11/92. Is
2	that what you're going to tell this jury? I
3	want to know that.
4	A. What I'm going to say is that that.
5	is an incorrect characterization of the labor
б	course. Yes, I'm going to say that.
7	MR. NOVAK: Okay. All righty. I
8	amldone.
9	
10	(Deposition concluded at 6:15 p.m.)
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17	С. П. Паман интернет и ит Предокразование издержить на конструкции и полнование и полнование и полнование и пол Полнование и полнование и полнован
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1	CERTIFICATE
2	The State of Ohio,)
3	ss:
4	County of Cuyahoga.)
5	
6	I, Rebecca L. Stonerock, a Notary
7	Public within and for the State of Ohio, duly
8	commissioned and qualified, do hereby certify
9	that the within-named witness, WILLIAM J.
10	TODIA, M.D., was by me first duly sworn to
11	testify the truth, the whole truth and nothing
12	but the truth in the cause aforesaid; that the
13	testimony then given by the above-referenced
14	witness was by me reduced to stenotypy in the
15	presence of said witness; afterwards
16	transcribed, and that the foregoing is a true
17	and correct transcription of the testimony so
18	given by the above-referenced witness.
19	I do further certify that this
20	deposition was taken at the time and place in
21	the foregoing caption specified and was
22	completed without adjournment.
23	
24	
25	
	Name View Brance and

RENNILLO REPORTING SERVICES (216) 523-1313 (888) 391-DEPO 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 day of ptembh 1999. Rebacca L. Stonerock Rebecca L. Stonerock, Notary Public within and for the State of Ohio My commission expires March -17, 2002.

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5	
6	The deposition of WILLIAM J. TODIA,
7	M.D., taken in the matter, on the date, and at
8	the time and place set out on the title page
[~] §	hereof.
10	It was requested that the
11	deposition be taken by the reporter and that
12	same be reduced to typewritten form.
13	It was agreed by and between
14	counsel and the parties that the Deponent will
15	read and sign the transcript of said
16	deposition.
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1	AFFIDAVIT	
2	The State of Ohio,)	
9) SS:	
л	County of Cuyahoga)	
5		
6		
7		
8	Before me, a Notary Public in and for	
9	said County and State, personally appeared	an an an
10	WILLIAM J. TODIA, M.D., who acknowledged that	
11	he/she did read his/her transcript in the	
12	above-captioned matter, listed any necessary	
13	corrections on the accompanying errata sheet,	
14	and did sign the foregoing sworn statement and	
15	that the same is his/her free act and deed.	
16	In the TESTIMONY WHEREOF, I have hereunto	
17	affixed my name and official seal at this	- Mentality
18	day of A.D 1999:	
19		
20		
21		
22	Notary Public	
23		
24		
25	My Commission Expires:	

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1 DEPOSITION ERRATA SHEET 2 JASMINE MERRIWEATHER, ETC., ET AL. 3 RE : 4 VS. ELYRIA MEMORIAL HOSPITAL, ET AL. 5 RRS File No.: 836 WILLIAM J. TODIA, M.D. 6 Deponent: 7 Deposition Date: SEPTEMBER 17, 1999 8 -9 To the Reporter: 10 I have read the entire transcript of my 11 Deposition taken in the captioned matter or the 12 same has been read to me. I request that the following changes be entered upon the record 13 14 for the reasons indicated. I have signed my 15 name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to 16 17 the original transcript. 18 19 20 21 22 23 24 25 RENNILLO REPORTING SERVICES

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William J. Todia, M.D.

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WESTON HURD FALLON PAISLEY & HOWLEY L.L.P

COUNSELLORS AT LAW

Kathleen Mulligan, R.N. 216/687-3330 KM2500@MCIMAIL.COM

3/17 2.

February 27, 1998

William Todia, M.D. MetroHealth Medical Center 2500 MetroHealth Drive Cleveland, Ohio **44**109

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 <u>only</u> 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.

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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,

Kathlee Millig

KATHLEEN MULLIGAN, R.N. Legal Assistant

KM:lmw Encs.

WESTON HURD FALLON PAISLEY & HOWLEY L.L.P.

COUNSELLORS AT LAW

Kathleen Mulligan, R N **21**61687-3330 KM2500@MCIMAIL COM

September 3, 1998

William Todia, M.D. MetroHealth Medical Center 2500 MetroHealth Drive Cleveland, Ohio **44**109

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,

The Mullise PLAINTIFFS **EXHIBIT** 1/23/58 TODIA KATHLEEN **MULLIGAN**, R.N. Legal Assistant W Dire & Jeffer --> I still I found is and a - countre to and is u countre to and in to u countre serios - at heget The KM:lmw the ser ola 2500 TERMINAL TOW ER • SO PUBLIC SQUARE • CLEVEI AND, OH 44113-2241 • 216/241 6602 • I AX 216/621 8369