IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
CHARLES TENNEY, III, Etc.,)
et al.,)
Plaintiffs,)
vs.) No. 448548
URMILA PATEL, M.D., et. al.,)
Defendants.)

The deposition of DAVID ZBARAZ, M.D., called by the Defendant for examination, taken pursuant to notice and pursuant to the provisions of the Code of Civil Procedure and the Rules of the Supreme Court of the State of Ohio pertaining to the taking of depositions for the purpose of discovery, taken before JUDY ANN MAATMAN, a Notary Public within and for the County of Lake, State of Illinois, and a Certified Shorthand Reporter of said state, at 1535 Lake Cook Road, Suite 502, Northbrook, Illinois, on the 25th day of November, 2002 at 3:00 pm.

APPEARANCES:
BECKER & MISHKIND CO., L.P.A.,
(Skylight Office Tower,
1660 W. 2nd Street,
Suite 660,
Cleveland, OH 44113,
(216) 241-2600), by:
MR. HOWARD D. MISHKIND,
Appeared on behalf of the Plaintiff;

WESTON HURD FALLON PAISLEY & HOWLEY,
(2500 Terminal Tower,
50 Public Square,
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(216) 241-6602), by:
MS. CAROL METZ,
Appeared on behalf of the Defendant,
Urmila Patel, M.D.;

APPEARANCES (CONT'D)
BONEZZI SWITZER MURPHY & POLITO CO LPA,
(1400 Leader Building,
526 Superior Avenue,
Cleveland, Ohio 44114,
(216) 875-2767), by:
MR. DONALD H. SWITZER,
Appeared on behalf of the Defendant,
Southwest General Health Center.

REPORTED BY:

Judy Ann Maatman, CSR
License No. 084-002498.

(WHEREUPON, the witness was duly sworn.)

DAVID ZBARAZ, M.D.,
called as a witness herein by the Defendant, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. SWITZER:

Q. Doctor, my name is Don Switzer. I represent Southwest General Health Center. I'm going to ask you the questions first.

Since we're doing this by telephone, obviously you and I both need to make sure that the other person finishes speaking before we start talking or else we'll be cut out.

If you don't hear me at any time, please let me know and I'll repeat the question.

A. That's fair.

Q. All right. Doctor, I do have a report that you authored, I believe it's July 2, 2002?

A. Yes, sir.

Q. Is that the only report or letter that you've prepared setting forth your opinions in

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this case?
A. Yes, it is.
Q. Do you have any notes that you've prepared as you've gone through and reviewed this case?
A. Yes, I do.
Q. How many pages of notes do you have?
A. I have three pages of notes.
Q. Okay.
A. And I'll be happy to make a copy for the court reporter to attach to the deposition transcript.
MR. SWITZER: Great. Can you just mark -- let's mark that Exhibit A.
THE WITNESS: I'll give them to her now.
(WHEREUPON, said document was marked Zbaraz Deposition Exhibit No. A, for identification, as of 11/25/02.)
BY MR. SWITZER:
Q. Doctor, when did you prepare those notes?
A. I prepared them contemporaneously with

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

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

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

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I don't know what else to say about myself, but go ahead and ask the questions.
Q. How many deliveries did you personally perform --
A. In my career?
Q. No. I haven't finished the question yet.
A. Oh, okay.
Q. -- for each of the years starting with 1999?
A. 1999.
Q. I mean a range. I'm sure you may have the exact numbers, some doctors do.
A. I wish I was that compulsive, but I'm not. And I would say I probably do, in 1999 until around this year, probably about a hundred deliveries a year now.
Q. What's your incidence of shoulder dystocia?
A. I can't tell you with any degree of certainty, but I think it probably approximates a national average of somewhere under one percent.
Q. You say you teach -- you teach residents or medical students?

