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.)

DEPOSITION UPON ORAL EXAMINATION OF STEVEN WARSOF, M.D.

TAKEN ON BEHALF OF THE DEFENDANTS

Virginia Beach, Virginia

May 5, 2003

TAYLOE ASSOCIATES, INC.
Registered Professional Reporters
Telephone: (757) 461-1984
Norfolk, Virginia

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Appearances:

On behalf of the Plaintiffs:
GARY W. OSBORNE, ESQUIRE
Law Offices of Gary W. Osborne
7150 Granite Circle
Toledo, Ohio 43617
(419) 842-8200

On behalf of the Defendant St. Thomas Hospital:
ELIZABETH N. DAVIS, ESQUIRE
Roetzel & Andress
222 S. Main Street
Akron, Ohio 44308
(330) 849-6621

On behalf of the Defendant Estate of Mortier:
MARK D. FRASURE, ESQUIRE
Buckingham, Doolittle & Burroughs, LLP
4518 Fulton Drive, NW
Canton, Ohio 44735-5548
(330) 492-8717

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WITNESS

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Deposition upon oral examination of STEVEN WARSOF, M.D., taken on behalf of the Defendants, before Tracy B. Marinelli, RPR, a Notary Public for the Commonwealth of Virginia at Large, commencing at 5:00 p.m. on the 5th day of May, 2003, at the offices Tidewater Perinatal Center, 1080 First Colonial Road, Virginia Beach, Virginia.

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STEVEN WARSOF, M.D., called as a witness, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. FRASURE:

Q. Is it Doctor Warsof?
A. Yes.
Q. I'm Mark Frasure, Doctor. I represent the estate of Doctor Mortier, the OB in the case. I'll ask you some questions to find out what your opinions are here. You're maternal-fetal, perinatal?
A. Yes.
Q. Board certified?
A. Yes.
Q. How much medical/legal review do you do?
A. How would you like it?
Q. Per year. I'm not talking about

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testimony, just getting cases in from Mr. Osborne or a defense attorney.
A. I think I've looked at 68 cases since 1996.
Q. Okay. And how is that broken down percentagewise?
A. I would say it's about 50/50.
Q. Okay. Has the rate of intake stayed about the same --
A. A little bit more in --
Q. -- about ten or 12 a year, something like that?
A. A little bit more in the last year or two.
Q. Okay. How many depositions, roughly -- I know these are estimates -- do you give a year?
A. One or two. I think I've given eight malpractice depositions.
Q. Did you know Mr. Osborne before this case?
A. No.
Q. Anyone in his firm?
A. I don't think so.
MR. FRASURE: Who are in your firm, Gary?
MR. OSBORNE: He doesn't know anyone.

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

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

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

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

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Then the second area that I'm concerned about is at 10:30 with the recognition of late decelerations and the plan to proceed with the cesarean section and then the baby not being delivered for essentially two hours later, with essentially no monitoring during that window of time.

Q. What type of monitoring do you think there should have been?

A. Some fetal heart monitoring.

Q. Internal monitoring?

A. Anything.

Q. There had been internal monitoring, I think, earlier, hadn't there?

A. Right, up until 10:30. Now, there may have been monitoring but we don't know what it is.

Q. Right, we don't have the strips.

A. We don't have any strips, nor do we have any nurses' notes or any documentation about what the heart rate was like during that period of time. So considering the outcome of the baby, with Apgars of one and one, the assumption has to be that it continued to be bad.

Q. If there had been an internal monitor for a while, I think, and there was, would it make any sense to take the internal monitor out even if a C

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section has been planned?

A. Well, you know, what strikes me, you know, as a clinician trying to make sense of what happened during this two hours is that people got her ready for a C section, and you have to undo everything, the monitoring, bring her to the operating room, and that's probably what happened, and then for some inexplicable reason everybody just waited until -- you know, until the delivery at 12:31.

