IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SECOND CIVIL DIVISION

FELICIA (BROWN) BARR AND
MARCELL BARR PLAINTIFFS

vs. NO. CV-2002-5986

WOMEN'S COMMUNITY HEALTH CENTER
and THOMAS TVEDTEN, M.D. DEFENDANTS

MOTION FOR SUMMARY JUDGMENT

Come now Separate Defendant, Thomas Tvedten, M.D., by and through his attorneys, Mitchell, Williams, Selig, Gates & Woodyard, and for his Brief in Support of Motion for Summary Judgment, state the following:

1. On June 7, 2002, Plaintiff filed a medical malpractice lawsuit against the Defendants, wherein Plaintiff alleged that Defendants' actions on or about June 10, 2000 caused a medical injury to Felicia Barr.

2. The only expert witness Plaintiff has presented has, through two depositions (attached hereto as *Exhibits A and B)* clearly established that he is unfamiliar with the standard of care applicable in Little Rock, Arkansas to a General Practitioner ("GP") performing 20 week pregnancy terminations in or around June, 2000.

3. "[T]he proof required to survive a motion for summary judgment in a medical malpractice case must be in the form of expert testimony." *Ford v. St. Paul Fire and Marine Ins. Co.*, 339 Ark. 434, 5 S.W.3d 460 (1999); *see also Eady v. Lansford,* 351 Ark. 249, 92 S.W.3d 57 (2002).

4. Despite the allegations found in Plaintiff's Complaint, Plaintiff has failed to produce any competent expert testimony to establish the standard of care applicable to Dr.

Tvedten. Therefore, under Arkansas case law, Dr. Tvedten has demonstrated that no genuine issues of material fact exist and he is entitled to judgment as a matter of law. *Robson v. Tinnin,* 322 Ark. 605, 911 S.W.2d 246 (1995).

5. Furthermore, attached to this Motion is the Affidavit of Dr. Jerry Edwards and the Affidavit of Thomas Tvedten which contradicts the assumptions made by Plaintiff's expert about the standard of care applicable in this case. *Exhibits C and D.*

6. Although this Motion is being filed slightly less than the full 45 days prior to trial as envisioned by Rule 56, this Motion is being filed within 48 hours of receiving the transcript from Plaintiff's expert's evidentiary deposition taken on July 8, 2009. Therefore, Dr. Tvedten asks that the Court reduce the time for filing dispositive motions under the power granted to the Court under Rule 56 for good cause shown.

WHEREFORE, Dr. Tvedten asks that this Court grant his Motion for Summary Judgment, dismiss Plaintiff's lawsuit against him, and for all other relief this Court deems appropriate.

Respectfully submitted,

MITCHELL, WILLIAMS, SELIG, GATES & WOODYARD, P.L.L.C.
425 West Capitol Avenue
Little Rock, Arkansas 72201
(501) 688-8800

By: _____
Ken Cook (Ark. Bar No. 78030)
Michelle H. Cauley (Ark. Bar No. 98146)

CERTIFICATE OF SERVICE

I, Michelle H. Cauley, certify that a copy of the foregoing was mailed, postage prepaid, on the 22nd day of July, 2009, to:

Mr. Glenn Wright
Wilson & Wright
100 North Main
Suite #2601
Memphis, TN 38103

Mr. Don Bacon
Friday, Eldredge & Clark
400 W. Capitol
Suite 2000
Little Rock, AR 72201

Michelle H. Cauley

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SECOND DIVISION

NO. CIV-2002-5986

CERTIFIED COPY

FELICIA BROWN (BARR) AND MARCELL BARR,

Plaintiffs,

vs.

WOMEN'S COMMUNITY HEALTH CENTER AND THOMAS TVEDTEN, M.D.,

Defendants.

DEPOSITION OF

JAMES RAY DINGFELDER, M.D.

CHAPEL HILL, NORTH CAROLINA

APRIL 25, 2005

ATKINSON-BAKER, INC.
COURT REPORTERS
500 North Brand Boulevard, Third Floor
Glendale, California 91203
(818) 551-7300

REPORTED BY: WANDA B. LINDLEY, CVR-CM

JOB NO.: 9F0300F

EXHIBIT
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N THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SECOND DIVISION

NO. CIV-2002-5986

FELICIA BROWN (BARR) AND MARCELL BARR,
Plaintiffs,
vs.
WOMEN'S COMMUNITY HEALTH CENTER AND THOMAS TVEDTEN, M.D.,
Defendants.

Deposition of JAMES RAY DINGFELDER, M.D., taken on behalf of the Defendants in the Hampton Inn, Carolina Room, 1740 U.S. Highway 15-501 South, Chapel Hill, North Carolina, commencing at 9:26 a.m., Monday, April 25, 2005, before Wanda B. Lindley, CVR-CM.

APPEARANCES

FOR THE PLAINTIFF:

WILSON & WRIGHT
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I N D E X

WITNESS: James Ray Dingfelder, M.D.

EXHIBITS

QUESTIONS WITNESS WAS INSTRUCTED NOT TO ANSWER:

(None)

INFORMATION TO BE SUPPLIED:

(None)

STIPULATIONS

Pursuant to notice to take deposition, the deposition of James Ray Dingfelder, M.D., was taken before Wanda B. Lindley, CVR-CM and Notary Public. The deposition was taken in the Hampton Inn, Carolina Room, 1740 U.S. Highway 15-501 South, Chapel Hill, North Carolina, commencing 9:26 a.m., Monday, April 25, 2005.

Reading and signing of the deposition was requested by counsel.

JAMES RAY DINGFELDER, M.D.,

having first been duly sworn in the matter provided by law, was examined and testified as follows:

EXAMINATION

BY MS. CAULEY:

Q. Dr. Dingfelder, could you give us your full name and address?

A. My name is James Ray Dingfelder, M.D., and I live at 215 Wild Turkey Trail in Chapel Hill, North Carolina. My office is at 180 Providence Road in Chapel Hill, North Carolina.

Q. Doctor, I understand you've given depositions before in your career. Is that correct?

A. Yes.

Q. Okay. So you understand the ground rules as to why we're here, I'm assuming, but let me still give you my little spiel, if you will.

This is a discovery deposition. The purpose is for me to obtain as much information as I can from you about the opinions that you're going to express at trial. I'm going -- I intend to ask very concise questions, but if at any time I ask a question that's confusing to you or you don't understand, if you would

please let me know so I'll be happy to rephrase it. The point is for me to be able to rely on the testimony that you give me here today at trial.

I intend to give you ample opportunity to express any and all opinions you have in this matter so that we can be certain that we've covered the breadth of all your opinions.

I had sent a Notice of Deposition, but I don't believe that you had had an opportunity to receive this. I think there was some problem in it arriving late. But let me show this to you, and I'm going to mark that as Exhibit 1 and kind of go over some of the documents that I had requested that you bring today and see if you've brought those, and if not, if we can make arrangements to obtain the documents listed there that you may have that you haven't brought with you.

A. (Reviewing documents.) I think I have all the records, and the only other thing I brought with me is a textbook which has a chapter that I wrote several years ago.

Q. Okay. Well, we can -- we can get that. If I could see that Notice, Doctor.

(Witness hands document to Ms. Cauley.)

Q. Thank you.

MS. CAULEY: Mark that as Exhibit 1.

(Defendants' Exhibit 1 was marked for identification.)

Q. BY MS. CAULEY: Now, I notice you have brought with you a file. And if I could look at that, please. I'm assuming that that's all the information that would be responsive to documentation I have requested. And I'd like to take just kind of an inventory of this initially.

The first thing that you've handed me is a handwritten -- or some handwritten notes on a note pad. It says "Lamicel 5 milligrams times two plus Cytotec at 0900 hour." And there's a few other things written down about Versed, "time to O.R.," Pitocin. What is this, Doctor?

A. Those are notes that I took after I read the initial chart.

Q. Okay. There is also -- looks like a calculation out here to the side. It says "vertex diameter." What is that?

A. That has to do with how -- I'll have to look at it again.

(Reviewing document.) I think it was a via-- informal calculations on how wide of a diameter would be necessary -- in real centimeters how wide it would be necessary to dilate the cervix.

Q. Okay. Are those calculations you did on your own?

A. Yes.

Q. Okay. Do you know where you obtained the information to make these calculations?

A. Yes. The suction cannulas that are -- that are used to -- in cases like this are expressed in numbers, Number 16, and -- and then roughly 3.18 was the -- would tell you how -- how many centimeters around they would be.

Q. Okay. So you ---

These numbers that you're using here are based on the diameter and the size of the instrumentation that's used to perform the actual termination. Is that correct?

A. Yes.

Q. Okay. There's also a note down here that says, "3/13/01, discussed" -- looks like "discussed with Wright & Wilson."

Is that the first conversation you had with Ms. Barr's attorneys in this case?

A. Yes.

Q. Okay. I'll hand that to you. And I'd like to make a copy of that and attach that note that we've just been discussing as Exhibit 2 so that we'll

know on down the road what it is we were referring to.

(Defendants' Exhibit 2 was marked for identification.)

Q. BY MS. CAULEY: Okay, Doctor, if I could have the next thing that's in your file. Or if you just want to hand me your file, I'll just kind of go through and inventory it, and that may speed us along a little bit.

A. (Reviewing documents.) Actually, those are -- a recent letter.

Q. All right. This letter is a letter dated August 4th of 2004 sent from Mr. Wright -- sent by Mr. Wright to you. It references that you had been contacted a couple of years ago. Would that be in reference to the date you had scribbled, the 3/13 of '01?

A. Yes.

Q. Okay. And it says, "We previously sent the medical records and deposition of Thomas Tvedten."

At this point in this letter of August 4th of 2004, had you reviewed anything other than the deposition of Dr. Thomas Tvedten and the medical records in this case?

A. I'm not sure. I note the date of the deposition of Dr. Andrews is July 13th, 2004, so I'm not

sure when I reviewed that, but I had -- I have a copy of that deposition.

Q. Well, and in this letter, it says that it is enclosing a copy of --

A. Ah.

Q. -- the deposition of Dr. Andrews. So my question was, up until this point, August 4th of 2004, had you reviewed anything other than the deposition of Thomas Tvedten and the medical records?

A. No.

Q. Okay. And what medical records had you reviewed at that point?

A. The clinic records of Family Healthcare of Little Rock and the hospital medical records. They're obviously not the complete nurses' notes and things, but the operating -- operative report and pathology report --

Q. Okay.

A. -- which are here. I think there's two copies of the same one there.

Q. Okay. These records that you've handed to me, is this the extent of the medical records that you reviewed in this case?

A. Yes.

Q. And as you referenced, it looks like

there's simply two copies of the medical records from Family Healthcare of Little Rock.

(Reviewing documents.) Okay. And I don't see any kind of notes or highlighting or -- well, I take that back. On the Family Healthcare documentation, I don't see any kind of notes or highlights. Is that correct?

A. Yes.

Q. Okay. And it looks as though on the records from the University of Arkansas, the only highlighting that I see is on the Surgical Pathology Report. Make certain I haven't missed anything.

A. That is correct.

Q. Okay. I'd like to attach a copy of those medical records to your deposition as Exhibit 3.

(Defendants' Exhibits 3 and 4 were marked for identification.)

Q. BY MS. CAULEY: And I believe I've asked, but just to be certain, you haven't reviewed any other medical records as we sit here today other than those that we're going to attach as Exhibit 3 to your deposition. Is that correct?

A. Yes, that's correct.

Q. Attached to ---

And, if you would, hand those ---

MS. CAULEY: Off the record.

(Off the record)

(Back on the record)

Q. BY MS. CAULEY: Doctor, the attached -- well, you handed me the letter of August 4th, 2004, and we reviewed that a little bit. And it references an affidavit in the second paragraph. Let me show you this.

The August 2004 letter references needing you to sign an affidavit, and then there's an affidavit that you have handed me in this case. I'll show you that.

Was that affidavit sent to you along with that letter in August of 2004?

A. Was it -- was it? Yes.

Q. Yes, sir. Who prepared that affidavit, if you know?

A. I don't know.

Q. Did you prepare that affidavit?

A. No.

Q. And this affidavit was executed on the 13th day of August, 2004. At that point had you read the deposition of Nancy Andrews, which it appears was enclosed in the August 4th, 2004, letter?

A. Yes.

Q. These opinions that are expressed in this affidavit, are these opinions that you had previously given to Ms. Barr's attorneys back a couple of years earlier when you first spoke with them in 2001?

A. I think so.

Q. I'm just ---

A. I --

Q. In simple -- in simple terms, I'm just trying to figure out how someone knew to draft these opinions and send it to you in August --

A. Yes.

Q. -- of 2004, and I would assume that was from the opinions you had expressed back in 2001. Is that correct?

A. Yes.

Q. Okay. So these are opinions that you expressed prior to reading the deposition of Dr. Andrews?

A. Yes.

Q. Did reading the deposition of Dr. Andrews change any of your opinions that you had previously expressed in 2001?

A. No.

Q. Okay.

MS. CAULEY: And I would like to attach a copy

of this affidavit as Exhibit --

COURT REPORTER: 5.

MS. CAULEY: 5, thank you.

(Defendants' Exhibit 5 was marked for identification.)

Q. BY MS. CAULEY: Okay. What else do we have in your file, Doctor?

A. (Handing document to Ms. Cauley.)

Q. The deposition -- you've handed me the deposition of Dr. Thomas Tvedten, M.D.

And did you initially review this deposition ---

Well, let me ask you this question. When was -- do you recall when this deposition was sent to you?

A. No.

(Outside noise interference.)

(Off the record)

(Back on the record)

Q. BY MS. CAULEY: Doctor, I was asking you about when you had reviewed the deposition of Dr. Tvedten, and I believe your answer was you don't recall?

A. Correct.

Q. Do you have any correspondence in your

file showing when this deposition was sent to you?

A. Only a letter that -- dated August 4th, 2004, which indicated that it was prior to that.

Q. Okay. Back in 2001 when you were first contacted about this case, what were you told as far as the -- well, let me -- let me back up.

How were you first contacted? Was it by a telephone call or was it through some other means?

A. I don't recall.

Q. Okay.

A. I presume it was by telephone.

Q. Okay. Do you recall what you were told about the allegations in this case when you were first contacted?

A. No.

Q. Do you recall when you first reviewed the medical records in this case?

A. Not off the top of my head. If I had put a note on the -- (reviewing file) -- the only note I have is that I discussed it by telephone on March 13th of '01, so I must have reviewed the records shortly before that.

Q. Okay. Do you know how Ms. Barr's attorneys found you as far as knew that you may be available to review the records in this case?

A. No, I don't, although I may -- I may have reviewed a case for them in previous years, but I -- I don't recall any such case, but I may have.

Q. Okay. Well, that was going to be my next question is whether you've worked with Ms. Barr's attorneys in the past. And you simply don't recall?

A. No, I don't.

Q. Okay. The next ---

I'll hand you back Dr. Tvedten's deposition. What is the next thing that you have in your file?

A. That's it.

Q. I think the deposition of Dr. Andrews. Is that what --

A. Yes.

Q. -- that is right there?

A. Uh-huh.

Q. Okay. What we have just inventoried in the file that you've brought, is that the -- is that everything that you have reviewed in this case?

A. Yes.

Q. Okay. As we sit here today, have you reviewed all of the materials that you intend to review in order to give your final opinions in this case?

A. Yes.

Q. Okay. And just so we're clear, you don't intend to review any additional information or obtain any additional information prior to rendering your final opinions here today, do you?