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A. Both.
Q. Do you have your residents and medical students read any textbooks on obstetrics?
A. Not specifically, but they invariably do read in obstetrics. They're encouraged to read.
If you're looking for a relatively authoritative text in obstetrics, you can use Williams in a current edition, for whatever time frame you want for this case. I won't tell you that all of Williams is authoritative, but it's as good a text as you'll find, and the majority of it certainly is authoritative.
Q. You're a member of ACOG, I assume?
A. Yes, sir.
Q. Are you a fellow?
A. Yes, sir.
Q. They have publications on shoulder dystocia, don't they?
A. Yes, they do.
Q. Do you consider those publications to be authoritative?
A. In general, yes.
Q. Have you -- you may have told me this

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and I probably wasn't listening, did you review any of the reports of the other experts in the case?
A. I was sent reports of several experts, but I'm trying to remember their names.
One was a Dr. Pettit, it was a letter forwarded to me from a Dr. George Pettit. Another -- I'm sorry, I don't have these organized well.
There were several other experts on your side whose letters I read, and I just don't -- they should be in --
Q. Let me -- I want to ask you if you know any of these other experts.
A. Oh, go ahead.
Q. Let me just give you the names and let me know if you know them?
A. Okay.
Q. Joanne Zelten, she's an RN, I believe, from the Chicago area?
A. No, I don't.
Q. Dr. David -- I'm torturing his name, Simckes, S-i-m-c-k-e-s?
A. No, sir, I don't.

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Q. Dr. James O'Leary?
A. James O'Leary, I've heard his name. I don't know him personally.
Q. How have you heard his name?
A. Well, I've read some literature that he's put out. And I think I -- at home I have his book.
Q. What book is that?
A. A book on shoulder dystocia.
Q. Is that a textbook?
A. Yes.
Q. Did you have that before you became involved in this case?
A. Oh, yeah, I've had it for years.
Q. Oh, okay. So it's an old book?
A. Yeah. I'm kind of an old guy, so I guess I have old books, but, yes.
Q. Old guys can write new books.
A. That's true.
Q. Have you reviewed any other publications by Dr. O'Leary?
A. Not that I recall.
Q. Okay. Do you consider him to be an authority on shoulder dystocia?

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A. Dr. O'Leary considers himself to be an authority, and I wouldn't want to doubt him.
Q. Well, we mentioned Pettit. Do you know Dr. Pettit?
A. No, sir, I don't.
Q. How about Dr. Duchon?
A. No, sir.
Q. Dr. Burkons?
A. No.
Q. Dr. Gimovsky?
A. No.
Q. Let me ask you some questions about the case if we can.
Do you consider -- we'll refer to the baby as Charlie, if we can, for the purposes of the deposition.
A. All right.
Q. And Charles as the father?
A. Yes.
Q. Do you consider Charlie to have been a macrosomic baby?
A. Charlie, at delivery, weighed 9 pounds and 13 ounces. So he was borderline macrosomic, yes.

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Q. What is your cutoff -- what is the cutoff you use for macrosomic?
A. Above 4500 grams.
Q. So he was just beneath that?
A. Yes, sir. I think -- I didn't -- 9.13, I didn't calculate it exactly in grams, but I think it's very close.
Q. I think it's -- and don't take my math as being correct, Doctor, I think it's -- I came up with 4455.
A. Yeah, that seems like a reasonable number.
Q. What are the risk factors in general for macrosomia?
A. Well, you might have cephalopelvic disproportion, in which case the baby wouldn't pass through the pelvis and would require a cesarean section. You can have -- you'd have mid pelvic arrest with a macrosomic infant which would require an operative delivery either by forceps or vacuum.
But in our case today you can also have delivery of the head and with a macrosomic infant, difficulty with delivery of the

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shoulders.
Macrosomic infants after delivery sometimes have increased problems with regulation of blood sugar, and certainly because they're macrosomic, if it's recognized prior to delivery, on occasion you might even recommend that a patient undergo cesarean section if you think there's some risk in attempting to deliver this size baby from below.
Q. Is cephalopelvic disproportion involved in this case?
A. No, sir, it isn't.
Q. Let me back up a minute. Did Dawn Davis have any risk factors for macrosomia?
A. The only one I'm aware of is that she gained about 50 pounds during her pregnancy, but she was not diabetic, and I don't recall there being any strong family history of diabetes. But in any event, I think the only risk factor I know for macrosomia for her would be excessive weight gain.
Q. Is macrosomia predictable with any degree of probability?
A. No, probably not. It is if a patient

