

SUMMIT COUNTY, OHIO  
COURT OF COMMON PLEAS  
CASE NO. 2002-07-3929

ROBERT L. BROOKS, an )  
incompetent, by the guardian )  
of his person and estate, )  
MARY BROOKS, et al., )  
Plaintiffs, )  
v. )  
ST. THOMAS HOSPITAL, et al., )  
Defendants. )

CERTIFIED COPY

DEPOSITION UPON ORAL EXAMINATION  
OF STEVEN WARSOFF, M.D.  
TAKEN ON BEHALF OF THE DEFENDANTS

Virginia Beach, Virginia  
May 5, 2003

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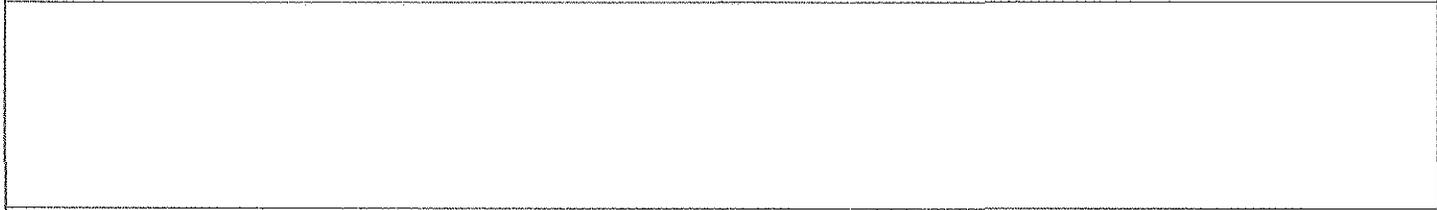
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1 Appearances:  
 2  
 3 On behalf of the Plaintiffs:  
 4 GARY W. OSBORNE, ESQUIRE  
 5 Law Offices of Gary W. Osborne  
 6 7150 Granite Circle  
 7 Toledo, Ohio 43617  
 8 (419) 842-8200  
 9  
 10 On behalf of the Defendant St. Thomas  
 11 Hospital:  
 12 ELIZABETH N. DAVIS, ESQUIRE  
 13 Roetzel & Andress  
 14 222 S. Main Street  
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 16 (330) 849-6621  
 17  
 18 On behalf of the Defendant Estate of Mortier:  
 19 MARK D. FRASURE, ESQUIRE  
 20 Buckingham, Doolittle & Burroughs, LLP  
 21 4518 Fulton Drive, NW  
 22 Canton, Ohio 44735-5548  
 23 (330) 492-8717  
 24  
 25

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I N D E X  
 W I T N E S S

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 3  
 4 ON BEHALF OF THE DEFENDANTS: Examination by: Page  
 5 STEVEN WARSOF, M.D. Mr. Frasure 4  
 6 Ms. Davis 25  
 7 Mr. Frasure 53  
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1 Deposition upon oral examination of  
 2 STEVEN WARSOF, M.D., taken on behalf of the  
 3 Defendants, before Tracy B. Marinelli, RPR, a Notary  
 4 Public for the Commonwealth of Virginia at Large,  
 5 commencing at 5:00 p.m. on the 5th day of May, 2003,  
 6 at the offices Tidewater Perinatal Center, 1080 First  
 7 Colonial Road, Virginia Beach, Virginia.  
 8 -----  
 9 STEVEN WARSOF, M.D., called as a witness,  
 10 having been first duly sworn, was examined and  
 11 testified as follows:  
 12 EXAMINATION  
 13 BY MR. FRASURE:  
 14 Q. Is it Doctor Warsof?  
 15 A. Yes.  
 16 Q. I'm Mark Frasure, Doctor. I represent  
 17 the estate of Doctor Mortier, the OB in the case.  
 18 I'll ask you some questions to find out what your  
 19 opinions are here. You're maternal-fetal, perinatal?  
 20 A. Yes.  
 21 Q. Board certified?  
 22 A. Yes.  
 23 Q. How much medical/legal review do you do?  
 24 A. How would you like it?  
 25 Q. Per year. I'm not talking about

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1 testimony, just getting cases in from Mr. Osborne or a  
 2 defense attorney.  
 3 A. I think I've looked at 68 cases since  
 4 1996.  
 5 Q. Okay. And how is that broken down  
 6 percentagewise?  
 7 A. I would say it's about 50/50.  
 8 Q. Okay. Has the rate of intake stayed  
 9 about the same --  
 10 A. A little bit more in --  
 11 Q. -- about ten or 12 a year, something like  
 12 that?  
 13 A. A little bit more in the last year or  
 14 two.  
 15 Q. Okay. How many depositions, roughly -- I  
 16 know these are estimates -- do you give a year?  
 17 A. One or two. I think I've given eight  
 18 malpractice depositions.  
 19 Q. Did you know Mr. Osborne before this  
 20 case?  
 21 A. No.  
 22 Q. Anyone in his firm?  
 23 A. I don't think so.  
 24 MR. FRASURE: Who are in your firm, Gary?  
 25 MR. OSBORNE: He doesn't know anyone.

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1 Jack Leizerman, Mike Bell.  
 2 BY MR. FRASURE:  
 3 Q. How did you come about to review this  
 4 case? Was it through Mr. Osborne?  
 5 A. Yes.  
 6 Q. And when were you contacted, roughly?  
 7 A. January of '02, I think.  
 8 Q. Okay. Have you issued any reports,  
 9 written reports?  
 10 A. No.  
 11 Q. Have you reviewed depositions of the  
 12 mother and the grandmother?  
 13 A. Yes.  
 14 Q. And the two residents, or resident and a  
 15 neonatologist I think?  
 16 A. I just received the neonatologist over  
 17 the weekend.  
 18 Q. What -- in hindsight -- looking back in  
 19 hindsight, what do you think the condition of the  
 20 child was when the mother arrived at 2:00 a.m. on the  
 21 morning of delivery, in hindsight?  
 22 A. Well, I think from what we have the  
 23 tracing was normal. So we have a baby that had  
 24 some growth delay but otherwise normal as far as an  
 25 obstetrician could tell.

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1 Q. What do you base the growth delay on?  
 2 A. There were comments about the baby being  
 3 small.  
 4 Q. Okay. What -- in hindsight what do you  
 5 think the gestational age of the baby was?  
 6 A. I guess I would have to go with what --  
 7 in hindsight -- I guess my hindsight is the same sight  
 8 as I have from reviewing the records. I think the  
 9 comments were between 33 and 35 weeks.  
 10 Q. Does that make the baby somewhat  
 11 premature?  
 12 A. Slightly premature, yes.  
 13 Q. Okay. In hindsight do you believe  
 14 the baby came in with infection of the amniotic  
 15 fluid?  
 16 A. It's hard to say. You know, there is  
 17 this issue, of course, about being ruptured for  
 18 several days beforehand, but I guess the -- as a  
 19 clinician the question is was the baby clinically  
 20 infected, and at least as best as we can tell the  
 21 mother was afebrile. Using the typical parameters  
 22 that we use, the mother was afebrile, and as far as we  
 23 know the fetal heart rate was normal. So the  
 24 assumption is that, at least when she showed up 3:00  
 25 in the morning, that the baby was clinically well.