A. No.

Q. And prior to rendering your final opinions at trial, you don't intend to review any additional materials?

A. The only additional material I might try to review is to further strengthen my position that the basic problem here was over-dilation.

Q. What additional information would you intend to review?

A. I don't know. I -- you know, I would -- if I happened to find some other reference that showed other bad outcomes due to over -- over-dilation of the cervix, that would strengthen my position.

Q. And if I'm understanding your answer correctly, Doctor, what you're saying is if there's any additional medical literature or things out there that you come across that may strengthen your opinions, you may review that prior to trial. Is that --

A. Yes.

Q. -- your under-- my ---

Is my understanding correct?

A. Yes.

Q. Okay. But, factually, is there any additional information with respect to this case, factually, that you feel you need in order to render your final opinions here today and at trial?

A. No.

Q. And other than just happening to come across additional medical literature, do you intend to do any additional medical literature reviews with respect to any issues in this case --

A. No.

Q. -- prior to trial?

A. No.

Q. And I would ask that if you do review any additional materials, that you would let Mr. Wright know so that he can let me know and I can have the opportunity to ask you a few more questions, whether it be just by telephone deposition, but so that I could have the opportunity to ask you questions about your review of additional materials prior to trial. Is that fair enough?

A. Yes.

Q. Okay. How many hours have you spent reviewing this case?

A. Not -- not many. Probably a total of

six.

Q. Have you billed Ms. Barr's attorneys for your time so far?

A. Not currently. We -- initially, I think we did.

(Outside noise interference.)

MS. CAULEY: Hold on. We've got our ground crew back again.

(Off the record)

(Back on the record)

Q. BY MS. CAULEY: Doctor, before we took our break, I was asking you whether you had billed Ms. Barr's attorneys for your review in this case, and I believe your answer was that you had initially. What have you billed Ms. Barr's attorneys --

A. Yeah, I had --

Q. -- for to-date?

A. It would seem to-date -- I don't know. My office people do that.

Q. Do you bill based on the hours that you spend in reviewing, or is it in some other form?

A. Mostly the billing is for the hours that we spend in deposition.

Q. But with respect --

A. Or half -- half of a day is what it will

amount to.

Q. But with respect just to reviewing records and materials that have been sent to you, do you keep track of that in any way?

A. No. To tell you the truth, no.

Q. You have documented, it appears, some kind of a telephone call or some kind of contact in March of '01, which you had previously told me represented your initial contact on this case, and then there's also the letter of August 4th, 2004.

Other than those two contacts, do you know of any other contacts you've had with Ms. Barr's attorneys in relation to this case?

A. No.

Q. You don't recall any other conversations that you've had with them?

A. No, I don't.

Q. When you rend---

When you first rendered your opinions that are referenced in your affidavit about the allegations in this case, the allegations of medical malpractice against Dr. Tvedten, when you had first rendered those opinions, do you recall what information you had reviewed prior to rendering those opinions?

A. No, I don't. I don't specifically

recall. I believe they sent me the medical records that I have today.

Q. Okay. And those are the records that we've attached as an exhibit to your deposition?

A. Yes.

Q. Okay. I understand you have served as an expert witness in other medical malpractice cases in the past. Is that --

A. Yes.

Q. -- correct?

Do you know approximately how many cases you've testified in as an expert witness?

A. No, I don't. I don't -- I don't know the number. It's --

Q. Can you estimate for me?

A. Well, depending on one's definition of testimony. If it's an affidavit --

Q. Well, let -- let's break --

A. -- or --

Q. -- it down. How about trial testimony? How -- do you recall or can you estimate how many times in your career you have given trial testimony as an expert witness?

A. I've been asked this question before, and I -- and I never know how to answer it because I don't

know what a trial is or I don't know what trial testimony is. If it means did I leave this town and go to a distant city and appear in a courtroom, that kind of trial, that could have been once a year for 25 years.

Q. So could have been approximately 25 if you're estimating?

A. Yes.

Q. And with respect to not going and actually giving live testimony at trial, just with respect to giving deposition, --

A. Yes.

Q. -- do you know or can you estimate approximately how many depositions you've given in your career as an expert witness?

A. Another 50 or 60. Every -- another -- twice a year.

Q. Do you know how many cases you have reviewed approximately over the last 25 years? And when I say "reviewed," I mean contacted by --

A. Yes.

Q. -- an attorney, sent medical records, and asked to review and give opinions.

A. Specifically, no, I don't know the number, but I would estimate perhaps that I've looked at four to six cases a year. Half of them -- roughly half

of them I find no case at all, and then the other half there's maybe a case.

Q. So four to six cases per year, and you've been doing this for approximately 25 years?

A. Yes.

Q. Okay. So somewhere between a hundred and a hundred and fifty cases per year -- I mean, a hundred -- start over.

You've reviewed approximately a hundred to a hundred and fifty cases in your career?

A. Probably in addition to the ones I give, you know, --

Q. Okay.

A. -- actual testimony. So it could be 200.

Q. Okay. So out of those just approximately 200 cases, how many of those have been on behalf of a defendant physician?

A. Not very many. Half a dozen.

Q. And I don't profess to be a math genius, but I would assume that out of -- six out of approximately 200 would be a very small fraction of your cases that you've reviewed on behalf of defendant physicians. Is that a fair statement?

A. Yes. By the very nature of this work, you're not asked by defendant physicians to be their

reviewer. That happens in a different manner.

Q. Do you have an understanding as to how it happens when you're asked -- what different process takes place when you're asked to review a case on behalf of a defendant physician versus being asked to review a case on behalf of a plaintiff?

A. Well, of course. In -- almost invariably the defendant physician obtains the services of a colleague in the same hospital or town or a nearby medical school; someone that they know. And in most cases, this someone they know is all too willing to provide testimony. I would do the same.

Q. Have you been asked by any of your colleagues to review any cases on their behalf?

A. Yes.

Q. And have you done so?

A. Yes.

Q. And have you provided testimony on their behalf?

A. Yes.

Q. And when you're doing so, I would assume that just because of the fact that they are colleagues of yours and you practice in the same area, you still wouldn't lower your standards or your integrity and give opinions that you didn't truly believe were sound and

valid opinions, would you?

A. I wouldn't. I have -- it has been my opinion that in some cases I've heard supporting testimony from a local physician that was less than totally honest, in my opinion.

Q. But you wouldn't do that in your review --

A. Absolutely not.

Q. -- of a case.

Because that would be compromising your integrity, correct?

A. Absolutely.

Q. And you wouldn't expect that to be a common occurrence, would you, that physicians would commonly compromise their integrity just to testify on behalf of a colleague?

A. I don't -- I don't know one way or the other. I've had -- I've seen it happen.

Q. When did you first begin reviewing medical-legal cases?

A. I reviewed a few when I was on the full-time faculty here at the University of North Carolina School of Medicine. It was an allowed sort of extracurricular activity by the department for a number of years, and then for whatever reason the department

decided they would prohibit that activity. Or not exactly prohibit it, but they prohibited payment for this activity, so naturally no one wanted to do it after that.

Q. Have you ever advertised your services?

A. No.

Q. How much do you charge per hour?

A. I'm not sure anymore. What my office manager says. We used to charge -- would charge, like, $400 for the first hour and then 250 or something about -- something like that after -- per hour after that.

Q. Do you know what your rates are for giving actual live trial testimony?

A. Approximately the same.

Q. Do you plan to come to Arkansas to give testimony in this particular case?

A. I would, if necessary.

Q. Have you been asked?

A. No.

Q. What percentage of your income comes from reviewing and providing testimony in legal cases such as this?

A. I don't know, but it's always been less than five percent.

Q. We have inventoried all the materials

that you've reviewed in this case that you've been sent by Ms. Barr's attorneys. Have you -- after reviewing these, materials, have you asked her attorneys to send you any additional materials that would shed light on any of the factual issues in this case?

A. No.

Q. And are you aware that Ms. Barr herself has given a deposition in this case?

A. I -- I don't recall whether I heard that or not.

Q. But you haven't asked to see her deposition or her testimony in this case?

A. No.

Q. And you don't intend to prior to trial?

A. I might ask to see it if there is anything of interest.

Q. Okay. 'Cause I think I had asked you previously if there was any other factual information that you intended to review or that you needed prior to rendering your final opinions, and I understood your answer to be no.

A. (No audible response.)

Q. And the reason -- and I'm not trying to -- to trick you or anything like that. I just want to make certain that as we sit here today that you've

reviewed all the materials that you intend to review so that we can get your final opinions in this case.

A. I might ask to see that, but I doubt that it would provide any further information to me.

Q. Okay. If you do review any additional information, any additional materials, would you let me know through Mr. Wright so that I can have the opportunity to ask you questions about that and whether it has changed your opinions in any way?

A. Yes.

Q. Have you performed any review of any medical literature in this case?

A. No, I have not.

Q. And I think I asked you earlier that if -- if you do review any medical literature, the same -- the same provision, that you would let Mr. Wright know so that I could have the opportunity to ask you additional questions about any information you've obtained from any medical literature.

A. Yes.

Q. I've asked you about all the contact that you had with Ms. Barr's attorneys, and I think we've covered that. Other than the two instances, the one in 2001 and the one in 2004 that are noted in your file, you also spoke with Mr. Wright shortly before this

deposition. Is that correct?

A. You -- you mean ten minutes ago?

Q. Yes, sir.

A. Yes.

Q. Okay. Other than that conversation immediately before this deposition started, have you had any other conversations with Mr. Wright or anyone from his firm?

A. Ever or just -- I mean ---

Q. Other than the ones that we've discussed, --

A. Yes.

Q. -- the 2001 --

A. No.

Q. -- and the letter of 2004.

A. Not that I recall.

Q. Okay. What did you and Mr. Wright discuss immediately prior to this deposition?

A. Today?

Q. Yes, sir.

A. Nothing that had anything to do with the facts of the case. I just wanted to know if there were any -- was any new information that I was going to be asked.

Q. Such as?

A. Such as anything that I was not aware of; any new aspects of this -- in the case.

Q. So you were asking about whether there had been any new developments in the case?

A. Yes.

Q. What else did the two of you talk about?

A. Really nothing else. Nothing. That was it.

Q. The conversation lasted for about five to 10 minutes, if I recall --

A. Yes.

Q. -- correctly. And the only thing that you recall is just discussed -- asking the question whether there had been any new developments in the case?

A. Yes.

Q. And the answer to that question was?

A. No.

Q. And you don't recall anything else that the two of you talked about over five to 10 minutes?

A. No. We spent half the time finding a place to sit down.

Q. I understand you've been sued for malpractice before in your career. Is that correct?

A. Yes.

Q. Okay. Can you tell me about each

instance starting with the earliest in which you've been sued for malpractice?

A. When I was in the medical school I was involved in three or four different cases, but in fact most -- or all of them were in aspects that had -- in which I was the supervisor rather than the actual operator. But because I was the supervisor, I was named in the cases.

The very first case involved a patient who gradually lost function of one of her kidneys after having a hysterectomy, and the kidney function was lost on the side that the resident operated on that I was supervising, so I had to take responsibility.

That's -- an out-of-court settlement was reached, although the precise etiology of this injury never was determined because, as I said, the patient just gradually lost function of her kidney. It could have been from kinking of her ureter from scar tissue formation. Just -- it's unknown. It was not investigated.

Q. Okay. What was the next case?

A. Another case, a resident performed a tubal ligation by laparoscopy, and it ultimately failed. I was just present in the room, but I actually didn't do the procedure.

Q. Do you know why the tubal ligation failed?

A. Probably the resident didn't cauterize the tube long enough. In those days, they didn't have meters on the cauterizing instrument that indicated what the total amount of voltage was and that kind of thing. They have them now. They awarded the lady three -- $3,000 or something. A small fee.

Q. I'm assuming that she --

A. Yes.

Q. -- found out that the tubal ligation --

A. Yes.

Q. -- failed by becoming pregnant?

A. Right.

Q. Okay. And were the ---

The award, did it cover simply the cost of --

A. Her pregnancy.

Q. -- her pregnancy and things of that nature?

Okay. What was the next case?

A. There was a case of alleged failure to counsel and offer amniocentesis to a patient for genetic studies, and the patient ultimately had a Down's syndrome child and sued the hospital and myself for the

-- an allegation that she was not counseled about her ability -- or her right to have amniocentesis.

Q. What was your role in that case?

A. I was the attending physician at an out-- outlying clinic where this counseling took place.

Q. And what was the --

A. To make a long story short, the case was dismissed after the plaintiff's presentation and went to -- and on the grounds that there was no right to such action in North Carolina.

Q. And you said three or four different cases. Do you recall another case while you were in medical school?

A. One case, I saw a patient in the clinic the day before she came to the hospital in labor and had a bad outcome. After a week of trial, I was dropped from the case by the judge.

Q. Other than those four cases in medical school, have you been sued for medical malpractice?

A. Yes. Following -- then after I went into full-time private practice -- let's see. I had one very bad ca-- outcome case in which a child that was delivered in a -- by a forceps rotation suffered some sort of undetermined spinal cord injury. And it was never determined what, if any, role the forceps delivery

played in this injury because the child lived for nine or 10 months but had a respiratory complication and died without having an autopsy, so no one ever found out what the precise cause was.

Q. What were the allegations against you in that case?

A. That it was a forceps injury.

Q. Were you the surgeon -- or were you the obstetrician delivering the child?

A. Yes.

Q. And what was the outcome of that case?

A. They had a negotiated settlement. The insurance company recommended it and insurance -- they negotiated a settlement.

Q. Did you give your consent to that settlement?

A. Unfortunately, yes.

Q. Do you regret giving your consent to the settlement?

A. Yes, because they then turned around and canceled my insurance.

Q. Was it a large settlement?

A. Yeah, about 800,000.

Q. After they canceled your insurance, what did you do with respect to obtaining additional medical

malpractice insurance?

A. I just went to a different company, but ---.

Q. Did you have any trouble in obtaining insurance after that incident?

A. Not really, no.

Q. Any other times that you've been sued for medical malpractice?

A. One case when a local anesthetic needle broke off in the patient's abdominal wall during an injection -- injection of local anesthesia. And it required -- ultimately required a second laparoscopy to find the -- the needle fragment, and the patient sued for some type of pain and suffering or -- I don't know what the allegation was, but they -- they had -- I think the insurance company paid ten or twelve thousand dollars to settle the case.

Q. Did you give your consent to that settlement?

A. Yes.

Q. Do you recall what the allegation was against you as to how you -- well, I'm assuming that the allegation was that you had somehow breached the standard of care?

A. Yes. I -- no, I don't know what the

allegation was.

Q. Let -- let me ask it in a little --

A. It never went beyond the initial stages. I mean, there -- I don't think anybody even gave testimony or deposition that some standard was breached.

Q. Do you know in what way the plaintiff claimed you had done something wrong?

A. No, I don't.

Q. Any other times when you've been sued for medical malpractice?

A. I don't recall any other ones offhand today.

Q. If you do as we --

A. Okay.

Q. -- continue on, if you'll just stop me at any point in time. And, also, I should have said that at the beginning. If at any time as we go through this deposition, and we'll probably be here for a few hours, but any time you remember something to a question that you may not have recalled earlier on or if you need to add anything to a question, please just feel free to stop me and add to that.

In some of those cases, particularly the one with the large settlement of the child that had been delivered by forceps, I assume that the plaintiff had an

expert witness who testified that you had in some way been negligent?