Q. I'll ask a dumb question. Is the internal monitoring usually one of the last things that's removed as a patient is converting to a C section?

A. Well, you have to -- you have to take that off in order to move to the OR, so, you know, first, last, I guess the wisest thing to do is to continue to monitoring up until the end, and certainly a lot of places today, you know, will -- there is a monitor in the operating room. Now, I know in 1983, you know, monitors -- I mean, we were pretty good at monitoring in 1983, but, you know, things are a little bit more available today than they were then. It sounds like the nurses and everybody was ready at 10:30, C section, let's go and then nothing happened.

Q. Now, it seems like you're assuming that

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the plan was for an emergency C section. Are you making that assumption?

A. Well, it certainly wasn't a scheduled section.

Q. I understand, but can't -- is it possible that a patient like this, who is not making progress in labor apparently, that the doctors can decide within the standard of care, okay, let's go do a cesarean and it not be necessary to make it an emergency cesarean, not something that has to be done in 20 or 30 minutes?

A. Well, you know, there is -- a lot of words are being used that are confusing. There is the stat C section, you know, run in the back. It didn't seem like they needed to do that, but with the persistent late decelerations noted at 10:30 you need to move or show that these decelerations have cleared. Now, if, you know, at 10:30 they said persistent late decelerations and said, okay, let's do a C section and then they continued monitoring and all of a sudden the tracing got better, then you could say, well, maybe we'll take a little bit more time, and, you know, that's understandable, but that doesn't seem to be the case here because they -- at least we have no evidence that the tracing got better, and

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then, of course, the outcome of a baby with Apgars of one and one clearly denotes that things were not getting better.

Q. Okay. I think you had a third area of criticism. The first one was showing up three or four days before and not being dealt with and then second was at 10:30 a.m.

A. And I guess the third area would be the lack of documentation about what happened during that --

Q. Beginning at around 10:30?

A. Yes. I mean, the documentation before that is suboptimal but not terrible. It's absent after 10:30.

Q. As to what was being done or --

A. Going on, what was going on with the mother, what was going on with the baby.

Q. If the mother did come in three or four -- going back now in time, if the mother did come in three to four days earlier complaining of ruptured membranes, what did the standard of care require at that time?

A. Well, I think an evaluation for ruptured membranes, which is typically a sterile -- what we call a sterile speculum evaluation and a nitrazine

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test.
Q. Do you think in hindsight she had ruptured membranes three to four days, likely?
A. Likely.
Q. What -- if that had been done, what would the outcome have been? Would there have been an earlier delivery?
A. Well, it's hard to know a hundred percent for sure. I know what standard management would have been.
Q. What would the standard of care dictate?
A. It would have dictated that she be put into the hospital to be evaluated, start her on antibiotics, close monitoring, and if there is any evidence of infection to move ahead to deliver.
Q. Were antibiotics given prophylactically back in the early '80s?
A. With ruptured membranes?
Q. Yes.
A. I think it was, but I -- there may have been regional variation on that.
Q. If antibiotics had been given three to four days earlier, what difference, if any, do you think that would have caused?
A. Well, I would have thought that with

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

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

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

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

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

A. Yes.

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

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

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when you tend to see the bad outcomes.

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

A. As good as I can say it.

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

A. Could you repeat that again?

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

MR. OSBORNE: Can I enter an objection?

MR. FRASURE: Sure.

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

THE WITNESS: The mother has chorioamnionitis.

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

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

BY MR. FRASURE:

Q. Which she did essentially here, you're

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saying?

A. Right, yes.

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

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

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

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

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

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A. Yes.