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1 Q. Can the baby be clinically well and have  
 2 ruptured membranes for three to four days?  
 3 A. Yes, and even longer.  
 4 Q. There were some exams done shortly after  
 5 the baby arrived, right?  
 6 A. Yes.  
 7 Q. Did they indicate that clinically there  
 8 were not signs of amnionitis?  
 9 A. I think the fluid was -- well, it's --  
 10 help me a little bit here. I think in the first  
 11 evaluation there was some comment about -- at 2:00  
 12 a.m. it was nonodorous. That's what I was looking  
 13 for. You know, one of the other clinical findings of  
 14 infection is the smell, the odor, and nonodorous,  
 15 that's good. That would be against the baby and the  
 16 mother being severely infected at that time.  
 17 Q. Is another sign typically of that disease  
 18 tender uterus upon examination or not?  
 19 A. It can be, you know, but certainly when  
 20 somebody is in labor the uterus is tender.  
 21 Q. Did you note in the deposition of the  
 22 mother where she said -- either the mother and/or the  
 23 grandmother she was -- I don't know the exact word she  
 24 used but she was in a lot of -- the mother seemed to  
 25 be in a lot of distress during the evening and

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1 couldn't get any pain relief? Does that mean anything  
 2 to you here in this context?  
 3 A. Are we talking about after 2:00 in the  
 4 morning?  
 5 Q. Yeah, shortly after she came in.  
 6 A. I mean, I guess that's labor.  
 7 Q. That's what I thought too but I didn't  
 8 know whether you attached any unusual meaning. Let me  
 9 go at it this way, chronologically when is your first  
 10 standard of care criticism? When does it start and  
 11 what it is?  
 12 A. I guess my two areas of concern is the  
 13 patient showing up three or four days before, and you  
 14 know, this is by her deposition and her mother's  
 15 deposition, complaining of ruptured membranes and not  
 16 being evaluated. I think that a woman at this  
 17 gestational age or really at any gestational age who  
 18 says I think my water has broken or I think I'm  
 19 leaking, this is a potentially very serious thing and  
 20 it's not, oh, it's just urine and don't worry about  
 21 it. So I think although I'm willing -- I'm certainly  
 22 happy to say sometimes it turns out just to be your  
 23 urine, but to make that statement without seeing a  
 24 doctor, a nurse, without any evaluation is a deviation  
 25 from the standard of care.

1 Then the second area that I'm concerned  
 2 about is at 10:30 with the recognition of late  
 3 decelerations and the plan to proceed with the  
 4 cesarean section and then the baby not being delivered  
 5 for essentially two hours later, with essentially no  
 6 monitoring during that window of time.  
 7 Q. What type of monitoring do you think  
 8 there should have been?  
 9 A. Some fetal heart monitoring.  
 10 Q. Internal monitoring?  
 11 A. Anything.  
 12 Q. There had been internal monitoring, I  
 13 think, earlier, hadn't there?  
 14 A. Right, up until 10:30. Now, there may  
 15 have been monitoring but we don't know what it is.  
 16 Q. Right, we don't have the strips.  
 17 A. We don't have any strips, nor do we have  
 18 any nurses' notes or any documentation about what the  
 19 heart rate was like during that period of time. So  
 20 considering the outcome of the baby, with Apgars of  
 21 one and one, the assumption has to be that it  
 22 continued to be bad.  
 23 Q. If there had been an internal monitor for  
 24 a while, I think, and there was, would it make any  
 25 sense to take the internal monitor out even if a C

1 section has been planned?  
 2 A. Well, you know, what strikes me, you  
 3 know, as a clinician trying to make sense of what  
 4 happened during this two hours is that people got  
 5 her ready for a C section, and you have to undo  
 6 everything, the monitoring, bring her to the  
 7 operating room, and that's probably what happened, and  
 8 then for some inexplicable reason everybody just  
 9 waited until -- you know, until the delivery at 12:31.  
 10 Q. I'll ask a dumb question. Is the  
 11 internal monitoring usually one of the last things  
 12 that's removed as a patient is converting to a C  
 13 section?  
 14 A. Well, you have to -- you have to take  
 15 that off in order to move to the OR, so, you know,  
 16 first, last, I guess the wisest thing to do is to  
 17 continue to monitoring up until the end, and certainly  
 18 a lot of places today, you know, will -- there is a  
 19 monitor in the operating room. Now, I know in 1983,  
 20 you know, monitors -- I mean, we were pretty good at  
 21 monitoring in 1983, but, you know, things are a little  
 22 bit more available today than they were then. It  
 23 sounds like the nurses and everybody was ready at  
 24 10:30, C section, let's go and then nothing happened.  
 25 Q. Now, it seems like you're assuming that

1 the plan was for an emergency C section. Are you  
 2 making that assumption?  
 3 A. Well, it certainly wasn't a scheduled  
 4 section.  
 5 Q. I understand, but can't -- is it possible  
 6 that a patient like this, who is not making progress  
 7 in labor apparently, that the doctors can decide  
 8 within the standard of care, okay, let's go do a  
 9 cesarean and it not be necessary to make it an  
 10 emergency cesarean, not something that has to be done  
 11 in 20 or 30 minutes?  
 12 A. Well, you know, there is -- a lot of  
 13 words are being used that are confusing. There is  
 14 the stat C section, you know, run in the back. It  
 15 didn't seem like they needed to do that, but with  
 16 the persistent late decelerations noted at 10:30 you  
 17 need to move or show that these decelerations have  
 18 cleared. Now, if, you know, at 10:30 they said  
 19 persistent late decelerations and said, okay, let's do  
 20 a C section and then they continued monitoring and all  
 21 of a sudden the tracing got better, then you could  
 22 say, well, maybe we'll take a little bit more time,  
 23 and, you know, that's understandable, but that doesn't  
 24 seem to be the case here because they -- at least we  
 25 have no evidence that the tracing got better, and

1 then, of course, the outcome of a baby with Apgars of  
 2 one and one clearly denotes that things were not  
 3 getting better.  
 4 Q. Okay. I think you had a third area of  
 5 criticism. The first one was showing up three or four  
 6 days before and not being dealt with and then second  
 7 was at 10:30 a.m.  
 8 A. And I guess the third area would be the  
 9 lack of documentation about what happened during  
 10 that --  
 11 Q. Beginning at around 10:30?  
 12 A. Yes. I mean, the documentation before  
 13 that is suboptimal but not terrible. It's absent  
 14 after 10:30.  
 15 Q. As to what was being done or --  
 16 A. Going on, what was going on with the  
 17 mother, what was going on with the baby.  
 18 Q. If the mother did come in three or  
 19 four -- going back now in time, if the mother did come  
 20 in three to four days earlier complaining of ruptured  
 21 membranes, what did the standard of care require at  
 22 that time?  
 23 A. Well, I think an evaluation for ruptured  
 24 membranes, which is typically a sterile -- what we  
 25 call a sterile speculum evaluation and a nitrazine

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1 test.  
 2 Q. Do you think in hindsight she had  
 3 ruptured membranes three to four days, likely?  
 4 A. Likely.  
 5 Q. What -- if that had been done, what would  
 6 the outcome have been? Would there have been an  
 7 earlier delivery?  
 8 A. Well, it's hard to know a hundred percent  
 9 for sure. I know what standard management would have  
 10 been.  
 11 Q. What would the standard of care dictate?  
 12 A. It would have dictated that she be put  
 13 into the hospital to be evaluated, start her on  
 14 antibiotics, close monitoring, and if there is any  
 15 evidence of infection to move ahead to deliver.  
 16 Q. Were antibiotics given prophylactically  
 17 back in the early '80s?  
 18 A. With ruptured membranes?  
 19 Q. Yes.  
 20 A. I think it was, but I -- there may have  
 21 been regional variation on that.  
 22 Q. If antibiotics had been given three to  
 23 four days earlier, what difference, if any, do you  
 24 think that would have caused?  
 25 A. Well, I would have thought that with

