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THE STATE of OHIO, :
: SS:
COUNTY of CUYAHOGA.

IN THE COURT OF COMMON PLEAS

MONICA DIXON, et cetera, plaintiffs,

vs. : Case No. 324550

UNIVERSITY HOSPITALS OF CLEVELAND, et al., defendants.

Deposition of CYNTHIA AUSTIN, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at University Hospitals, 11100 Euclid Avenue, Cleveland, Ohio, on MONDAY, FEBRUARY 9TH, 1998, commencing at 1:12 p.m. pursuant to agreement of counsel.

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I N D E X

WITNESS: CYNTHIA AUSTIN, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

CYNTHIA AUSTIN, M.D.

Of lawful age, a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. CULLERS:

Q. State your name, please.

A. Cynthia Austin.

Q. Your business and residence address, please?

A. I'm at University Hospitals, 11100 Euclid Avenue, Cleveland, Ohio 44106.

Q. Your residence address, please?

MR. NORCHI: We'd rather not give out the residence address. If I have to, if it is important I can give it to you, this is a public document.

MR. CULLERS: For the purpose of if I have to serve a subpoena.

THE WITNESS: I'd rather it not come to my house.

MR. NORCHI: The problem with a public record, the address for the doctor,

it's not safe to do. If you want the information, I'll send it to you.

MR. CULLERS: It's not a big deal.

Q. I would like to ask you some questions about your involvement in the care of Monica Dixon.

A. Um-hum.

Q. I need you to respond to each of my questions verbally.

A. Okay.

Q. The first thing I want to do is refer you to the discharge summary. This discharge summary was prepared by Joan Krietsky?

A. Yes.

Q. Is this your signature here?

A. Yes.

Q. Do I take that to mean you have adopted this discharged summary as your own?

A. What you would take it to mean is that a physician, attending physician's signature has to be on every chart. The medical records sent this to me, I was present at the delivery. Even though I wasn't the admitting, probably the discharge physician, I signed it.

Q. What is the effect of your signing that, do

you adopt that as --

A. I don't know what you mean by adopt. Do I read it over, think it's a reasonable reflection of what happened in the hospital, yes.

Q. That's what I wanted to know.

If you look at the operative report, please. If you turn to the second page, please, this also indicates it was prepared by Joan Krietsky?

A. That is inaccurate. That is the custom in this hospital, that the dictating service writes Joan Krietsky. I didn't do the delivery, that doesn't imply I did the delivery. They always put the resident for the attending.

Q. I'm not trying to imply anything. I want to find out what it was.

A. I was the attending on that case. If I was not present in the room, it still would have been done that way.

Q. That is your signature?

A. That's my signature.

Q. Do I take it that because you signed this, that you reviewed this prior to signing it and agreed with what is stated as far as what occurred during the course of the operation?

A. Yeah, I imagine 1 read it over.
Q. By your signature do I take that to mean this accurately describes what occurred during the operative procedure?
A. Yes.
Q. The first thing I want to ask you about is on the operative note, pre-operative diagnosis indicates intrauterine pregnancy at **40-2/7** weeks with a fetal distress, macrosomia; do you see that?
A. I see it, yes.
Q. What is macrosomia?
A. I wouldn't agree that, that this baby is macrosomic.
Q. What is macrosomia?
A. I would say macrosomia is **4500** grams or greater.
Q. The postoperative diagnosis indicates macrosomia as part of the postoperative diagnosis?
A. I see that.
Q. You disagree with that?
A. I would disagree with that in this case.
Q. Is there a reason why you didn't indicate that you disagreed with that finding **--**
A. I was ~~signing.
Q. I know. Excuse me, I need you to let me

finish the question. Sorry.

Is there some reason you didn't indicate you disagreed with a postoperative diagnosis of macrosomia when you reviewed and signed the operative note?

A. I did not think it was a big enough disagreement to bother telling the resident she needed to redictate the whole thing.

Q. What was your thought process why you did that?

A. 1 wouldn't have paid enough attention to cosigning a note that I sat down and had a lot of thought process over everything single word in this.

Q. Do you specifically recall reading the postoperative diagnosis as including the diagnosis of macrosomia?

A. I don't specifically recall anything about this case.

Q. Earlier I was asking you why it was that you probably didn't think it was that big of a difference in what you recall and what the postoperative diagnosis says about macrosomia being present. I'm not sure if I understand what you said.

