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| <p style="text-align: right;">Page 1</p> <p>1        IN THE COURT OF COMMON PLEAS<br/> 2        CUYAHOGA COUNTY, OHIO<br/> 3 CHARLES TENNEY, III, Etc., )<br/> 4 et al., )<br/> 5        Plaintiffs, )<br/> 6        vs. ) No. 448548<br/> 7 URMILA PATEL, M.D., et. al., )<br/> 8        Defendants. )<br/> 9        The deposition of DAVID ZBARAZ, M.D., called<br/> 10 by the Defendant for examination, taken pursuant<br/> 11 to notice and pursuant to the provisions of the<br/> 12 Code of Civil Procedure and the Rules of the<br/> 13 Supreme Court of the State of Ohio pertaining to<br/> 14 the taking of depositions for the purpose of<br/> 15 discovery, taken before JUDY ANN MAATMAN, a<br/> 16 Notary Public within and for the County of Lake,<br/> 17 State of Illinois, and a Certified Shorthand<br/> 18 Reporter of said state, at 1535 Lake Cook Road,<br/> 19 Suite 502, Northbrook, Illinois, on the 25th day<br/> 20 of November, 2002 at 3:00 pm.<br/> 21<br/> 22<br/> 23<br/> 24</p> | <p style="text-align: right;">Page 3</p> <p>1 APPEARANCES (CONT'D)<br/> 2 BONEZZI SWITZER MURPHY &amp; POLITO CO LPA,<br/> 3 (1400 Leader Building,<br/> 4 526 Superior Avenue,<br/> 5 Cleveland, Ohio 44114,<br/> 6 (216) 875-2767), by:<br/> 7 MR. DONALD H. SWITZER,<br/> 8        Appeared on behalf of the Defendant,<br/> 9        Southwest General Health Center.<br/> 10<br/> 11 REPORTED BY:<br/> 12<br/> 13 Judy Ann Maatman, CSR<br/> 14 License No. 084-002498.<br/> 15<br/> 16<br/> 17<br/> 18<br/> 19<br/> 20<br/> 21<br/> 22<br/> 23<br/> 24</p>  |
| <p style="text-align: right;">Page 2</p> <p>1 APPEARANCES:<br/> 2 BECKER &amp; MISHKIND CO., L.P.A.,<br/> 3 (Skylight Office Tower,<br/> 4 1660 W. 2nd Street,<br/> 5 Suite 660,<br/> 6 Cleveland, OH 44113,<br/> 7 (216) 241-2600), by:<br/> 8 MR. HOWARD D. MISHKIND,<br/> 9        Appeared on behalf of the Plaintiff;<br/> 10<br/> 11 WESTON HURD FALLON PAISLEY &amp; HOWLEY,<br/> 12 (2500 Terminal Tower,<br/> 13 50 Public Square,<br/> 14 Cleveland, Ohio 44113,<br/> 15 (216) 241-6602), by:<br/> 16 MS. CAROL METZ,<br/> 17        Appeared on behalf of the Defendant,<br/> 18        Urmila Patel, M.D.;<br/> 19<br/> 20<br/> 21<br/> 22<br/> 23<br/> 24</p>  | <p style="text-align: right;">Page 4</p> <p>1        (WHEREUPON, the witness was<br/> 2        duly sworn.)<br/> 3        DAVID ZBARAZ, M.D.,<br/> 4 called as a witness herein by the Defendant,<br/> 5 having been first duly sworn, was examined and<br/> 6 testified as follows:<br/> 7        EXAMINATION<br/> 8 BY MR. SWITZER:<br/> 9        Q. Doctor, my name is Don Switzer. I<br/> 10 represent Southwest General Health Center. I'm<br/> 11 going to ask you the questions first.<br/> 12        Since we're doing this by<br/> 13 telephone, obviously you and I both need to make<br/> 14 sure that the other person finishes speaking<br/> 15 before we start talking or else we'll be cut<br/> 16 out.<br/> 17        If you don't hear me at any time,<br/> 18 please let me know and I'll repeat the question.<br/> 19        A. That's fair.<br/> 20        Q. All right. Doctor, I do have a report<br/> 21 that you authored, I believe it's July 2, 2002?<br/> 22        A. Yes, sir.<br/> 23        Q. Is that the only report or letter that<br/> 24 you've prepared setting forth your opinions in</p> |

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1 this case?  
 2 A. Yes, it is.  
 3 Q. Do you have any notes that you've  
 4 prepared as you've gone through and reviewed this  
 5 case?  
 6 A. Yes, I do.  
 7 Q. How many pages of notes do you have?  
 8 A. I have three pages of notes.  
 9 Q. Okay.  
 10 A. And I'll be happy to make a copy for  
 11 the court reporter to attach to the deposition  
 12 transcript.  
 13 MR. SWITZER: Great. Can you just mark --  
 14 let's mark that Exhibit A.  
 15 THE WITNESS: I'll give them to her now.  
 16 (WHEREUPON, said document  
 17 was marked Zbaraz  
 18 Deposition Exhibit No. A,  
 19 for identification, as of  
 20 11/25/02.)  
 21 BY MR. SWITZER:  
 22 Q. Doctor, when did you prepare those  
 23 notes?  
 24 A. I prepared them contemporaneously with

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1 P-i-s-c-o-l-a; the deposition of a Timothy  
 2 McKnight, physician; the deposition of a Charles  
 3 Tenney, Jr.; the deposition of Coleen Zelonis,  
 4 Z-e-l-o-n-i-s, a nurse; deposition of a Jill  
 5 Castenic, C-a-s-t-e-n-i-c, also a nurse; the  
 6 deposition of a Dawn Davis.  
 7 Q. Okay. Doctor, do you have an updated  
 8 curriculum vitae?  
 9 A. Yes, I do.  
 10 Q. You know, frankly, I don't have one.  
 11 A. Okay. Would you like me to --  
 12 Q. I should have followed up with Howard  
 13 before today.  
 14 A. Oh, okay.  
 15 Q. Could you just give that to the court  
 16 reporter also?  
 17 A. Yes, I will.  
 18 MR. SWITZER: And if she can mark that as  
 19 Exhibit B.  
 20 THE WITNESS: That will be fine.  
 21 Yes, I've given it to her now.  
 22 MR. SWITZER: Let me know when you're ready.  
 23 MR. MISHKIND: Don, just for your  
 24 information, it's a 5-page document which is his

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1 my review of the case.  
 2 Q. So, on or before July 2, 2002?  
 3 A. Yes, sir.  
 4 Q. Do those notes set forth any opinions  
 5 with respect to deviations from standard of care  
 6 other than what you set forth in your report?  
 7 A. No, sir, they don't.  
 8 Q. Okay.  
 9 A. The notes are mainly a time line and  
 10 mainly recapitulating what went on with the labor  
 11 and delivery. They really aren't talking about  
 12 any deviations.  
 13 Q. Okay. Have you conducted any medical  
 14 research for your work in this case?  
 15 A. Not specifically.  
 16 Q. I know you reviewed the medical  
 17 records?  
 18 A. Yes, sir.  
 19 Q. Would you tell me what else you  
 20 reviewed?  
 21 A. Yes. I reviewed some deposition  
 22 transcripts. Let me get to the depositions  
 23 first. There's a deposition of a Dr. Patel, the  
 24 deposition of a Nurse Piscola, that's

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1 CV, and it's going to be marked as Defendant's  
 2 Exhibit B and the court reporter is ready.  
 3 (WHEREUPON, said document  
 4 was marked Zbaraz  
 5 Deposition Exhibit No. B,  
 6 for identification, as of  
 7 11/25/02.)  
 8 BY MR. SWITZER:  
 9 Q. Doctor, do you -- well, let me back-up  
 10 a minute.  
 11 Tell me about the nature of your  
 12 practice right now?  
 13 A. I'm in the private practice of  
 14 obstetrics and gynecology. I've been in practice  
 15 since 1970. I practice at -- I'm at one hospital  
 16 now which is Northwestern Memorial Hospital in  
 17 Chicago. I have a teaching position at the  
 18 University, I'm a Clinical Assistant Professor of  
 19 OB-GYNE at Northwestern.  
 20 I spend the majority of my time in  
 21 private practice, but I probably spend around 5  
 22 to 10 percent of my time in teaching activities,  
 23 whether it's on review committees or teaching  
 24 third year medical students or residents.

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1 I don't know what else to say  
2 about myself, but go ahead and ask the questions.

3 Q. How many deliveries did you personally  
4 perform --

5 A. In my career?

6 Q. No. I haven't finished the question  
7 yet.

8 A. Oh, okay.

9 Q. -- for each of the years starting with  
10 1999?

11 A. 1999.

12 Q. I mean a range. I'm sure you may have  
13 the exact numbers, some doctors do.

14 A. I wish I was that compulsive, but I'm  
15 not. And I would say I probably do, in 1999  
16 until around this year, probably about a hundred  
17 deliveries a year now.

18 Q. What's your incidence of shoulder  
19 dystocia?

20 A. I can't tell you with any degree of  
21 certainty, but I think it probably approximates a  
22 national average of somewhere under one percent.

23 Q. You say you teach -- you teach  
24 residents or medical students?

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1 and I probably wasn't listening, did you review  
2 any of the reports of the other experts in the  
3 case?

4 A. I was sent reports of several experts,  
5 but I'm trying to remember their names.

6 One was a Dr. Pettit, it was a  
7 letter forwarded to me from a Dr. George Pettit.  
8 Another -- I'm sorry, I don't have these  
9 organized well.

10 There were several other experts  
11 on your side whose letters I read, and I just  
12 don't -- they should be in --

13 Q. Let me -- I want to ask you if you  
14 know any of these other experts.

15 A. Oh, go ahead.

16 Q. Let me just give you the names and let  
17 me know if you know them?

18 A. Okay.

19 Q. Joanne Zelten, she's an RN, I believe,  
20 from the Chicago area?

21 A. No, I don't.

22 Q. Dr. David -- I'm torturing his name,  
23 Simckes, S-i-m-c-k-e-s?

24 A. No, sir, I don't.

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1 A. Both.