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

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

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

A. I don't believe they do.

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

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assumption, then she comes in at 1:00 or 2:00 in the morning on the 11th. Am I correct the standard of care, starting at that point at least, allows them to watch her as they did because of her clinical situation up until around the 10:30 time frame?
A. That's correct, and I say that assuming that -- you know, we have been making certain assumptions, that the limited documentation is accurate. Again, we don't have a tracing. We know at one point that someone said -- Doctor Maiorelo said the fetal heart tracing was normal, that if it was abnormal he would have written something, so, you know, we're just assuming all this stuff is accurate.
Q. But the right testing was done upon admission and the right type of follow-up was done?
A. Right.
Q. Okay. I was looking for the baby's heart rate. While I'm looking let me ask you this, do you have any opinions on the keeping of fetal monitoring strips in the hospital, how long that's done? Oh, here we go. Any opinions on that?
A. So the question is how long does someone need to keep a fetal heart tracing?
Q. In your opinion. Do you have any --
A. I think that's something probably for

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you-all to decide rather than for me to decide.
Q. I was looking at an intrapartum flow sheet. It looks like it has a heart rate up until 11:30. Am I reading that right?
MR. OSBORNE: No. You just have the first part. I mean, you have the second part. Is that all you want him to look at?
MR. FRASURE: I can show him the first part too, of course.
MR. OSBORNE: You can show him whatever you want. I just wanted to make sure.
MR. FRASURE: Do you have that?
MR. OSBORNE: That was the one that was faxed to you.
MR. FRASURE: They're separated by a couple pages.
THE WITNESS: This is this here, I believe.
MR. FRASURE: It starts at 0240.
THE WITNESS: So that's this page here and that's this page here, uh-huh.
BY MR. FRASURE:
Q. It looks like the baby's heart rate stays in around the 140, 150 range on the first sheet. Am I reading that right?

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A. Uh-huh, yes.
Q. And on the second sheet it looks like it goes to 11:30 and is 130, 140, 140. You had said earlier, I think, that you -- we don't know what the baby's heart rate is, and I realize we don't have it until 12:30, but can we agree at least until 11:30 the indication for the baby's heart rate is okay?
A. Well, you know, it's a little bit difficult to say because, you know, he's also saying at 10:30, Maiorelo, that it's persistent late decelerations, so, you know, at one moment in time it's 140, but is that accompanied by decelerations down into the 60s or 30s? You know, we really don't know so we have some conflicting information. I guess, in fairness to everybody, it's incomplete information.
Q. I need to ask you what your rates are that you quoted Mr. Osborne for review and deposition time and trial testimony.
A. $300 an hour.
Q. I'm sorry, $300?
A. $300 an hour for review of records, $500 deposition and trial testimony and if there is travel involved.

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MR. FRASURE: I'll pass to Ms. Davis in the interest of time. Thank you.
EXAMINATION
BY MS. DAVIS:
Q. Doctor, did you notice in the -- I believe it was the discharge summary -- let me get the right sheet -- that there was a reference of once the baby was delivered they determined that the gestational age was 27 to 28 weeks? Did you see that?
A. I didn't see that. That seems to -- what I saw was 33 to 35 weeks.
Q. If you look at -- let me get the right -- let me get the right record here. If you look at the -- let me find it here.
MR. OSBORNE: Are you referring to this?
MS. DAVIS: No. Give me a second.
THE WITNESS: I would be surprised if -- oh, I see something here that says approximately 27 weeks' gestation in the preoperative diagnosis, but that certainly flies in the face of all other information that was provided, including the ultrasound examination done at that time, I think an earlier ultrasound evaluation, as well as the neonatal evaluation of the baby.