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is diabetic and you truly expect a large infant. But very frequently it's difficult to ascertain the difference in palpation between a baby that weighs 8 pounds and a baby that weighs 9 and a half pounds. It's just not that accurate.
Ultrasound can be used to try and ascertain fetal weight, but the formulas just aren't very accurate, and they're not used to determine macrosomia except when there's a really markedly macrosomic infant.
Q. Let me talk about shoulder dystocia if I can.
A. Sure.
Q. Did Dawn Davis have any risk factors for shoulder dystocia?
A. Only her short stature. She stood about, if I remember correctly, 5'1" inches tall -- yes, she was 5'1" inches tall, and at the end of her pregnancy weighed 198 pounds, so you'd be concerned about her short stature. You'd be concerned about the size of her pelvis, and you might be concerned because of the excessive weight gain if there would be any soft tissue dystocia.

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Q. Is shoulder dystocia predictable with any degree of probability?
A. Not really. The majority of shoulder dystocia occurs in babies that are not excessively heavy. Certainly we expect it in a macrosomic infant, but it frequently can be unpredictable and occur even in a normal weighted infant.
Q. Why is that?
A. Because the shoulder dystocia is a response to the baby's shoulder being caught behind the symphysis pubis, not allowing the shoulder to deliver easily after the baby's head is delivered. This can occur even in a non-macrosomic infant sometimes depending on the rapidity of the descent of the fetus.
It is well-known to occur in normal size fetuses, especially in precipitous labors, labors that occur very quickly that don't allow the baby's shoulders to rotate out of the axis -- the entry or posterior axis and therefore, get caught behind the symphysis pubis.
The majority of shoulder dystocia

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is not predictable. It comes unexpectedly and every obstetrician has to be aware of its possibility and have significant knowledge in the way to handle it safely for the mother and fetus.
Q. This was not a precipitous delivery here, was it?
A. No, it wasn't a precipitous delivery.
Q. I mean labor, I'm sorry.
A. Right. That's exactly true. It wasn't a precipitous labor.
Q. Does the standard of care require an automatic C-section if shoulder dystocia is anticipated?
A. It would depend on the communication between the physician and the patient. If a woman had had previous shoulder dystocia, and now is pregnant again and the baby is as big or bigger, the mother certainly should be apprised that this could be a situation that might occur again, and she should be given the option of delivering via cesarean section.
In this case, though it was known to be a good-sized infant, it was not -- I saw no

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indication that a macrosomic infant was anticipated. And in my opinion, if you don't know for sure, it is certainly acceptable to allow labor to progress and intervene surgically if, in fact, an arrest of labor occurs and the head doesn't -- does not descend.
Q. I'd like to ask you a few questions about brachial plexus injuries.
A. Yes, sir.
Q. In general.
A. Yes.
Q. Are there any figures that you are aware of, statistics indicating what percentage of children with permanent brachial plexus injuries on one or the other side of their body are as a result of -- Let me withdraw the question. It wasn't going to make any sense.
A. It's okay. I was losing you anyway.
Q. I lost myself in that question.
MR. MISHKIND: Can I join in on that loss?
BY MR. SWITZER:
Q. Yes. Let me back up and ask it the right way.
What percentage of babies who are

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born following shoulder dystocia being encountered during the delivery process end up having some type of brachial plexus injury?
A. Probably around 10 to 15 percent in my -- from my recollection of statistics, 10 to 15 percent of bracial -- I'm sorry, 10 to 15 percent of shoulder dystocia may result in a brachial plexus or Erb's type palsy. Now the majority of these are resolved spontaneously. In other words, they go away with no treatment in a relatively short amount of time.
About 10 percent of these brachial plexus injuries are permanent injuries. In other words, if we have shoulder dystocia in approximately 1 percent of cases, of that 1 percent, about 10 to 15, possibly 20 percent of kids will have some brachial plexus injury, at least a temporary injury. Of those, 10 percent will be a permanent injury.
Q. Let me ask you, just following up on that. I mean, here basically we have a -- let's just round it off to a 4500 gram baby?
A. Yes, sir.
Q. Are you aware of any statistics which

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

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

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

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

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

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

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

Q. Was Charlie dysmorphic?

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

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

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

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

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

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

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

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

Q. Such as an epidural?

A. Yes, such as an epidural.

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

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

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

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

Q. Let me ask you about fundal pressure?

A. Sure.

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

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

BY THE WITNESS:

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

In other words, I don't see using

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

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

BY MR. SWITZER:

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

A. Okay.

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

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

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

Q. Would those be considered outlet forceps?

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

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

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A. Sure.