A. Yes.

Q. Did you disagree with that expert witness?

A. And the only case that ever went beyond that to the point of depositions and such was the one I had talked about earlier where -- well, there were two cases. One was the alleged amniocentesis/genetic studies case. They -- and they -- they brought two -- two physicians came from out of state, and they couldn't qualify either one as an expert in North Carolina for some strange reason.

Q. Well, let's -- let's talk, then, just about the one where there was the settlement of approximately 800,000. Surely your insurance company wouldn't have agreed to pay almost a million dollars in a case unless there was expert testimony on the other side that you had somehow been negligent. Is that a fair assumption?

A. No, it isn't, in fact. Strangely enough, they recommended -- because the defendants' insurance company had prepared a so-called "day in the life" of the baby video, they were so influenced by this, I guess that they thought the potential for a much larger

settlement was there, so without ever taking any expert -- other expert testimony, they agreed to settle the case.

Q. Okay. Do you believe that when an expert witness reviews a medical malpractice case that it's important for that expert to be fair and impartial?

A. Sure.

Q. And you believe that the expert witness should not be an adversary or an opponent for any physician, but should rather be objective --

A. Yes.

Q. -- in the review of the medical documentation.

A. Yes.

Q. And in any of the cases where you've been sued for medical malpractice or if you are ever sued in the future for medical malpractice, you would want your expert or the expert hired by the plaintiff to be fair and impartial, wouldn't you?

A. Yes.

Q. And you wouldn't want such person to guess or speculate in giving their opinions, would you?

A. No.

Q. And you wouldn't want the expert witness to base their opinions on assumptions, would you?

A. I guess I don't know what the legal definition of "assumption" is.

Q. Well, not even leg-- I don't know that I'm -- there's necessarily a legal definition of assumption. Just from a normal layman's use of the term "assumption." You wouldn't want an expert medical witness to make -- to base their expert medical opinions on assumptions, would you?

A. You're -- you're skirting the case. Unless you define the word "assumption" to me and I know what you're talking about, I don't know what you're talking about.

Q. You would want an expert witness to base their opinions on the facts as they are known, --

A. Yes.

Q. -- correct?

A. Yes.

Q. And you would not want an expert witness to assume facts that were not known and couldn't -- and were not established, would you?

A. No.

Q. Because to do so would be then to guess or speculate.

A. That sounds reasonable.

Q. You would also want an expert witness who

was reviewing a case where you had been accused of being medically negligent to be knowledgeable in your particular field, wouldn't you?

A. Yes.

Q. And you would also want that expert witness to be knowledgeable and experienced in the particular surgical procedure that may be at issue in the case against you, wouldn't you?

A. Yes.

Q. And you would want that expert medical witness to be knowledgeable of the standard of care that was applicable to you, wouldn't you?

A. Yes.

Q. And you would want the person accusing you of malpractice to have a sound basis for any opinions that he rendered against you, wouldn't you?

A. Yes.

Q. And if the person suing you didn't do these things, then that wouldn't be fair to you, would it?

A. In theory, no.

Q. When you first talked to Ms. Barr's attorneys about this case, did they tell you what issues they felt were important in this case or any of the specific issues that they wanted you to look at in this

case?

A. No, I don't recall them mentioning any specific issue.

Q. Were there any specific areas in the records that they pointed you to that they wanted you to concentrate on?

A. Offhand, I don't -- I don't recall one way or the other.

Q. What do you know about Dr. Thomas Tvedten?

A. Very little.

Q. Can you tell me what you do know about Dr. Tvedten?

A. All I know about him is what I recall reading in his deposition about his background.

Q. Do you know ---

What do you know about his experience and training?

A. I don't have any of it memorized. I'd have to go back and read through what he said.

Q. Okay. Do you have any basis or any belief that his experience and training is inadequate to perform the procedures that he performs?

A. No.

Q. Do you know how many second-trimester

pregnancy terminations Dr. Tvedten had performed prior to Ms. Barr's procedure?

A. No.

Q. Can you tell me your experience in performing second-trimester pregnancy terminations?

A. As far as?

Q. Have you performed any --

A. My background?

Q. Have you performed any second-trimester pregnancy terminations in your career?

A. Yes.

Q. How often ---

How many have you performed in your career?

A. Second-trimester, --

Q. Yes, sir.

A. -- that was your question? Okay. I don't know. It's in the thousands.

Q. At what stage of gestation does North Carolina law prohibit a woman from having an abortion?

A. It's unclear, but it's probably 20 weeks. What's unclear is what 20 weeks means.

Q. Why is that unclear? Why is there confusion about that issue?

A. Because everybody counts from day zero,

so the patient's not even pregnant when the clock starts to tick and so, you know, 20 weeks is 20 weeks after the last period, but for the first two weeks the patient wasn't pregnant really.

Q. How -- how do you count it in your practice? Do you count it from day zero or do you count -- or do you give those two weeks?

A. No, I -- I always have done the same.

Q. Count it from day zero?

A. Count it from day zero. But, in fact, this question came -- did come up in an abstract sense about 10 or 15 years ago at our hospital, and I wrote to our State Attorney General and asked his opinion, and his opinion was that the clock started on the date of conception. So, in fact, it would be legal to do pregnancy termination up to 22 weeks in North Carolina. Now, I will emphasize no one does that, but this is -- that was his legal opinion. That was one Attorney General's legal opinion.

Q. Have you ever performed pregnancy termination on a woman who was past 20 weeks' pregnancy?

A. No.

Q. How many doctors in North Carolina perform voluntary abortions? When I say "voluntary," I mean elective abortions.

A. I don't know that anybody knows for -- probably the statistics in the state. I would venture to guess it's in the hundreds.

Q. Just in the Chapel Hill/Raleigh/Durham area, the Research Triangle area, how many doctors would you estimate perform voluntary pregnancy terminations?

A. And, again, I will ask -- I will have to ask you for a clarification question. Are you talking about a -- how many physicians have ever done a therapeutic abortion in the hospital on a patient of theirs, or how many people actually do clinics, or what are you talking about?

Q. I'm -- I'm talking about physicians who routinely perform voluntary pregnancy terminations in a clinic setting. I understand there may be circumstances where physicians don't normally perform voluntary abortions, but they may on occasion. I'm -- I'm speaking --

A. Yes.

Q. -- in terms of how many physicians routinely perform voluntary pregnancy terminations in the Research Triangle area.

A. I don't know. I -- I would say that -- probably at least 10 or 12, including two or three attendings at each of the two medical schools, Duke and

U.N.C., that do regular outpatient clinics in their institutions teaching residents.

Q. In those approximately 10 to 12 that you've estimated, do you include yourself as one of those?

A. Yes.

Q. Can you tell me about your clinic practice? Do you -- are you actively practicing medicine?

A. Yes.

Q. What percentage of your patients would you estimate are pregnancy termination patients, patients that come to see you for the purpose of having their pregnancy terminated?

A. In my office, five percent maybe.

Q. Can you put that in numbers of per month, how many elective pregnancy terminations you perform currently in your practice?

A. 15 or 20, I'd say.

Q. So you estimate about 15 to 20 -- you perform 15 to 20 abortions per month?

A. In my office. And then I sometimes cover the -- a clinic that will have ---.

Q. What clinic is that?

A. The Raleigh -- in Raleigh. The Raleigh

Women's Health Clinic.

Q. What is the Raleigh Women's Health Clinic?

A. It's a clinic that does pregnancy terminations, sterilizations, family planning, contraception, pap smears, that type of thing.

Q. Out of the 15 to 20 pregnancy terminations you do in your office, how many of those are second-trimester terminations, approximately?

A. It -- it varies. Not -- not many. Well, three or four.

Q. So -- and I understand you're estimating, but approximately three to four a month of the pregnancy terminations that you perform are second-trimester?

A. Perhaps more. I'm actually ignoring the definition of second-trimester, which would be what in your -- what is your definition?

Q. Well, let me ask you, what would your definition be, or do you have a definition as to what --

A. Well, strictly speaking, --

Q. -- is first --

A. -- if you divide pregnancy into three trimesters, then it would be -- 14 weeks and above would be second-trimester.

Q. What is your understanding as to how far

along Felicia Barr was when she had her pregnancy termination?

A. 20 weeks.

Q. 20 weeks, okay. So let's use that so that we don't have to speak in terms of first- and second-trimester.

Approximately how many of the patients that you perform pregnancy terminations on per month are at 20 weeks' gestation?

A. I'm really stumped on that one. It's -- it's -- it could be all four, it could be one or two some months. It's just -- it's hard to know.

Q. Can you average about how many per month, or if it's easier to do it on a per-year basis?

A. Neither one. It's -- but, I mean, at -- at -- 20 weeks is right at the limit. That would be the last that gets you in the door, so you're -- I'm not going to see too many. You'd be seeing a number of more that were 17 or 18 or 19.

Q. So for you to perform a pregnancy termination on a woman that is at 20 weeks, would that be a relatively rare occurrence in your practice?

A. It would be probably, in my own office, not too many. It's more -- I'm more apt to see those patients at the Raleigh clinic.

Q. How often do you work in the Raleigh clinic?

A. Three, four times a month. Once -- probably -- probably once a week. Usually Saturdays.

Q. Do you perform your pregnancy terminations in your office or at the Raleigh clinic?

A. Yes.

Q. Do you perform pregnancy terminations in any other setting?

A. Hospital.

Q. How often do you perform pregnancy terminations in hospitals?

A. Very rarely; only because of medical problems usually.

Q. Okay. But even a patient that's at 20 weeks that's right at the limit under North Carolina law, if there wasn't any other reason as far as any concern as health to the mother, then that would still be performed either in your clinic or in the Raleigh clinic?

A. Almost always. Once in a great while the patient just has a preference or has some odd insurance situation that demands a hospital.

Q. Do you recall when you last performed a pregnancy termination on a woman who was at 20 weeks'

gestation?

A. No, but I -- well, probably last week.

Q. Would you agree that uterine perforations are a known risk of a pregnancy termination?

A. Yes.

Q. And would you agree that that's a -- that that is something that can happen sometimes despite a physician using his best efforts and best abilities?

A. Yes.

Q. And in your career have you had a situation where you've been performing a pregnancy termination on a woman and you have perforated her uterus?

A. Yes.

Q. Is that a common occurrence in your experience?

A. No.

Q. But it is certainly something that can happen despite a physician's best efforts.

A. No.

Q. Explain your answer.

A. It's my opinion that complications such as uterine perforation are a hundred percent preventable, but the time and effort that would be expended in preventing this occasional or rare

complication is -- is -- it takes so much effort that the operator elects to take a calculated risk and proceeds under the assumption that it probably won't occur. So it's a matter of weighing the risks and benefits of -- of the time and expense and other factors that might go into your decision.

So I would hesi-- I mean, I -- there's no question in my mind that they are all preventable. We just are not prepared to take -- to go to the expense, time, and other measures necessary to make them all preventable.

Q. And would you agree that just -- that a uterine perforation in and of itself that occurs during a pregnancy termination does not in and of itself mean that a physician committed malpractice that caused that uterine perforation?

A. Yes.

Q. You said that uterine perforations, in your opinion, are one hundred percent preventable. However, because of the fact that they do occur doesn't mean that a physician was medically -- committed medical malpractice, correct?

A. Yes.

Q. So let's explore your theory that they are a hundred percent preventable. How is a uterine

perforation a hundred percent preventable?

A. One can get an ultrasound machine and put it in the operating room and do the case under ultrasound. And you're -- and in doing this, one would pass a sound or a small dilator under direct vision and watch it go up through the correct route and into the correct cavity.

And it can be done, and there are a few operators who have taken that -- the -- who are of the opinion that that is the way to do all D & E's, and it takes them, of course, twice as long to do the case. And so others have elected to go the other route, and it's hard to say who's more correct.

Q. And in your practice do you use ultrasound?

A. Occasionally.

Q. I assume, based on your answer, that you don't always use ultrasound then.

A. Well, every patient gets ultrasounded, but initially to see their size and the angularity of their uterus, et cetera, but then --

Q. Absolutely.

A. -- not during -- not intraoperatively.

Q. Thank you for clarifying that. That was a poorly-phrased question.

So you're not going testify at trial that the standard of care requires using ultrasound intraoperatively, are you?

A. No.

Q. And it's my understanding from you that the only way that these uterine perforations are one hundred percent preventable is to use ultrasound intraoperatively.

A. Yes.

Q. Speaking of the standard of care, I have just asked you some questions about standard of care, and I know that in your opinions that you've expressed in your affidavit and as you and I have talked here today have used that term, standard of care, and I'd like to ask you to define in your own words what you mean by "standard of care."

A. My definition of "standard of care" is the degree of expertise and the methodology that is employed by the large majority of experienced, learned people in the field, and -- and it is exemplified by the standard literature of that field.

Q. But the actual standard of care that is applicable to various circumstances, that's not something that's just written somewhere that one can just go and flip to and look and see under certain

circumstances this is what the standard of care requires, correct? It's not just something that's just written down in black and white, is it?

A. Not always.

Q. You agree that clinical judgment has to factor into what is the applicable standard of care?

A. I guess I don't disagree with that.

Q. Well, you agree that physicians are required to rely not only on their training and experience, but also on their clinical judgment. Would you agree with that?

A. In general.

Q. Okay. What have you done to familiarize yourself with the standard of care for an OB/GYN performing abortions in Little Rock, Arkansas, in June of 2000?

A. Nothing more than to review the standard textbooks.

Q. What are those standard --

A. And --

Q. -- textbooks?

A. There are -- in obstetrics and gynecology, you mean?

Q. Yes, for -- for an OB/GYN performing abortions in Little Rock, Arkansas, in June of 2000.

What did you do to familiarize yourself with the standard of care that would be applicable to such a physician?

A. I actual-- I did not consult anyone in Little Rock, Arkansas. My presumption is that they perform their procedures the same way as other practitioners do around the country.

Q. Do you assume, then, that there is a national standard of care that covers all physicians performing abortions across the country?

A. Yes.

Q. And that standard of care doesn't differ between localities in the country?

A. Not in the usual major components of practice.

Q. And your opinions here today are all based on that assumption, that the standard of care that applies to physicians performing abortions is the same throughout the -- throughout the country?

A. That is my personal belief.

Q. And that's what your opinions as we sit here today, we're about to explore in detail, are based on, correct?

A. Yes.

Q. Do you know any physicians in Little Rock

who perform abortions?

A. No.

Q. Do you know how many physicians in Arkansas perform elective abortions?

A. No.

Q. Do you know how many clinics in Arkansas perform elective abortions?

A. No.

Q. Have you made any assumptions about that information such as assumed that there is a certain number?

A. No.

Q. Do you think that is important information in any way to know ---

In forming your opinions, is it important for you to know how many physicians in Arkansas perform these procedures and how many clinics in Arkansas perform these procedures?

A. No, it isn't. I don't see how it makes any difference.

Q. Okay. And is that going back to your opinion that there's just a national standard of care that covers all physicians performing these procedures?

A. Yes.

Q. Okay. I'd like to visit with you about

your opinions in this case. I know you probably thought we were never going to get to it.

I have --

MR. BACON: Michelle, are you going to take a break for a minute?

MS. CAULEY: Yeah, I think this is probably a good time 'cause we're about to launch off into a new area. So if we -- if everyone wants to take five minutes, that'll work for me.

MR. BACON: Thank you.