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BY MS. DAVIS:
Q. Doctor, help me here. What is the title of that record?
A. St. Thomas Hospital Medical Center, Akron, Ohio, discharge summary. At least that's what I'm looking at.
MR. OSBORNE: Well, there is actually a discharge summary that is a discharge summary. Then there is a discharge summary that's really an op note. Is that the one that's the op note?
THE WITNESS: This one looks like it's an op note, and that reference to 27 weeks, that I'm looking at at least, is in the preoperative diagnosis.
MS. DAVIS: I had it marked and I lost it.
THE WITNESS: It's on the side with some handwriting that says op note.
MR. OSBORNE: That is my handwriting.
BY MS. DAVIS:
Q. You said it was a preoperative estimation, Doctor?
A. First of all, are we all looking at the same page?
Q. It says discharge summary, okay, and then

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

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

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

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age for a baby in weeks?
A. Full term?
Q. Full term.
A. Forty weeks. You know, usually we consider term 37 to 42 weeks. Some people say 38 to 42 weeks.
Q. And you noticed throughout that -- throughout the record that whenever a history was taken of the mother with respect to her last menstrual period there was always a question mark put there?
A. Right, and that's why there was an early ultrasound done, and although it wasn't -- we don't have any documentation of exactly what the scan showed, I think there was an assignment of gestational age based on that, which put her at 33 to 35 weeks, which was consistent with the neonatologist's evaluation.
Q. And your basis for concluding that the mother had gone to the hospital several days prior to the November 11th presentation is based upon the mother's testimony in her deposition, correct?
A. And the grandmother's.
Q. And the grandmother's?
A. Yes.
Q. Do you have any other basis for that

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assumption?
A. There is no other documentation I was able to find.
Q. And just to be clear, as I understand it, with respect to the care that was rendered on November 11th of 1983, you don't have any criticisms until after 11:00; is that correct?
A. After 11:00.
Q. You believe the baby should have been delivered at what time at the latest?
A. 11:00, 11:15.
Q. What is the basis for that, Doctor?
A. Well, the plan at 10:30 was to proceed with cesarean section. I think the permit said cesarean section at 11:00. The nurses come in ready for cesarean section at 11:00. Let's go to cesarean section.
Q. In a situation like this, once the C section was called for what is the time frame within which the baby should be delivered?
A. Well, it depends on the clinical situation, and, you know, there are some times when, you know, the right answer to that is five minutes and sometimes there is no urgency at all, but for there not to be urgency you have to -- what is the

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heart rate, how is the mother doing, how is the baby doing. If the mother and baby are doing fine then certainly you can -- you don't have to do it in 30 minutes or rush, or there is plenty time, but in this situation again we don't know what the fetal heart rate tracing is. We only know the outcome for the baby, and so you have to -- at least I would assume as a clinician that what happened was that the baby got worse and worse, so I would say that it should have been done within a half hour.
Q. Even in light of the fact that Mr. Frasure pointed out that on the record there it indicates at 11:30 there was a fetal heart rate of 140? That wouldn't be significant to you?
A. Well, because we don't know, you know, what the heart rate was sort of in between, whether there was severe decelerations, whether there was bradycardias and just at that one moment it was at 140, we don't know about the variability, you know, that's -- that one point in time really wouldn't make me think one could delay this.
Q. Is it fair to say, then, that you can't say one way or the other whether in an earlier C section at 10:30 or 11:00 or within that time frame would have made a difference in the outcome?

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A. I think it would have made a difference in the outcome because, you know, of course the longer a baby stays in jeopardy the worse the outcome, and we know at 10:30 that there is persistent late decelerations according to Doctor Maiorelo. I don't know exactly when that started, how long it was going for, but certainly at least standard obstetrical teaching is that the longer you expose the baby to insult the worse the outcome.
Q. Can you state, however, within a reasonable degree of medical probability more likely than not that the outcome would have been different?
A. I believe the -- certainly the Apgars would have been better and I think the resuscitation would have been easier if the baby was delivered sooner.
Q. What do you know about Robert Brooks' present condition, anything?
A. Only what is in the depositions.
Q. Do you hold any opinions as to what are the causes of his present conditions?
A. I would have to defer to a neurologist.
Q. You're not going to render any opinions relative to that?
A. That's correct.