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

A. Yes, sir.

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

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

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

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

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

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

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

Q. Can you quantify hard?

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

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

A. Apparently so.

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

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

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

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

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

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

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

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

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

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

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

A. Sure.

Q. -- if I can.

What is suprapubic pressure?

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

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Q. And in what direction is that generally applied?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Absolutely. The force could be

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

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

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

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

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

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given during a contraction.

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

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

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

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

A. Yes. Yes.

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

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

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

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

A. That's correct, sir.

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

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

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

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

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

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

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

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

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

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

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

A. Yes, sir.

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

shoulder dystocia?
A. Yes, sir.
Q. And you have an opinion there that it caused a more rapid descent of the fetal head?
A. Yes, sir.
Q. Can you give me the basis for that opinion?
A. Well, in my opinion, any time fundal pressure is used, it accentuates what normal labor would be and would cause a more rapid descent of the fetal head. Certainly it was given 12 minutes and then 7 minutes prior to delivery of the head, so it had to be given as the baby's head was beginning to crown. There was no question that the baby was close to delivery. There's no question that had it not been given, it would have probably taken several extra contractions for this baby's head to deliver.

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

the shoulders to normally rotate out of the anterior-posterior -- anterior-posterior diameter of the pelvis, and more likely than not, caused the shoulders to be entrapped behind the pubis.
Q. When was the head engaged?
A. Well, the head was engaged at 9:47. There was the diagnosis of the patient being rim dilated at 9:47 in the morning, and that that was the first time that the station was zero station. And by definition at zero station, the head was engaged.
Q. I want you to tell me then because it's still unclear to me what is the basis for your opinion that the two instances of fundal pressure that were used here did not allow sufficient time for the infant's shoulder to rotate into the correct axis?
A. Well, several bases for that opinion. Number one, there was no indication for the use of fundal pressure.

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

Three, if the head descends more

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

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

There was absolutely no medical indication for the use of fundal pressure. And in my opinion this was a deviation of the standard of care to use it. There was no need for it. Two --
Q. Is the basis for your opinion that had these two instances of fundal pressure not been

applied, that there would not have been any shoulder dystocia in this case?
MR. MISHKIND: Don, excuse me, before he answers that question, just for the record, I'm not sure the doctor was done answering the previous question. You started asking a question and he said the word "two".

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

Were you done with your answer?
BY THE WITNESS:
A. I think so.
MR. MISHKIND: Okay. I'm sorry, Don.
MR. SWITZER: I thought so too.
MR. MISHKIND: I heard him say "two" and I didn't know whether he was going on to give further bases for his previous answer, so --
BY MR. SWITZER:
Q. Doctor, what is the basis for your opinion in this case that but for the two instances of fundal pressure being applied, that there would not have been any shoulder dystocia

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encountered?
A. I said more likely than not shoulder dystocia may or may not have been encountered in this case, but I think that the shoulders had no chance to rotate and so made the incidence of shoulder dystocia more likely.
I can't give you a percentage, but best I can say to you is in my opinion, more likely than not, the fundal pressure contributed to the shoulder dystocia.
Q. Well, you can't give an opinion in this case based on reasonable medical probability that had the fundal pressure not been applied that shoulder dystocia would not have been encountered?
A. Sir, I can tell you that I don't think it would have been encountered, but I can't tell you that had it been encountered anyway, it would have been less severe.
Q. And, again, that's what I'm trying to explore?
A. I'm trying to help you explore that.
Q. What is the basis for your opinion that this fetus' shoulders would most likely have