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1 antibiotics that they would have moved forward to  
 2 deliver.  
 3 Q. Same day or --  
 4 A. Typical management at 34 weeks in 1983  
 5 would be wait until the next morning and start Pit.  
 6 Q. Pitocin?  
 7 A. Pitocin, that's right.  
 8 Q. And then if she doesn't progress?  
 9 A. Then you do a C section.  
 10 Q. When she comes in, then, to the hospital  
 11 at 2:00 or 3:00 a.m. on the 11th, does the standard of  
 12 care require antibiotics to be given then? Let's say  
 13 she hasn't been seen before. Well, regardless, she  
 14 comes in on the 11th. Clinically she is what she is.  
 15 A. Well, you know, we were talking about --  
 16 I mean, you asked that question a few minutes ago  
 17 about did standard -- was everybody doing antibiotics  
 18 for ruptured membranes in 1983, and I think my answer  
 19 was there was regional variation, and so --  
 20 Q. Same answer?  
 21 A. Yes. It certainly could have been done.  
 22 Would it have made any difference in the outcome? The  
 23 answer in my mind is no because the antibiotics are  
 24 not to treat chorioamnionitis, it's to try to prolong  
 25 the latent phase with ruptured membranes, so I don't

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1 think that the outcome would have been that much  
 2 different. That remains a challenge for us in  
 3 clinical obstetrics, is once chorioamnionitis sets in  
 4 no amount of antibiotics or we do not have an  
 5 antibiotic today that will cure that  
 6 chorioamnionitis. The treatment is delivery.  
 7 Q. What was the -- does chorioamnionitis  
 8 cause a persistent late decel or does it lead to fetal  
 9 distress that is reflected in those --  
 10 A. I think, you know, of course, this is  
 11 a complex and confusing and not well understood  
 12 thing, but certainly there is an association of  
 13 chorioamnionitis, infection to the baby, making the  
 14 baby sick, the sick fetus then exhibiting abnormal  
 15 fetal heart rate patterns, and so I guess that's the  
 16 way I would put it.  
 17 Q. Did the prematurity of the baby affect  
 18 the outcome of the baby here in your opinion?  
 19 A. When you say the outcome, you mean the  
 20 long-term outcome or --  
 21 Q. Did it contribute -- well, yes, either  
 22 the short-term or long-term outcome.  
 23 A. Well, I mean, the -- in 1983 a 34-week  
 24 baby should have had an excellent prognosis, and so I  
 25 don't think that the prematurity could excuse this

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1 management. You know, certainly a 34-week baby should  
 2 have Apgars of seven and eight or eight and nine and  
 3 not one and one.  
 4 Q. Okay. Have we covered all of your areas  
 5 of standard of care opinions?  
 6 A. Yes, that I'm aware of at this time.  
 7 Q. What would have been the probable outcome  
 8 if the baby had been delivered let's say at -- what do  
 9 you think, an 11:00 delivery was indicated?  
 10 A. Yes.  
 11 Q. If the baby in fact had been delivered  
 12 cesarean at 11:00 a.m. instead of 12:30, whatever it  
 13 was, what difference in your -- based upon reasonable  
 14 medical probability, do you think would have been the  
 15 outcome?  
 16 A. Of course, we're somewhat hindered  
 17 because we don't have the tracing, but from the  
 18 general idea I think the outcome would have been much  
 19 better. You know, I don't think I could tell you for  
 20 sure what the Apgars would have been, but certainly  
 21 the baby would have been healthier than it turned out  
 22 to be.  
 23 Q. Can you -- are you saying the baby would  
 24 have been "normal"?  
 25 A. I think the outcome would have been much

1 better. It's hard for me to say normal, abnormal.  
 2 I'm trying to be reasonable because I don't really  
 3 know what the tracing looked like. You know, if we  
 4 had severe bradycardia for a half hour, then, you  
 5 know, the Apgars would have been better, but we really  
 6 don't know. All I can say for sure is that the  
 7 outcome would have been significantly better for the  
 8 baby if it was delivered at 11:00.

9 Q. What is -- what are the ranges of  
 10 outcome for a baby that has chorioamnionitis let's  
 11 say and that goes undiagnosed -- for good or bad it  
 12 goes undiagnosed during labor, even if delivery is  
 13 timely? Aren't you dealing with a range that includes  
 14 serious problems?

15 A. Yes.

16 Q. What leads you to think in this case,  
 17 Doctor Warsof, that the baby would have been okay  
 18 essentially or much better if delivered at 11:00 with  
 19 the disease that he had here?

20 A. Well, because the tracing as described  
 21 was normal up to that point. In the cases that we  
 22 were referring to before, at least as I'm thinking  
 23 clinically, we have a period of time when the tracing  
 24 is abnormal and allowed to continue in that fashion,  
 25 and then the outcome would have been much -- that's

1 when you tend to see the bad outcomes.

2 Q. So chorioamnionitis -- am I saying that  
 3 correctly?

4 A. As good as I can say it.

5 Q. It can go undiagnosed and still be within  
 6 the standard of care hypothetically?

7 A. Could you repeat that again?

8 Q. One can have that disease, a baby  
 9 can, and it can go undiagnosed throughout labor  
 10 hypothetically without there being a departure from  
 11 the standard of care?

12 MR. OSBORNE: Can I enter an objection?

13 MR. FRASURE: Sure.

14 MR. OSBORNE: You keep saying that the  
 15 baby had chorioamnionitis. I'm not sure that that's  
 16 something that babies get.

17 THE WITNESS: The mother has  
 18 chorioamnionitis.

19 MR. FRASURE: I'm sorry. I apologize.

20 THE WITNESS: So can chorioamnionitis go  
 21 unrecognized and it still be within the standard of  
 22 care? If the mother has a normal temperature, has a  
 23 normal white count, then --

24 BY MR. FRASURE:

25 Q. Which she did essentially here, you're

1 saying?

2 A. Right, yes.

3 Q. But you're saying -- are you saying that  
 4 there were some indications beginning to develop of  
 5 there being a problem, of which this disease could be  
 6 one of the causes?

7 A. With the -- yes, the development of the  
 8 late decelerations and the foul smelling amniotic  
 9 fluid that was present at the delivery.

10 Q. What is the mechanism, Doctor, of why the  
 11 presence of this disease would begin to cause the  
 12 fetal distress? Is it the baby becomes overwhelmed by  
 13 the infection?

14 A. That's my understanding, that the baby  
 15 becomes infected with all the sequela, whether it's  
 16 toxic shock, blood pressure issues, infection in the  
 17 lungs. Some of the problems develop -- you know, as  
 18 long as the baby is in utero it's oxygenating through  
 19 the placenta, but once it's born it has to breathe,  
 20 but if there is infection in the lungs then it's  
 21 already born with pneumonia, and that can be very  
 22 difficult for the baby.

23 Q. Well, in hindsight there was an infection  
 24 obviously present for a while, don't you think, more  
 25 than just an hour or two before delivery?

1 A. Yes.

2 Q. Why doesn't -- maybe I'm not asking  
 3 this well. Why doesn't the presence of that infection  
 4 earlier show fetal distress signs, cause fetal  
 5 distress signs?