MR. NORCHI: I object. What is the question? I don't think that is what her testimony was. If there is a question in there, that doesn't make sense.

MR. CULLERS: I was asking a question, before I was finish d she began answering, that is why I was repeating. I'll ask a different question.

MR. NORCHI: Ask any question you want.

MR. CULLERS: I understand.

Q. Based on what you said, it's my understanding you do not agree that this was a macrosomic baby?

A. Technically speaking, no.

Q. Technically speaking you do not believe it was macrosomic?

MR. NORCHI: You have to wait until he finishes with his question.

Q. You disagree this was a macrosomic baby?

A. Right.

Q. What I was asking earlier is why didn't you make an indication or do something to indicate to the resident that this was not a macrosomic infant?

MR. NORCHI: Objection. Asked and answered. You can answer again, Doctor.

A. I looked it over generally, this is a reasonable reflection, this is her dictation, not mine, she doesn't have to agree with everything I say. I would not say this is macrosomia, a 4100 gram baby. It was not a significant enough thing for me to page her, say redo your dictation.

Just parenthetically, if this was my patient, I would have dictated it.

Q. If it would have been your patient?

A. My private patient, I would have dictated it.

Q. What is the difference?

A. Mrs. Dixon is a patient who is cared for by the residents, first time I met her is when I appeared at her delivery. I was not the obstetrician.

Q. You were considered to be the attending?

A. For that delivery, not for her prenatal care.

Q. At what point does your responsibility come into play?

A. 7:30 a.m. when I came on call.

Q. 7:30 a.m. on the date of delivery?

A. 3-14-95 apparently.

Q. Prior to that time, who fulfilled your role?

A. It looks like it was Dr. Sogor.
Q. You indicated that macrosomia is **4,500** grams or greater?
A. Yes.
Q. Therefore are you saying that a baby that is **4,000** grams or greater is not macrosomic?
A. I would say it's a large baby.
Q. Wouldn't meet the definition of macrosomic?
A. Wouldn't meet mine, no.
Q. Did you ever have any discussion with Dr. Krietsky your not feeling this was a macrosomic baby?
A. No, not that I remember.
Q. You said likely it wouldn't have been something you would have discussed with her?
A. Not likely.
Q. When you came on at **7:30** on **3-14**, what is the process that you went through to find out what the status of this labor and delivery was?
A. I don't remember specifically.
Q. What do you typically do?
A. Typically at **7:30** we meet for OB rounds. At that time patients that are currently active are reviewed, ongoing antenatal care. It's a rounds meeting with the residents largely for teaching

purposes.

Q. Do you review the chart at all?

A. No.

Q. You don't do any of that?

A. No, the charts are with the patients.

Q. Do you review the charts?

A. No, the residents present the patients.

Q. That's your sole source of information when you come on about the patient's status?

A. That's correct.

Q. We're sort of talking over each other. I would like you to try to wait until I've finished with my question, I'll try to wait until you're done before I start talking.

At any point during rounds when you came on at 7:30 do you recall whether suspected macrosomia was discussed?

A. I have no memory of the rounds with this patient.

Q. Before today, did you have an opportunity to review the chart?

A. Yes.

Q. Based on information that is contained in the discharge summary and in the operative note, are you aware that it is indicated that macrosomia was

suspected?

A. I'm aware of that.

Q. Do you think that it is likely you would have become aware that someone made that determination that macrosomia was suspected?

A. You're focusing on this word macrosomia. We knew this was a large baby. I would agree this is a large baby. When a baby is suddenly -- nobody goes from being **4400** grams to **4500** grams and something magic happens. It's a relatively large baby, we can agree on that if that satisfies whatever you are getting at here.

Q. Actually I'm looking at the record, that's all I've got to rely on. It says macrosomia as a pre-operative diagnosis, indicating that's something that is suspected?

A. What I think that it says is we expect a large baby.

Q. When you suspected a large baby, was there a difference in your mind about what type of -- strike that.

When you suspect a large baby, did you suspect that the baby would be over 4,000 grams but not over 4500 grams?

A. My recollection of this case, based on what I

have in here, we were not expecting a baby over 4500 grams. We were not surprised to see one **4100,** which I would still agree is a big baby.