2 Q. Do you have your residents and medical  
3 students read any textbooks on obstetrics?

4 A. Not specifically, but they invariably  
5 do read in obstetrics. They're encouraged to  
6 read.

7 If you're looking for a relatively  
8 authoritative text in obstetrics, you can use  
9 Williams in a current edition, for whatever time  
10 frame you want for this case. I won't tell you  
11 that all of Williams is authoritative, but it's  
12 as good a text as you'll find, and the majority  
13 of it certainly is authoritative.

14 Q. You're a member of ACOG, I assume?

15 A. Yes, sir.

16 Q. Are you a fellow?

17 A. Yes, sir.

18 Q. They have publications on shoulder  
19 dystocia, don't they?

20 A. Yes, they do.

21 Q. Do you consider those publications to  
22 be authoritative?

23 A. In general, yes.

24 Q. Have you -- you have told me this

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1 Q. Dr. James O'Leary?

2 A. James O'Leary, I've heard his name. I  
3 don't know him personally.

4 Q. How have you heard his name?

5 A. Well, I've read some literature that  
6 he's put out. And I think I -- at home I have  
7 his book.

8 Q. What book is that?

9 A. A book on shoulder dystocia.

10 Q. Is that a textbook?

11 A. Yes.

12 Q. Did you have that before you became  
13 involved in this case?

14 A. Oh, yeah, I've had it for years.

15 Q. Oh, okay. So it's an old book?

16 A. Yeah. I'm kind of an old guy, so I  
17 guess I have old books, but, yes.

18 Q. Old guys can write new books.

19 A. That's true.

20 Q. Have you reviewed any other  
21 publications by Dr. O'Leary?

22 A. Not that I recall.

23 Q. Okay. Do you consider him to be an  
24 authority on shoulder dystocia?

|  |  |
|--|--|
| <p style="text-align: right;">Page 13</p> <p>1 A. Dr. O'Leary considers himself to be an<br/>2 authority, and I wouldn't want to doubt him.<br/>3 Q. Well, we mentioned Pettit. Do you know<br/>4 Dr. Pettit?<br/>5 A. No, sir, I don't.<br/>6 Q. How about Dr. Duchon?<br/>7 A. No, sir.<br/>8 Q. Dr. Burkons?<br/>9 A. No.<br/>10 Q. Dr. Gimovsky?<br/>11 A. No.<br/>12 Q. Let me ask you some questions about<br/>13 the case if we can.<br/>14 Doyou consider -- we'll refer to<br/>15 the baby as Charlie, if we can, for the purposes<br/>16 of the deposition.<br/>17 A. All right.<br/>18 Q. And Charles as the father?<br/>19 A. Yes.<br/>20 Q. Do you consider Charlie to have been a<br/>21 macrosomic baby?<br/>22 A. Charlie, at delivery, weighed 9 pounds<br/>23 and 13 ounces. So he was borderline macrosomic,<br/>24 yes.</p>  | <p style="text-align: right;">Page 15</p> <p>1 shoulders.<br/>2 Macrosomic infants after delivery<br/>3 sometimes have increased problems with regulation<br/>4 of blood sugar, and certainly because they're<br/>5 macrosomic, if it's recognized prior to delivery,<br/>6 on occasion you might even recommend that a<br/>7 patient undergo cesarean section if you think<br/>8 there's some risk in attempting to deliver this<br/>9 size baby from below.<br/>10 Q. Is cephalopelvic disproportion<br/>11 involved in this case?<br/>12 A. No, sir, it isn't.<br/>13 Q. Let me back up a minute. Did Dawn<br/>14 Davis have any risk factors for macrosomia?<br/>15 A. The only one I'm aware of is that she<br/>16 gained about 50 pounds during her pregnancy, but<br/>17 she was not diabetic, and I don't recall there<br/>18 being any strong family history of diabetes. But<br/>19 in any event, I think the only risk factor I know<br/>20 for macrosomia for her would be excessive weight<br/>21 gain.<br/>22 Q. Is macrosomia predictable with any<br/>23 degree of probability?<br/>24 A. No, probably not. It is if a patient</p>                                 |
| <p style="text-align: right;">Page 14</p> <p>1 Q. What is your cutoff -- what is the<br/>2 cutoff you use for macrosomic?<br/>3 A. Above 4500 grams.<br/>4 Q. So he was just beneath that?<br/>5 A. Yes, sir. I think -- I didn't --<br/>6 9.13, I didn't calculate it exactly in grams, but<br/>7 I think it's very close.<br/>8 Q. I think it's -- and don't take my math<br/>9 as being correct, Doctor, I think it's -- I came<br/>10 up with 4455.<br/>11 A. Yeah, that seems like a reasonable<br/>12 number.<br/>13 Q. What are the risk factors in general<br/>14 for macrosomia?<br/>15 A. Well, you might have cephalopelvic<br/>16 disproportion, in which case the baby wouldn't<br/>17 pass through the pelvis and would require a<br/>18 cesarean section. You can have -- you'd have mid<br/>19 pelvic arrest with a macrosomic infant which<br/>20 would require an operative delivery either by<br/>21 forceps or vacuum.<br/>22 But in our case today you can also<br/>23 have delivery of the head and with a macrosomic<br/>24 infant, difficulty with delivery of the</p> | <p style="text-align: right;">Page 16</p> <p>1 is diabetic and you truly expect a large infant.<br/>2 But very frequently it's difficult to ascertain<br/>3 the difference in palpation between a baby that<br/>4 weighs 8 pounds and a baby that weighs 9 and a<br/>5 half pounds. It's just not that accurate.<br/>6 Ultrasound can be used to try and<br/>7 ascertain fetal weight, but the formulas just<br/>8 aren't very accurate, and they're not used to<br/>9 determine macrosomia except when there's a really<br/>10 markedly macrosomic infant.<br/>11 Q. Let me talk about shoulder dystocia if<br/>12 I can.<br/>13 A. Sure.<br/>14 Q. Did Dawn Davis have any risk factors<br/>15 for shoulder dystocia?<br/>16 A. Only her short stature. She stood<br/>17 about, if I remember correctly, 5'1" inches tall<br/>18 -- yes, she was 5'1" inches tall, and at the end<br/>19 of her pregnancy weighed 198 pounds, so you'd be<br/>20 concerned about her short stature. You'd be<br/>21 concerned about the size of her pelvis, and you<br/>22 might be concerned because of the excessive<br/>23 weight gain if there would be any soft tissue<br/>24 dystocia.</p> |

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1 Q. Is shoulder dystocia predictable with  
2 any degree of probability?

3 A. Not really. The majority of shoulder  
4 dystocia occurs in babies that are not  
5 excessively heavy. Certainly we expect it in a  
6 macrosomic infant, but it frequently can be  
7 unpredictable and occur even in a normal weighted  
8 infant.

9 Q. Why is that?

10 A. Because the shoulder dystocia is a  
11 response to the baby's shoulder being caught  
12 behind the symphysis pubis, not allowing the  
13 shoulder to deliver easily after the baby's head  
14 is delivered. This can occur even in a  
15 non-macrosomic infant sometimes depending on the  
16 rapidity of the descent of the fetus.

17 It is well-known to occur in  
18 normal size fetuses, especially in precipitous  
19 labors, labors that occur very quickly that don't  
20 allow the baby's shoulders to rotate out of the  
21 axis -- the entry or posterior axis and  
22 therefore, get caught behind the symphysis  
23 pubis.

24 The majority of shoulder dystocia

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1 indication that a macrosomic infant was  
2 anticipated. And in my opinion, if you don't  
3 know for sure, it is certainly acceptable to  
4 allow labor to progress and intervene surgically  
5 if, in fact, an arrest of labor occurs and the  
6 head doesn't -- does not descend.

7 Q. I'd like to ask you a few questions  
8 about brachial plexus injuries.

9 A. Yes, sir.

10 Q. In general.

11 A. Yes.

12 Q. Are there any figures that you are  
13 aware of, statistics indicating what percentage  
14 of children with permanent brachial plexus  
15 injuries on one or the other side of their body  
16 are as a result of -- Let me withdraw the  
17 question. It wasn't going to make any sense.

18 A. It's okay. I was losing you anyway.

19 Q. I lost myself in that question.

20 MR. MISHKIND: Can I join in on that loss?

21 BY MR. SWITZER:

22 Q. Yes. Let me back up and ask it the  
23 right way.

24 What percentage of babies who are

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1 is not predictable. It comes unexpectedly and  
2 every obstetrician has to be aware of its  
3 possibility and have significant knowledge in the  
4 way to handle it safely for the mother and  
5 fetus.

6 Q. This was not a precipitous delivery  
7 here, was it?

8 A. No, it wasn't a precipitous delivery.

9 Q. I mean labor, I'm sorry.

10 A. Right. That's exactly true. It wasn't  
11 a precipitous labor.

12 Q. Does the standard of care require an  
13 automatic C-section if shoulder dystocia is  
14 anticipated?

15 A. It would depend on the communication  
16 between the physician and the patient. If a woman  
17 had had previous shoulder dystocia, and now is  
18 pregnant again and the baby is as big or bigger,  
19 the mother certainly should be apprised that this  
20 could be a situation that might occur again, and  
21 she should be given the option of delivering via  
22 cesarean section.

23 In this case, though it was known  
24 to be a good-sized infant, it was not -- I saw no

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1 born following shoulder dystocia being  
2 encountered during the delivery process end up  
3 having some type of brachial plexus injury?

4 A. Probably around 10 to 15 percent in my  
5 -- from my recollection of statistics, 10 to 15  
6 percent of brachial -- I'm sorry, 10 to 15 percent  
7 of shoulder dystocia may result in a brachial  
8 plexus or Erb's type palsy. Now the majority of  
9 these are resolved spontaneously. In other  
10 words, they go away with no treatment in a  
11 relatively short amount of time.