6 A. I guess my thinking about this as a  
 7 clinician is that, you know, you have an early  
 8 infection that the baby is -- can tolerate and --  
 9 but when that infection gets more longstanding and  
 10 accompanied by the stress of labor and how that  
 11 affects the baby, that the longer the exposure the  
 12 longer the time without treatment, and treatment  
 13 can only start for the baby after it's born, that the  
 14 sicker the baby will get with time, and sometimes the  
 15 babies can get very sick very quickly, and as you  
 16 mentioned, this was a premature baby and it was also  
 17 a growth delayed baby, which would make it more  
 18 susceptible to infection.

19 Q. Do any of the articles in your CV, if you  
 20 recall, deal with this disease?

21 A. I don't believe they do.

22 Q. To be sure I understand this, let's  
 23 assume for the moment that she did seek medical  
 24 attention three to four days earlier and she was  
 25 told what she says she was told. Taking that as an

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<p>1 assumption, then she comes in at 1:00 or 2:00 in the  2 morning on the 11th. Am I correct the standard of  3 care, starting at that point at least, allows them to  4 watch her as they did because of her clinical  5 situation up until around the 10:30 time frame?  6 A. That's correct, and I say that assuming  7 that -- you know, we have been making certain  8 assumptions, that the limited documentation is  9 accurate. Again, we don't have a tracing. We know at  10 one point that someone said -- Doctor Maiorelo said  11 the fetal heart tracing was normal, that if it was  12 abnormal he would have written something, so, you  13 know, we're just assuming all this stuff is accurate.  14 Q. But the right testing was done upon  15 admission and the right type of follow-up was done?  16 A. Right.  17 Q. Okay. I was looking for the baby's heart  18 rate. While I'm looking let me ask you this, do you  19 have any opinions on the keeping of fetal monitoring  20 strips in the hospital, how long that's done? Oh,  21 here we go. Any opinions on that?  22 A. So the question is how long does someone  23 need to keep a fetal heart tracing?  24 Q. In your opinion. Do you have any --  25 A. I think that's something probably for</p>	<p>1 you-all to decide rather than for me to decide.  2 Q. I was looking at an intrapartum flow  3 sheet. It looks like it has a heart rate up until  4 11:30. Am I reading that right?  5 MR. OSBORNE: No. You just have the  6 first part. I mean, you have the second part. Is  7 that all you want him to look at?  8 MR. FRASURE: I can show him the first  9 part too, of course.  10 MR. OSBORNE: You can show him whatever  11 you want. I just wanted to make sure.  12 MR. FRASURE: Do you have that?  13 MR. OSBORNE: That was the one that was  14 faxed to you.  15 MR. FRASURE: They're separated by a  16 couple pages.  17 THE WITNESS: This is this here, I  18 believe.  19 MR. FRASURE: It starts at 0240.  20 THE WITNESS: So that's this page here  21 and that's this page here, uh-huh.  22 BY MR. FRASURE:  23 Q. It looks like the baby's heart rate stays  24 in around the 140, 150 range on the first sheet. Am I  25 reading that right?</p>

Page 24	Page 25
<p>1 A. Uh-huh, yes.  2 Q. And on the second sheet it looks like it  3 goes to 11:30 and is 130, 140, 140. You had said  4 earlier, I think, that you -- we don't know  5 what the baby's heart rate is, and I realize we don't  6 have it until 12:30, but can we agree at least until  7 11:30 the indication for the baby's heart rate is  8 okay?  9 A. Well, you know, it's a little bit  10 difficult to say because, you know, he's also saying  11 at 10:30, Maiorelo, that it's persistent late  12 decelerations, so, you know, at one moment in time  13 it's 140, but is that accompanied by decelerations  14 down into the 60s or 30s? You know, we really don't  15 know so we have some conflicting information. I  16 guess, in fairness to everybody, it's incomplete  17 information.  18 Q. I need to ask you what your rates are  19 that you quoted Mr. Osborne for review and deposition  20 time and trial testimony.  21 A. \$300 an hour.  22 Q. I'm sorry, \$300?  23 A. \$300 an hour for review of records, \$500  24 deposition and trial testimony and if there is travel  25 involved.</p>	<p>1 MR. FRASURE: I'll pass to Ms. Davis in  2 the interest of time. Thank you.  3 EXAMINATION  4 BY MS. DAVIS:  5 Q. Doctor, did you notice in the -- I  6 believe it was the discharge summary -- let me get  7 the right sheet -- that there was a reference of once  8 the baby was delivered they determined that the  9 gestational age was 27 to 28 weeks? Did you see  10 that?  11 A. I didn't see that. That seems to -- what  12 I saw was 33 to 35 weeks.  13 Q. If you look at -- let me get the right --  14 let me get the right record here. If you look at  15 the -- let me find it here.  16 MR. OSBORNE: Are you referring to this?  17 MS. DAVIS: No. Give me a second.  18 THE WITNESS: I would be surprised if --  19 oh, I see something here that says approximately 27  20 weeks' gestation in the preoperative diagnosis, but  21 that certainly flies in the face of all other  22 information that was provided, including the  23 ultrasound examination done at that time, I think an  24 earlier ultrasound evaluation, as well as the neonatal  25 evaluation of the baby.</p>

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1 BY MS. DAVIS:  
 2 Q. Doctor, help me here. What is the title  
 3 of that record?  
 4 A. St. Thomas Hospital Medical Center,  
 5 Akron, Ohio, discharge summary. At least that's what  
 6 I'm looking at.  
 7 MR. OSBORNE: Well, there is actually a  
 8 discharge summary that is a discharge summary. Then  
 9 there is a discharge summary that's really an op  
 10 note. Is that the one that's the op note?  
 11 THE WITNESS: This one looks like it's an  
 12 op note, and that reference to 27 weeks, that I'm  
 13 looking at at least, is in the preoperative  
 14 diagnosis.  
 15 MS. DAVIS: I had it marked and I lost  
 16 it.  
 17 THE WITNESS: It's on the side with some  
 18 handwriting that says op note.  
 19 MR. OSBORNE: That is my handwriting.  
 20 BY MS. DAVIS:  
 21 Q. You said it was a preoperative  
 22 estimation, Doctor?  
 23 A. First of all, are we all looking at the  
 24 same page?  
 25 Q. It says discharge summary, okay, and then

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1 Mr. Osborne apparently wrote on it. It says op note,  
 2 but we're looking at the same thing.  
 3 A. So what I said was that reference to 27  
 4 weeks' gestation, at least as I see it, is as the  
 5 preoperative diagnosis.  
 6 Q. Okay. Well, if you look at -- I'm  
 7 reading it differently and I just want to see what you  
 8 think this --  
 9 A. Where are you reading?  
 10 Q. I'm reading down where it saying  
 11 following this. Do you see that?  
 12 MR. FRASURE: Under procedure?  
 13 MS. DAVIS: Under procedure. It would  
 14 be, I believe, the fourth full sentence.  
 15 THE WITNESS: Well, again, I think part  
 16 of the problem might have been that this baby was  
 17 growth delayed, and it was -- I think its weight was  
 18 1400 grams, which is -- well, 1400 grams is probably  
 19 closer to typically a 30-week baby, but again that  
 20 flies in the face of -- probably the best dating of  
 21 this pregnancy was by an ultrasound examination that  
 22 was done earlier, I think, which put her at 34 to 35  
 23 weeks, so at least -- as well as the neonatologist's  
 24 evaluation of the baby, which Dubowitz did at 33 to 35  
 25 weeks, and so I think that probably is the best