(Off the record)

(Recess: 10:51 a.m. - 11:01 a.m.)

(Back on the record)

Q. BY MS. CAULEY: All right, Doctor, we're back, and as I told you before the break, I would like to now get into your opinions in this case. And if I could see that affidavit again.

(Reviewing document.) Okay. I have before me your affidavit attached hereto as Exhibit 5, and this is dated August 13th of 2004. And I'd like for you to read that, and I'm going to ask you some questions about it.

A. (Reviewing document.)

Q. You've had a chance to read through that now?

A. Yes.

Q. Are those still your opinions as we sit here today?

A. Yes.

Q. And those are the opinions that you intend to offer at the trial of this matter?

A. Yes.

Q. Okay. Let's explore those. The first one that I have is you intend to testify that Dr. Thomas Tvedten used an inappropriately-large cervical dilator given the patient's stage of gestation to dilate the cervix.

Let's talk about that. What is your basis for your opinion that Dr. Tvedten used an inappropriately-large cervical dilator?

A. That's based on the fact that it's unnecessary to dilate the cervix to this large a diameter to terminate a 20-weeks-size pregnancy.

Q. Okay. And you specifically say he "used an inappropriately-large cervical dilator." Do you -- what size dilator do you believe was used in this case?

A. I believe they showed a Number 71 --

Q. What does that mean?

A. -- dilator. As the dilator is increased in size, they assign a number to them which is roughly

three times the diameter. And in order to admit a Number 16 suction curette, you would need to have a Number forty-- well, if the -- they -- they don't come -- they come in odd sizes, strangely enough, so there is no 48, three times 16. There -- so either 49 or 51 would be the dilator of sufficient size to admit a Number 16 suction curette and, more importantly, to admit the other instruments that are used to grasp the products of conception and bring them through the cervix.

Q. And, if you could, just walk we through this kind of the same way that you intend to walk a jury through this.

A. Uh-huh.

Q. If you could speak to me as though I know nothing, which may not be too from the truth. If you could, just kind of walk me through what you believe was used, how it was used, and how it was inappropriate and what should have been used.

A. According to the record, the operator used a Number 71 dilator. That's -- instead of what I said was appropriate, which would be a Number 51. And according to his explanatory operative note, he used a Number 71 dilator.

Then he used some other instruments that

-- not too long thereafter found that he was obtaining yellow fat material which was not supposed to be encountered, and this caused him to realize that he had injured the uterus and cervix to the point that he abandoned the procedure and sent the patient to the hospital.

Q. All right. And I want to take one step at a time as far as going through each of your opinions, and the first one is the inappropriately large cervical dilator. And, if you could, explain to me how -- what is a cervical dilator? Is it -- could you just describe it for me?

A. I'm trying to think of a -- another -- a similar instrument, but it's a rod that's approximately a foot long, and it comes with a tapered tip. And the diameter of it is approximately one-third the number that's assigned to it. So a -- a number -- as I said before, there -- they only come in odd sizes, but just to help the -- with the math, a -- a -- a 60 would be two centimeters or 20 millimeters, two centimeters in diameter. A 71 dilator, which he used, is getting -- if we wanted to round it off, it would be close to 75, which would be actually an inch in diameter.

But as I said before, a Number 49 or 51, which would easily allow a 16-millimeter cannula to

be introduced, would be plenty sufficient to terminate a 20-week pregnancy. There just simply is no need to go beyond this, and for every millimeter that one goes beyond it, you're stretching the cervix unnecessarily further and further and further. And at some point the cervix just won't stretch anymore. It's going to split instead.

Q. How -- how do these cervical dilators come, as far as -- I mean, are they all the same? Are they different brands? Or is it all just simply -- I mean, one cervical dilator is the same regardless of where you are? I mean, can there be any confusion amongst the numbers and things of that nature?

A. Not -- not with the numbers. There are some different kinds, but --

Q. And the reason I ask is because in the progress notes it says, "patient dilated easily to 71 dilation," and there's no doubt in your mind that that means that he used a cervical dilator Number 71?

A. Yes.

Q. Okay. How --

A. He may have derived his philosophy -- he may have derived his philosophy and his methodology from operators who are more used to doing pregnancies that are even further along.

For example, the occasional -- or, actually, very rare operators that are experienced with pregnancy terminations up into the 24-week categories, mostly done for fetal anomalies, and the name of one of those operators is actually mentioned in his operative note. It's -- as far as an instrument goes, named the Hearn forceps. Dr. Warren Hearn is in Colorado and sees a -- a fair number of patients that are at the 24-week level and he has developed a separate set of instruments that are used for those. That is probably where this Number 71 dilator comes from.

I hasten to tell you that the operating rooms at the hospitals that I work at such as Durham Regional Hospital and the University of North Carolina Hospitals I'm sure don't even have Number 71 dilators.

Q. When you say a "71 dilator," how many, as far as millimeters or -- would that be? I mean, is that -- what is -- what does the 71 refer to?

A. It's -- it's just an arbitrary -- it's a number that reflects three times the actual diameter in millimeters.

Q. Okay.

A. So a Number 69 dilator would be 13 millimeters.

Q. You stated that operating rooms in

hospitals that you work in don't even have dilators this large. How -- are these dilators, are they used for anything other than pregnancy terminations?

A. I don't think so.

Q. Okay. Do you know how large they come?

A. No. To my knowledge, I've never seen one and would have no reason for it or use for it.

Q. Okay. What's the largest dila-- cervical dilator that you use in your practice?

A. A 51.

Q. And how often do you use a 51 cervical dilator?

A. Almost never, because in our -- in our practice, the patients are pretreated the day before with the standard Laminaria and a sufficient number are placed at the cervix, the next day will be found to be dilated sufficient to admit the standard suction curette without any dilators being needed.

Q. Okay. And I believe I asked you this earlier, but when it says "patient dilated easily to 71 dilation," there is no doubt in your mind that what that means is that he used a cervical dilator that was a Number 71?

A. Yes.

Q. And it's your ---

It's my understanding that your testimony is that the largest cervical dilator that he should have used and would have been within the standard of care would have been a 51?

A. Yes.

Q. And your opinion is that if Dr. Tvedten would have used a cervical dilator no larger than a Number 51, that he would have been within the standard of care?

A. Yes.

Q. And when you say 51, again, what do you mean in terms of measurements? A 51 would be what?

A. It's a Number 51, but it's roughly three times -- it's roughly the size of a 16-millimeter suction curette.

Q. But these cervical dilators come just assigned numbers to them, and your opinion is that Dr. Tvedten used a Number 71 cervical dilator and the standard of care required that he use a dilator no larger than a Number 51, correct?

A. Right. Yes.

Q. All right. Now, it's your opinion, as I -- as I understand your opinion, as I read further, that you are of the opinion that as a result of Dr. Tvedten using this, what you believe an inappropriately-large

cervical dilator, that that caused a split laceration in Ms. Barr's cervix which extended upward into the body of the uterus. Is that correct?

A. Yes.

Q. Okay. What signs or symptoms should a physician look for to detect whether or not a cervical laceration, a split laceration that you described, is occurring?

A. Could I hear the question once more?

Q. Certainly. Your -- the way I understand your opinion, that because he used this inappropriately-large cervical dilator, that it caused a split laceration of the cervix. And my question was, what signs or symptoms should a physician be looking for to determine whether or not they are causing a laceration to the cervix?

A. Well, I'm not sure that they should be looking for anything. They may not see anything, in fact.

Q. Okay. Well, let me ask the question this way: would there be signs of a cervical laceration after it took place?

A. Not necessarily. The -- it just depends on where the laceration is as to whether it hits an artery and whether or not it causes bleeding. I'm sure

there have probably been other lacerations that fortuitously occurred in the midline perhaps where there would be the least amount of bleeding. And if the uterus was then emptied appropriately and is all contracted down, I can conceive that it actually went undetected.

Q. Do you have an opinion as to exactly where this laceration occurred?

A. Again, what's described by the pathologist as about -- on the right, lower lateral side. I believe they said it was at the -- I'd have to look at the records to be sure -- it was eight o'clock position or such.

(Reviewing documents.) Yeah, they didn't give a clock description. They just called it right lateral inferior.

Q. And it's your opinion that this laceration began at the cervix?

A. Yes.

Q. Why do you believe that it began at the cervix instead of beginning at the uterus?

A. Because it went all the way through all of these points. It extended from the lower uterine segment down and through the length of the cervix and into the cervix.

Q. The way you just described that, it sounded as though it started at the uterus and then went down towards the cervix.

A. That's just a matter of describing it. We could equally say that it started from the bottom and went upward or went from the top and went to the bottom or it could have been from the middle and went in both directions.

Q. Can -- can you tell, Doctor, where this perforation began, whether it began in the cervix and went upwards or whether it began in the uterus and went downwards?

A. No, I don't think so.

Q. So is it fair to say, then, that you can't tell whether this began as a uterine perforation or a cervical laceration?

A. Strictly speaking, one couldn't tell, but then if -- if it began as a uterine perforation, then one would have to postulate that an instrument was placed in the uterine perforation and then pulled on or otherwise used to extend the laceration downward through the cervix. That's less likely, I would say.

Q. What about if the laceration began in the uterus and then the patient had uterine contractions as a result of Pitocin, for example, that caused the uterus

to contract? Could that cause the initial perforation to extend -- such as extend possibly downward with those uterine contractions?

Kind of like a -- and this is probably a poor analogy, but like if you have a rip in your pantyhose and it starts out at one place, and then there's pressure that is placed on it, then the rip is going to extend one direction or another.

Is it possible that this could have begun as a uterine perforation and then through contractions carried downward towards the cervix?

A. No, no.

Q. Why is that not possible?

A. That's -- that's just utter speculation; has no basis in anything I've ever heard.

Q. Would you also agree that it's speculation as to where this perforation began, whether it was in the uterus or in the cervix?

A. It's more than speculation. It's almost certainly due to over-dilation.

Q. And I want to explore that with you. Why is it that you feel so certain that it was -- or almost certainly that it was -- it began at the cervix due to over-dilation versus beginning as a uterine perforation and extending downward towards the cervix?

A. Because the cervix -- the endocervix, the lower uterine segment part, is the part that gets damaged from over-dilation. It's -- it's possible to pass a dilator into the upper uterus and then perforate the side of the uterus either with a small dilator or a sound, and I'm sure this is -- has happened inadvertently many times and nothing happens. The uterus just closes the hole back up as long as one is -- no other damage is done to adjacent organs with a smooth-tip dilator, the -- and a blood -- blood vessel isn't hit, the uterus just sustains the injury, and by contracting down it covers up the problem.

Q. Let me repeat back to you what I understand your answer to be to make -- to make certain that I do understand this, which is very important to me in preparing for trial.

The reason you believe this began as a cervical laceration and extended up towards the uterus versus beginning as a uterine perforation and extending downwards to -- towards the cervix is that, in your opinion, uterine perforations normally don't result in cervical lacerations. They don't begin in the uterus and then carry downward and toward -- towards the cervix; that normally uterine lacerations heal themselves and are of not much consequence.

Is that a fair summary of what you just said, or did I mis-- misunderstand?

A. No, that's a fair summary.

Q. Is it an accurate summary?

A. It's an accurate summary. You will -- but I hesitate to add you will not see this in the general literature because it's largely anecdotal. Experienced operators will tell each other or confess to each other that they have occasionally perforated the uterus and nothing happened, and they just observed the patient and sent them home and nobody wrote it up in the literature because nothing happened.

Q. In this particular case, we know that the fetal head, the calvarium, ended up outside the uterus; ended up in the abdominal cavity, I believe. Do you have any opinion as to how that happened or whether that could have caused an increase in a laceration that began in the uterus?

A. It's easy to see how it happened. The -- once there is an -- a laceration, any -- any and all fetal parts can be extruded out through the laceration.

Q. When something like that happens, would that -- would you expect the laceration to increase when the fetal parts are extruded outside the uterus?

A. No.

Q. Why?

A. Because they're not sharp enough to do that. I've heard this speculation in other cases that sharp -- razor-sharp pieces of fetal bone caused this injury or that injury. I think that's rank speculation. There is no evidence whatsoever that fetal parts who were at 20 weeks and under are sharp enough to cause tears to the myometrium.

Q. But let's assume that a tear was already there, a uterine perforation was already there due to possibly an instrument or whatever the reason, that a uterine perforation was already in existence and then the fetal parts are extruded through the uterus. Could just the moving of the fetal parts through that initial laceration, could that cause the laceration to increase? Or do you have an opinion about that?

A. In my opinion, no.

Q. And what do you base that opinion on?

A. The same story. It isn't like -- the same reason: it isn't like these pieces of soft bone are like little razors being pushed out through the -- through a laceration.

Q. So, if I understand, your opinion is that the fetal parts, and in this particular instance the calvarium being extruded -- extruded through the uterus

could not have increased the laceration because there were no sharp bony fragments or there wouldn't have been any sharp bony fragments. Is that your opinion?

A. Yes.

Q. Okay. Is there anything else that you want to add to that or --

A. Yes. We -- we remove the fetus in parts down through the cervix ordinarily, and these parts are not so sharp that they're like little razor blades passing through the cervix; otherwise, we'd be routinely injuring the cervix when all the -- when the pieces were extracted. This would happen all the time, and it doesn't. So I think that's evidence enough that there -- these are not little sharp pieces of bone.

Q. We had talked about whether there would have been any evidence of a cervical laceration taking place that a physician would have noticed, and I thought I understood you to say that you don't -- that it's possible there wouldn't have been any bleeding or any evidence that the cervical laceration was taking place. Is that correct?

A. Yes.

Q. Do you have an opinion one way or the other whether it was more likely than not that there would have been evidence of a cervical laceration after

it happened that a physician should have seen?

A. No, I don't know that there was any evidence.

Q. So you're not going to testify at trial that there were certain signs and symptoms of a cervical laceration that Dr. Tvedten should have noticed during or after what you believe to be a cervical laceration took place?

A. Not during. After -- after, yes, but in fact, he did notice it after it --

Q. Okay.

A. -- after it happened.

Q. Are you critical of anything that Dr. Tvedten did after he realized that there had been a perforation as far as how he acted, whether he responded promptly and administered the proper plan of care?

A. No.

Q. So your criticisms in this case are going to be limited to simply the -- what you believe to be an over-dilation causing a cervical laceration.

A. Yes.

Q. And your opinions are that once that took place, you don't have any criticism of Dr. Tvedten as to how he responded to the actual injury.

A. No.

Q. So going back to my original question, you don't believe that there were any -- there was anything that he should have seen sooner to put him on notice that there was a problem or injury.

A. No.

Q. Have you reviewed Dr. Tvedten's testimony?

A. Yes.

Q. Have you reviewed it recently?

A. Only parts.

Q. Okay. In reviewing it previously and in reviewing certain parts of it recently, is there anything that sticks out in your mind about Dr. Tvedten's testimony that you don't believe to be factually accurate?

A. No, not offhand.

Q. So there wasn't anything in reviewing his deposition that you looked at and you noted or thought in your mind, "Wow, that just -- that doesn't seem like that could have been correct"?

A. No. I just -- I don't see any right now.

Q. Dr. Tvedten testified that the -- this procedure is typically done as a two-day procedure where the Laminaria and Cytotec is inserted 12 hours or so before the actual procedure. You recall that.

A. Yes.

Q. And in this particular case, we know that Ms. Barr did not arrive in time the day before to have those medications inserted into her cervix, correct?