12 About 10 percent of these brachial  
13 plexus injuries are permanent injuries. In other  
14 words, if we have shoulder dystocia in  
15 approximately 1 percent of cases, of that 1  
16 percent, about 10 to 15, possibly 20 percent of  
17 kids will have some brachial plexus injury, at  
18 least a temporary injury. Of those, 10 percent  
19 will be a permanent injury.

20 Q. Let me ask you, just following up on  
21 that. I mean, here basically we have a -- let's  
22 just round it off to a 4500 gram baby?

23 A. Yes, sir.

24 Q. Are you aware of any statistics which

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1 talk about what percentage of 4500 gram babies  
2 versus, let's say, 4000 gram babies end up with  
3 permanent brachial plexus injuries following a  
4 shoulder dystocia delivery?

5 A. No, I don't have those figures off the  
6 top of my head. I don't know that there would be  
7 a very significant difference depending on the  
8 skill of the operator and the size of the  
9 mother's pelvis, and the way the manipulations  
10 are conducted at time of delivery.

11 Q. Let me follow-up on that then. Do you  
12 believe that the incidence of permanent brachial  
13 plexus injury following an obstetrician  
14 encountering shoulder dystocia would be higher in  
15 general the more that the baby weighed?

16 A. In general, that seems logical to be  
17 true, but I haven't read any statistics that I  
18 can recall that bear this out, that makes a  
19 difference for 500 grams of infant.

20 Q. Okay. What about -- let's talk about  
21 8 pounds versus 12 pounds. Maybe that will be a  
22 little bit easier?

23 A. Well, sure, I think that is easier. I  
24 think that the incidence of injury in trying to

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1 accommodate its passage through the mother's  
2 pelvis. And molding is a common occurrence in a  
3 lady who is laboring and is delivering through  
4 the vagina and it's significantly encountered the  
5 larger the baby gets because more molding is  
6 required to allow the baby -- the head to safely  
7 pass through the vaginal canal.

8 Q. Let me ask you about the second stage  
9 of labor. Is there a general range for a  
10 primigravida versus a multigravida with respect  
11 to what you would expect to see in a second stage  
12 of labor?

13 A. Yes, most people expect the upper  
14 limits of normal to be a two hour second stage of  
15 labor in a primigravida patient. That might be  
16 somewhat increased to three hours by some authors  
17 when regional block anesthesia is used.

18 Q. Such as an epidural?

19 A. Yes, such as an epidural.

20 Q. Is there any way to predict how long  
21 the second stage of labor will last for any  
22 particular patient?

23 A. Well, there are three variables that  
24 occur in the second stage of labor: We have the

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1 deliver a 12-pound baby from below would be  
2 greater than trying to deliver an 8-pound baby  
3 from below. No question about it. But what  
4 percentage would be permanent injuries, I really  
5 can't tell you. I just don't have the statistics  
6 at my fingertips.

7 Q. Was Charlie dysmorphic?

8 A. Not to my knowledge. He had some  
9 molding of his head, but I don't think any of his  
10 features looked dysmorphic, to my knowledge, from  
11 what I read in the pediatric notes.

12 Though he had a cephalohematoma,  
13 he had some bruising of his face, he did have  
14 bilateral pneumothoraxes and certainly a right  
15 brachial plexus, right Erb's palsy. I don't  
16 remember any of his features being dysmorphic.

17 Though, I must tell you, that's  
18 well beyond my area of expertise. Once I hand the  
19 baby to the pediatrician, I no longer care for  
20 this baby.

21 Q. You mentioned molding. What is the  
22 significance of molding of the head?

23 A. Well, it indicates that the baby's  
24 head had changed its shape in trying to

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1 size of the passage, the size of the passenger,  
2 and the powers that are being given applied by  
3 the mother. And those three variables are  
4 unpredictable.

5 You can certainly measure the size  
6 of the baby after delivery. You can certainly  
7 measure the passage to a greater or lesser  
8 extent. But you never know how hard the mother's  
9 going to push or is able to push, so the true  
10 length of second stage is unpredictable.

11 Q. Let me ask you about fundal pressure?

12 A. Sure.

13 Q. In the second stage of labor, is  
14 fundal pressure ever appropriate to be used?

15 MR. MISHKIND: Let me just object for the  
16 record to the term "ever", but Doctor, you can go  
17 ahead and answer the question.

18 BY THE WITNESS:

19 A. I can't imagine a circumstance where  
20 fundal pressure is appropriate except sometimes  
21 after a baby's shoulders are released in a very  
22 macrosomic infant in an attempt to get the rest  
23 of the baby to deliver.

24 In other words, I don't see using

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1 fundal pressure appropriately before the delivery  
2 of the head. I think that's inappropriate.

3 I don't see using fundal pressure  
4 with a shoulder dystocia. I think that's very  
5 inappropriate. If a very large macrosomic infant  
6 is delivered, the shoulders are delivered, and  
7 still the remainder of the baby is difficult to  
8 deliver then applying fundal pressure instead of  
9 pulling on baby's head or shoulders after  
10 delivery of shoulders might be appropriate.

11 BY MR. SWITZER:

12 Q. Well, let's talk about before shoulder  
13 dystocia then?

14 A. Okay.

15 Q. Try and break it down. So it's your  
16 opinion that it is inappropriate to use fundal  
17 pressure at anytime during the second stage of  
18 labor, again, without any shoulder dystocia --  
19 prior to any shoulder dystocia? I'm sorry.

20 A. Correct. I can't -- I'm having  
21 difficulty conceiving of any circumstance where I  
22 would want to apply fundal pressure during the  
23 second stage of labor prior to delivery -- prior  
24 or after delivery of the head.

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1 In the one circumstance where the  
2 mother might be totally exhausted, the baby is  
3 just -- is crowning and just needs -- mother  
4 absolutely refuses because of either the epidural  
5 giving her no powers at all or the baby having  
6 some fetal distress, where it -- just a small  
7 amount of fundal pressure will allow the baby to  
8 be delivered, I can see that being the case. But  
9 in my opinion, a better remedy would not be  
10 applying fundal pressure, but putting forceps on  
11 the baby's head and delivering it through the  
12 pelvis.

13 Q. Would those be considered outlet  
14 forceps?

15 A. Well, it would depend on where the  
16 baby's head is. If the baby's head is at the  
17 outlet, then it's outlet forceps. If the baby's  
18 head is in the mid-pelvis, it would be mid-  
19 forceps. If the baby's head is a little lower  
20 than mid-pelvis, but not quite outlet, it would  
21 be low forceps. It depends on the station of the  
22 baby's head when the forceps are applied.

23 Q. Let me ask you this, and let's go back  
24 to the time that's involved in this case --

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1 A. Sure.

2 Q. -- that we're here about today, which  
3 is in September of 2000.

4 A. Yes, sir.

5 Q. Is it your opinion that the standard  
6 of care for obstetricians, and we'll talk about  
7 obstetrical nurses too, prohibited the use of  
8 fundal pressure before the delivery of the head  
9 other than in that situation you just discussed?

10 A. I think there would have to be an  
11 exceedingly good reason to warrant the use of  
12 fundal pressure in the second stage of labor in  
13 an individual patient. I would have to be given  
14 a reason that it was used.

15 In my opinion in general, I think  
16 that it's inappropriate and outside the standard  
17 of care for fundal pressure to be applied during  
18 the second stage of labor.

19 Q. Okay. When fundal pressure is  
20 applied, how can you calculate how much force was  
21 actually applied?

22 A. Well, you can't. I don't know that  
23 there's any way you could, but I assume -- I  
24 won't even assume. If someone is pushing on a

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1 woman's fundus and actually records that she's  
2 pushing, she's pushing hard. Pushing that isn't  
3 hard is of no significance, and there's no reason  
4 to do it.

5 The only reason to apply fundal  
6 pressure in the second stage of labor is to aid  
7 in the descent of the fetal head, and the only  
8 way to aid in descent of the fetal head with  
9 fundal pressure is to push hard.

10 Q. Can you quantify hard?

11 A. No. Like I can't quantify long. I  
12 would say, for most people it would be to push on  
13 the fundus with as much strength as they could  
14 muster compatible with the ability of the patient  
15 to tolerate the discomfort.

16 Q. But in this case, I mean, fundal  
17 pressure was applied twice before the head was  
18 delivered?

19 A. Apparently so.

20 Q. Can you -- do you have any opinion as  
21 to how much pressure or force, however you want  
22 to measure it, was actually exerted by this  
23 nurse?

24 A. No. I have no way to calculate that,

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1 nor I wasn't there to watch it. I assume that if  
2 a nurse is instructed to give fundal pressure,  
3 she'll push as hard as she can. If the nurse  
4 wasn't instructed to give fundal pressure, well,  
5 then she shouldn't have been giving it in the  
6 first place.

7 Q. So is the amount of force that's  
8 actually exerted through the fundus, so to speak,  
9 to the fetus dependent to some extent upon the  
10 body habitus of the patient?

11 A. Yes, and the body habitus of the nurse  
12 also. I mean, there are some nurses who I  
13 wouldn't want to meet in a dark alley, who could  
14 wipe the ground up with me, and others that I  
15 could probably take on in a pretty fair fight.  
16 So I think it depends on the nurse and her  
17 leverage and how high above the delivery table  
18 she is, and her ability to apply pressure on the  
19 fundus of the uterus.

20 I mean, a lot less pressure is  
21 done if the nurse is standing to the side of the  
22 patient on the table reaching up to a -- on a  
23 delivery table than would be applied by a nurse  
24 who is standing on a chair or a stool or on the

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1 Q. And in what direction is that  
2 generally applied?

3 A. Downward or laterally depending on the  
4 instructions of the physician who is ordering the  
5 suprapubic pressure. Sometimes you are  
6 attempting to -- with suprapubic pressure, you're  
7 attempting to -- you're always attempting to  
8 dislodge the anterior shoulder from its  
9 entrapment behind the symphysis pubis.