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1 assessment of the baby's actual gestational age rather  
 2 than sort of the -- probably this was done by Doctor  
 3 Maiorelo, a second-year resident just delivering the  
 4 baby and seeing what he pulled out.  
 5 BY MS. DAVIS:  
 6 Q. So we can agree that the estimate that  
 7 was given was after the baby was delivered, correct,  
 8 of 27 or 28 weeks?  
 9 A. Yes. I guess that's when he -- one would  
 10 assume that this was dictated after the -- well, it's  
 11 interesting, it was dictated two months after the  
 12 surgery.  
 13 Q. My question is this, okay, irrespective  
 14 of when it was dictated, the reference to the weight,  
 15 the way it's referred to here, whether you agree with  
 16 it or not, is a reference which is made once the  
 17 delivery was accomplished, correct? That's the way  
 18 I'm reading it.  
 19 A. Well, you -- one would think that --  
 20 yes. Certainly this was dictated after the baby was  
 21 born.  
 22 Q. That's not my question. If you read it  
 23 it says, following this a transverse incision was made  
 24 into the myometrium, in the lower uterine segment,  
 25 through which a severely depressed infant was born.

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1 Appgars are one and one. Weight and length not  
 2 recorded secondary to immediate resuscitation of the  
 3 newborn. Gestational age approximately 27 to 28  
 4 weeks. My question is, would you agree that the  
 5 notation here is based upon an assessment of the child  
 6 that was made after the delivery?  
 7 A. Right, by probably the second-year  
 8 resident.  
 9 Q. That's fine. Let's assume for a moment  
 10 that this baby was 27 to 28 weeks. Does that impact  
 11 your opinions in any way?  
 12 A. I guess it would impact my opinion that  
 13 I would congratulate the neonatology team for very  
 14 successful resuscitation of a premature baby and the  
 15 fact that the baby survived at all.  
 16 Q. So if the baby -- I understand there is a  
 17 question of whether that is accurate or not, but if  
 18 the baby was 27 to 28 weeks you would not expect the  
 19 baby to survive at all generally?  
 20 A. In 1983 a 28 weeker probably had a 50/50  
 21 chance of surviving, but then if you throw on a 28  
 22 weeker that is born severely hypoxic and asphyxiated  
 23 then I think the chances of it surviving would have  
 24 been much lower.  
 25 Q. What is -- what is the normal gestational

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<p>1 age for a baby in weeks?  2 A. Full term?  3 Q. Full term.  4 A. Forty weeks. You know, usually we  5 consider term 37 to 42 weeks. Some people say 38 to  6 42 weeks.  7 Q. And you noticed throughout that --  8 throughout the record that whenever a history was  9 taken of the mother with respect to her last menstrual  10 period there was always a question mark put there?  11 A. Right, and that's why there was an  12 early ultrasound done, and although it wasn't -- we  13 don't have any documentation of exactly what the scan  14 showed, I think there was an assignment of gestational  15 age based on that, which put her at 33 to 35 weeks,  16 which was consistent with the neonatologist's  17 evaluation.  18 Q. And your basis for concluding that the  19 mother had gone to the hospital several days prior to  20 the November 11th presentation is based upon the  21 mother's testimony in her deposition, correct?  22 A. And the grandmother's.  23 Q. And the grandmother's?  24 A. Yes.  25 Q. Do you have any other basis for that</p>	<p>1 assumption?  2 A. There is no other documentation I was  3 able to find.  4 Q. And just to be clear, as I understand it,  5 with respect to the care that was rendered on November  6 11th of 1983, you don't have any criticisms until  7 after 11:00; is that correct?  8 A. After 11:00.  9 Q. You believe the baby should have been  10 delivered at what time at the latest?  11 A. 11:00, 11:15.  12 Q. What is the basis for that, Doctor?  13 A. Well, the plan at 10:30 was to proceed  14 with cesarean section. I think the permit said  15 cesarean section at 11:00. The nurses come in ready  16 for cesarean section at 11:00. Let's go to cesarean  17 section.  18 Q. In a situation like this, once the C  19 section was called for what is the time frame within  20 which the baby should be delivered?  21 A. Well, it depends on the clinical  22 situation, and, you know, there are some times when,  23 you know, the right answer to that is five minutes  24 and sometimes there is no urgency at all, but for  25 there not to be urgency you have to -- what is the</p>

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<p>1 heart rate, how is the mother doing, how is the baby  2 doing. If the mother and baby are doing fine then  3 certainly you can -- you don't have to do it in 30  4 minutes or rush, or there is plenty time, but in this  5 situation again we don't know what the fetal heart  6 rate tracing is. We only know the outcome for the  7 baby, and so you have to -- at least I would assume as  8 a clinician that what happened was that the baby got  9 worse and worse, so I would say that it should have  10 been done within a half hour.  11 Q. Even in light of the fact that Mr.  12 Frasure pointed out that on the record there it  13 indicates at 11:30 there was a fetal heart rate of  14 140? That wouldn't be significant to you?  15 A. Well, because we don't know, you know,  16 what the heart rate was sort of in between, whether  17 there was severe decelerations, whether there was  18 bradycardias and just at that one moment it was at  19 140, we don't know about the variability, you know,  20 that's -- that one point in time really wouldn't make  21 me think one could delay this.  22 Q. Is it fair to say, then, that you can't  23 say one way or the other whether in an earlier C  24 section at 10:30 or 11:00 or within that time frame  25 would have made a difference in the outcome?</p>	<p>1 A. I think it would have made a difference  2 in the outcome because, you know, of course the longer  3 a baby stays in jeopardy the worse the outcome, and  4 we know at 10:30 that there is persistent late  5 decelerations according to Doctor Maiorelo. I don't  6 know exactly when that started, how long it was going  7 for, but certainly at least standard obstetrical  8 teaching is that the longer you expose the baby to  9 insult the worse the outcome.  10 Q. Can you state, however, within a  11 reasonable degree of medical probability more likely  12 than not that the outcome would have been different?  13 A. I believe the -- certainly the Apgars  14 would have been better and I think the resuscitation  15 would have been easier if the baby was delivered  16 sooner.  17 Q. What do you know about Robert Brooks'  18 present condition, anything?  19 A. Only what is in the depositions.  20 Q. Do you hold any opinions as to what are  21 the causes of his present conditions?  22 A. I would have to defer to a neurologist.  23 Q. You're not going to render any opinions  24 relative to that?  25 A. That's correct.</p>

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1 Q. So as I understand it the opinions with  
 2 respect to whether it would have made a difference in  
 3 the outcome pertain to the immediate post birth  
 4 period? Is that what you're referring to?  
 5 A. Yes.  
 6 Q. Okay. What time frame are we talking  
 7 about?  
 8 A. The first few days of life.  
 9 Q. So anything after that with respect to  
 10 the child's conditions, medical problems, you would  
 11 defer to a neurologist on that?  
 12 A. Yes, right, and if you -- putting it  
 13 that way, I guess my area of expertise would be up  
 14 to the delivery and the immediate obstetrical  
 15 outcome. You know, I'm not going to comment  
 16 about whether the resuscitation was done well or  
 17 appropriately or anything like that.  
 18 Q. And as I understand it, just to be clear,  
 19 you're not going to comment as an expert with respect  
 20 to the causes of the child's condition over the years  
 21 and the present condition, correct?  
 22 A. That's correct.  
 23 Q. Okay. Doctor, in the record it  
 24 indicated, in the nurse's notes, that the mother had  
 25 gained approximately 15 pounds. Do you recall seeing

