EXHIBIT A

[redacted] Patient #2

Several aspects of this do not meet the standard of care. This patient did not have preeclampsia by any criteria, such as blood pressure, proteinuria. Edema can be varying and has been discarded as a diagnostic criterion. Uric acid, while helpful in some cases may be elevated by diet alone. Since she never has seen the patient, admitting for laboratory and 23-hour observation may have been useful in this case, with normal amniotic fluid and protein, she should have been discharged. The use of NST's is unreasonable and I have never seen it ordered every three hours. Beyond the lack of an indication for induction, the use of Pitocin is unusual and below the standard of care. The admission note was inadequate in justifying the induction, and the lack of at least daily notes with a patient being actively managed for delivery with uterotonic agents and the lack of any reasoning for proceeding with a cesarean section is below the standard of care.

[redacted] Patient # 13

Within the Standard of Care. However, documentation concerns remain.

[redacted] Patient # 12

The trial of labor after cesarean is known to have multiple risks; the most catastrophic is uterine rupture in 1% of patients. It should not be done in a center that does not have 24-hour anesthesia coverage and adequate blood-banking facilities. There is no evidence in the prenatal or hospital record on previous cesarean section scar or counseling on VBAC. This patient should have probably been sectioned 4 hours before it was performed and additionally this is a macrosomic infant. The patient was type and crossed prior to surgery, which is an unnecessary task and expense. This case falls below the standard of care on medical documentation, timely intervention and poor utilization of resources.

[redacted] Patient # 11

Severe variable decelerations early in labor requiring additional maneuvers, likely caused by oliohydramnios, but not considered: No amnioinfusion performed. No placement of fetal scalp electrode until 7 hours later.

At 09:20 the physician noted 7 cm dilation, 90% effacement, -1 station which is compatible with active labor. At 13:30 the physician noted 6-7 cm dilated and static at 90% effaced, -1 station. This indicated active phase arrest requiring cesarean section at 13:30. In this patient oxytocin was contraindicated due to severe decelerations of FHR. Fetal Heart Monitoring continued to evolve to more ominous patterns; recurrent prolonged decelerations, intermittent late decelerations, and the presence of intermittent

complex decelerations, which does not support that the fetus was tolerating labor and a cesarean section was indicated. At the decision to proceed with cesarean section for fetal distress, the ACOG 30 minute rule should have been observed. The physician documented to proceed with cesarean section at 18:02. The incision was documented at 19:15 with delivery at 19:18.

At the time of cesarean section it was noted the patient had an "oblique lie" this would be highly unusual. There was a lack of description of where meconium was found in relationship to the baby's vocal cords. There is no rational for the thrombophilia work up, which has no diagnostic value in the recently delivered patient because of the dynamic relationship of clotting parameters in the immediate post partum patient. This falls below the standard of care on medical reasoning and documentation.

[redacted] Patient #4

There is no evidence of fetal intolerance to labor and cervical exam documentation by the physician was not provided. The cause of a postoperative fever, especially in a morbidly obese patient who has had an anesthetic and is not ambulating well according to the nurses' notes is atelectasis. In the initial radiology report atelectasis was suggested in the left lower lobe. The physical exam performed was rudimentary. This case falls beneath the standard of care on multiple levels.

The term "chronic renal" has no meaning or explanation, nor was any laboratory data obtained. The patient did not have an indication for a cesarean section by the fetal monitoring strips. I doubt the infant was an oblique lie, because this is not usually found in a prima gravida. To order antibiotics without seeing the patient is unacceptable. An obese patient lying on her back with chest wall compression with gravid breasts in the immediate postoperative time frame is atelectasis until proven otherwise. The antibiotic choice when the patient was transferred to ICU is for endomyometritis, not pneumonia. A procalcitonin level is inappropriate in this clinical scenario. The medical documentation and care is below the standard.

[redacted] Patient #6

I am confused why a BPP was performed @ 33 weeks, rather than a NST, and then no further fetal testing done despite continued elevated B/P's. A trial of labor for a vaginal birth after cesarean mandates that the previous uterine scar is documented by some means or a note that it was discussed with a medical records person at the hospital. This patient had her child in New York by the medical records and the scar is not documented, only that she had gestational diabetes and the indication for surgery was failure to progress. The estimated fetal weight is not documented. There is no documentation why a diagnosis of transient pregnancy induced hypertension is considered. The most common etiology of fetal distress with late decelerations is most likely epidural anesthesia with maternal hypotension, especially in patients with pregnancy-induced hypertension.