A. Correct.

Q. And she arrived the next morning. And what do you recall Dr. Tvedten telling her about performing the procedure as a one-day procedure?

A. That it could be done. He actually used a different form of Laminaria called Lamicel which are -- that generally work faster.

Q. Do you have any --

A. And that, in combination with Cytotec, can accelerate the process. I -- I see how this can be useful on occasion, and probably it would have worked if they had not dilated her so much.

Q. So is it fair for me to assume based on those statements that you're not critical of Dr. Tvedten's choice to provide her with the Lamicel and the Cytotec and to attempt to do it as a one-day procedure; you're just critical of the choice of dilator that he used. Is that fair?

A. The size, yes.

Q. Okay.

A. The reason that I wouldn't be so critical

is that she's already had two -- two or three full-term --

Q. Three.

A. -- pregnancies. This could be a little different if it was a person that had never ever been pregnant before.

Q. And that's ---

Generally speaking, women with a history of three spontaneous vaginal deliveries, it's reasonable to expect that her cervix would dilate easier than others.

A. Yes.

Q. And just so I'm clear, you're not critical of Dr. Tvedten's decision to try to perform this procedure as a one-day procedure.

A. No.

Q. So if ---

Based on our discussion here today, is it fair to say that your opinions in this case and the opinions you're going to offer at trial are limited very narrowly to the choice of dilator that Dr. Tvedten used in this particular instance?

A. Yes.

Q. And but for Dr. Tvedten using what you believe was an inappropriately-large cervical dilator,

you would not have any criticisms of Dr. Tvedten's care and treatment of Ms. Barr?

A. Correct.

Q. Okay. So the only ---

And your opinions that you're going to offer at trial, the only opinions that you have in this case as to where Dr. Tvedten breached the standard of care was in his choice of using what you believe was an inappropriately-large cervical dilator.

A. Yes.

Q. If Dr. Tvedten had used a smaller cervical dilator -- a 51 as you had stated, in your opinion, would have been within the standard of care -- and the same result would have happened as far as the same laceration, would you still be critical of Dr. Tvedten or would -- under those circumstances, would you simply state that it was a risk in a -- of the procedure and was not indicative of any negligence on the part of Dr. Tvedten?

A. Yes, I would say the latter.

Q. Just a minute.

(Pause in proceedings.)

Q. I had asked you earlier some questions about standard care and what you had done to familiarize yourself with the standard of care that would be

applicable to a physician performing pregnancy terminations in Little Rock, Arkansas, in June of 2000, and I believe you stated that there was nothing specific to Little Rock, that you just -- your opinions are based on a national standard of care as far as -- that applies equally throughout the country based on medical literature and training, correct?

A. Yes.

Q. Do you know anything about Arkansas physicians as far as what size cervical dilators they typically use in performing pregnancy terminations and what is common throughout the State of Arkansas?

A. No.

Q. Do you believe that information is important in forming opinions about whether or not Dr. Tvedten violated the standard of care in this particular case by using a particular cervical dilator?

A. Possibly. I'll say that I can hardly imagine this is the case, but if -- if it turns out that he was the only physician doing second-trimester pregnancy terminations in Ark-- in the entire state and he was routinely dilating 20-week patients up to Number 71, on the one hand, one might say he was establishing the standard of care in Arkansas, but on the other hand I would say he's clearly wrong.

Q. Let me put it this way: let's assume that Dr. Tvedten isn't the only physician in Arkansas performing second-trimester abortions, but let's say that all physicians in Arkansas who perform second-trimester abortions are using the same size cervical dilator as what Dr. Tvedten used.

Would you then change your opinion about whether or not Dr. Tvedten violated the applicable standard of care in using the cervical dilator that he did in this procedure?

A. No. I'd still say they would -- they would -- if they hadn't had other disasters, they're darned lucky that they haven't, 'cause that's clearly too -- too large.

Q. So under that scenario your opinion would be that all physicians in Arkansas performing second-trimester abortions are violating the national standard of care.

A. If they're dilating -- routinely dilating people to Number 71 at 20 weeks, yes.

Q. You would agree it may be the local standard of care, but you believe that that local standard of care would be in violation of the national standard of care.

A. Yes.

Q. I'm finishing a lot earlier than I thought I would, but I think we've covered everything.

Based on my understanding of your opinions in this case being narrowed simply to the cervical dilator issue, have I given you an opportunity to express all the opinions that you intend to render against Dr. Tvedten at the trial of this matter?

A. Yes.

Q. Okay. There aren't any other opinions that you intend -- or criticisms of Dr. Tvedten's care and treatment of Felicia Barr that you intend to render at trial that you and I haven't discussed here today?

A. No.

Q. And have I been polite and courteous to you today?

A. It's been overwhelming.

Q. And I've given you an opportunity to fully and fairly answer all my questions?

A. Yes.

Q. Okay. And have you understood all my questions?

A. Yes.

Q. Okay.

MS. CAULEY: That's all I've got, and I'll pass the witness.

MR. BACON: I've got just a few. Doctor, can you hear me okay?

THE WITNESS: Yes, sir.

EXAMINATION

BY MR. BACON:

Q. I represent the Women's Community Health Center, the clinic where this procedure occurred. Based on what I have -- know about what's been furnished about your opinions and what I've heard you tell Ms. McCauley [sic] today, I think I know the answer to this, but let me ask you, do you have any opinions at all that you intend to give or will give or have at this point that are in any way critical of the nursing staff or any of the other staff at the clinic other than Dr. Tvedten?

A. No.

Q. Okay. Now, let me ask you just a couple of things, and this -- I don't mean to repeat but since I'm by telephone, there were occasions when I wasn't sure I heard clearly.

And one is with regard to the questions that were about the fact that some of the -- like the fetal skull ended up in the abdominal cavity, and you were asked about -- questions about whether any of the fetal parts or the products of conception passing

through the uterine wall could have increased the size of the laceration. Do you remember those questions?

A. Yes.

Q. And I understand your testimony about the bones being soft and -- and not being sharp-edged, but here's my question: if you have a laceration of the uterus, and -- and my numbers may be too unrealistic, but just for example, if you have a half-a-centimeter laceration and a fetal skull that is three-quarters-of-a centimeter passes through the uterine wall, isn't the fact that that being larger than the laceration, isn't that going to increase the size of the laceration?

A. No. I mean, the reason is that the products are going to take the path of least resistance. If the cervix is already dilated to 71, it'll go out through the cervix preferentially rather than through a half-centimeter uterine perforation in the upper part of the uterus.

Q. Okay. My final question: when you were given kind of a summary question by Ms. McCauley [sic], I wasn't sure I heard. But as I understand what you're telling us, if in this case the same exact complications occurred but the operator had used a Number 51 dilator, then you would have no criticism at all.

A. That's correct.

MR. BACON: Thank you, Doctor. That's all I have.

MS. CAULEY: I have -- do you have any, 'cause I --

MR. WRIGHT: Go ahead.

MS. CAULEY: Okay.

FURTHER EXAMINATION

BY MS. CAULEY:

Q. I -- I just want to clarify one area I did not ask you about, Doctor.

I have attached to your deposition all the medical records that you've reviewed in this case, and those records are limited to Dr. Tvedten's care and also a couple of notes from the University Hospital.

Can I assume from that that you don't intend to offer any opinions at trial about Ms. Barr's current condition and whether any of her current ailments may or may not be related to her hysterectomy or any injury that she sustained as a result of the termination -- her pregnancy termination in June of 2000?

A. As of this date, no. I -- I'm not aware of any other complications. If someone brings this to my attention, of course I'll have to answer the

question.

Q. Okay. And in all fairness to me, if that happens, if you review additional medical records or review additional evidence and you do intend then to offer opinions at trial about the origin of Ms. Barr's current problems or conditions or past problems and conditions, would you give me the opportunity to come back and redepose you and ask you additional questions about those areas?

A. Yes.

Q. Because as we currently sit here, you don't have any opinions on -- on those issues, correct?

A. Correct.

Q. Okay.

EXAMINATION

BY MR. WRIGHT:

Q. Just a few questions, Doctor.

I think you testified earlier that you reviewed the medical records from the Women's Community Health Center in Little Rock?

A. Yes.

Q. The medical records from the University of Arkansas Medical Center in Little Rock?

A. Yes.

Q. The pathology report from the University of Arkansas Medical Center in Little Rock?

A. Yes.

Q. The deposition from Dr. Tvedten of Little Rock?

A. Yes.

Q. The deposition of Dr. Nancy Andrews from Little Rock?

A. Yes.

Q. Now, based on your review of those records and those depositions, is it your opinion that the recognized standard of acceptable professional practice for physicians involved in pregnancy termination would be the same in Little Rock as it is in Raleigh, Durham, or Chapel Hill?

A. Yes.

Q. Would ---

Can you think of another similar community as Little Rock that you think the standard would be the same or similar?

A. Beyond -- here in this state or any --

Q. Any --

A. -- other thing?

Q. Any state.

A. I think it's the same in all states.

Q. Okay. Was there anything about -- in the records you reviewed from the State of Arkansas or from Little Rock that would indicate to you that the standard was dissimilar from -- from this area?

A. No.

MR. WRIGHT: That's all I have.

MS. CAULEY: I have nothing further.

MR. BACON: That's all for me. Thank you.

MS. CAULEY: All right. We're going to hang up, Don.

MR. BACON: Goodbye. Thanks a lot.

MS. CAULEY: Bye-bye.

MR. BACON: Bye.

COURT REPORTER: Mr. Wright, do you want the doctor to read and sign his deposition?

MR. WRIGHT: Yes.

(Discussion off record)

(Deposition adjourned at 11:58 a.m.)

(Further deponent saith not.)

Witness Certificate

I, **JAMES RAY DINGFELDER, M.D.**, do hereby certify that:

I have read the foregoing **86** pages of the record of testimony as given by me on **April 25, 2005**, at the time and place herein aforementioned;

To the best of my knowledge and belief, the foregoing 86 pages are a complete and accurate record of all the testimony given by me at said time, except as to where noted on the attached addendum, if any.

_____
JAMES RAY DINGFELDER, M.D.

State of North Carolina
County of Orange

Sworn to and subscribed before me on this, the
_____ day of _____, 2005.

_____
Notary Public

My Commission Expires: _____

REPORTER'S CERTIFICATE

State of North Carolina - County of Chatham

I, W. B. Lindley, a Certified Verbatim Reporter and Notary Public for the state of North Carolina, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

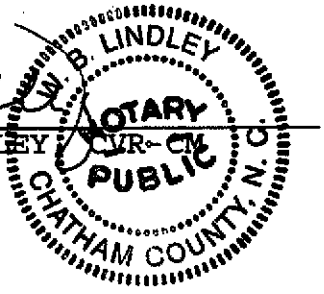
That the testimony of the witness, the questions propounded, and all objections and statements made at the time of the examination were recorded by stenomask method by me and were thereafter transcribed;

That the foregoing is a true and correct transcript to the best of my ability and understanding.

I further certify that I am not a relative or employee of any attorney of the parties, nor financially interested in the action.

In witness whereof, I have hereunto set my hand and official seal on this, the **10th** day of **May, 2005.**

W. B. LINDLEY, CVR-CM



My Commission Expires: April 30, 2007

IN THE CIRCUIT COURT FOR THE SIXTH JUDICIAL CIRCUIT

SECOND DIVISION

X - - - - - - - - - - - - - - - X

FELICIA BROWN, :

Plaintiff, :

vs. : NO.: CV-2002 005986

WOMEN'S COMMUNITY HEALTH :

CENTER, et al., :

Defendants. :

X - - - - - - - - - - - - - - - X

COPY

Durham, North Carolina

Wednesday, July 8, 2009

Videotaped Telephone Deposition of **JAMES RAY DINGFELDER, M.D.**, a witness herein, called for examination by counsel for the Plaintiff in the above-entitled matter, pursuant to notice, the witness being duly sworn by SARA A. ROOTH-BURKETT, a Registered Professional Reporter and Notary Public in and for the State of North Carolina, taken at Regus, 2530 Meridian Parkway, Suite 300, Third Floor, Durham, North Carolina, at 10:08 a.m., on Wednesday, July 8, 2009, and the proceedings being taken down by Stenotype by SARA A. ROOTH-BURKETT, and transcribed under her direction.

EXHIBIT
tabbies
B

APPEARANCES:

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VIDEOGRAPHER:

ROBERT W. BODENHEIMER, JR., CLVS

C O N T E N T S

-oOo-

E X H I B I T S

(Exhibits attached.)

-oOo-

S T I P U L A T I O N S

It was stipulated by and between counsel representing the respective parties, and the witness, as follows:

1. That all objections are reserved, except as to the form of the question.

2. That the witness will read and sign the transcript to the deposition.

3. That an objection by one Defendant attorney shall serve as an objection for both Defendant attorneys.

P R O C E E D I N G S

Whereupon,

THE VIDEOGRAPHER: We are on the record. The time is 10:08 a.m. on June [sic] 8th, 2009. This begins Tape Number One. We're at 2530 Meridian Parkway, Durham, North Carolina, today for the deposition of James Dingfelder, M.D.

This is being taken in the case of Felicia Brown-Barr versus Women's Community Health Center, et al. This is being heard In The Circuit Court For The Sixth Judicial Circuit, Second Division. Case Number CV-2002 005986.

The court reporter is Sara Rooth-Burkett. The videographer is Robert Bodenheimer.

If the taking attorney will please introduce yourself for the audio record.

MR. WRIGHT: Glenn Wright for the Plaintiff.

MS. CAULEY: Michelle Cauley on behalf of Dr. Thomas Tvedten.

MR. BACON: Don Bacon on behalf of Women's Community Health Center.

THE VIDEOGRAPHER: The court reporter may now place the witness under oath.

JAMES R. DINGFELDER, M.D.,

business address at Eastowne OB GYN and Infertility, 180 Providence Road, Suite Number 3, Chapel Hill, North Carolina 27514, (919) 493-8466, was called as a witness by counsel for the Plaintiff and, having been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. WRIGHT:

Q. Would you state your full name for the record, please, sir.

A. My full name is James Ray Dingfelder, M.D.

Q. And your business address?

A. My business address is 180 Providence Road in Chapel Hill, North Carolina.

Q. And are you married?

A. I am married, yes.

Q. Any children?

A. I have a total of five.

Q. What is your profession?

A. I'm a obstetrician and gynecologist practicing in Chapel Hill, North Carolina.

Q. Do you have a CV?

A. Yes, I do.

MR. WRIGHT: I'd like to have that marked as Exhibit Number 1, please.

MS. CAULEY: No objection.

(Exhibit 1 was marked for identification.)

BY MR. WRIGHT:

Q. Dr. Dingfelder, will you give us your educational background, beginning with high school.

A. I attended and was graduated from McDowell High School in Erie, Pennsylvania, in 1956. I then attended Wesleyan University in Middletown, Connecticut, and transferred later to Thiel College. That's a Luth- -- small Lutheran school in Greenville, Pennsylvania, just south of my hometown of Erie, Pennsylvania. I was graduated from it in 1961 with a bachelor's degree in biology.

The year after that, I enrolled at Jefferson Medical College in Philadelphia. After four years there, in 1965, I received my M.D. degree. I did a one-year rotating internship at my hometown hospital, Hamot Hospital, in Erie, Pennsylvania.

Q. What is an internship?

A. In -- in the old days, an internship was an exposure to many of the various specialties in medicine and surgery, and many family practice or general practice doctors did no more training after

that. They did a one-year general rotating internship and then went into practice.