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rotated into the correct axis without the application of the fundal pressure?
A. Because the shoulder dystocia was obviously relieved after a four minute episode of manipulation by the obstetrician. In my opinion, because the anterior shoulder eventually slid beneath the anterior -- beneath the pubis, had there been more time allowed in second stage, this could have occurred naturally instead of with -- requiring manipulation.
Q. Okay. And what is the basis for your opinion that had the infant's shoulders been allowed to rotate into the correct axis without applying the fundal pressure that there would not have been an impaction of the fetal shoulders?
A. Well, if the shoulders had been allowed to rotate into the correct axis at the time the head was delivered, the shoulders would already have been at an angle to the symphysis and have easily slid beneath the symphysis without any obstruction.
Q. Well, you mean there would not have been a shoulder dystocia?
A. More likely than not, I think the

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shoulder dystocia would have been avoided. Or said a different way, had it been encountered, I think it would have been less severe and easier to correct.
Q. Well you're aware of -- in reading the literature, I'm assuming, that there's numerous incidents of shoulder dystocia without any fundal pressure being applied --
A. Of course.
Q. -- right?
A. Of course.
Q. How did those occur then?
A. They do occur, but I will tell you that if fundal pressure was applied to every patient in the second stage of labor, we would significantly increase the incidence of shoulder dystocia.
We do know that the incidence of shoulder dystocia is significantly higher, as I said earlier, in precipitous labors. And the precipitous second stage of labor means the head descends too quickly through the pelvis and the shoulders can't rotate.
In my opinion, the application of

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fundal pressure mimics the precipitous type delivery and again, did not allow the shoulders to rotate. And I think that is why I brought up the incidence of increased shoulder dystocia with precipitous labor. Fundal pressure does move the head through the pelvis too quickly, and again, makes a natural physiologic phenomenon of rotation of the shoulders beneath the pubis more difficult to accomplish before the delivery of the head.
Q. Do you believe you satisfactorily explained then the biomechanics of how this shoulder dystocia occurred in this case?
A. Yes. But I can't tell you that there could -- in the absence of shoulder dystocia -- I'm sorry, in the absence of fundal pressure, there wouldn't have been any shoulder dystocia. I just, as I said earlier, I think it would be less -- it would have been less severe.
Q. And you're giving these opinions without knowledge of the number of variables that we discussed earlier as far as the pressure and the angles and things like that?
A. Yes.

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

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

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

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

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Q. Assuming you're aware by now that there's a discrepancy between what's recorded in the record and some of the deposition testimony?
A. So I'm aware.
Q. Let's just talk about the medical records and what's documented?
A. Okay.
Q. Do you have Dr. Patel's operative report or delivery record?
A. Yes, I do. I'm not sure I have it in front of me this moment.
Labor course -- you mean the labor course?
Q. The Labor and Delivery Summary, I'm sorry.
A. Yes, I have it in front of me, sir.
Q. Based upon Dr. Patel's description in this Labor and Delivery Summary, what she did after the shoulder dystocia was encountered, is it your opinion that what Dr. Patel described in that note was a deviation from the standard of care?
MR. MISHKIND: Objection, go ahead.
BY THE WITNESS:

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A. I'm sorry, could you ask the question again, please?
BY MR. SWITZER:
Q. The manner in which Dr. Patel described how she delivered this baby after the shoulder dystocia was encountered, did that comply with the standard of care as set forth in the Labor and Delivery Summary?
MR. MISHKIND: Objection, go ahead.
BY THE WITNESS:
A. It complied with the standard of care insofar as the McRoberts maneuver with suprapubic pressure is an accepted first step toward the alleviation of a shoulder dystocia.
In my opinion, there was a significant time interval between delivery of the head and delivery of the baby which was approximately four minutes. Had there truly been a dystocia lasting four minutes, suprapubic pressure and the McRoberts maneuver were inappropriately applied for that length of time.
And the reason I say that is that when shoulder dystocia is encountered, there are several maneuvers that could be done -- attempted

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to alleviate the shoulder dystocia. If you try the first one for up to 30 seconds, possibly a minute without rapid resolution of the shoulder dystocia, you must go on to another method of relieving the shoulders.
If you just keep fundal -- I'm sorry, just keep suprapubic pressure and downward traction on the baby's head, with flexion of the legs as in McRoberts, and that's the only maneuver you use, and then eventually the shoulders are freed after 3 or 4 minutes of attempting this one maneuver, in my opinion, the maneuver's been attempted for too long and you're more likely than not going to sustain permanent injury.
BY MR. SWITZER:
Q. I think I better ask the question a different way then based on what you said.
A. Sure.
Q. What is your understanding of what Dr. Patel did to accomplish delivery of this baby after the shoulder dystocia was encountered?
MR. MISHKIND: Excuse me for one second. Don, you're talking about based upon the records