This was not addressed in a timely fashion with fetal distress during a VBAC, and a cesarean section must be considered. The patient should have at least been moved to the OR in anticipation of performance of a cesarean section. It was pure luck that this infant had enough fetal reserve not to become hypoxic at birth. The provider was involved in the care, but there is no documentation present as to her thought or her decision making process, and her reasons for intervening or not. Finally, it is unclear why the advanced uterotonic agents were used, (usual cause is uterine atony), and the way they are used is not logical – an oral agent at the same time as an IM injection, which was proceeded by a 3rd line agent. No documentation exists in the records I received as to why the medications were used. This case falls below the standard of care on multiple grounds.

[redacted] Patient #3

This patient should have been checked for dilation by 2200 and when it was determined that she had a desultory labor, an IUPC placed to determine the strength of contractions and if inadequate, augmented and after several hours, undergo a cesarean section. There is no documentation in the medical record on how this patient's labor was managed. Again the use of "oblique lie" as an indication for cesarean section is a misuse of terminology.

The use of the Surgicel on the surgical site adds expense and probably increases scarring at the superior junction of the bladder flap, making future dissections at cesarean delivery difficult. The management of labor is below the standard of care. The use of a type and cross adds to expense and ties up those units for 48 hours in most hospitals; this should only be used if the probability of a transfusion is close to 90%. The overall management is below the standard of care, with ongoing poor documentation.

[redacted] Patient #8

Within the Standard of Care. However, documentation concerns remain.

[redacted] Patient #9

This case is below the standard of care on several levels. First, the lack of documentation of adequacy of labor and lack of timely intervention because of a very disturbing monitoring strip. For the sake of brevity, the same problems on the use of laboratory, (type and cross), Surgicel and obstetrical terminology continue. The use of Clindamycin for GBS prophylaxis without penicillin allergy is questionable, (and in some hospitals gives poor coverage). Additionally, there is essentially no documentation on the obstetrician's thought process or approach to this patient.

[redacted] Patient #5

Induction at 40/3 weeks is reasonable, but allowing the active phase of labor to last for 14 hours until a decision to do cesarean section is below the standard of care. The level of obstetrical involvement is below the standard of care, both in interventions and documentation. Consideration of labor obstruction by fetal macrosomia was never considered. Documentation of uterine activity via IUPC for adequacy of uterine contraction is absent. Essentially, the role of the obstetrician in the care of this and other patients seems to be delegated to nursing until they get the physician involved. The use of Surgicel on the uterine incision is well explained above.

[redacted] Patient # 7

The obstetrician should have some working knowledge regarding normal physiological changes of the early post partum state to advise the consultants. The patient had mild hypertension in the third trimester (140/89 @ 29 weeks and 141/92 @ 33/6 weeks), but that is not documented in the H &P. On post partum day #1, the patient was noted to have "hypertension" (actual levels not noted in the physician's note). The echocardiogram findings are consistent with some level of hypertensive cardiac disease, but can be found with preeclampsia and hypertensive disorders of pregnancy. The patient was started on a usual regiment for cardiomyopathy, which is probably an overtreatment. Why was a renal ultrasound, abdominal ultrasound, and a lipid profile ordered in this post partum patient? The documentation, care, and use of consultants in this case were below the standard of care.

[redacted] Patient #10

This case is below the standard of care. The latest an intervention should have been considered was by 17:30 and a cesarean delivery performed earlier. There is no documentation or explanations for the late decelerations and category III tracings in the medical record provided. Prior to going home for the evening, the provider should have checked on the patient and reviewed the tracing, specifically after nurses called to discuss.

[redacted] Patient #1

The intrapartum management of this patient met the standard of care, however, the documentation was poor.
Estimated fetal weight and ultrasound determinations were not performed and or documented on the medical record and is below the standard of care.

On admission, a type and cross for 2 units was ordered; In the prenatal records it was noted that Dr. Dinsmore delivered the patient in the past and had to transfuse her. Documentation concerning prior delivery was poor and reasons for transfusion were not explained.