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1 that?  
 2 A. Yes.  
 3 Q. Is that of any significance to you?  
 4 A. It's consistent with the baby being small  
 5 for gestational age.  
 6 Q. You had said earlier 1400 grams.  
 7 A. That's my understanding of the baby's  
 8 birth weight.  
 9 Q. Can you translate that for me into  
 10 pounds, approximately?  
 11 A. I assume you want an accurate number.  
 12 Q. As accurate as you can get.  
 13 A. So that's probably three pounds and an  
 14 ounce.  
 15 MR. FRASURE: 1400 grams?  
 16 THE WITNESS: There are 454 grams to a  
 17 pound.  
 18 BY MS. DAVIS:  
 19 Q. In looking at the records I noticed  
 20 that the mother was 5'6", weighing 119 pounds. That's  
 21 awfully thin for a woman who is even 33 to 35 weeks  
 22 pregnant, correct?  
 23 A. Where was that? I didn't see that. I  
 24 don't recall it.  
 25 Q. It's on the -- I don't know if I marked

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1 that but it's on the --  
 2 A. I see it. I got the impression that was  
 3 119 kilos.  
 4 Q. Kilos for the mom?  
 5 MR. OSBORNE: That's a big woman right  
 6 there.  
 7 THE WITNESS: My experience in obstetrics  
 8 would put that more the average, 119 kilos.  
 9 MR. OSBORNE: That would be about 250  
 10 pounds.  
 11 BY MS. DAVIS:  
 12 Q. Well, if you look at the nursing history  
 13 on admission, Doctor, it would be in the labor and  
 14 delivery records.  
 15 A. Where it says actual 119?  
 16 Q. Yes.  
 17 A. Yes.  
 18 Q. You -- we don't know if that's kilos or  
 19 pounds, correct?  
 20 A. That's correct.  
 21 Q. If it was kilos, what would that  
 22 translate to into pounds?  
 23 A. It would be 261.  
 24 Q. I guess what we can do is we can go back  
 25 and look at her records prior to her becoming pregnant

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1 and add 15 pounds to it and that would give us a more  
 2 accurate estimation?  
 3 A. Yes, but irrespective, it wouldn't make  
 4 any difference in the clinical outcome in my mind.  
 5 Q. So if she was 5'6" and weighed 119 pounds  
 6 that wouldn't be significant to you in any way?  
 7 A. It certainly wouldn't account for the  
 8 baby being born with Apgars of one and one. If  
 9 anything, if she was that thin it should make it  
 10 easier for the doctors to evaluate her in labor.  
 11 Q. I'm talking about is there any  
 12 significance with respect to the condition of the  
 13 baby?  
 14 A. Well, it might put the baby at increased  
 15 risk for growth delay, which it did have.  
 16 Q. That could be one explanation of the  
 17 growth delay in fact, correct?  
 18 A. There is certainly an association of thin  
 19 women -- underweight women who gain less than average  
 20 weight are more likely to have a growth delayed baby,  
 21 which she did, but, again, that -- most growth delayed  
 22 babies should be born with normal Apgars.  
 23 Q. I don't know if you noticed in her chart  
 24 that it indicated that she was a smoker. Did you see  
 25 that?

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1 A. Right, and that's consistent with the  
2 baby being small in gestational age as well.  
3 Q. What is -- there is testing that was done  
4 for PG. It says amnio stat for PG was negative. What  
5 is that?  
6 A. PG is phosphatidyl glycerol. PG stands  
7 for phosphatidyl glycerol, and it's a way of assessing  
8 for fetal lung maturity.  
9 Q. And that was negative in this case?  
10 A. And it was negative, which would imply  
11 that the baby doesn't necessarily have lung maturity  
12 so that it would put the doctors on warning that this  
13 baby may need some neonatal resuscitation.  
14 Q. Which in fact the baby did?  
15 A. But needed it for severe asphyxia rather  
16 than just respiratory support for prematurity. Those  
17 are very different issues.  
18 Q. Were this baby's -- were this baby's  
19 lungs mature or not?  
20 A. That's a funny question because when we  
21 talk about the PG being negative and then we say that  
22 the lungs are not mature, that does not imply  
23 necessarily that the baby will need respiratory  
24 assistance. It just implies that it may need  
25 respiratory assistance. So just because the PG was

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1 negative doesn't mean that the baby was going to  
2 need to be on a ventilator or have any severe  
3 problem. Lots of babies at 1400 grams that were  
4 growth delayed if born with a normal heart rate  
5 will do great. In fact, small babies or growth  
6 delayed babies because of the stress of growth delay  
7 tend to have accelerated respiratory function and do  
8 better than the average size baby.  
9 Q. If this baby was 33 to 35 weeks, what  
10 should the weight of the baby have been?  
11 A. Probably two and-a-half kilos or five  
12 pounds. I think there was a chart in here that kind  
13 of gives you the percentiles if that's helpful to you.  
14 Q. You agree, Doctor, that even at 33 to 35  
15 weeks this baby was premature, correct?  
16 A. Slightly premature.  
17 Q. As a slightly premature baby, what are  
18 the complications associated with prematurity in and  
19 of itself?  
20 A. There can be all kinds of complications,  
21 prematurity in terms of needing respiratory support,  
22 respiratory distress syndrome. There is some concerns  
23 about liver and gut prematurity that could happen. Am  
24 I helping you?  
25 Q. I just want to know what they are.

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1 A. Prematurity can affect all of the baby's  
2 organ systems.  
3 Q. And if this baby was 27 to 28 weeks, what  
4 are the complications associated with that level of  
5 prematurity?  
6 A. I mean, the same but of course worse, or  
7 at least potentially worse, more frequent. You have  
8 more frequent complications the more premature the  
9 baby is.  
10 Q. As a maternal-fetal specialist what kind  
11 of concerns do you have with a mother who by her own  
12 history had poor prenatal care?  
13 A. Well, we have lots of concerns. We're  
14 concerned about accurate gestational age. We're  
15 concerned about prematurity. We're concerned about  
16 growth problems and everything that she exhibited.  
17 This is -- and because of the patient's late prenatal  
18 care, because of the issues that people knew about  
19 when she presented, that makes it all the more  
20 inexplicable where Doctor Mortier went, you know,  
21 and delayed this delivery because it was not a secret  
22 that there were these issues in this labor, and it  
23 certainly warranted even closer care during the  
24 delivery process.  
25 Q. With respect to Ms. Brooks' claim that

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1 she went to the hospital several days prior and there  
2 was no --  
3 A. Is that a work product, Gary?  
4 MS. DAVIS: Actually I'm going to ask for  
5 a copy of that as well. I'm making a request for a  
6 copy of the typed notes that were prepared by the  
7 witness in review of the records.  
8 MR. OSBORNE: These are my notes.  
9 MS. DAVIS: Oh, these are yours?  
10 MR. OSBORNE: Yes.  
11 MS. DAVIS: I still would like a copy.  
12 MR. OSBORNE: That's fine with me.  
13 THE WITNESS: I was going to say I have  
14 no notes.  
15 MS. DAVIS: These were notes you provided  
16 to the doctor, correct?  
17 MR. OSBORNE: Yes. I don't care, you can  
18 look at them.  
19 BY MS. DAVIS:  
20 Q. The mother had testified that she had  
21 gone to the hospital several days prior, and you are  
22 critical -- you are critical of the hospital for not  
23 seeing to it that she saw a doctor or a nurse or some  
24 care provider, correct?  
25 A. To be evaluated.