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because if you -- you qualified your previous question that there's some discrepancy between the testimony. Is this question based solely on the records?
MR. SWITZER: Yes. I'm sorry, I wasn't clear.
BY MR. SWITZER:
Q. Yes, Doctor.
A. That the patient was placed in McRoberts position, that suprapubic pressure was given, and the baby's head -- I'm sorry, and the shoulder dystocia was alleviated.
Q. And you're saying if that indeed is what transpired in this case, that that did not comply with the standard of care?
A. What I'm saying to you is that if that transpired over a 4-minute period of time, that was an inappropriate length of time to try this one maneuver, and other maneuvers should have been attempted or at least documented to help relieve the shoulder dystocia. Because if McRoberts doesn't work almost immediately with suprapubic pressure, the only way to get it to work if it doesn't work is to pull harder on the

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baby's head. And in my opinion, this excessive lateral traction is what led to the damage to the infant.
Q. Well, didn't she extend the episiotomy?
A. Yes. And she said calling for help, extending the episiotomy all took her less than 30 seconds. That's what she said in her deposition.
Q. The Apgars in this case were 7 and 8?
A. Yes, sir, they were.
Q. Those are good Apgars?
A. Sure. So obviously there was no urgent rush to get this baby delivered without applying excessive traction. The baby was doing just fine. The monitor indicated the baby was in no trouble, probably had a very good oxygen reserve, and though the shoulder dystocia lasted for 4 minutes, obviously the baby tolerated this very well.
Some things the baby didn't tolerate. It had bilateral pneumothoraces which were a life-threatening situation. I'm not a pediatrician, and I cannot tell you if these

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pneumothoraces -- bilateral pneumothoraces that the baby encountered were in any way related to the shoulder dystocia. I would certainly defer to a neonatologist or a pediatric expert to speak to that.
Q. Tell me what evidence you have in this case that Dr. Patel applied excessive traction?
A. In my opinion, the shoulder dystocia was relieved in here with the McRoberts maneuver and the baby immediately showed evidence of significant weakness of the right shoulder. This has proved to be a total avulsion of the nerve roots, making this a permanent injury. And this permanent injury in my opinion, in this scenario, would only occur with excessive lateral traction on the fetal head.
It's my opinion that the shoulder dystocia was relieved with the McRoberts maneuver, but also Dr. Patel applying excessive lateral traction to the fetal head avulsing the nerve roots causing the permanent damage.
Q. Do you consider yourself to be an expert in neurology?
A. Oh, absolutely not.

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Q. Obviously we're talking about a brachial plexus injury here?
A. Yes, we are, sir.
Q. Is it your opinion in this case that brachial plexus -- permanent brachial plexus injuries do not occur following shoulder dystocia other than in the setting of excessive lateral traction?
A. Basically, yes. However, when there's a life-threatening situation on the part of the fetus, it is entirely acceptable to apply force to deliver the baby so the baby is born without significant central nervous system damage.
In this case there was no reason to apply excessive force. Baby was doing just fine for those few minutes, and certainly other maneuvers to more gently free the shoulders could have been attempted and were not used.
In fact, Dr. Patel in her deposition said she had never used any other procedure ever to free shoulder dystocia in all of her experience. And so, she only could use, because she had no experience, she only could use the McRoberts, and in my opinion the McRoberts

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maneuver was inadequate for gently freeing the shoulders without causing damage.
Q. Would you tell me what in your opinion Dr. Patel should have done following the McRoberts procedure or maneuver?
A. Yes, sir. Had she appropriately applied the McRoberts position, and with the use of suprapubic pressure, if within 15 to 30 seconds there was no freeing of the anterior shoulder, in my opinion, she should have put her hand into the vagina behind the anterior shoulder and attempted manually to dislodge the shoulder by rotating it from underneath the pubis.
Had that been unsuccessful, she could have tried the entire Woods Screw maneuver which involves rotating the baby 180 degrees so the anterior shoulder becomes the posterior shoulder, and in doing so, relieves the impaction and allows the shoulders to deliver.
Had that been unsuccessful, then she could have proceeded to try to deliver the posterior shoulder first and -- I'm sorry, deliver the arm, posterior arm first, thereby relieving the posterior shoulder allowing it to

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deliver, then allowing the baby to deliver easily.