10 Sometimes the pressure is downward  
11 to get the shoulder to come free, sometimes the  
12 pressure would be laterally, either to the right  
13 or the left depending on the instructions of the  
14 obstetrician to try to get the shoulder to rotate  
15 and then come beneath the pubic bone.

16 Q. When is it appropriate to apply  
17 suprapubic pressure during the second stage of  
18 labor?

19 A. Well, the only time it's appropriate  
20 is when the diagnosis of shoulder dystocia is  
21 made, and then only during the time you're trying  
22 to dislodge the shoulder, the anterior shoulder,  
23 from behind the symphysis pubis.

24 Q. Let me back up a minute. Now, fundal

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1 bed itself, she'd certainly get more leverage and  
2 apply more pressure.

3 I wasn't there. I don't know how  
4 much pressure she applied.

5 Q. So there's a lot of variables that  
6 exist in this case with respect to actually  
7 determining how much force was applied during the  
8 fundal pressure applied by this nurse before the  
9 delivery of the head?

10 A. Yes. I have no information. Nobody  
11 said there were that many foot -- pounds of  
12 pressure or ergs, or the patient -- or the nurse  
13 weighed such and such and pushed so hard. I  
14 don't know. All it said in the record is that  
15 fundal pressure was applied.

16 Q. Let me ask you some other type  
17 questions with respect to suprapubic pressure --

18 A. Sure.

19 Q. -- if I can.

20 What is suprapubic pressure?

21 A. That's the same as fundal pressure,  
22 but instead of being applied to the fundus, it's  
23 applied to the area just above the pubic bone on  
24 the mother's abdomen.

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1 pressure, when that is applied -- let me back up  
2 again a minute.

3 With respect to the nurse that  
4 applied fundal pressure in this case before the  
5 head was delivered, in what direction did she  
6 apply that fundal pressure?

7 A. Well, there's only one way to apply  
8 the fundal pressure, that's downward.

9 Q. Well, downward in what direction? I  
10 mean, you mean down towards the bed or is it down  
11 towards the feet or --

12 A. Usually it's pressure in the direction  
13 of the vagina.

14 Q. Do you know what direction it was  
15 applied in this case?

16 A. No, sir. But I think it would be kind  
17 of silly to think she pushed up.

18 Q. Well, I don't know, I mean --

19 A. I think it would be kind of silly to  
20 think she pushed to the side.

21 Q. The force of the pressure could --  
22 there's different angles that it could be applied  
23 at; is that correct?

24 A. Absolutely. The force could be



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1 directed on top of the fundus pushing downward or  
2 on top of the fundus pushing more toward the  
3 vaginal orifice, you're correct.

4 Q. The suprapubic pressure, is that  
5 applied generally during a contraction if it's to  
6 be used?

7 A. Not necessarily. Because what you're  
8 trying to do is with a contraction, if you have  
9 the patient -- you know the patient should not be  
10 encouraged to push during a contraction because  
11 you're trying to rotate the baby's shoulder from  
12 beneath the pubis. And a contraction would tend  
13 to force the shoulder against the pubis even  
14 stronger, so you could give suprapubic pressure  
15 at anytime, but I would normally give it when the  
16 patient is not contracting.

17 Q. If for some reason the obstetrician  
18 believed that fundal pressure is necessary for  
19 delivery of the head, should that fundal pressure  
20 be applied while the patient is pushing?

21 A. In the hypothetical that the physician  
22 requires that fundal pressure be given, then it  
23 should -- if in the hypothetical the physician  
24 requires that it be given, then it should only be

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1 Q. What is your understanding of -- I  
2 want to back up a minute.

3 What is your understanding of when  
4 Dr. Patel arrived in the birthing room prior to  
5 the delivery of Charlie?

6 A. The understanding I have is Dr. Patel  
7 arrived in the delivery room at -- in the  
8 birthing room, if you will, at 10:52 in the  
9 morning.

10 Q. According to the records, Dawn Davis  
11 was completely dilated at around 9:57 a.m.?

12 A. That's correct, sir.

13 Q. Now she had an epidural started, I  
14 believe, around 1:24 or so in the morning?

15 A. Well, the epidural was given at 1:16  
16 in the morning. By 1:24 she had good relief of  
17 the pain by the epidural.

18 Q. And then there was redose about 8:00  
19 or 8:20 or something like that?

20 A. Yes, she was very comfortable until  
21 about 7:59 in the morning where she complained of  
22 increased pain, and the anesthesiologist was  
23 called to redose the epidural. So approximately  
24 8:00 in the morning, yes.

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1 given during a contraction.

2 Fundal pressure is made -- is  
3 intended to aid in the expulsive efforts of the  
4 uterus. And there's no rhyme or reason to push on  
5 the fundus unless the uterus is contracting at  
6 that time.

7 Q. What is your understanding of when  
8 Dr. Patel arrived in the labor room -- or we'll  
9 just call it the birthing room because I believe  
10 that Mrs. Tenney was in one room throughout the  
11 labor and delivery?

12 A. Well, I have a nursing note at 10:52  
13 in the morning that Dr. Patel is in the room. But  
14 we know he -- we know that Dr. Patel, she, saw  
15 the patient earlier than that because she did an  
16 exam. But we think -- I think from the nursing  
17 notes, she appears -- Dr. Patel appears to have  
18 been in the room as of 10:52 in the morning on  
19 the 13th of September, 2000.

20 Q. Pardon me for not taking good notes  
21 when you talked earlier, but did you say you had  
22 read Dawn and Charles' deposition transcript?  
23 Charles and Dawn Tenney?

24 A. Yes. Yes.

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1 Q. What effect did the epidural that she,  
2 being Dawn Davis, received have on the progress  
3 of her labor?

4 A. It may have slowed it some. I don't  
5 know with any degree of certainty, but certainly  
6 epidurals tend to slow down labors in general.

7 Q. I know that the -- I believe the toco  
8 from the contractions was removed at about 10:53?

9 A. That's correct. When Dr. Patel came  
10 in the room, he -- she ordered that the toco be  
11 removed. So that was approximately half an hour  
12 prior to delivery.

13 Q. And then what is your understanding of  
14 when the episiotomy was cut by Dr. Patel or  
15 performed, I guess, is a better term?

16 A. My understanding is Dr. Patel cut a  
17 midline episiotomy just prior to delivery of the  
18 head, and then extended the episiotomy when, in  
19 fact, the shoulder dystocia was encountered.

20 Q. Doctor, let me -- I'm looking at your  
21 report of July 2, 2002?

22 A. Yes, sir.

23 Q. And Page 1 of that report talks about  
24 the fundal pressure that was applied before the

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1 shoulder dystocia?

2 A. Yes, sir.

3 Q. And you have an opinion there that it  
4 caused a more rapid descent of the fetal head?

5 A. Yes, sir.

6 Q. Can you give me the basis for that  
7 opinion?

8 A. Well, in my opinion, any time fundal  
9 pressure is used, it accentuates what normal  
10 labor would be and would cause a more rapid  
11 descent of the fetal head. Certainly it was  
12 given 12 minutes and then 7 minutes prior to  
13 delivery of the head, so it had to be given as  
14 the baby's head was beginning to crown. There was  
15 no question that the baby was close to delivery.  
16 There's no question that had it not been given,  
17 it would have probably taken several extra  
18 contractions for this baby's head to deliver.

19 I don't understand why it would  
20 have been given. The second stage was certainly  
21 not prolonged, and the second stage was  
22 progressing very normally. But in my opinion,  
23 the more rapid descent of the fetal head did not  
24 -- like in a precipitous labor, did not allow

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1 quickly, it decreases the amount of time that the  
2 shoulders have to rotate out from behind the  
3 pubis, and therefore, increases the incidence of  
4 shoulder dystocia.

5 Because this patient certainly was  
6 not exhausted, she had been resting well, it said  
7 in the records several occasions, after the  
8 epidural, she was unaware of her contractions,  
9 she only became aware that she had pain about  
10 8:00 in the morning. The epidural was redosed,  
11 patient was apparently resting fairly  
12 comfortably, there was no reason to believe that  
13 this patient was exhausted. She had never  
14 stopped making significant progress in descent.  
15 Her second stage was less than two hours long, so  
16 she's not -- she does not have a prolonged second  
17 stage.

18 There was absolutely no medical  
19 indication for the use of fundal pressure. And  
20 in my opinion this was a deviation of the  
21 standard of care to use it. There was no need  
22 for it. Two --

23 Q. Is the basis for your opinion that had  
24 these two instances of fundal pressure not been

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1 the shoulders to normally rotate out of the  
2 anterior-posterior -- anterior-posterior diameter  
3 of the pelvis, and more likely than not, caused  
4 the shoulders to be entrapped behind the pubis.

5 Q. When was the head engaged?

6 A. Well, the head was engaged at 9:47.  
7 There was the diagnosis of the patient being rim  
8 dilated at 9:47 in the morning, and that that was  
9 the first time that the station was zero  
10 station. And by definition at zero station, the  
11 head was engaged.

12 Q. I want you to tell me then because  
13 it's still unclear to me what is the basis for  
14 your opinion that the two instances of fundal  
15 pressure that were used here did not allow  
16 sufficient time for the infant's shoulder to  
17 rotate into the correct axis?

18 A. Well, several bases for that opinion.  
19 Number one, there was no indication for the use  
20 of fundal pressure.

21 Two, fundal pressure, if applied  
22 with force will cause the head to descend more  
23 quickly.

24 Three, if the head descends more

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1 applied, that there would not have been any  
2 shoulder dystocia in this case?

3 MR. MISHKIND: Don, excuse me, before he  
4 answers that question, just for the record, I'm  
5 not sure the doctor was done answering the  
6 previous question. You started asking a question  
7 and he said the word "two".

8 Now, Doctor, in fairness to you,  
9 I'm not sure whether you were done with your  
10 answer or whether the "two" meant that you were  
11 going to say something else.