Q. Okay.

A. In my case, I was, after that first year, I was undecided, but I was -- the Vietnam War decided for me, and I was -- entered the military. So I was in the U.S. Air Force for two years active duty.

Q. What rank did you reach?

A. Captain in the Medical Corps. I was a general medical officer.

Q. And you would have been discharged what year?

A. So I was discharged in the year that I entered my residency training, 1968.

Q. Tell us about that.

A. And I did a four-year obstetrical/gynecological residency in the University Hospitals of Cleveland, Ohio.

Q. What does residency training mean?

A. Residency training is a graduated exposure to increasingly complex surgery and medical cases over a four-year training period. It's a culmination of your last year of residency when you are a chief resident. Excuse me. And that --

during that last year, you do -- have most of the supervisory responsibilities and do most of your surgery.

Q. And was there a fellowship as well?

A. The last -- in that last year, you had the opportunity of doing a fellowship, which I did. Mine -- mine happened to be in -- additional training in fetal monitoring; that is, monitoring the progress of fetuses during labor.

Q. Are you licensed to practice medicine?

A. Yes, I am practice -- licensed now in North Carolina and have been since I moved here in 1972.

Q. Have you been continuously licensed?

A. Yes, I have.

Q. Are you board certified?

A. Yes.

After board certification comes -- after finishing a training examination and an oral examination, approximately 18 months after beginning practice, you go for an examination and are questioned by examiners.

Q. And when were you board certified?

A. So I was board certified in 1974.

Q. Are all doctors board certified?

A. No, they are not. You must pass the certification exam. I think the current rates of passing are somewhere in the 80 to 85 percent of applicants pass on the first try, a few take a second or even a third try before they pass the boards, and then a small percentage never are successful.

Q. What specialty are you board certified in?

A. So I am now board certified in obstetrics and gynecology.

Q. What is obstetrics?

A. Obstetrics is the branch of medicine that deals with pregnancy and its complications.

Q. What is gynecology?

A. Gynecology is the aspect of that specialty dealing with the illnesses, both medical and surgical, of women, excluding the obstetrical conditions.

Q. Could you give us your employment history?

A. From 1972 to 1981, I was a full-time associate professor of OB-GYN at University of North Carolina in Chapel Hill. And during those years I did -- I conducted clinical research, I had teaching responsibilities with the OB-GYN residents in training, and performed surgery as well as

obstetrical deliveries.

After 1981, since I had seen more patients and patient contacts in the clinics than anyone else in the department for eight years running, it became clear to me that my interests and emphasis ought to be on -- more on direct patient care rather than the clinical research, teaching aspect, so I elected to enter total private practice in Chapel Hill.

Q. And have you been in private practice since 1981?

A. So I have been in private practice since 1981. Because of that, entering private practice, my locale for surgery and deliveries changed to a nearby hospital called Durham Regional Hospital. It is a approximately 400-bed facility that's operated by the Duke Medical School system.

Q. Are you a member of any professional societies?

A. Yes.

The main society is the American College of Obstetrics and Gynecology. I'm also a member of the American College of Surgeons. I also am a member of various state and local medical societies.

Q. What hospitals are you affiliated with?

A. In the past, I have had admitting

privileges at North Carolina Memorial Hospital in Chapel Hill, but I am -- as I said earlier, most of my admissions and work has been done at Durham Regional Hospital.

Q. And tell us about your academic appointments.

A. I, at one time, I had a -- a clinical appointment at UNC here in Chapel Hill. Since I did all my work at Durham Regional Hospital, I let that appointment lapse, but I continue to be a consulting assistant professor at Duke Medical -- Duke University.

Q. From when to when?

A. That began in 198- -- '81, and it has continued to the present.

Q. Now, your CV on page 5 indicates a number of publications. What does that mean?

A. During those first eight years that I was at -- full time at University of North Carolina, we were always encouraged to write medical articles. And I conducted a field of research that largely involved investigation of hormones that influence pregnancy. Some of these hormones, generally known as prostaglandins, are still in use today to induce labor for full-term patients that need to be

delivered.

In the early days, they were also used to -- as an investigation tool to possibly induce abortion. It turned out that although they were effective, it was a long, drawn-out affair, and the -- the outpatient surgical methods were much preferred.

Q. If you would look at your publications on page 5, would you give us the title of the first one under number 1.

MS. CAULEY: Glenn, do you have another copy of his CV?

MR. WRIGHT: Yeah.

BY MR. WRIGHT:

Q. Could you give us the title of what's under number 1, please?

A. Number 1?

Q. Yes, sir.

A. Number 1 is "Placental aspects of fetal heart rate patterns."

Q. And what does that mean?

A. And that was written in the last year of my residency training in Cleveland, Ohio.

Q. And number 2?

A. The same. That was also a -- I was a

member of a team that wrote an article. That had to do with a very rare tumor that occurred to a young lady during pregnancy.

Q. And what was the title of number 3?

A. Number 3 is "Problem Pregnancy and Abortion Counseling," in which I wrote a chapter called "Medical aspects of abortion." That was the first article that I -- I wrote during -- since I came to Chapel Hill in 1972.

Q. And I think the total number of publications is 61; is that correct?

A. Correct.

Q. And that would have been over the course of how many years?

A. Roughly 20.

Q. Okay. How many patients are you currently seeing?

A. Currently, I see approximately a hundred a week.

Q. And what type of services do you provide?

A. Since I -- I did my last obstetrical delivery about a year ago, I have now concentrated mainly on office gynecology, seeing patients. Many of them I've seen for 20, 25 years, just doing their annual examinations and such. And I continue to do

pregnancy terminations both in my office facility, which is an approved abortion facility, and as well as a clinic in Raleigh.

Q. Have you reviewed legal cases for violations of the standard of care before?

A. Yes.

Q. Approximately how many, in the course of your career?

A. I really -- I have not counted lately. I've reviewed over a hundred cases. I -- half of those, after I review the case, I send word back to the person who sent me the case that I didn't think there was any kind of malpractice issue involved, so...

Q. Have you reviewed cases for both sides, both the plaintiff/patient or the defendant/doctor?

A. Yes.

Q. Have you testified as an expert in a medical malpractice case before, either by way of a deposition or live testimony in court?

A. Yes.

Q. Do you have any idea how many times?

A. No, I don't. It's probably, if -- if one counts depositions and not just actual courtroom appearances, it's probably 50 or 60.

Q. Have those 50 or 60 been in various states?

A. Yes.

Q. Do you have any idea how many states they've been in?

A. Offhand, I could say they're probably in ten or 12 different states.

Q. I'm going to ask your opinions today, and I would like to have an understanding with you that all of the opinions you give us will be based upon a reasonable degree of medical certainty, whether I use that term or not when I ask the question. Will you agree to do that?

A. Yes.

Q. Were you sent medical records from the Women's Community Health Center from June 10, 2000, and from UAMS hospital regarding Felicia Brown-Barr to review for any violations of the standard of care?

A. Yes.

Q. Let me pass you an item --

MS. CAULEY: Oh, I'm sorry. I thought that was my copy.

BY MR. WRIGHT:

Q. -- and ask you if you recognize that.

A. Yes, I do.

Q. Is that a record you were sent from the Women's Community Health Center? It may have been called something else at that time.

A. Yes.

Q. Okay. Did you review that record?

A. Yes, I did.

Q. Tell us, what -- what is a voluntary pregnancy termination procedure.

A. It is what is otherwise known as a therapeutic abortion. It can be done, depending on the stage of pregnancy, it can be done totally with medical, pharmacologic agents: pills, in other words. That's usually only up till the seventh or eighth week of pregnancy. After that, it's usually done by one or more surgical methods.

Q. Tell us about the stages of pregnancy.

A. Pregnancy has been rather arbitrarily divided into three trimesters. Since pregnancy lasts a total of approximately 39 weeks -- actually, 38 weeks from conception -- it's been conveniently divided into 13-week segments. So the first 13 weeks being the first trimester, the second trimester from 14 to 26 or 27, the last trimester being from 27 to 39 or 40.

Q. Are you familiar with the standard of care for an OB-GYN performing voluntary pregnancy termination procedures in Raleigh/Durham, North Carolina?

MS. CAULEY: Object to form.

THE WITNESS: Yes.

BY MR. WRIGHT:

Q. And how are you familiar?

A. I am familiar because I have observed and worked with all of the providers of -- that have currently, or even recently, done pregnancy terminations in Raleigh, North Carolina.

Q. How many pregnancy terminations have you performed?

A. I never kept track of it, but it's -- it's certainly in the thousands.

Q. What is meant by the term "standard of care"?

A. Standard of care is the level and degree of medical expertise practiced by the majority of competent practitioners in a given area, given specialty.

Q. And how many babies have you delivered in your career?

A. Again, I wish I had kept better records.

I know it's been probably 4- or 5,000.

Q. You have any idea what percentage of your practice was performing voluntary pregnancy termination procedures?

A. It's never been more than 5 percent.

Q. In your opinion, is the standard of care in the city of Little Rock, Arkansas, the same or similar to the standard of care in Raleigh/Durham, North Carolina, for an OB-GYN performing voluntary pregnancy termination procedures?

MS. CAULEY: Object to form.

THE WITNESS: Yes, I think it is very similar.

BY MR. WRIGHT:

Q. And why do you say that?

A. Mostly because the two areas are quite similar. The -- from what I've read about Little Rock, the size of the hospital, the number of beds in that hospital and the number of beds in the hospital that I practice in are very close to the same.

Q. Now, you're talking about the hospital that Miss Brown-Barr was treated in this case --

A. Right.

Q. -- correct?

Go ahead.

A. Right.

The size of the general community, both the city of Little Rock itself and the city of Durham, for example, have roughly the same given populations, but the, in my opinion, more important figure is the metropolitan area, the -- the -- the larger area where all the physicians and patients are drawn from.

The Little Rock area seems to approach 7- or 800,000 residents, and that's approximately what the so-called Research Triangle area that includes the Raleigh/Cary/Durham area as well, they're approximately the same.

Q. What about specialties available?

A. They have all of the same specialties: cardiovascular, internal medicine. Both of the schools have family medicine training programs.

Q. When you say "schools," you meant medical school -- you mean medical --

A. Medical schools.

Q. -- schools; correct?

A. Correct.

Q. What about the equipment that's been used in the documents that you've examined from Little

Rock and from Raleigh/Durham?

A. The medical records seem to show that the same type of equipment is available. The places that one would order such equipment from are not peculiar to either locale. We order from all over the country.

The same with the medical literature that we all read come -- it's -- it comes from other places. So we all read the same thing. We're all trained the same way. We all use the same equipment, in both places.

Q. And you've reviewed the deposition of Dr. Andrews, the surgeon who treated Miss -- Miss Brown-Barr in this case; correct?

A. Yes, I have.

Q. Were you asked to offer an opinion as to whether the standard of care was violated by Dr. Tvedten in his care and treatment of Miss Brown-Barr back on June 10, 2000?

A. Yes, I was.

Q. Was the standard of care violated by Dr. Tvedten in his treatment of Felicia Brown-Barr on July 10 --

MS. CAULEY: I --

MR. WRIGHT: -- June 10, 2000?

MS. CAULEY: And I'm going to object to the form. And, Glenn, just so I don't have to keep interrupting, can we have a standing objection to his opinions --

MR. WRIGHT: Yes. Sure.

MS. CAULEY: -- in this case? Okay.

THE WITNESS: What was the question again?

BY MR. WRIGHT:

Q. Was the standard of care --

A. -- care -- oh, yes.

Q. -- violated by Dr. Tvedten in his treatment of Felicia Brown-Barr on June 10, 2000?

A. Yes, I believe it was.

Q. And how was it violated?

A. I think the doctor used instruments that caused the patient's cervix to be forcefully dilated to a diameter that was inappropriately large and unnecessary to complete this kind of procedure, by -- by forcing open the cervix to such a wide extent, it just literally cracked it open and split the cervix.

Q. What injuries did it cause Miss -- Miss Barr?

A. Well, this -- the split extended not only through the cervix, which is the bottom opening to

the uterus, but the split then extended upwards into the uterus itself, and it -- it exposed such a large hole that parts of the pregnancy were extruded out through this hole into the abdominal cavity, and subsequently they were recovered in the abdominal cavity.

Q. What was the gestation period for Miss Brown-Barr?

A. According to the records, she was listed as at 20 weeks' gestation.

Q. In your opinion, how could these injuries to Miss Barr have been avoided?

A. I think if the doctor had just dilated sufficient to admit the largest suction curette that's available, which is 16 millimeters, the cervix could have been dilated to approximately 47 or 49, is the number, and that's sufficient to admit a 16-millimeter suction curette.

It's also sufficient to admit the extraction forcep instruments that are used to extract the pieces of the products of conception. It's certainly adequate to do any pregnancy terminations up to the 21st week of pregnancy.

Q. What is a uterine perforation?

A. A uterine perforation is merely the

creation of a artificial opening in the uterine wall, which can range from minuscule, meaning 1 or 2 millimeters, to as large as this one, which ranged to 4, 4 and a half inches in length.

Q. Now, is a uterine perforation a known consequence of a termination procedure?

A. Well, it's -- it has happened before. It's not -- it's not always a bad event or a complication. In fact, the majority probably are just merely observed for a while, and they're so trivial that the uterus just closes the perforation and things go on as before.

Q. How are these injuries in this case different from that?

A. In this case, the injury was so large that parts of the fetus were extruded out into the abdominal cavity. And apparently, parts of the pelvic organs, the -- the ovary in particular, were -- were pulled through this rent, or tear, in the side of the uterus and extracted by the operator during the initial procedure.

Q. And what's the purpose of an ovary?

A. Most humans are born with two ovaries, and the ovaries contain the eggs that are -- subsequently can be fertilized to form a new -- new

pregnancy. The ovaries also produce an estrogen hormone, which is the main female hormone for a large part of a person's reproductive life.

MR. WRIGHT: Let's have this marked as Exhibit Number 2, please.

(Exhibit 2 was marked for identification.)

BY MR. WRIGHT:

Q. And you indicated that you had reviewed some medical records from the hospital in this case; correct?

A. Yes, I had.

Q. Do you recognize those records I just passed you?

A. Yes, I do.

Q. Could you tell us what the diagnosis was under A, B, and C?

A. This is a pathology report that shows the -- three separate items were examined by the pathologist. One was the -- the fetal skull, which as we said before had been extruded through the rupture, the hole in the side of the uterus. The second was the --

Q. So that it remained intact when -- when she --

A. Yes.
Q. -- was taken to the hospital?
A. Yes.
Q. Go ahead.
A. The second is the -- the uterus itself was, since the patient underwent a hysterectomy, the uterus was submitted for pathology, and they examined it to see if there were anything -- was anything unusual.
Q. What is a hysterectomy?
A. A hysterectomy is the removal of the uterus, or womb. It does not necessarily include the tubes or ovaries.
Q. And under C.
A. Under C is a Fallopian tube, right salpingectomy. That means that the right Fallopian tube was removed and submitted for pathology. That appears to be the totality of the tissues that were removed by the surgeon.
Q. Okay. If I can direct your attention to the second page of the report, the middle paragraph, it -- it references a tear. Do you see that?
A. Yes.
Q. Could you read that to us and tell us what that means?