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1 Q. So exactly who are you critical of?  
 2 A. Well, it's my understanding that she  
 3 presented to the hospital clinic that day and so I  
 4 don't know -- my assumption is that the -- that this  
 5 is a clinic that is run by the hospital, staffed by  
 6 hospital employees and so therefore I'm critical of  
 7 that organization or whoever is the responsible person  
 8 for that organization.  
 9 Q. When she came in on November 11th, 1983,  
 10 of who are you critical?  
 11 A. My feelings are that Doctor Mortier was  
 12 the individual who was the attending physician that  
 13 was responsible for her care. He was on the scene.  
 14 He should have been aware and was the responsible  
 15 party.  
 16 Q. Any criticism of anyone else?  
 17 A. Well, we've had some discussion about  
 18 this, but, you know, there was concern about did the  
 19 residents notify the doctor, did the nurses have a  
 20 responsibility to push this C section forward, and  
 21 the answer to that is yes, yes and yes. However, as a  
 22 physician, the role of a physician is to -- it's your  
 23 responsibility so my major criticism is with him, and  
 24 I think he has to have the responsibility for this.  
 25 Q. Let's assume for a moment that Ms.

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1 Brooks did present to -- we have a dispute about  
 2 whether she presented because we don't have any  
 3 records that support presentation, and even by her own  
 4 testimony she said that she didn't fill out any  
 5 paperwork. There was no -- no evidence that she was  
 6 there so we do have a dispute on that, but let's  
 7 assume for a moment that she was there. Do you  
 8 believe that if she had had medical care at that time  
 9 that the outcome would have been different?  
 10 A. Yes.  
 11 Q. What?  
 12 A. You know, because my assumption is  
 13 that the baby is sick because of chorioamnionitis,  
 14 developed all these problems as a result of this  
 15 prolonged period of time in which she had ruptured  
 16 membranes, my assumption would be that if she had  
 17 documented ruptured membranes she would have been  
 18 admitted to the hospital and that she would have been  
 19 cared for in an appropriate fashion and the outcome  
 20 would have been good. You know, now, if she wound up  
 21 getting delivered that day and they ignored the late  
 22 decelerations for hours and hours and had the same  
 23 clinical outcome or the same clinical course, then  
 24 it might have been the same, but I would have hoped  
 25 it would have been better. Let me try to say that

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1 again. We can screw up a delivery at any time, and so  
 2 I guess I would say that I would hope that if she was  
 3 admitted and this was recognized at 2:00 a.m. -- I'm  
 4 sorry, a few days before that the outcome would have  
 5 been different because they would have been following  
 6 her more closely.  
 7 Q. You can't say within a reasonable degree  
 8 of medical probability that the outcome would have  
 9 been different, can you?  
 10 A. I could say if the outcome was the same  
 11 if she had been delivered three days before then there  
 12 would probably have been some -- some poor obstetrical  
 13 practice.  
 14 Q. How long does it take for  
 15 chorioamnionitis to develop, Doctor?  
 16 A. It can be a short period of time or you  
 17 can have a long latent period of time. Certainly  
 18 we've had people with ruptured membranes for weeks  
 19 that wind up without chorioamnionitis.  
 20 Q. So what is the shortest period of time  
 21 that it could develop?  
 22 A. Before they're even ruptured.  
 23 Q. So there are other causes of  
 24 chorioamnionitis other than rupture of membranes,  
 25 correct?

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1 A. But you can have chorioamnionitis without  
 2 ruptured membranes, although that's a rare thing. The  
 3 most common thing is to have chorioamnionitis with  
 4 ruptured membranes.  
 5 Q. What are the percentages of mothers who  
 6 develop chorioamnionitis without rupture of membranes?  
 7 A. You mean what percentage of women with  
 8 chorioamnionitis don't have ruptured membranes?  
 9 Q. Correct.  
 10 A. Small, two or three percent. It's  
 11 associated with one organism, Listeria.  
 12 Q. And what percentage of women who have  
 13 ruptured membranes develop chorioamnionitis?  
 14 A. Now, that's a good question and,  
 15 you know, I guess it depends what we mean by  
 16 chorioamnionitis, okay, and probably if left in  
 17 utero, if the baby is left in utero all of them will  
 18 eventually develop chorioamnionitis, and that's  
 19 why when you have ruptured membranes near term  
 20 we get them delivered before -- so we'll induce  
 21 them and start Pitocin so that they won't develop  
 22 chorioamnionitis or that the degree of  
 23 chorioamnionitis will be much lower. Is that  
 24 responsive to your question?  
 25 Q. Not exactly.

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<p>1 A. Okay. Do you want to try it again?</p> <p>2 Q. Let me ask you this, what are causes of</p> <p>3 chorioamnionitis not associated with ruptured</p> <p>4 membranes?</p> <p>5 A. Well, again, I already mentioned one is</p> <p>6 infection from the Listeria, which is a bacteria that</p> <p>7 seems to be able to get into the uterus without</p> <p>8 ruptured membranes, and I guess, two, invasive</p> <p>9 procedures such as amniocentesis, CVS or PUBS can lead</p> <p>10 to chorioamnionitis with intact membranes. Those are</p> <p>11 the things that come to mind right offhand.</p> <p>12 Q. Can chorioamnionitis develop without a</p> <p>13 known cause?</p> <p>14 MR. FRANSURE: Idiopathic.</p> <p>15 MS. DAVIS: Without knowing what the</p> <p>16 cause is.</p> <p>17 THE WITNESS: Chorioamnionitis is by</p> <p>18 definition I guess an infection of the uterus, so the</p> <p>19 implication is that there has to be a bug there</p> <p>20 someplace. So can you have chorioamnionitis without</p> <p>21 there being a bug? Actually no because then you can't</p> <p>22 have the itis if you don't have a bug, but you</p> <p>23 certainly can have chorioamnionitis and most cases of</p> <p>24 chorioamnionitis not result in babies with Apgars of</p> <p>25 one and one, and that's, I think, the important issue</p>	<p>1 here. Not to confuse people, that you can have</p> <p>2 chorioamnionitis but if it -- the patient is cared for</p> <p>3 appropriately the outcome for the baby is mutually</p> <p>4 good.</p> <p>5 BY MS. DAVIS:</p> <p>6 Q. Doctor, have you ever been sued for</p> <p>7 malpractice?</p> <p>8 A. Yes.</p> <p>9 Q. How many times?</p> <p>10 A. There have been four claims made against</p> <p>11 me.</p> <p>12 Q. What were the nature of the lawsuits</p> <p>13 against you?</p> <p>14 A. The first one -- do you want names or</p> <p>15 just --</p> <p>16 Q. I just want to know what is the basis of</p> <p>17 the malpractice, very briefly?</p> <p>18 A. The first case was a baby that died after</p> <p>19 an amniocentesis. The second case was a uterine</p> <p>20 perforation at the time of a D&amp;C for a missed</p> <p>21 abortion. The third case is a ruptured cecum in the</p> <p>22 postoperative period from a cesarean section. The</p> <p>23 fourth case is a shoulder dystocia. There is five</p> <p>24 cases, I'm sorry, and the fifth case is a lady who</p> <p>25 has -- states that she hasn't been able to have</p>