12 Were you done with your answer?

13 BY THE WITNESS:

14 A. I think so.

15 MR. MISHKIND: Okay. I'm sorry, Don.

16 MR. SWITZER: I thought so too.

17 MR. MISHKIND: I heard him say "two" and I  
18 didn't know whether he was going on to give  
19 further bases for his previous answer, so --

20 BY MR. SWITZER:

21 Q. Doctor, what is the basis for your  
22 opinion in this case that but for the two  
23 instances of fundal pressure being applied, that  
24 there would not have been any shoulder dystocia

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1 encountered?

2 A. I said more likely than not shoulder  
3 dystocia may or may not have been encountered in  
4 this case, but I think that the shoulders had no  
5 chance to rotate and so made the incidence of  
6 shoulder dystocia more likely.

7 I can't give you a percentage, but  
8 best I can say to you is in my opinion, more  
9 likely than not, the fundal pressure contributed  
10 to the shoulder dystocia.

11 Q. Well, you can't give an opinion in  
12 this case based on reasonable medical probability  
13 that had the fundal pressure not been applied  
14 that shoulder dystocia would not have been  
15 encountered?

16 A. Sir, I can tell you that I don't think  
17 it would have been encountered, but I can't tell  
18 you that had it been encountered anyway, it would  
19 have been less severe.

20 Q. And, again, that's what I'm trying to  
21 explore?

22 A. I'm trying to help you explore that.

23 Q. What is the basis for your opinion  
24 that this fetus' shoulders would most likely have

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1 shoulder dystocia would have been avoided. Or  
2 said a different way, had it been encountered, I  
3 think it would have been less severe and easier  
4 to correct.

5 Q. Well you're aware of -- in reading the  
6 literature, I'm assuming, that there's numerous  
7 incidents of shoulder dystocia without any fundal  
8 pressure being applied --

9 A. Of course.

10 Q. -- right?

11 A. Of course.

12 Q. How did those occur then?

13 A. They do occur, but I will tell you  
14 that if fundal pressure was applied to every  
15 patient in the second stage of labor, we would  
16 significantly increase the incidence of shoulder  
17 dystocia.

18 We do know that the incidence of  
19 shoulder dystocia is significantly higher, as I  
20 said earlier, in precipitous labors. And the  
21 precipitous second stage of labor means the head  
22 descends too quickly through the pelvis and the  
23 shoulders can't rotate.

24 In my opinion, the application of

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1 rotated into the correct axis without the  
2 application of the fundal pressure?

3 A. Because the shoulder dystocia was  
4 obviously relieved after a four minute episode of  
5 manipulation by the obstetrician. In my opinion,  
6 because the anterior shoulder eventually slid  
7 beneath the anterior -- beneath the pubis, had  
8 there been more time allowed in second stage,  
9 this could have occurred naturally instead of  
10 with -- requiring manipulation.

11 Q. Okay. And what is the basis for your  
12 opinion that had the infant's shoulders been  
13 allowed to rotate into the correct axis without  
14 applying the fundal pressure that there would not  
15 have been an impaction of the fetal shoulders?

16 A. Well, if the shoulders had been  
17 allowed to rotate into the correct axis at the  
18 time the head was delivered, the shoulders would  
19 already have been at an angle to the symphysis  
20 and have easily slid beneath the symphysis  
21 without any obstruction.

22 Q. Well, you mean there would not have  
23 been a shoulder dystocia?

24 A. More likely than not, I think the

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1 fundal pressure mimics the precipitous type  
2 delivery and again, did not allow the shoulders  
3 to rotate. And I think that is why I brought up  
4 the incidence of increased shoulder dystocia with  
5 precipitous labor. Fundal pressure does move the  
6 head through the pelvis too quickly, and again,  
7 makes a natural physiologic phenomenon of  
8 rotation of the shoulders beneath the pubis more  
9 difficult to accomplish before the delivery of  
10 the head.

11 Q. Do you believe you satisfactorily  
12 explained then the biomechanics of how this  
13 shoulder dystocia occurred in this case?

14 A. Yes. But I can't tell you that there  
15 could -- in the absence of shoulder dystocia --  
16 I'm sorry, in the absence of fundal pressure,  
17 there wouldn't have been any shoulder dystocia.  
18 I just, as I said earlier, I think it would be  
19 less -- it would have been less severe.

20 Q. And you're giving these opinions  
21 without knowledge of the number of variables that  
22 we discussed earlier as far as the pressure and  
23 the angles and things like that?

24 A. Yes.

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1 Q. When you say the shoulder dystocia  
2 would have been less severe, what do you mean?  
3 A. Well, if the shoulders had been  
4 allowed with a few extra pushes on the mother's  
5 part to rotate partly under the symphysis pubis,  
6 it would have been much less difficult for the  
7 obstetrician to get it to rotate the rest of the  
8 way beneath the symphysis pubis and the shoulders  
9 -- and the anterior shoulder may have been free  
10 just a little bit easier, just easy enough to  
11 avoid damage.  
12 Q. This opinion that you have that but  
13 for the fundal pressure that the -- and I may be  
14 paraphrasing, the anterior shoulder would have  
15 been able to rotate beneath the symphysis pubis,  
16 you don't have any basis for that other than your  
17 opinion; is that correct?  
18 A. Yes.  
19 Q. When did the head crown?  
20 A. I assume the head -- I have no  
21 incidents from the record of when the head was  
22 crowning, but we know that at 10:53, Dr. Patel  
23 ordered the patient prepped for delivery, and you  
24 would not order a patient prepped for delivery --

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1 a primigravida patient unless the head was  
2 crowning.  
3 Q. I'm looking at my notes, Doctor, and  
4 that's the reason for the silence.  
5 A. That's okay. I enjoyed taking a sip  
6 of my Coke and kind of catching my breath, too.  
7 (Whereupon, there was a discussion  
8 held off the record.)  
9 BY MR. SWITZER:  
10 Q. Do you know the position of the fetus'  
11 shoulders before the fundal pressure was applied?  
12 A. No, sir, I don't.  
13 Q. Which is the interior shoulder in this  
14 case, the right or the left?  
15 A. It should be the right shoulder. If  
16 there's a left occipital anterior, than the right  
17 shoulder is anterior.  
18 Q. Have we -- since it's your opinion, do  
19 you believe we satisfactorily explored the basis  
20 for your opinion on Page 1 of your report  
21 concerning the fundal pressure?  
22 A. Yes, sir.  
23 MR. MISHKIND: Show an objection, but his  
24 answer stands. That's okay.

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1 BY THE WITNESS:  
2 A. Yes, sir.  
3 BY MR. SWITZER:  
4 Q. And you really can't give us any  
5 information as to how far this fetus descended  
6 with the fundal pressure, correct?  
7 A. That's correct, sir.  
8 Q. And you can't give us an opinion  
9 whether or not this fundal pressure was effective  
10 helping the fetus to descend?  
11 A. Well, the only reason to give fundal  
12 pressure is to try to get the fetus to descend,  
13 but you're right, there was no measurement made  
14 of how much the fetus descended when the fundal  
15 pressure was given.  
16 Q. The --  
17 A. It's like saying, you know, when  
18 someone is punched, you know, how hard was the  
19 punch after the punch was given. You just don't  
20 know, but the person was still punched. There's  
21 a problem here.  
22 Q. How many times did Mrs. -- I'm sorry,  
23 I referred to her as Mrs. -- did Dawn Davis push  
24 after the fundal pressure was completed?

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1 A. Well, we know the fundal pressure was  
2 given at 11:08 and again at 11:13, and she  
3 delivered the baby's head at 11:20. I suppose I  
4 could look at the fetal -- no, I can't look at  
5 the fetal monitor strip because the toco was  
6 removed, but she was having contractions  
7 approximately every two to three minutes during  
8 that time interval, so therefore I would just --  
9 by the way the labor was going, I would assume  
10 that she pushed at least two or three times more  
11 prior to delivery of the head.  
12 I'm sorry, just as a comment, in  
13 the computerized notes made by Nurse Piscola,  
14 fundal pressure was given at 9:13, then she  
15 listed again pushing at 9:16 and pushing at 9:18,  
16 -- I'm sorry, I misspoke. Fundal pressure was  
17 given at 11:15. Then she mentioned pushing at  
18 11:16, again pushing at 11:18, and the next note  
19 at 11:20 is that the head was delivered. So, the  
20 patient probably pushed, as I said, twice more  
21 prior to delivery of the head.  
22 Q. Let me move on to what happened after  
23 the shoulder dystocia was encountered?  
24 A. Yes, sir.

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1 Q. Assuming you're aware by now that  
2 there's a discrepancy between what's recorded in  
3 the record and some of the deposition testimony?

4 A. So I'm aware.

5 Q. Let's just talk about the medical  
6 records and what's documented?

7 A. Okay.

8 Q. Do you have Dr. Patel's operative  
9 report or delivery record?

10 A. Yes, I do. I'm not sure I have it in  
11 front of me this moment.

12 Labor course -- you mean the labor  
13 course?

14 Q. The Labor and Delivery Summary, I'm  
15 sorry.

16 A. Yes, I have it in front of me, sir.

17 Q. Based upon Dr. Patel's description in  
18 this Labor and Delivery Summary, what she did  
19 after the shoulder dystocia was encountered, is  
20 it your opinion that what Dr. Patel described in  
21 that note was a deviation from the standard of  
22 care?

23 MR. MISHKIND: Objection, go ahead.

24 BY THE WITNESS:

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1 to alleviate the shoulder dystocia. If you try  
2 the first one for up to 30 seconds, possibly a  
3 minute without rapid resolution of the shoulder  
4 dystocia, you must go on to another method of  
5 relieving the shoulders.

6 If you just keep fundal -- I'm  
7 sorry, just keep suprapubic pressure and downward  
8 traction on the baby's head, with flexion of the  
9 legs as in McRoberts, and that's the only  
10 maneuver you use, and then eventually the  
11 shoulders are freed after 3 or 4 minutes of  
12 attempting this one maneuver, in my opinion, the  
13 maneuver's been attempted for too long and you're  
14 more likely than not going to sustain permanent  
15 injury.