Q. Why is that?

A. Why?

Q. Why were you not suspecting it was going to be a baby over **4,500** grams, you weren't surprised it was a baby over 4,000 grams?

A. You are asking my impression from having reviewed the record? That was my impression when I looked through the chart. It's been a while since I looked through the chart. 1 had nothing specific on my mind.

Q. When you are looking forward, you are planning the management of a labor and delivery, you suspect macrosomia, there isn't a difference in the way you approach how you are going to manage that labor based on whether or not you think it's going to be a baby that weighs **4,500** grams as opposed to a baby that weighs 4,000 grams, is there?

A. There would be some circumstances under which if I were the physician in charge of the prenatal care, that on occasion I might determine that it was better to do a primary C-section.

Q. Under what circumstances?
A. Now we're getting off the subject of this particular case, not under these circumstances.
Q. Under what circumstances would you make that recommendation?
A. If the baby were clearly over 4500 grams by estimated fetal weight using a good ultrasound, I was concerned by my clinical impression of the size of the woman's vagina, I might discuss with her the option of a C-section.
Q. The determination obviously of estimating fetal weight is important in determining how you are going to manage labor and delivery?
A. Yes.
Q. You're aware from your review of the records that this was a gestational diabetic pregnancy?
A. Diet controlled.
Q. Pardon?
A. Controlled with diet, mild.
Q. Was this a gestational diabetic pregnancy?
A. Yes.
Q. It was controlled by diet?
A. Right.
Q. Could you refer to the discharge summary, please. If you look down at the laboratory data,

if you would; do you see that?
A. Um-hum.
Q. I need you to answer.
A. Yes.
Q. There is information contained in there about the values from the glucose tolerance tests; do you see that?
A. Yes.
Q. Do those values that are contained within the last three sentences of that paragraph captioned laboratory data meet the definition of gestational diabetes?
A. Yes.
Q. Gestational diabetes is a factor that can result in macrosomia?
A. Yes.
Q. Do you have any information about this patient's fundal height on her presentation?
A. I have it in the record here, I think.
MR. NORCHI: Romney, is this --
MR. CULLERS: Off the record.

(Discussion had off the record.)

Q. Let me ask some general questions about the factors that are in the 3-13 record starting at 12:44. I don't have it with me. Let me ask you some questions.

I was asking you about fundal height. What is fundal height?

A. It is the measurement from the top of the symphysis to the top of the fundus.

Q. Is the fundal height 41 to 42 centimeters indicative of a large baby?

A. No.

Q. It is not?

A. No, that is a term baby. That's normal term. You expect approximately 1 centimeter per week. She was 40 and a half weeks, 41, 42, that's about what I expect.

Q. There is nothing about a fundal height of 41 to 42 centimeters of being indicative of a macrosomic fetus?

A. I wouldn't think so, no.

Q. Do you know if at any time during your involvement anyone indicated that an estimate fetal weight was done?

A. I don't remember.

Q. Do you know if a sonographic estimated fetal

weight was ever done?
A. I don't know.
Q. I would like to ask you to assume that the patient arrived on **3-13-95** at 12:44.
MR. **NORCHI:** After midnight.
Q. 12:44 p.m., was **3** to 4 centimeters dilated.
A. You are talking about noon the day before?
Q. Yes.
Then she did not progress beyond that dilatation until some hours later. She left, she went home. I would like you to assume also that on **3-13-95** when her cervical dilatation was **3** to **4** centimeters, she was at a high station, minus **2** to minus **3**; do those facts indicate that the baby's head is not engaged?
A. Yeah. If the exam is accurate, yeah. I have a note from **3-11-95** that says that she was **3** to 4, minus 1, by somebody else's exam.
Q. Can you turn to the next page, see if that continues to **3-13**. She came back on **3-13?**
A. This is a screening room flow sheet that is two days before.
Q. Is it true that normally the baby's head will be at zero station --
A. No.

MR. NORCHI: Let him finish, there is no predicate.

Q. Is it normal on the onset of labor, active labor, that the baby's head will be at zero station?

A. No. That is normal. So are other things. You don't have to be at zero station to start labor, no.

Q. Do you usually find that when a patient starts labor, that the baby's head is engaged?

A. No.

Q. You don't usually find that?

A. Often, yes. Usually, no.

Q. Not necessarily something you expect to find?

A. I don't personally, no. It's not necessary. It's common with the first baby the baby is engaged, with subsequent babies commonly not. Either can go either way. It's all within the realm of normal.