A. There was a large rupture of the uterus on the posterior right lateral inferior portion of the uterus.

Q. And what does that mean?

A. Essentially, that means that there was a tear extending along the -- if -- if the uterus, enlarged uterus, were in the shape of my fist, (The witness indicated.) my two fists, there was a tear along the right side.

Q. Okay.

A. The tear ran from the very bottom, half or two thirds of the way up the side of the uterus.

Q. And the next statement?

A. The tear extends from the lower uterine segment down and through the length of the cervix and endocervix.

So a uterus is comprised of two portions: the cervix, which is the lower portion, and the so-called fundus, which is the upper 9/10ths of the total uterus.

So the bottom is the -- is just the cervix. In this case, the laceration, or tear, involved the entire cervix, and then extended upwards for a distance into the body of the uterus.

Q. Let me see this.

Let me direct you to the Discharge Summary that's a part of this report. Under the History of that report, it indicates the condition that Ms. Brown-Barr was in when she was taken to the hospital; is that correct?

A. Yes.

Q. Was there a blood loss in this case?

A. Yes.

Q. And -- and it references hematocrit and blood pressure. Do you see those?

A. Yes, I do.

Q. What does that indicate to you?

A. She was in so-called shock from blood loss, is what it amounts to. Her hematocrit on arrival was 27 percent.

Q. What is a normal hematocrit for a person her age and her size, in your opinion?

A. A normal hematocrit would be between 35 and 40.

Q. Okay. And it mention -- mentions blood pressure as well; correct?

A. Yes.

Q. And what blood pressure did -- did she have?

A. Her pressure was between 70 and 80 for the

top figure, and between 30 and 40 on the bottom figure.

Q. And down toward the middle of Hospital Course, it mentions how much blood loss occurred. Do you see that?

A. Yes.

Q. And what was that?

A. Her estimated blood loss was approximately 2500 cc's.

Q. The surgeon mentions cul-de-sac. Could you tell us what that means?

A. Cul-de- -- Cul-de-sac is -- is the area inside the abdominal cavity that's down under the uterus. If -- if one opens the abdomen and looks in and sees the uterus sitting there, if you went down under the uterus, in back of it, that would be the so-called cul-de-sac.

Q. Would Miss Brown-Barr be able to bear children after this hysterectomy?

A. No.

Q. To what age, in your opinion, can a female bear children?

A. By natural means or artificial means?

Q. Nat- -- natural means.

A. Natural means, it's not unusual to bear

children up to age 45. It becomes increasingly rare, but still possible, after age 45. I had one lady two years ago deliver at age 46.

Q. Did Miss Brown-Barr experience pain, in your opinion, in this case?

A. Yes.

Q. Now, the records indicate that she was hospitalized for a three-day period. Based on your experience, was that reasonable and medically necessary in this case?

A. Yes. Of course.

Q. Were the actions of Dr. Tvedten the proximate cause of Miss Barr's injury, more likely than not, in your opinion?

A. Yes. I believe so.

MR. WRIGHT: That's all I have.

EXAMINATION BY COUNSEL FOR THE DEFENDANT DR. TVEDTEN

BY MS. CAULEY:

Q. Good morning, Dr. Dingfelder.

A. Hello.

Q. I believe we met one other time about four years ago when I first took your deposition. Do you --

A. Yes.

Q. -- recall that?

If you don't, I wouldn't fault you.

A. Yes.

Q. In fact, I have a copy of your deposition. I'm going to give that to you just in case we need to refer to it.

Since your last deposition, I have done a little bit of medical literature review, and I have found a few things in the medical literature that I want to ask you about and see if you agree or disagree with them.

First of all, before we get into that, what is a D&E? Is that the procedure we're talking about --

A. Yes.

Q. -- with Miss Barr?

A. It stands for dilation and extraction.

Q. Okay. So when the literature uses the term "D&E," we're talking about the procedure that Miss Barr underwent with Dr. Tvedten.

A. Yes.

Q. All right, sir. First question: Do you agree that all D&E techniques require adequate dilation of the cervix?

A. Yes.

Q. All right, sir. Do you agree that ample cervical dilation is important in second trimester terminations?

A. Yes.

Q. Miss Barr was a second trimester pregnancy termination; correct?

A. Correct.

Q. All right, sir. And do you agree that when dilation is suboptimal, the risks of excessive blood loss and uterine injury increase?

A. Yes and no. I -- I don't know what type of uterine injury you're talking about.

Q. Okay. What type of uterine injury would you expect the risk of would be increased when dilation is suboptimal?

A. I can't think of any. That's why I said I don't --

Q. Okay.

A. -- I don't know why even say that.

Q. Well, then let me rephrase it this way.

You can't, as we sit here today, you can't think of any increased risk of uterine injury when dilation is suboptimal?

A. Well, you can go to a ridiculous extreme. If you don't dilate the cervix enough, you wouldn't

be able to -- to put any instruments into the cervix to perform the operation.

Q. Is it important for the cervix in second trimester terminations to be dilated sufficiently to allow whatever instruments are needed to maneuver freely inside the uterus?

A. Yes.

Q. And that requires ample cervical dilation to do that; correct?

A. Yes.

Q. All right, sir. We've talked a little about uterine perforations, or you and Mr. Wright have. I want to follow up on some of those questions.

Would you agree that a uterine perforation is a known risk and complication of the type of surgical abortion that Miss Barr underwent?

A. Yes.

Q. And in fact, for Miss Barr, she was informed of this risk through the informed consents prior to agreeing to this procedure, wasn't she?

A. Yes.

Q. And I'm going to -- if you will pull to that first tab in your deposition. No, sir. There's one more in front of it.

All right. Now, that is part of an exhibit that's attached to your deposition, which is also part of the Exhibit 2 that was attached to your deposition here today.

A. Yes.

Q. Do you recognize this document?

A. Yes.

Q. And what is this?

A. That's the consent form that the patients sign when they are going to undergo the procedure.

Q. And this is specifically the consent form signed by Miss Brown-Barr prior to her termination procedure in June of 2000; correct?

A. Yes.

Q. And would you read the highlighted portion of this consent form?

A. That says, "The possible complications of the procedure used means there is a possibility of uterine perforation."

Q. All right, sir. And then if you'll turn to the second -- well, and before we leave that one, that is signed by Miss Barr; correct?

A. I assume so.

Q. It has a signature bearing Felicia --

A. It has --

Q. -- Brown.
A. Yes. Correct.
Q. All right, sir. And this next document, is this also another form of consent given to Miss Brown?
A. Yes.
Q. And would you read the highlighted portions of this consent that was given to Miss Brown.
A. "Very infrequently, however, certain complications may arise. These complications may include infection, perforation of the cervix, spontaneous abortion, and/or septic abortion."
Q. Okay. And do you have any reason to believe that Miss Barr-Brown -- I'm sorry -- Brown-Barr was not given all of this information and signed for this information prior to her termination procedure?
A. I have no way to know. I -- I don't see her signature on that one, but maybe it's --
Q. If you'll flip over to the page before.
A. Maybe it's the next page?
Q. No, sir. It's the page before it, actually. I think the copies were messed up a little bit. Turn the page before.

A. Oh, I see. Okay. That would look to be her signature. The --

Q. All right, sir.

A. As I read it, I would have worded it a little bit differently, but since I don't know what a perforation of the cervix actually is...

Q. All right. But we are talking here today about uterine perforations and cervical lacerations I guess would be another way to describe it.

A. Yes.

Q. All right, sir. The reason -- wouldn't you agree that the reason these kinds of risks are told to the patients prior to these procedures is because an injury such as this can occur during these procedures even when the physician does everything correctly during the procedure?

A. Yes.

Q. And that's because, in other words, an injury such as a uterine perforation during a surgical abortion can occur even when the physician is exercising reasonable care and not violating the standard of care.

A. Yes.

Q. And we know from your past deposition that even you yourself have perforated a uterus during a

surgical abortion, haven't you?

A. Probably more than once.

Q. Would you agree that the risk of a uterine perforation is increased the further along the pregnancy is?

A. Yes.

Q. And Miss Barr was actually at the legal limit for having her pregnancy terminated, wasn't she?

A. I presume so. I'm not sure what the limits are in Arkansas.

Q. All right. The limits for a pregnancy termination in North Carolina are 20 weeks; correct?

A. Correct.

Q. And assuming that the law is the same in Arkansas, then Miss Barr would have been right at the end of that limit --

A. Yes.

Q. -- for having a pregnancy terminated.

A. Correct.

Q. Now, my understanding, unless anything has changed since your last deposition, is -- is that you are not critical of any aspect of Dr. Tvedten's care of Miss Barr except his choice in size of dilator.

A. Correct.

Q. All right, sir. So from the time Miss Barr arrived on the morning of June 10th of 2000 until the time the medical records reflect she was sent to the University Hospital, all of the care that Dr. Tvedten provided, you are not critical of that except for that one particular decision on the size of dilator.

A. Yes.

Q. You're not critical of his choice of the Lamicel and the Cytotec, are you?

A. No. I -- I would -- I would prefer an alternative, but I would allow him to his choice.

Q. Well, in fact, and remember, we're back nine years ago. This is in 2000. So we have to think in terms of in 2000.

Would you agree that Lamicel and Cytotec was a reasonable choice and that they're fast acting and work together?

A. Yes.

Q. All right. You're also not critical of Dr. Tvedten for attempting to do this procedure in one day based on Miss Barr's past vaginal delivery history.

A. Again, I would prefer, and I think it's

probably a safer method, to do a two-day procedure when it's 20 weeks, but I will concede that there are some experts who do it in one day.

Q. All right. And in fact, you had previously testified that the fact that Miss Barr had three spontaneous vaginal deliveries would make it reasonable to assume that her cervix would easily dilate in one day, didn't you?

A. I cannot recall what I testified then. I'm a bit surprised if I used the word "easily," but...

Q. Okay. All right. And in fact, if you'll turn to page 76 in your deposition, we can see exactly what it was.

If you'll look on page 76, beginning with line 8, I asked you the question: "Generally speaking, women with a history of three spontaneous vaginal deliveries, it's reasonable to expect her cervix would dilate easier than others."

And what did you say?

A. "Yes."

Q. And then the next question I asked you is: "And just so I'm clear, you're not critical of Dr. Tvedten's decision to try to perform this procedure as a one-day procedure."

And what did you say?

A. "No."

Q. All right. Is that still your testimony here today?

A. Yes. I think so.

Q. All right, sir. You're also not critical of any informed consent issues in this case, are you?

A. No.

Q. And you're also not critical of Dr. Tvedten's actions once he realized the perforation had occurred.

A. No.

Q. And you're not critical or you don't think that there was anything that should have alerted him to this problem any earlier.

A. No.

Q. So we're back down to simply the choice of dilator; correct?

A. Yes.

Q. All right, sir. Let's talk a little bit more about that.

In your deposition, you previously stated that the largest dilator that you believe Dr. Tvedten should have used, and would have been

within the standard of care, was a 51 dilator. Do you recall that?

A. Yes.

Q. Now, here when Mr. Wright was asking you some questions, you referenced needing only a dilator of a 48 or 49.

Are you changing your testimony about the 51, or is that -- was that just an estimate that you went through with Mr. Wright?

A. It's -- I can -- I understand how -- why some people do use 49 or 51. I personally think it's unnecessary, but I don't see much -- any danger in doing -- using a 49 or 51 if that's what that person's used to. The largest suction curette is number 16, and it will be -- it will be easy to admit a number 16 if one dilates to 47. That's enough.

Q. Okay.

A. So I don't see any point in going beyond that.

Q. But with respect to at what point, in your opinion, a physician crosses over into medical negligence, you believe that Dr. Tvedten could have used a dilator as large as a 51 and not been, in your opinion, medically negligent; is that --

A. Yes.
Q. -- correct?
All right. Dr. Tvedten, however, used a number 71 dilator, in this case.
A. Yes.
Q. Now, let's talk these numbers, this 51 versus 71. That refers to the millimeters of circumference of the dilator, doesn't it?
A. Yes.
Q. And circumference is the total area of the circle, so to speak.
A. Just distance around. Yes.
Q. The distance around. I'm not a math person. I apologize on that on the front end.
The diameter in my non-math mind I would describe as basically being the width of the circle. Is that a --
A. Yes.
Q. -- fair statement?
A. That's correct. Yes.
Q. All right, sir. Now, between -- to get that width, that number to know exactly how wide that opening is, you have to take the circumference and then divide it by pi, which is 3.14; right?
A. Yes.

Q. All right. So we basically have a difference of 20 millimeters of circumference between the number 51 dilator, that you believe would have been within the standard of care, and the number 71 dilator that Dr. Tvedten used; is that correct?

A. Yes.

Q. So we take that 20 millimeters of circumference and divide it by pi, 3.14, and we get 6.4 millimeters difference in diameter between the two dilators; is that correct?

A. Yes.

Q. All right. Now, I already told you I'm not a math person, so I looked this up before, but if -- if I'm wrong, I want you to tell me.

My understanding is there's 25.4 millimeters in an inch.

A. Uh-huh.

Q. Is that correct?

A. Yep.

Q. All right, sir. So 6.4 millimeters difference in diameter, really when we are -- when it is all said and done, what we are talking about is one quarter of an inch, aren't we?

A. No. It's more than that.

Q. How so?

A. I don't -- I think you're -- no one's ever asked me this, that I can remember, but I don't think it -- that it's a simple dividing pi and that -- that the number is a reflection of the circumference versus the radius.

Q. So you -- it's your testimony that a number 51 dilator does not refer to 51 millimeters of circumference?

A. No.

Q. That is not your testimony.

A. I don't know. I don't know what it means, but the -- I know the numbers are -- it's roughly three times.

Q. Okay. Do you know as we sit here today, Dr. Dingfelder, the difference in diameter between a number 51 dilator and a number 71 dilator?

A. I've never seen a number 71.

Q. Okay.

A. So I don't -- I do not know.

Q. Well, I guess it's fair to say if you've never seen one --

A. I think it's --

Q. -- you couldn't testify as to how much larger it is to a 51, could you?

A. Not in numbers.

Q. Okay. If in analyzing a number 51 and a number 71, measuring them, putting the numbers on paper, if it turns out that there is only a one quarter inch difference in diameter between the two, would that surprise you?

A. Yes.

Q. Would that change any of your opinions in this case about the -- Dr. Tvedten's choice to use a 71 dilator?

A. No.

Q. Strictly speaking, from the evidence in this case, the medical records, wouldn't you agree that you cannot tell where this laceration began? In other words, whether it began in the uterus and moved down to the cervix, or whether it began in the cervix and moved up to the uterus?

A. Well, I think almost every one of these that I've ever been associated with, reading about or actual, in my own case, they start in the cervix.

Q. Okay. But the known risk, that we already talked about, is of a uterine perforation; correct?

A. Well, yes and no. The cervix is part of the uterus.

Q. Okay. Do you -- let's go to page 67 of

your deposition.

On line 9, I asked you the question: "Can you tell, Doctor, where this perforation began, whether it began in the cervix and went upwards, or whether it began in the uterus and went downwards?"

And what was your answer?

A. "No, I don't think so."

Q. Yes, sir.

And then I asked you: "So is it fair to say, then, that you can't tell whether this began as a uterine perforation or a cervical laceration?"

And --

A. My answer was: "Strictly speaking, one couldn't tell, but then if -- if -- if it began as a uterine perforation, then one would have to postulate that an instrument was placed in the perforation and then pulled down, (The witness indicated.) or otherwise used to extend the laceration downward through the cervix. That's less likely I would say."