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

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

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that but it's on the --
A. I see it. I got the impression that was 119 kilos.
Q. Kilos for the mom?
MR. OSBORNE: That's a big woman right there.
THE WITNESS: My experience in obstetrics would put that more the average, 119 kilos.
MR. OSBORNE: That would be about 250 pounds.
BY MS. DAVIS:
Q. Well, if you look at the nursing history on admission, Doctor, it would be in the labor and delivery records.
A. Where it says actual 119?
Q. Yes.
A. Yes.
Q. You -- we don't know if that's kilos or pounds, correct?
A. That's correct.
Q. If it was kilos, what would that translate to into pounds?
A. It would be 261.
Q. I guess what we can do is we can go back and look at her records prior to her becoming pregnant

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

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

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

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

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she went to the hospital several days prior and there was no --
A. Is that a work product, Gary?
MS. DAVIS: Actually I'm going to ask for a copy of that as well. I'm making a request for a copy of the typed notes that were prepared by the witness in review of the records.
MR. OSBORNE: These are my notes.
MS. DAVIS: Oh, these are yours?
MR. OSBORNE: Yes.
MS. DAVIS: I still would like a copy.
MR. OSBORNE: That's fine with me.
THE WITNESS: I was going to say I have no notes.
MS. DAVIS: These were notes you provided to the doctor, correct?
MR. OSBORNE: Yes. I don't care, you can look at them.
BY MS. DAVIS:
Q. The mother had testified that she had gone to the hospital several days prior, and you are critical -- you are critical of the hospital for not seeing to it that she saw a doctor or a nurse or some care provider, correct?
A. To be evaluated.

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

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

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

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

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A. Okay. Do you want to try it again?
Q. Let me ask you this, what are causes of chorioamnionitis not associated with ruptured membranes?
A. Well, again, I already mentioned one is infection from the Listeria, which is a bacteria that seems to be able to get into the uterus without ruptured membranes, and I guess, two, invasive procedures such as amniocentesis, CVS or PUBS can lead to chorioamnionitis with intact membranes. Those are the things that come to mind right offhand.
Q. Can chorioamnionitis develop without a known cause?
MR. FRANSURE: Idiopathic.
MS. DAVIS: Without knowing what the cause is.
THE WITNESS: Chorioamnionitis is by definition I guess an infection of the uterus, so the implication is that there has to be a bug there someplace. So can you have chorioamnionitis without there being a bug? Actually no because then you can't have the itis if you don't have a bug, but you certainly can have chorioamnionitis and most cases of chorioamnionitis not result in babies with Apgars of one and one, and that's, I think, the important issue

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here. Not to confuse people, that you can have chorioamnionitis but if it -- the patient is cared for appropriately the outcome for the baby is mutually good.
BY MS. DAVIS:
Q. Doctor, have you ever been sued for malpractice?
A. Yes.
Q. How many times?
A. There have been four claims made against me.
Q. What were the nature of the lawsuits against you?
A. The first one -- do you want names or just --
Q. I just want to know what is the basis of the malpractice, very briefly?
A. The first case was a baby that died after an amniocentesis. The second case was a uterine perforation at the time of a D&C for a missed abortion. The third case is a ruptured cecum in the postoperative period from a cesarean section. The fourth case is a shoulder dystocia. There is five cases, I'm sorry, and the fifth case is a lady who has -- states that she hasn't been able to have

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sexual relations with her husband because of a uterine rupture that was repaired after a VBAC.
Q. Are those all of them?
A. Yes. That's plenty.
Q. The first one you said was the baby died after the amniocentesis?
A. Yes.
Q. What was the -- how many months?
A. Nine months, term baby, and that was a defense verdict.
Q. And the second one?
A. The question?
Q. I'm sorry, the second lawsuit.
A. The outcome?
Q. Yes.
A. That was -- what do you call it when the judge dismisses the case after the plaintiff puts on his thing?
Q. Directed verdict?
A. Directed verdict.
Q. So that went to trial?
A. Yes.
Q. And the next one?
A. Both of those two went to trial.
Q. The next one.