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<p>1 sexual relations with her husband because of a uterine</p> <p>2 rupture that was repaired after a VBAC.</p> <p>3 Q. Are those all of them?</p> <p>4 A. Yes. That's plenty.</p> <p>5 Q. The first one you said was the baby died</p> <p>6 after the amniocentesis?</p> <p>7 A. Yes.</p> <p>8 Q. What was the -- how many months?</p> <p>9 A. Nine months, term baby, and that was a</p> <p>10 defense verdict.</p> <p>11 Q. And the second one?</p> <p>12 A. The question?</p> <p>13 Q. I'm sorry, the second lawsuit.</p> <p>14 A. The outcome?</p> <p>15 Q. Yes.</p> <p>16 A. That was -- what do you call it when the</p> <p>17 judge dismisses the case after the plaintiff puts on</p> <p>18 his thing?</p> <p>19 Q. Directed verdict?</p> <p>20 A. Directed verdict.</p> <p>21 Q. So that went to trial?</p> <p>22 A. Yes.</p> <p>23 Q. And the next one?</p> <p>24 A. Both of those two went to trial.</p> <p>25 Q. The next one.</p>	<p>1 A. The next one I was dismissed from.</p> <p>2 Q. There were other defendants I'm assuming?</p> <p>3 A. Right, but then the case just went away.</p> <p>4 Q. And the next one?</p> <p>5 A. There is the shoulder dystocia case that</p> <p>6 happened in 1990 and has not yet gone to trial.</p> <p>7 Q. And the last one?</p> <p>8 A. Has not yet gone to trial.</p> <p>9 Q. It's pending?</p> <p>10 A. Yeah, 1990.</p> <p>11 Q. And the previous 1990 case, that is still</p> <p>12 pending?</p> <p>13 A. Oh, okay, I'm sorry. The 1990 one was a</p> <p>14 shoulder dystocia, and that's still pending, I</p> <p>15 assume. The VBAC one happened in 2000, not 1990.</p> <p>16 Q. And that's still pending?</p> <p>17 A. That's still pending. We'll be going to</p> <p>18 trial May 28th of this year, federal court in Norfolk,</p> <p>19 Virginia.</p> <p>20 Q. And as I understand it you've not done</p> <p>21 any research or published in the area of</p> <p>22 chorioamnionitis; is that correct?</p> <p>23 A. That's correct.</p> <p>24 Q. Have you published in the area of what</p> <p>25 occurs when there is a premature rupture of membranes</p>

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1 for a prolonged period of time?  
 2 A. I don't think so. Most of my research  
 3 interests were with prenatal diagnosis and ultrasound.  
 4 Q. I saw there are a lot of references to  
 5 ultrasound. I'm almost done, Doctor. I'm just going  
 6 over this so I don't ask the same things that Mr.  
 7 Frasure asked you.  
 8 How many times have you delivered --  
 9 excuse me. How many times have you testified in court  
 10 in a medical/legal case?  
 11 MR. OSBORNE: Besides his own?  
 12 MS. DAVIS: Yes.  
 13 THE WITNESS: Five.  
 14 BY MS. DAVIS:  
 15 Q. Where were those cases?  
 16 A. Trial appearance in Cleveland, Tennessee.  
 17 Q. There is a Cleveland, Tennessee?  
 18 A. Yes. It confused me also. Chattanooga,  
 19 Tennessee; Newport News, Virginia; Ashland, Kentucky  
 20 and Charlottesville, Virginia.  
 21 Q. In each of those cases were you  
 22 testifying on behalf of the patient or on behalf of  
 23 the defendant?  
 24 A. We have three plaintiff and three  
 25 defense. Now, you asked me about these -- my own

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1 personal malpractices. Just to be complete, there was  
 2 another case in which I guess I was a witness and I  
 3 had a trial appearance as a witness but I wasn't  
 4 really on either side.  
 5 Q. You were a fact witness?  
 6 A. Fact witness.  
 7 Q. In other words, it was a case where you  
 8 were involved in taking care of the baby?  
 9 A. Right. It was in 1981. It went to trial  
 10 in 2002.  
 11 Q. But you were not considered an expert in  
 12 that case?  
 13 A. I was not an expert.  
 14 Q. What were the issues in that case?  
 15 A. A baby with good Apgars that turned out  
 16 to have some syndrome and they were claiming perinatal  
 17 asphyxia.  
 18 Q. And who were you -- when did you take  
 19 care of the baby?  
 20 A. I took care of the mother in 1981.  
 21 Q. During her pregnancy?  
 22 A. Her delivery, yes.  
 23 Q. She was high risk?  
 24 A. Mezzo mezzo.  
 25 Q. You were involved in the delivery?



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1 A. Yes.  
 2 Q. Who was being sued?  
 3 A. I think George Washington University.  
 4 That's where I did my residency.  
 5 Q. Were they being sued based upon the care  
 6 that you provided?  
 7 A. I guess the care that was provided for --  
 8 to this patient, which I was the chief resident, not  
 9 the attending.  
 10 Q. Was your care in question? That's the  
 11 question.  
 12 A. Yes.  
 13 Q. What was the outcome of that case?  
 14 A. Defense verdict.  
 15 Q. Did you believe that you did anything  
 16 wrong in that case?  
 17 A. No.  
 18 Q. What was the name of the case?  
 19 A. I think Johnson versus George Washington.  
 20 Q. And where -- where was the case?  
 21 A. In the District of Columbia.  
 22 Q. What year was that?  
 23 A. January, '02.  
 24 Q. That was the trial date?  
 25 A. Yes, and the actual delivery was in '81.

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1 MS. DAVIS: I'm going to let Mr. Frasure  
 2 ask you a few more, Doctor, and we should be done  
 3 shortly.  
 4 EXAMINATION  
 5 BY MR. FRASURE:  
 6 Q. Real quickly, Doctor, is there an  
 7 increased incidence of chorioamnionitis with say  
 8 prematurity of 33 to 35 weeks?  
 9 A. I wouldn't put it that way. I guess  
 10 I would kind of say that there was more premature  
 11 ruptured membranes that lead to delivery at 33 to 35  
 12 weeks and so if you've got more premature ruptured  
 13 membranes then you're going to have more  
 14 chorioamnionitis.  
 15 Q. Is there any increased incidence between  
 16 prenatal care that begins late in the process and  
 17 chorioamnionitis?  
 18 A. I would say late prenatal care is  
 19 associated with problems and -- which include ruptured  
 20 membranes.  
 21 Q. And what -- why is that mechanically or  
 22 conceptually?  
 23 A. Probably socioeconomically.  
 24 Q. And one other thing. I didn't ask you,  
 25 have you ever had your license suspended or revoked in



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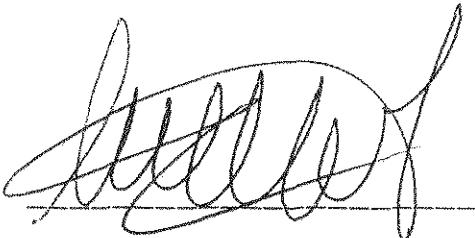
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I, the undersigned, STEVEN WARSOFF, M.D.,  
do hereby certify that I have read the foregoing  
deposition and that, to the best of my knowledge, said  
deposition is true and accurate (with the exception of  
the following corrections listed below:)

Page	Line	Correction
31	25	you have to know what is
46	8	I guess to invasive procedures

6/9/03  
Date

  
Signature

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STATE OF: Virginia )

CITY OF: Virginia Beach ) To wit:

Subscribed and sworn to before me this  
9th day of June, 2003 at  
VA Beach, Virginia.

  
Notary Public

June 30, 2005

MY COMMISSION EXPIRES