16 BY MR. SWITZER:

17 Q. I think I better ask the question a  
18 different way then based on what you said.

19 A. Sure.

20 Q. What is your understanding of what  
21 Dr. Patel did to accomplish delivery of this baby  
22 after the shoulder dystocia was encountered?

23 MR. MISHKIND: Excuse me for one second.  
24 Don, you're talking about based upon the records

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1 A. I'm sorry, could you ask the question  
2 again, please?

3 BY MR. SWITZER:

4 Q. The manner in which Dr. Patel  
5 described how she delivered this baby after the  
6 shoulder dystocia was encountered, did that  
7 comply with the standard of care as set forth in  
8 the Labor and Delivery Summary?

9 MR. MISHKIND: Objection, go ahead.

10 BY THE WITNESS:

11 A. It complied with the standard of care  
12 insofar as the McRoberts maneuver with suprapubic  
13 pressure is an accepted first step toward the  
14 alleviation of a shoulder dystocia.

15 In my opinion, there was a  
16 significant time interval between delivery of the  
17 head and delivery of the baby which was  
18 approximately four minutes. Had there truly been  
19 a dystocia lasting four minutes, suprapubic  
20 pressure and the McRoberts maneuver were  
21 inappropriately applied for that length of time.

22 And the reason I say that is that  
23 when shoulder dystocia is encountered, there are  
24 several maneuvers that could be done -- attempted

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1 because if you -- you qualified your previous  
2 question that there's some discrepancy between  
3 the testimony. Is this question based solely on  
4 the records?

5 MR. SWITZER: Yes. I'm sorry, I wasn't  
6 clear.

7 BY MR. SWITZER:

8 Q. Yes, Doctor.

9 A. That the patient was placed in  
10 McRoberts position, that suprapubic pressure was  
11 given, and the baby's head -- I'm sorry, and the  
12 shoulder dystocia was alleviated.

13 Q. And you're saying if that indeed is  
14 what transpired in this case, that that did not  
15 comply with the standard of care?

16 A. What I'm saying to you is that if that  
17 transpired over a 4-minute period of time, that  
18 was an inappropriate length of time to try this  
19 one maneuver, and other maneuvers should have  
20 been attempted or at least documented to help  
21 relieve the shoulder dystocia. Because if  
22 McRoberts doesn't work almost immediately with  
23 suprapubic pressure, the only way to get it to  
24 work if it doesn't work is to pull harder on the

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1 baby's head. And in my opinion, this excessive  
2 lateral traction is what led to the damage to the  
3 infant.

4 Q. Well, didn't she extend the  
5 episiotomy?

6 A. Yes. And she said calling for help,  
7 extending the episiotomy all took her less than  
8 30 seconds. That's what she said in her  
9 deposition.

10 Q. The Apgars in this case were 7 and 8?

11 A. Yes, sir, they were.

12 Q. Those are good Apgars?

13 A. Sure. So obviously there was no  
14 urgent rush to get this baby delivered without  
15 applying excessive traction. The baby was doing  
16 just fine. The monitor indicated the baby was in  
17 no trouble, probably had a very good oxygen  
18 reserve, and though the shoulder dystocia lasted  
19 for 4 minutes, obviously the baby tolerated this  
20 very well.

21 Some things the baby didn't  
22 tolerate. It had bilateral pneumothoraces which  
23 were a life-threatening situation. I'm not a  
24 pediatrician, and I cannot tell you if these

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1 Q. Obviously we're talking about a  
2 brachial plexus injury here?

3 A. Yes, we are, sir.

4 Q. Is it your opinion in this case that  
5 brachial plexus -- permanent brachial plexus  
6 injuries do not occur following shoulder dystocia  
7 other than in the setting of excessive lateral  
8 traction?

9 A. Basically, yes. However, when there's  
10 a life-threatening situation on the part of the  
11 fetus, it is entirely acceptable to apply force  
12 to deliver the baby so the baby is born without  
13 significant central nervous system damage.

14 In this case there was no reason  
15 to apply excessive force. Baby was doing just  
16 fine for those few minutes, and certainly other  
17 maneuvers to more gently free the shoulders could  
18 have been attempted and were not used.

19 In fact, Dr. Patel in her  
20 deposition said she had never used any other  
21 procedure ever to free shoulder dystocia in all  
22 of her experience. And so, she only could use,  
23 because she had no experience, she only could use  
24 the McRoberts, and in my opinion the McRoberts

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1 pneumothoraces -- bilateral pneumothoraces that  
2 the baby encountered were in any way related to  
3 the shoulder dystocia. I would certainly defer  
4 to a neonatologist or a pediatric expert to speak  
5 to that.

6 Q. Tell me what evidence you have in this  
7 case that Dr. Patel applied excessive traction?

8 A. In my opinion, the shoulder dystocia  
9 was relieved in here with the McRoberts maneuver  
10 and the baby immediately showed evidence of  
11 significant weakness of the right shoulder. This  
12 has proved to be a total avulsion of the nerve  
13 roots, making this a permanent injury. And this  
14 permanent injury in my opinion, in this scenario,  
15 would only occur with excessive lateral traction  
16 on the fetal head.

17 It's my opinion that the shoulder  
18 dystocia was relieved with the McRoberts  
19 maneuver, but also Dr. Patel applying excessive  
20 lateral traction to the fetal head avulsing the  
21 nerve roots causing the permanent damage.

22 Q. Do you consider yourself to be an  
23 expert in neurology?

24 A. Oh, absolutely not.

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1 maneuver was inadequate for gently freeing the  
2 shoulders without causing damage.

3 Q. Would you tell me what in your opinion  
4 Dr. Patel should have done following the  
5 McRoberts procedure or maneuver?

6 A. Yes, sir. Had she appropriately  
7 applied the McRoberts position, and with the use  
8 of suprapubic pressure, if within 15 to 30  
9 seconds there was no freeing of the anterior  
10 shoulder, in my opinion, she should have put her  
11 hand into the vagina behind the anterior shoulder  
12 and attempted manually to dislodge the shoulder  
13 by rotating it from underneath the pubis.

14 Had that been unsuccessful, she  
15 could have tried the entire Woods Screw maneuver  
16 which involves rotating the baby 180 degrees so  
17 the anterior shoulder becomes the posterior  
18 shoulder, and in doing so, relieves the impaction  
19 and allows the shoulders to deliver.

20 Had that been unsuccessful, then  
21 she could have proceeded to try to deliver the  
22 posterior shoulder first and -- I'm sorry,  
23 deliver the arm, posterior arm first, thereby  
24 relieving the posterior shoulder allowing it to

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1 deliver, then allowing the baby to deliver  
2 easily.

3 Had that not been successful, she  
4 could have attempted the reverse of the Woods  
5 Screw maneuver, which is turning the baby the  
6 other way, in other words, pushing on the  
7 anterior part of the shoulder trying to rotate  
8 the shoulder.

9 And had that yet not been  
10 successful, then she could have attempted other  
11 methods such as try to fracture the clavicle.

12 But in my opinion because the  
13 McRoberts maneuver was eventually successful in  
14 delivering the baby, had she simply put her hand  
15 in the vagina and rotated the shoulder manually  
16 from behind the pubis, this baby could have been  
17 delivered easily, and in my opinion,  
18 atraumatically.

19 Q. What do you mean atraumatically?

20 A. Without causing trauma to the baby.

21 Q. You mean without any permanent  
22 brachial plexus injury?

23 A. Yes, sir.

24 Q. Do you believe you're qualified to

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1 of time, my feeling is that this excessive  
2 traction from the McRoberts caused the brachial  
3 plexus injury. That it's permanent is testament  
4 to the amount of excessive lateral traction that  
5 was applied.

6 Q. How was the traction applied in this  
7 case?

8 A. Well, we know that the physician  
9 always would support the fetal head. We also  
10 know that the pediatrician noticed significant  
11 bruising of the fetal face and head at time of  
12 the initial exam.

13 And I think in my opinion, the  
14 bruising of the fetal head, the continuous  
15 formation -- the continuous application of  
16 traction during the McRoberts maneuver led to the  
17 excessive lateral traction which caused the  
18 brachial plexus injury.

19 There was certainly no injury to  
20 this fetus on the fetus' shoulder prior to  
21 impaction of the shoulders. And the only way  
22 that after shoulder impaction that there is a  
23 permanent injury is with excessive lateral  
24 traction.

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1 give opinions in this case as to the cause of the  
2 permanent brachial plexus injury?

3 A. Yes, sir.

4 MR. MISHKIND: Don, excuse me for one  
5 second. I need to use the mens room. Would now  
6 be a good time to take a break?

7 MR. SWITZER: Sure, go ahead.

8 (WHEREUPON, a short break was  
9 taken.)

10 MR. SWITZER: Would you read back my last  
11 question?

12 (WHEREUPON, the record was  
13 read by the reporter as  
14 requested.)

15 BY MR. SWITZER:

16 Q. Why?

17 A. Because in my opinion, with the rapid  
18 delivery of the baby after the shoulder was  
19 released, the size of the baby, the normal  
20 descent of the fetal head, you would have  
21 expected any shoulder dystocia to be minimal in  
22 this case, and it was relieved with the use of  
23 McRoberts maneuver only, even though in my  
24 opinion, applied for an excessively long period

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1 Now this sometimes could be caused  
2 by the mother pushing so hard at that time to  
3 cause the neck to stretch, but in this case there  
4 was an epidural on board, the patient had control  
5 of her pushing or not pushing, and in fact, the  
6 physicians wanted her to push harder or they  
7 wouldn't have ordered fundal pressure. So, in  
8 any instance there was no question that it wasn't  
9 excessive force on the part of the mother that  
10 caused it. It had to be excessive force on the  
11 part of the physician.