And that's what I say now. That's not -- not -- I even go further than that now. I would say it's unlikely.

Q. Okay. Why is it that when I took your deposition four years ago, you said it was less

likely, and now you're saying it is unlikely?

A. Well, the more -- the more I look at it and the more I realize that it was a complete laceration through all layers of the cervix, the only mechanism that I can think of that would do all this is just an excessively large dilator just literally splitting the whole thing.

Q. But back to what we were talking about before, you don't know how much larger a number 71 dilator is, do you?

A. Not precisely, but it's considerably larger, and it's -- it's way more than anybody uses, that I know of.

Q. When you say "considerably larger," you think it's considerably larger than a number 51. In other words, it's considerably larger than a quarter of an inch?

A. Yes.

Q. Okay. How much larger do you think a number 71 dilator is as far as in diameter to a number 51?

A. I don't know. I'd -- I would have to get measurements out. I'd have to see one and measure it. That's all.

Q. Well, and the reason I ask, you must have

something, some idea in your mind, because the way you describe it as this dilator is so much larger than a 51, that it literally cracked open the cervix. So in all fairness, you must have an idea in your mind as to how much larger, an estimate even, you think this number 71 is over this 51.

A. I know -- it's just larger. That's all I can say at the moment. I would have to have measuring instruments to really precisely tell you.

Q. How, just for the jury's sake since this is on video, how large is a quarter of an inch? Can you do -- use your fingers and show the jury?

A. Sure. (The witness indicated.)

Q. Just about that much.

A. Well, inch is about like that. Half inch, quarter of an inch, like that.

Q. Quarter, about that much more.

A. Right.

Q. And it's your belief that this number 71 dilator is sufficiently larger in diameter to a 51 by more than just that quarter inch; is that correct?

A. Yes, I think it is larger.

Q. All right. Is it your belief that Miss Barr's entire procedure could have been

accomplished with just a 16 millimeter diameter cannula?

A. Yes.

Q. Okay. And therefore, you don't think any other instrumentation would have been necessary to accomplish the procedure?

A. No, not just, just that, but the -- there are extracting forceps that will easily go through a cervix that admits a number 16 suction curette.

Q. Okay. So you do agree that there would have been more instruments needed to --

A. Oh, yes.

Q. -- complete Miss Barr's procedure than just that 16 --

A. Oh, yes. Absolutely.

Q. -- millimeter cannula.

Would you agree, then, that the instruments needed to complete her procedure might have required a diameter larger than 16 millimeters, to be able to maneuver freely inside her uterus?

A. No.

Q. Is it your belief that under no circumstances is there ever a reason to use a di- -- a cervical dilator above a number 51 for a second trimester pregnancy termination?

A. Yes, that is my belief.

Q. Okay. And I believe we went through this before in your deposition, but you don't know any of the physicians in Arkansas who perform second trimester terminations, do you?

A. Correct.

Q. Do you even know how many physicians there are in Arkansas that perform surgical abortions?

A. I don't know precisely. I think -- I've heard there are two others.

Q. Okay. If that is correct information and there are two others, then there's basically three in the entire state that perform these surgical abortions; correct?

A. That would be essentially true. Probably there's one or two at the university that can do it if necessary, but don't --

Q. Okay.

A. -- regularly do it.

Q. And out of these three physicians in Arkansas, we know with Dr. Tvedten that on occasion he'll use the number 71 dilator, because we know he did with Miss Barr; correct?

A. Yes.

Q. Do you have any information or knowledge

as to the type of dilators and the size of dilators that the other two physicians practicing in this area of medicine in Arkansas use?

A. No.

Q. Okay. If there was evidence and information that these two physicians also, on occasion, used number 71 dilators for second trimester terminations, would you believe that is also in violation of the standard of care?

A. Yes.

Q. All right, sir. Now, if, hypothetically, that were the case, that all three of these physicians practicing in Arkansas performing surgical -- surgical abortions on occasion use number 71 dilators, wouldn't you agree that that is within their local standard of care since they're the only ones in the state performing the procedure?

A. If -- if it was under exactly the same circumstances as this case, I would agree. I -- I can hardly imagine what those circumstances would be. But anyway, I would agree.

Q. Okay. And that's because you can't conceive of circumstances in which a physician would need to use a number 71 dilator for a second trimester termination; correct?

A. Correct.

Q. But as we've already established, if all the physicians in Arkansas who are practicing in this area and performing second trimester surgical abortions do on occasion use number 71 dilators, then Dr. Tvedten's actions in this case would be within the local standard of care set by those physicians in Arkansas.

A. Yes.

Q. And your opinions that Dr. Tvedten violated the standard of care in this case are based on your belief that there is, and/or should be, a national standard of care for performing these procedures across our country; correct?

A. No. I -- I -- I don't subscribe to any national standard of care for surgical procedures. It's just that everyone who's been trained in this, that I know of, seems to have the same technique.

Q. All right. Let's go to page 55 of your deposition.

On line 8, I asked you the question: "Do you assume, then, that there is a national standard of care that covers all physicians performing abortions across the country?"

And what was your answer?

A. "Yes."

Q. So today now I understood you to say that you don't subscribe to the theory of a national standard of care, so I'm -- I guess I'm confused.

A. Well, I -- I perhaps didn't know what the -- what that meant in those days, "national standard of care." People talk about local standard of care and national standard of care and a state standard of care and a regional standard of care. And -- and frankly, I think it's all the same, unless you're limited by lack of equipment or some such thing.

Q. Or training.

A. Or training? Well, I don't think that you should be doing something that you're not trained to do.

Q. Well, wouldn't you agree -- this is going to be kind of a give-away question, but wouldn't you agree that the whole issue of surgical abortion is a very controversial issue in our society?

A. Certain aspects of it are controversial.

Q. Yes, sir.

A. Obtaining it and -- is the controversial part.

Q. And therefore, this is not an area of medicine, wouldn't you agree, that there's a lot of

literature or medical textbooks or things included on standard guidelines for this procedure in our country?

A. Most surgical textbooks have chapters on techniques of surgical abortion.

Q. For D&Es.

A. For D&Es, yes.

Q. But are you familiar with the National Abortion Federation?

A. Yes.

Q. And what is the National Abortion Federation?

A. It's a -- just a group of people, both providers and clinic operators, that provide the training and education in certain areas.

Q. Okay. And are you a member of that organization?

A. Not currently. I have been in the past.

Q. Okay. And are you familiar with the publications put out by that organization on techniques for pregnancy termination?

A. No, I'm not.

Q. Okay. When you talk about literature on surgical abortion or pregnancy termination, are you referring to just whatever information is included

in the standard obstetrical textbooks, such as Williams?

A. No. There are specific textbooks that are -- have been -- have been written about the actual techniques of surgical abortion.

Q. And you've not reviewed any of those in preparation for your testimony here today, have you?

A. No.

Q. And the literature that you've written, I believe you and Mr. Wright went over that and talked about 61, I believe, publications listed on your CV?

A. Yes.

Q. Out of those, you haven't written anything on abortion or pregnancy termination in the last, say, 30 years; is that correct?

A. Ten you mean?

Q. In the last 30 years.

A. 1990, that would be 19 years.

Q. And I'm talking about on topics of surgical abortion.

A. Yes. This was called "Induced Abortion." Chapter in "Surgical Diseases of Pregnancy."

Q. Okay. Induced abortion is different than actually the kind of procedure that Miss Barr underwent, isn't it?

A. No.
Q. Induced abortion, you're not referring to medically induced abortion?
A. No.
Q. You're referring to surgical abortion.
A. No. Both. It's induced abortion as opposed to spontaneous abortion.
Q. Okay. And that was written 19 years ago?
A. Right.
Q. Okay. Have you written anything in the last 19 years on surgical abortion?
A. No.
Q. Now, you currently are seeing about a hundred patients a week? Did I understand that correctly?
A. Yes.
Q. And how long have you maintained that level of practice?
A. I don't -- I don't -- I don't know really.
Q. Okay. Well, in other words, have you recently cut down on your practice where you're at a hundred patients a week, or have you maintained that level --
A. No. That's been --
Q. -- for a while?

A. -- pretty much the level for a while.

Q. Okay. For at least the last -- since 2000?

A. Yeah. Pretty much.

Q. Okay. And 95 percent of your practice is devoted to obstetric and gynecological issues other than pregnancy termination.

A. Yes.

Q. And that is different than the kind of practice in which Dr. Tvedten was engaged in 2000. Would you agree with that?

A. I don't really know --

Q. Do you --

A. -- one way or the other.

Q. Do you know about what kind of practice Dr. Tvedten was engaged in in 2000?

A. No. I -- I think he did pregnancy terminations, but I don't know if it was exclusively that or whether he had any other office.

Q. Okay. Or what percentage of his practice made up pregnancy terminations.

A. Correct.

Q. And do you have any knowledge as to Dr. Tvedten's background and experience in performing this procedure?

A. No.

Q. And is the level of experience of the practitioner performing this procedure important to you in reviewing a case such as this and rendering your opinions?

A. Yes.

Q. But with respect to Dr. Tvedten, as we sit here today, you don't have that information?

A. What information would that be?

Q. Information concerning his experience in performing these procedures.

A. Well, I'm not -- I don't have precise information.

Q. Do you have any information?

A. Just what you told me.

Q. Which is what?

A. That's -- presumably, that's all he does.

Q. Just a minute.

Now, it's my understanding we're here today taking your deposition via video because you will not be attending the trial live and in person and testifying; is that correct?

A. I guess. I could --

Q. Well, I'll rely on --

A. -- if need --

Q. -- Mr. Wright to --
A. -- if need be.
Q. -- to let me know if that occurs.
A. Yes.
Q. As we sit here today, do you have any knowledge as to when the trial is set?
A. Sometime in August I heard.
Q. Okay. Have you made any travel arrangements to --
A. Not yet.
Q. -- be present live?
You mentioned that you are board certified in obstetrics and gynecology, and that was back in, I think you said 1974 --
A. Yes.
Q. -- when you obtained the certification.
Have you over the last 35 years recertified?
A. Twice.
Q. And that is by taking the exam?
A. Yes.
Q. And when was the last time you did that?
A. It was in 1990 --
Q. Okay. So you --
A. -- '91.

Q. -- have not recertified and taken -- gone through the board certification examination process since -- for the last 19 years?

A. Correct.

I us- -- I -- I was taking it ev- -- approximately every ten years, but I just missed it the last time round. I've thought about doing it again, but I'm close to retirement anyway, so I probably won't.

Q. Okay. And what -- and how old are you, if you don't mind me asking?

A. 71.

Q. 71.

And you just in the last year stopped your OB practice?

A. Yes.

Q. Are you still performing the same number of pregnancy terminations in your clinic that you were back when I deposed you four years ago?

A. Approximately.

Q. Has that slowed --

A. Maybe --

Q. -- down a little as well?

A. -- a little bit. Yeah.

Q. And before when I asked you, you couldn't

really give me a number as to how many 20-week pregnancy terminations you perform on average. Can you now?

A. No. It would just have to be -- it would be a guess.

Q. Okay. Are those more of the rare situations in pregnancy termination that you perform as far as on a spectrum --

A. Oh, yes.

Q. -- of level?

In other words, most people, most women who come to you for pregnancy termination are not nearly as far along as a 20-week pregnancy.

A. Oh, yes.

MS. CAULEY: Okay. Dr. Dingfelder, I believe that is all I have. Thank you very much.

EXAMINATION BY COUNSEL FOR THE DEFENDANT WOMEN'S COMMUNITY HEALTH CENTER

BY MR. BACON:

Q. Hello. This is Don Bacon, Doctor. I have a question.

A. Yes.

Q. I represent the -- the clinic. And I asked you in the deposition four years ago this question, and I just want to make sure that your

answer is still the same, and I assume it is based on your conversation with the other lawyers.

You do not have any opinions that are critical in any way of the nursing staff or any of the other staff at the clinic, other than Dr. Tvedten?

A. No. No, I do not.

MR. BACON: All right. Thank you, Doctor. That's all I have.

MR. WRIGHT: It's a wrap.

THE VIDEOGRAPHER: Stand by.

We are going off the record at 11:32 a.m. This ends Tape Number One and the deposition of James Dingfelder, M.D.

(Whereupon, at 11:32 a.m., the deposition in the above-entitled matter ceased.)

_____

Signature of the Witness

SUBSCRIBED AND SWORN to before me this ___ day of _____, 2009.

_____

NOTARY PUBLIC

My Commission expires: _____

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SECOND CIVIL DIVISION

FELICIA (BROWN) BARR AND
MARCELL BARR **PLAINTIFFS**

vs. **NO. CV-2002-5986**

WOMEN'S COMMUNITY HEALTH CENTER
and THOMAS TVEDTEN, M.D. **DEFENDANTS**

AFFIDAVIT OF JERRY EDWARDS, M.D.

I, Jerry Edwards, M.D., after being duly sworn upon oath, states as follows:

1. I am over the age of eighteen years, have personal knowledge of the statements made herein, and am competent to testify in all respects.

2. I am a licensed medical doctor in the state of Arkansas. I am currently one of three physicians in the State of Arkansas routinely performing second trimester surgical abortions.

3. On occasion I use a number 71 dilator when performing second trimester surgical abortions. This is a routine and acceptable size dilator to be used in second trimester surgical abortions in the State of Akransas, and the use of a number 71 dilator is within the standard of care practiced by physicians in Arkansas who routinely perform second trimester surgical abortions.

Further, Affiant sayeth not.

Jerry Edwards, M.D.

Subscribed and sworn to before me this 20th day of July, 2009.

Deborah K. Horton
Notary Public

DEBORAH K. HORTON
COM. EXP.
NOTARY
PUBLIC
8-15-2012
PULASKI COUNTY, AR

My Commission Expires:
8-15-2012

EXHIBIT
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IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SECOND CIVIL DIVISION

FELICIA (BROWN) BARR AND
MARCELL BARR **PLAINTIFFS**

vs. **NO. CV-2002-5986**

WOMEN'S COMMUNITY HEALTH CENTER
and THOMAS TVEDTEN, M.D. **DEFENDANTS**

AFFIDAVIT OF TOM TVEDTEN, M.D.

I, Tom Tvedten, M.D., after being duly sworn upon oath, states as follows:

1. I am over the age of eighteen years, have personal knowledge of the statements made herein, and am competent to testify in all respects.

2. I am a licensed medical doctor in the state of Arkansas. I am currently one of the only two physicians in the State of Arkansas routinely performing second trimester surgical abortions at 20 weeks gestation, the only other physician performing the procedure being Dr. Jerry Edwards. Plaintiff, Felicia (Brown) Barr was at 20 weeks gestation when she underwent the elective termination which is the subject of this lawsuit.

3. On occasion both Dr. Jerry Edwards and I use a number 71 dilator when performing second trimester surgical abortions at 20 weeks gestation. This is a routine and acceptable size dilator to be used in second trimester surgical abortions at 20 weeks gestation in the State of Arkansas, and is utilized during this procedure by the only two physicians in Arkansas who perform the procedure.

Further, Affiant sayeth not.

Tom Tvedten, M.D.

Subscribed and sworn to before me this 21 day of July, 2009.

Notary Public

CHRISTEN N. MAXWELL Commission No. 12365507 NOTARY PUBLIC My Commission Expires Dec. 6, 2017 ASHLEY CO., ARKANSAS

My Commission Expires:
December 6, 2017

EXHIBIT
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