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

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

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

Q. What do you mean atraumatically?

A. Without causing trauma to the baby.

Q. You mean without any permanent brachial plexus injury?

A. Yes, sir.

Q. Do you believe you're qualified to

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

A. Yes, sir.

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

MR. SWITZER: Sure, go ahead.

(WHEREUPON, a short break was taken.)

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

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

BY MR. SWITZER:

Q. Why?

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

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

Q. How was the traction applied in this case?

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

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

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

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

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

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

BY THE WITNESS:

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

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

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

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The only way this baby's neck -- I'm sorry brachial plexus, in my opinion, could have been damaged with the scenarios we give here is with excessive lateral traction. That's the only thing that could do it.
Now, if the head was -- if the shoulders were trapped, mother was uncontrollably pushing, and the obstetrician was saying don't push, then we could say, well, it was her excessive pushing in the wrong scenario. But we don't have that here. We have the shoulders being trapped, the obstetrician recognizing it, saying this is a shoulder dystocia, and then using maneuvers to try and relieve this dystocia without any participation on the part of the mother of pushing this baby out in an appropriate manner.
The only way the baby could have been damaged in my opinion is by excessive lateral traction on the basis of the obstetrician, not on the basis of uncontrollable pushing on the part of the mother with a trapped shoulder.
I don't know how else to say it,

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sir.
Q. Okay.
MR. MISHKIND: Hey, Don, off the record.
(WHEREUPON, there was a discussion held off the record.)
BY MR. SWITZER:
Q. Let me just ask a follow-up question. Doctor, obviously, I have your report, and you've given opinions about the fundal pressure, and you've given opinions about what transpired after the shoulder dystocia was encountered.
A. Yes, sir.
Q. And I'm just assuming that if the witnesses and the appearance of whoever's testimony is believed about the fundal pressure being applied after the shoulder dystocia was encountered, you're going to find that a deviation of the standard of care?
A. Without question.
Q. Okay. I'm assuming that. Taking all of those into consideration, have we covered all the opinions with respect to the deviations in the standard of care that you believe exist in this case?

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A. Yes, sir.
MR. MISHKIND: Objection.
BY THE WITNESS:
A. Oh, I'm sorry. Yes, sir.
BY MR. SWITZER:
Q. Let me just ask a few questions real quickly because I've never been involved in a case with you before.
A. Yes, sir.
Q. Have you reviewed other malpractice cases for Mr. Mishkind or his law firm?
A. No, sir, I have not.
Q. Do you advertise your services?
A. No, sir, I don't.
Q. How many cases approximately do you review on an annual basis?
A. Probably one or two new cases per month.
Q. Do you know how it came to be that Mr. Mishkind learned about your existence?
A. I don't know at all, sir. I have no clue.
Q. Maybe he just likes to go to Chicago?
A. I don't blame him. It's beautiful

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here.
Q. Have you ever been sued for malpractice?
A. Yes.
MR. MISHKIND: Objection.
BY THE WITNESS:
A. Yes, I have.
MR. SWITZER: Are we --
MR. MISHKIND: I objected and his answer was yes, he has.
BY MR. SWITZER:
Q. Okay. I said how many times?
MR. MISHKIND: Oh, we didn't hear that one. Even the court reporter didn't hear that.
BY THE WITNESS:
A. We didn't hear that part.
I've been sued three times over the past 32 years.
BY MR. SWITZER:
Q. And just in a two or three word description, can you tell me the claim in each case?
MR. MISHKIND: Just show a continuing line of objection to that question. Go ahead.