12 Q. If Dr. Patel used what she believed to  
13 have been gentle traction to deliver -- to try to  
14 deliver the baby once the shoulder dystocia was  
15 encountered, do you then rule out that gentle  
16 traction from an obstetrician can still result in  
17 a permanent brachial plexus injury?

18 MR. MISHKIND: Objection to the question, the  
19 form of the question, and the hypothetical, but  
20 go ahead and answer the question anyway.

21 BY THE WITNESS:

22 A. I feel that Dr. Patel may have felt  
23 she was giving gentle traction, but in fact, in  
24 the anxiety produced by shoulder dystocia in my



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1 opinion, she applied more than gentle traction  
 2 and, in fact, caused damage to the baby.  
 3 BY MR. SWITZER:  
 4 Q. Is there a difference between gentle  
 5 traction from an obstetrical standpoint and  
 6 excessive traction from a neurological standpoint  
 7 on the brachial plexus nerves?  
 8 A. I imagine there is. I don't know any  
 9 way to describe to somebody how hard you can  
 10 depress baby's head to try the shoulders to  
 11 deliver. It's a matter of experience. But I will  
 12 tell you that at times of shoulder dystocia,  
 13 that's an obstetric emergency, and things happen  
 14 in a rapid type fashion with lots of anxiety and  
 15 angst on the part of all the people in the room,  
 16 especially the obstetrician.  
 17 And that's when excessive force is  
 18 used on a baby's head which causes excessive  
 19 stretching of the neck with a trapped shoulder  
 20 that causes damage to the shoulder. In my  
 21 opinion, that's exactly the mechanism that  
 22 happened in this case.  
 23 Q. Have you written any publications on  
 24 shoulder dystocia?

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1 A. Not specifically for this case.  
 2 Q. I'm sorry. My question wasn't clear.  
 3 Have you ever written any publications --  
 4 A. Oh, written any? No, sir, I have not.  
 5 Q. -- regarding shoulder dystocia?  
 6 A. No, sir, I have not.  
 7 Q. How about on brachial plexus injuries?  
 8 A. No, sir.  
 9 Q. I'm still going to come back and maybe  
 10 you've answered the question, if so, just go  
 11 ahead and tell me because I still want to try and  
 12 understand why you believe you're qualified to  
 13 give an opinion that this child suffered a  
 14 permanent brachial plexus injury to those nerves  
 15 based on what you believe was excessive lateral  
 16 traction by Dr. Patel during the delivery  
 17 process.  
 18 I mean, that sounds like a  
 19 neurological opinion to me, and that's why I'm  
 20 asking you as an obstetrician?  
 21 A. Well, as an obstetrician, we're taught  
 22 how to deliver babies, and if you pull too hard  
 23 on a baby's head, you stretch the neck and can  
 24 cause damage.

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1 The only way this baby's neck --  
 2 I'm sorry brachial plexus, in my opinion, could  
 3 have been damaged with the scenarios we give here  
 4 is with excessive lateral traction. That's the  
 5 only thing that could do it.  
 6 Now, if the head was -- if the  
 7 shoulders were trapped, mother was uncontrollably  
 8 pushing, and the obstetrician was saying don't  
 9 push, then we could say, well, it was her  
 10 excessive pushing in the wrong scenario. But we  
 11 don't have that here. We have the shoulders  
 12 being trapped, the obstetrician recognizing it,  
 13 saying this is a shoulder dystocia, and then  
 14 using maneuvers to try and relieve this dystocia  
 15 without any participation on the part of the  
 16 mother of pushing this baby out in an appropriate  
 17 manner.  
 18 The only way the baby could have  
 19 been damaged in my opinion is by excessive  
 20 lateral traction on the basis of the  
 21 obstetrician, not on the basis of uncontrollable  
 22 pushing on the part of the mother with a trapped  
 23 shoulder.  
 24 I don't know how else to say it,

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1 sir.  
 2 Q. Okay.  
 3 MR. MISHKIND: Hey, Don, off the record.  
 4 (WHEREUPON, there was a discussion  
 5 held off the record.)  
 6 BY MR. SWITZER:  
 7 Q. Let me just ask a follow-up question.  
 8 Doctor, obviously, I have your report, and you've  
 9 given opinions about the fundal pressure, and  
 10 you've given opinions about what transpired after  
 11 the shoulder dystocia was encountered.  
 12 A. Yes, sir.  
 13 Q. And I'm just assuming that if the  
 14 witnesses and the appearance of whoever's  
 15 testimony is believed about the fundal pressure  
 16 being applied after the shoulder dystocia was  
 17 encountered, you're going to find that a  
 18 deviation of the standard of care?  
 19 A. Without question.  
 20 Q. Okay. I'm assuming that. Taking all  
 21 of those into consideration, have we covered all  
 22 the opinions with respect to the deviations in  
 23 the standard of care that you believe exist in  
 24 this case?



|  |   |
|--|---|
| <p style="text-align: right;">Page 65</p> <p>1 A. Yes, sir.</p> <p>2 MR. MISHKIND: Objection.</p> <p>3 BY THE WITNESS:</p> <p>4 A. Oh, I'm sorry. Yes, sir.</p> <p>5 BY MR. SWITZER:</p> <p>6 Q. Let me just ask a few questions real</p> <p>7 quickly because I've never been involved in a</p> <p>8 case with you before.</p> <p>9 A. Yes, sir.</p> <p>10 Q. Have you reviewed other malpractice</p> <p>11 cases for Mr. Mishkind or his law firm?</p> <p>12 A. No, sir, I have not.</p> <p>13 Q. Do you advertise your services?</p> <p>14 A. No, sir, I don't.</p> <p>15 Q. How many cases approximately do you</p> <p>16 review on an annual basis?</p> <p>17 A. Probably one or two new cases per</p> <p>18 month.</p> <p>19 Q. Do you know how it came to be that</p> <p>20 Mr. Mishkind learned about your existence?</p> <p>21 A. I don't know at all, sir. I have no</p> <p>22 clue.</p> <p>23 Q. Maybe he just likes to go to Chicago?</p> <p>24 A. I don't blame him. It's beautiful</p> | <p style="text-align: right;">Page 67</p> <p>1 BY THE WITNESS:</p> <p>2 A. Yes. Once it was for a woman who I</p> <p>3 did a hysterectomy on and she developed an</p> <p>4 ovarian cyst after the hysterectomy.</p> <p>5 BY MR. SWITZER:</p> <p>6 Q. Okay. That's fine. Next one?</p> <p>7 A. I'm sorry.</p> <p>8 Q. I told you just three words?</p> <p>9 A. All right. Once it was for a woman I</p> <p>10 did a hysterectomy on, and she developed a</p> <p>11 vesicle vaginal fistula.</p> <p>12 Q. Okay. Next one?</p> <p>13 A. And the third one, the only one where</p> <p>14 money was paid, was where a woman sued me because</p> <p>15 she developed an intra-abdominal infection after</p> <p>16 a tubal ligation.</p> <p>17 Q. Okay. Thank you, Doctor.</p> <p>18 A. You're welcome, sir.</p> <p>19 Q. I told you that was quick.</p> <p>20 A. Yes.</p> <p>21 Q. Tell me in the cases that you</p> <p>22 reviewed, is there any breakdown percentage-wise</p> <p>23 between the ones you review on behalf of the</p> <p>24 plaintiffs or the patients versus doctors or</p> |
| <p style="text-align: right;">Page 66</p> <p>1 here.</p> <p>2 Q. Have you ever been sued for</p> <p>3 malpractice?</p> <p>4 A. Yes.</p> <p>5 MR. MISHKIND: Objection.</p> <p>6 BY THE WITNESS:</p> <p>7 A. Yes, I have.</p> <p>8 MR. SWITZER: Are we --</p> <p>9 MR. MISHKIND: I objected and his answer was</p> <p>10 yes, he has.</p> <p>11 BY MR. SWITZER:</p> <p>12 Q. Okay. I said how many times?</p> <p>13 MR. MISHKIND: Oh, we didn't hear that one.</p> <p>14 Even the court reporter didn't hear that.</p> <p>15 BY THE WITNESS:</p> <p>16 A. We didn't hear that part.</p> <p>17 I've been sued three times over</p> <p>18 the past 32 years.</p> <p>19 BY MR. SWITZER:</p> <p>20 Q. And just in a two or three word</p> <p>21 description, can you tell me the claim in each</p> <p>22 case?</p> <p>23 MR. MISHKIND: Just show a continuing line of</p> <p>24 objection to that question. Go ahead.</p>  | <p style="text-align: right;">Page 68</p> <p>1 hospitals?</p> <p>2 A. It works out -- I used to think it was</p> <p>3 50/50, but more recently it's been 60/40 in favor</p> <p>4 of the defense.</p> <p>5 Q. Okay. How many depositions do you</p> <p>6 generally give on an annual basis?</p> <p>7 A. Oh, probably one per month at most.</p> <p>8 Q. What do you charge?</p> <p>9 A. \$300 an hour.</p> <p>10 MR. SWITZER: I don't know if we paid you yet</p> <p>11 or not.</p> <p>12 MR. MISHKIND: You haven't.</p> <p>13 MR. SWITZER: Okay.</p> <p>14 (WHEREUPON, a discussion</p> <p>15 was had off the record.)</p> <p>16 MR. SWITZER: Let me turn the questioning</p> <p>17 over to Carol because I know Howard is getting</p> <p>18 antsy there.</p> <p>19 EXAMINATION</p> <p>20 BY MS. METZ:</p> <p>21 Q. You said you were sued three times.</p> <p>22 A. Yes.</p> <p>23 Q. Were you by chance involved in the</p> <p>24 Supreme Court case, Williams v. Zbaraz?</p>   |

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1 A. Sure, but that was a civil action  
2 where I initially sued the State of Illinois for  
3 not allowing there to be monies paid for elective  
4 termination of pregnancy to people on Medicare --  
5 I'm sorry, on Medicaid. And when we won in the  
6 State of Illinois, it was appealed to the Supreme  
7 Court and then it was Supreme Court versus David  
8 Zbaraz, so it got reversed, so I don't know how  
9 to put that one, but it was a civil suit through  
10 the ACLU.