Q. Does a patient who is in the early stage of active labor, that is 3 to 4 centimeters dilated, and presents fetal presenting part at minus 2 or minus 3 --

A. This patient is not in active labor when she is admitted. Active labor is when cervical

dilatation begins. Latent phase can continue up to easily 5 centimeters. This patient was clearly 3 centimeters dilated two days before, was not in labor.

Q. You are saying that when the patient was admitted on 3-13 that she was not in active labor?

A. No, she was in the latent phase of labor based on my review of this chart.

Q. I would like you to refer to the delivery notes, these nursing notes.

A. Which ones?

Q. The nursing notes on 3-13 at 2400. The nursing note at 3-13-95 at 2400 indicates patient admitted in early active labor; is that what it says?

A. It's not an accurate representation of what is actually meant in obstetrical terms. She is contracting a lot is what the nurse means.

Active labor is a specific definition. The latent phase of labor can be extremely painful, can go on for 12 hours. You don't become active until she enters the active phase of dilatation.

Q. Patient admitted in early active labor in this note is inaccurate?

A. It's a subjective representation of the nurse's observation, not necessarily an objective description. She is not in active labor until the electrodes for the internal monitors are placed and the Pitocin started, she has enough contractions to produce the work that is required for the cervical dilatation.

Q. Can I ask you to flip back two pages, please, then one more. Never mind, I thought I recognized that as being the other.

Let me see if I understand this. When she was admitted on 3-13-95 she was not in active labor?

A. She was in latent labor.

MR. NORCHI: She came in earlier on the day on March 13th, left, was discharged, came back two hours later, around midnight, that is the note you are referring to?

MR. CULLERS: Correct.

MR. NORCHI: The note has early active labor, I make the distinction.

Q. At midnight on 3-13-95 are you testifying here that the plaintiff -- the patient was not in early active labor?

A. Based on my review of this record I do not

think she was in early active labor. The patient was in a lot of pain, latent phase labor. She was beginning her labor, she was not in false labor, we sent her home once, she comes back two hours later, she is very uncomfortable, it would be unkind to send her home again. No, I don't think she was in active labor.

Q. If you look down further in that same note on 3-13-95.

A. Back in the nursing notes?

Q. Yes, 2400. Tell me when you found it.

A. I'm back where you were.

Q. Go down four lines, Dr. Segal does a vaginal exam, that is recorded there, isn't it?

A. Yes.

Q. It indicates that the vaginal exam shows 4 to 5 centimeters dilatation; does it not?

A. Um-hum.

Q. Is that true?

A. That is what is written here, yes.

Q. You still believe that does not indicate the patient is in active labor?

A. Absolutely not. Also, one of the things you have to keep in mind as you look at these, like I said, I reviewed this a while ago, when Dr. Segal

examines her, says she is 4 to 5, I might say she is 3 to 4. We don't get a tape measure out. It's like that. 3 to 4, 4 to 5 can be the same exam.

Q. When it says 4 to 5 what does that mean? Means 4 and 5 obviously.

A. Between 4 and 5 centimeters dilated. His fingers are wider than mine, it's an estimate.

Q. Between 4 and 5 it means?

A. Yes.

Q. Is it the same type of estimate done when determining station?

A. Um-hum.

Q. I need you to answer.

A. Yes.

Q. Zero plus 1, that's somewhere between zero and plus 1?

A. That is an estimate.

Q. Between zero and plus 1?

A. Correct.

Q. If you go down to the nurses' notes on 3-13 at 2:07 a.m., you'll note that there is another vaginal exam performed; do you see that?

A. Yes.

Q. By Dr. Griffith?

A. Yes.

Q. The vaginal exam was 4 to 5 centimeters dilatation; is that correct?

A. Yes.

Q. Does that change your opinion about whether or not this patient is in active labor as of 2:07 a.m.?

A. Reinforces my impression that at midnight she was not in active labor, she was still in the latent phase of labor, not dilating her cervix.

Q. You indicated when you believe the patient entered the active phase of her labor.

A. Yes.

Q. Can you show me what time that is?

A. You look at the labor curve, progress of labor, very characteristic she is flat, flat, then she takes off here.

What happened at about that time, at 2:07 artificial rupture of membranes by Dr. Griffith, she still doesn't change her cervix, which would say to them that one of the possibilities is that the power, three P's, the power is inadequate to produce adequate work to change the cervix.