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BY THE WITNESS:
A. Yes. Once it was for a woman who I did a hysterectomy on and she developed an ovarian cyst after the hysterectomy.
BY MR. SWITZER:
Q. Okay. That's fine. Next one?
A. I'm sorry.
Q. I told you just three words?
A. All right. Once it was for a woman I did a hysterectomy on, and she developed a vesicle vaginal fistula.
Q. Okay. Next one?
A. And the third one, the only one where money was paid, was where a woman sued me because she developed an intra-abdominal infection after a tubal ligation.
Q. Okay. Thank you, Doctor.
A. You're welcome, sir.
Q. I told you that was quick.
A. Yes.
Q. Tell me in the cases that you reviewed, is there any breakdown percentage-wise between the ones you review on behalf of the plaintiffs or the patients versus doctors or

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hospitals?
A. It works out -- I used to think it was 50/50, but more recently it's been 60/40 in favor of the defense.
Q. Okay. How many depositions do you generally give on an annual basis?
A. Oh, probably one per month at most.
Q. What do you charge?
A. $300 an hour.
MR. SWITZER: I don't know if we paid you yet or not.
MR. MISHKIND: You haven't.
MR. SWITZER: Okay.
(WHEREUPON, a discussion was had off the record.)
MR. SWITZER: Let me turn the questioning over to Carol because I know Howard is getting antsy there.
EXAMINATION
BY MS. METZ:
Q. You said you were sued three times.
A. Yes.
Q. Were you by chance involved in the Supreme Court case, Williams v. Zbaraz?

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

Q. Okay.

A. That wasn't a malpractice suit.

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

A. Yes, it was me.

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

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

MR. MISHKIND: Objection.

BY THE WITNESS:

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

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

BY MS. METZ:

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

A. Yes, ma'am.

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

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

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

MR. MISHKIND: Objection. Go ahead, Doctor.

BY THE WITNESS:

A. No, I don't.

BY MS. METZ:

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

A. That's correct.

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

(Brief interruption.)

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

MR. MISHKIND: Go ahead, Carol.

BY MS. METZ:

Q. Did you answer the question about the episiotomy?

A. I feel that it was entirely

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appropriate to extend the episiotomy, yes.

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

MR. MISHKIND: Objection. Go ahead.

BY THE WITNESS:

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

BY MS. METZ:

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

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

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
CHARLES TENNEY, III, Etc.,)
et. al.,)
Plaintiffs,)
vs.) No. 448548
URMILA PATEL, M.D., et. al.,)
Defendants.)

I hereby certify that I have read the foregoing transcript of my deposition given at the time and place aforesaid, consisting of Pages 1 through 76, inclusive, and I do again subscribe and make oath that the same is a true, correct and complete transcript of my deposition so given as aforesaid, and includes changes, if any, so made by me.

_____
DAVID ZBARAZ, M.D.,

SUBSCRIBED and sworn to before me this ____ day of _____, 2002.

_____
Notary Public

STATE OF ILLINOIS)
)
COUNTY OF L A K E)

I, JUDY ANN MAATMAN, a Notary Public within and for the County of Lake, State of Illinois, and a Certified Shorthand Reporter of said state, do hereby certify:

That previous to the commencement of the examination of the witness, DAVID ZBARAZ, M.D., he was first duly sworn to testify to the whole truth concerning the matters herein;

That the foregoing deposition transcript was reported stenographically by me, was thereafter reduced to typewriting via computer-aided transcription under my personal direction, and constitutes a true record of the testimony given and the proceedings had;

That the said deposition was taken before me at the time and place specified;

That I am not a relative or employee of attorney or counsel, nor a relative or employee of such attorney or counsel for any of the parties hereto, nor interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand and affix my seal of office at Chicago, Illinois, this _____ day of _____, 2002.

_____
Notary Public, Lake County, Illinois

I N D E X

E X H I B I T S

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

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

A. Yes.

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

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

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

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

MS. METZ: I have no further questions.

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

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

FURTHER EXAMINATION

BY MR. SWITZER:

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

A. Sure.

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

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

BY THE WITNESS:

A. No, I would not.

BY MR. SWITZER:

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

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

BY MR. SWITZER:

Q. Well maybe we better separate them.

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

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

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

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

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

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

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

A. Yes, sir.

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

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

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

MR. SWITZER: That's fine.

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

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

(Witness excused.)