11 Q. Okay.

12 A. That wasn't a malpractice suit.

13 Q. I know. I was just wondering if that  
14 was you. I'm sorry.

15 A. Yes, it was me.

16 Q. With respect, if I understand your  
17 opinion correctly, you feel that Dr. Patel fell  
18 below the standard of care by not attempting  
19 other methods to relieve the shoulder dystocia.

20 If there were other methods that  
21 were attempted, do you still feel that her  
22 actions fell below the standard of care?

23 MR. MISHKIND: Objection.

24 BY THE WITNESS:

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1 A. In that hypothetical, if there were  
2 other actions that were attempted, they certainly  
3 didn't come out in her deposition, nor in the  
4 record in the hospital. And if she suddenly  
5 remembers other things that she did, I'd view  
6 them with a grain of salt, that someone should  
7 remember them several years after the fact.

8 However, nothing was mentioned  
9 about that, and before I could offer an opinion,  
10 I would have to hear how she did it and in what  
11 manner and for what reason.

12 BY MS. METZ:

13 Q. But if I understand you correctly, one  
14 of your criticisms of Dr. Patel was that she did  
15 the McRoberts maneuver with the suprapubic  
16 pressure for too long of a time, that she did not  
17 move into other methods; is that correct?

18 A. Yes, ma'am.

19 As I said in my opinion, if the  
20 McRoberts with suprapubic pressure is not almost  
21 immediately effective within 15, 30 seconds, 45  
22 seconds at the outside, then the only way to make  
23 it successful is to pull harder on the head. And  
24 in my opinion, that's exactly what happened, that

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1 there was excessive downward traction on the head  
2 which led to injury to the anterior shoulder.

3 Q. Outside of the length of time that you  
4 feel it was applied, do you feel applying the  
5 suprapubic pressure and the McRoberts maneuver  
6 was below the standard of care?

7 MR. MISHKIND: Objection. Go ahead, Doctor.

8 BY THE WITNESS:

9 A. No, I don't.

10 BY MS. METZ:

11 Q. And I assume you don't feel that the  
12 extension of the episiotomy was below the  
13 standard of care?

14 A. That's correct.

15 MR. MISHKIND: Carol, hold on one second.  
16 Someone just knocked at the door.

17 (Brief interruption.)

18 THE WITNESS: My partner, being nosy, put his  
19 head in the door. Go ahead, I'm sorry.

20 MR. MISHKIND: Go ahead, Carol.

21 BY MS. METZ:

22 Q. Did you answer the question about the  
23 episiotomy?

24 A. I feel that it was entirely

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1 appropriate to extend the episiotomy, yes.

2 Q. And if I understand your testimony  
3 right, you feel there is no other reason outside  
4 of excessive traction that could have led to this  
5 type of injury?

6 MR. MISHKIND: Objection. Go ahead.

7 BY THE WITNESS:

8 A. In this case, from the details given  
9 to me, I think that excessive traction was the  
10 etiology of the injury to the fetus -- to the  
11 infant, I'm sorry.

12 BY MS. METZ:

13 Q. And I'm sorry, could you just tell me  
14 what details that you're basing this opinion on?

15 A. The total control of the pushing  
16 process of the mother by the obstetrician, the  
17 use of fundal pressure, in my opinion,  
18 inappropriately during the latter part of the  
19 second stage of labor without evidence of  
20 exhaustion on the part of the mother and without  
21 any evidence of a prolonged second stage, the use  
22 of the McRoberts and suprapubic pressure maneuver  
23 to the exclusion of anything else for a  
24 significant length of time, and the obvious

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1 IN THE COURT OF COMMON PLEAS  
 2 CUYAHOGA COUNTY, OHIO  
 3 CHARLES TENNEY, III, Etc., )  
 4 et. al., )  
 5 Plaintiffs, )  
 6 vs. ) No. 448548  
 7 URMILA PATEL, M.D., et. al.,)  
 8 Defendants. )  
 9 I hereby certify that I have read the  
 10 foregoing transcript of my deposition given at  
 11 the time and place aforesaid, consisting of Pages  
 12 1 through 76, inclusive, and I do again subscribe  
 13 and make oath that the same is a true, correct  
 14 and complete transcript of my deposition so given  
 15 as aforesaid, and includes changes, if any, so  
 16 made by me.  
 17 \_\_\_\_\_  
 18 DAVID ZBARAZ, M.D.,  
 19 SUBSCRIBED and sworn to  
 20 before me this \_\_\_\_ day of  
 21 \_\_\_\_\_, 2002.  
 22 \_\_\_\_\_  
 23 Notary Public  
 24

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1 IN WITNESS WHEREOF, I do hereunto set my  
 2 hand and affix my seal of office at Chicago,  
 3 Illinois, this \_\_\_\_ day of  
 4 \_\_\_\_\_, 2002.  
 5 \_\_\_\_\_  
 6  
 7 Notary Public, Lake County, Illinois  
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1 STATE OF ILLINOIS )  
 2 )  
 3 COUNTY OF L A K E )  
 4 I, JUDY ANN MAATMAN, a Notary Public  
 5 within and for the County of Lake, State of  
 6 Illinois, and a Certified Shorthand Reporter of  
 7 said state, do hereby certify:  
 8 That previous to the commencement of the  
 9 examination of the witness, DAVID ZBARAZ, M.D.,  
 10 he was first duly sworn to testify to the whole  
 11 truth concerning the matters herein;  
 12 That the foregoing deposition transcript was  
 13 reported stenographically by me, was thereafter  
 14 reduced to typewriting via computer-aided  
 15 transcription under my personal direction, and  
 16 constitutes a true record of the testimony given  
 17 and the proceedings had;  
 18 That the said deposition was taken before me  
 19 at the time and place specified;  
 20 That I am not a relative or employee of  
 21 attorney or counsel, nor a relative or employee  
 22 of such attorney or counsel for any of the  
 23 parties hereto, nor interested directly or  
 24 indirectly in the outcome of this action.

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1 bruising appearance of the baby's face which, in  
2 my opinion, coincided with the excessive  
3 manipulation of the head on the part of the  
4 obstetrician.

5 Q. Have you ever testified in a trial  
6 before, Doctor?

7 A. Yes.

8 Q. In those cases that you review,  
9 approximately how many result in your testifying  
10 at trial?

11 A. Oh, very, very few. I probably  
12 testify in trial once or twice per year.

13 Q. Have you ever given a deposition or  
14 testified at trial in a case involving shoulder  
15 dystocia?

16 A. Not that I recall. Not in the recent  
17 past that I recall.

18 MS. METZ: I have no further questions.

19 THE WITNESS: It was nice to talk to you,  
20 Miss Metz.

21 MR. SWITZER: I have a few more questions,  
22 Doctor.

23 FURTHER EXAMINATION

24 BY MR. SWITZER:

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1 That probably would be easier, if I can. Let's  
2 separate them. Just based on the records.

3 A. I have nothing in the records that I  
4 would fault the nurses for in the conduct of the  
5 resolution of the shoulder dystocia.

6 Q. Let's talk -- let's incorporate the  
7 deposition testimony.

8 A. From the deposition testimony, and  
9 I've read the deposition of the mother, and I've  
10 read the deposition of Charles Tenney, Jr., I  
11 have not read the deposition which I know have  
12 been taken of the parents of the patient, and I  
13 am not familiar with their deposition at all, I  
14 haven't read them, but it would seem from reading  
15 those depositions, that, in fact, there was  
16 significant fundal pressure applied after  
17 delivery of the head, prior to delivery of the  
18 shoulders, and that, in fact, the nurse was on  
19 top of the bed, straddling the patient, pushing  
20 on the fundus when the shoulders had been -- had  
21 been found to be impacted.

22 In that case, it's my opinion that  
23 every well-qualified obstetric nurse should know  
24 that applying fundal pressure with the -- in the

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1 Q. Let me talk about the nurses for the  
2 hospital who I represent.

3 A. Sure.

4 Q. If the nurses -- I want you to assume  
5 that if the nurses applied this fundal pressure  
6 that we discussed before the shoulder dystocia at  
7 the request of Dr. Patel, would you be critical  
8 of the nurses in that scenario?

9 MR. MISHKIND: Objection, but go ahead and  
10 answer the question.

11 BY THE WITNESS:

12 A. No, I would not.

13 BY MR. SWITZER:

14 Q. And assuming that the nurses -- well  
15 let me talk about then the post-shoulder  
16 dystocia. I'm assuming that -- well, let me ask  
17 you this: Under what scenario would you be  
18 critical of the nurses in this hospital for the  
19 post-shoulder dystocia maneuvers here?

20 MR. MISHKIND: Are you talking about based  
21 upon the records or including the deposition  
22 testimony?

23 BY MR. SWITZER:

24 Q. Well maybe we better separate them.

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1 treatment of shoulder dystocia is inappropriate,  
2 contraindicated, and below the standard of care.

3 Q. Except in that limited instance that  
4 you talked about earlier?

5 A. Yes, sir.

6 MR. SWITZER: Okay. Thank you very much,  
7 Doctor.

8 THE WITNESS: My pleasure. It's nice to talk  
9 to you, sir.

10 MR. MISHKIND: Don, just for the record, I  
11 talked to the Doctor before the deposition and  
12 his preference is to read the deposition  
13 transcript. So there will be no waiver.

14 MR. SWITZER: That's fine.

15 MR. MISHKIND: I will provide him -- one way  
16 or another, we'll get the transcript to him for  
17 purposes of reading and signature.

18 MR. SWITZER: However you want to handle  
19 that, and Judy, why don't you go ahead and type  
20 them up and send them to me right away.

21 (Witness excused.)

22

23

24

|                         |                         |                         |                        |                         |                        |
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