They start Pitocin with an internal monitor, give her an epidural before they started,

with the epidural -- I can't find it.

Having reviewed this, what I'm looking for is the point she has internal monitors in, which is how we can really tell how strong contractions are. They monitor the Pitocin based on that. At that point they are able to modulate the intensity of the contraction. With Pitocin, that is about the time the curve takes off.

Q. Which is what time?

A. There is a gap between exams. This particular exam just before three o'clock, the next one isn't until 5:30 it looks like. I don't have an exam in between here recorded. Somewhere between those two is when she seems to have taken off.

Q. Let me stop you there.

Between three o'clock a.m. and 5:30 a.m. --

A. Between those two.

Q. Let me finish my question, please.

Somewhere between 3:00 a.m. and approximately 5:30 a.m. is when she entered the active phase of labor?

A. That's corre'ct.

Q. You say that based partially on your

observation in reviewing the chart, there were internal monitors that were placed about then that show more specific information?

A. I think, yes, if I understand your question.

What I'm saying is they observed her to be contracting, observed she was having pain, they observed she wasn't dilating her cervix. They ruptured her membrane, sometimes that alone is enough to increase the contractions, it causes the release of prostaglandins, that didn't seem to help.

They placed scalp electrodes, internal pressure catheters, gave her Pitocin, the cervix started changing. The Pitocin increased the intensity of the contractions, now you have good dilatation.

Q. What we're talking about --

A. IUPC fetal scalp electrodes, 3:30.

Q. What are you referring to?

A. In the notes here, 3:30 intrauterine pressure catheter, fetal scalp electrodes placed at 3:30.

Q. 3:30 a.m.

A. Yes.

Q. Does that more specifically narrow down when you believe she began active labor?

A. I'm using that in conjunction with the labor curve to try to tell me what happened. This would be done with the placement of the intrauterine catheters, you can more clearly tell the strength of the contraction. About that same time the contractions improved, which is coincident with when the Pitocin is being given with IUPC.

Q. Where were you looking to see the contraction improved?

A. I'm making an assumption.

Q. I thought you looked --

A. No, they are working with Pitocin based on an actual objective measurement of the strength of contraction.

Q. Can you explain briefly how that is done, how the objective measurement of the strength of the contraction is done?

A. When you have external monitors it's more a stretch you are measuring across the woman's fundus. Somebody who is talented at contracting their muscles can make it look like contractions by contracting muscles.

The intrauterine goes inside the uterus, sits in the amnionic fluid, measures the pressure by the contraction of the uterus.

Q. Is that recorded somewhere in the notes, results of that testing?
A. No.
Q. Is that something can you watch on the monitor as it's happening?
A. Yes.
Q. The values that are shown by the testing aren't recorded somewhere?
A. It's just on the tracing.
Q. It's on the tracing?
A. Yes.
Q. On the tracing?
MR. CULLERS: Off the record.

(Discussion had off the record.)

Q. By the way, have you reviewed the tracings in this case?
A. No.
Q. While we're talking about dilatation, I want to ask you some questions about the progress of the labor chart you had out earlier.
I was asking you about when you believe that her active phase of labor began, you

gave an estimation of sometime between three o'clock a.m. and 5:30 a.m.; do you remember that?

A. Yes.

Q. During this same time can you explain what is happening with the fetal presenting part by looking at the progress of the labor chart?

A. I don't think they recorded station on here. Wait, did they?

Q. Is station recorded?

A. It's recorded once.

Q. Isn't it recorded twice?

A. Okay, yes. One at two o'clock, one again at seven o'clock.

Q. At both two o'clock and seven o'clock, station is indicated at zero; is it not?

A. Yes.

Q. If the fetal presenting part does not descend at least a centimeter per hour during the course of active labor, doesn't that constitute protracted descent?

A. No.

Q. It doesn't?

A. No.

Q. What is the definition of protracted descent?

A. There is no specific way a descent has to happen.

A dilatation to meet minimal criteria has to be approximately a centimeter an hour. Descent, no. The baby can stay high until the mom starts pushing or they can come down. We write these things for guidelines, then clinical judgment come in.