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A. The next one I was dismissed from.
Q. There were other defendants I'm assuming?
A. Right, but then the case just went away.
Q. And the next one?
A. There is the shoulder dystocia case that happened in 1990 and has not yet gone to trial.
Q. And the last one?
A. Has not yet gone to trial.
Q. It's pending?
A. Yeah, 1990.
Q. And the previous 1990 case, that is still pending?
A. Oh, okay, I'm sorry. The 1990 one was a shoulder dystocia, and that's still pending, I assume. The VBAC one happened in 2000, not 1990.
Q. And that's still pending?
A. That's still pending. We'll be going to trial May 28th of this year, federal court in Norfolk, Virginia.
Q. And as I understand it you've not done any research or published in the area of chorioamnionitis; is that correct?
A. That's correct.
Q. Have you published in the area of what occurs when there is a premature rupture of membranes

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

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personal malpractices. Just to be complete, there was another case in which I guess I was a witness and I had a trial appearance as a witness but I wasn't really on either side.
Q. You were a fact witness?
A. Fact witness.
Q. In other words, it was a case where you were involved in taking care of the baby?
A. Right. It was in 1981. It went to trial in 2002.
Q. But you were not considered an expert in that case?
A. I was not an expert.
Q. What were the issues in that case?
A. A baby with good Apgars that turned out to have some syndrome and they were claiming perinatal asphyxia.
Q. And who were you -- when did you take care of the baby?
A. I took care of the mother in 1981.
Q. During her pregnancy?
A. Her delivery, yes.
Q. She was high risk?
A. Mezzo mezzo.
Q. You were involved in the delivery?

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A. Yes.
Q. Who was being sued?
A. I think George Washington University. That's where I did my residency.
Q. Were they being sued based upon the care that you provided?
A. I guess the care that was provided for -- to this patient, which I was the chief resident, not the attending.
Q. Was your care in question? That's the question.
A. Yes.
Q. What was the outcome of that case?
A. Defense verdict.
Q. Did you believe that you did anything wrong in that case?
A. No.
Q. What was the name of the case?
A. I think Johnson versus George Washington.
Q. And where -- where was the case?
A. In the District of Columbia.
Q. What year was that?
A. January, '02.
Q. That was the trial date?
A. Yes, and the actual delivery was in '81.

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

any way for disciplinary reasons?
A. No.
MR. FRASURE: That's all.
MS. DAVIS: I don't have any other questions.
MR. OSBORNE: He'll read it.
(The deposition was concluded at 6:25 p.m.)

CERTIFICATE

I, the undersigned, STEVEN WARSOF, 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

_____ _____
Date Signature

STATE OF: _____
CITY OF: _____

Subscribed and sworn to before me this _____ day of _____, 2003 at _____, _____.

_____
Notary Public

MY COMMISSION EXPIRES

COMMONWEALTH OF VIRGINIA AT LARGE, to wit:
To-wit.
I, Tracy B. Marinelli, RPR, a Notary Public for the Commonwealth of Virginia at Large, of qualification in the Circuit Court of the City of Chesapeake, Virginia, and whose commission expires July 31, 2006, do hereby certify that the within named deponent, STEVEN WARSOF, M.D., appeared before me at Virginia Beach, Virginia, as hereinbefore set forth; and after being first duly sworn by me, was thereupon examined upon his oath by counsel; that his examination was recorded in Stenotype by me and reduced to typescript under my direction; and that the foregoing constitutes a true, accurate, and complete transcript of such examination.

I further certify that I am not related to nor otherwise associated with any counsel or party to this proceeding, nor otherwise interested in the event thereof.

Given under my hand this 8th day of May, 2003 at Norfolk, Virginia.

_____
Tracy B. Marinelli, Notary Public

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C E R T I F I C A T E

I, the undersigned, STEVEN WARSOF, 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

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.

Judith Kiefer
Notary Public

June 30, 2005
MY COMMISSION EXPIRES