For example, if a patient is descending, not dilating, that still has some value when I'm trying to decide how she is progressing in labor. The 1 centimeter is the dilatation, not descent.

Q. Are you saying that once the patient is in active labor, that if she does not progress by the fetal presenting part descending at least one millimeter per hour, that that does not constitute protracted descent?

MR. **NORCHI:** Do you understand the question?

A. I think you said the patient once in active is not descending 1 centimeter an hour, no, that is not protracted.

Q. That is not protracted descent?

A. No.

Q. The reason I ask, I'm looking at the bottom of the chart, the progress of labor chart. If you look down where it says descent; do you see that?
A. Um-hum.
Q. In the center, protracted descent, do you see that?
A. I see it, I don't agree with that.
Q. Let me ask you if this is what it means: Does the word -- first of all, let me ask you this. Strike that.

Does this say protracted, in parenthesis less than 1 centimeter per hour?
A. That's what is says. It says what you think it says, but let me say she has come in early, the patient comes in zero, plus 1, plus 2, I would say all those things are normal.

Let's say she comes in, she was plus 3, some women sit at plus 3 before going into labor. She's got no place to descend to. You don't call that protracted descent.

Likewise, some babies are kind of high, they stay there until they are dilated, when they start pushing, down it comes. I understand what it says here, you understand what it says here, I disagree with it. Her labor pattern, once

she gets into an active phase, is adequate. She is doing fine.

Q. The next thing I want to ask you about dilatation is whether or not the fact that dilatation moves from 4 to 5, up to 5 over approximately two hours and 50 minutes, that constitutes protracted dilatation?

A. No, not if it's not active phase.

Q. The reason you say no is because you didn't believe she was in active phase at the time she was between 4 and 5?

A. No, I think she had been approximately the same for the last three days.

Q. Is what I'm saying true, that the reason you don't think that was protracted dilatation is because you didn't think she was in active labor until some later point after she is more than 5 centimeters dilated?

A. Yes. But let's say her active stage starts right here at three o'clock, I don't have anything to say it didn't start right there, three o'clock she is 5 centimeters dilated, when she does become complete?

Q. 8:35.

A. Five and a half hours, that is pretty good,

that is a centimeter an hour.
Q. It doesn't matter during that time station has remained static at least up until 7:00?
A. Not to me.
Q. Doesn't?
A. No.
Q. First of all, who is doing this chart, who is making this chart?
A. Nurses.
Q. Do they record station and the level of dilatation as it's happening?
A. As it's reported to them by a resident, whoever does the exam.
Q. That is what I mean. They don't take this, later go back?
A, No, it's recorded as it's done.
Q. Is there any reason why station isn't recorded again after seven o'clock a.m.; do you know why?
A. I don't know why.
Q. Wouldn't the appropriate course be to record that on the progress of labor chart?
A. I don't know what the nurse's standard is.
Q. We know that at eight o'clock, if you look at the progress notes, if you look at --

A. Nurse's or doctor's?
Q. Dr. Krietsky's progress note, if you look at that. Dr. Krietsky records fetal presenting part at zero to plus 1; is that right?
A. Yes.
Q. Again, zero to plus 1, that is somewhere between zero and plus 1, right?
A. Yes.
Q. So if we look at this progress of labor chart again at seven o'clock, station is charted at zero, then we rely on Dr. Krietsky's vaginal exam to show where station is, approximately an hour later, it's something less than 1 centimeter?
MR. NORCHI: Objection. Go ahead, Doctor.
A. I'm confused by what you are asking me.
Q. I'm asking between seven o'clock a.m. and eight o'clock a.m. station has changed a centimeter or less?
A. No, because this is not that kind of a measurement. This an estimate. So what I say this shows is that the head was coming down, that's all it would tell me.
Q. I understand that.
If station is changed I'm asking at

least a centimeter between seven o'clock a.m. and eight o'clock a.m.?
A. It's changed, coming down, that's all I could say for sure from those notes.
Q. You can't say it's changed a complete centimeter?
A. I can't say that. I can't say it has not changed by 2 centimeters. It's just come down.
Q. If you look at the progress and labor you assume station is accurately recorded at zero at seven o'clock a.m., then you referred to Dr. Krietsky's note; isn't it fair to conclude station has not changed at least 1 centimeter during that one hour period?
A. What time are we talking about, seven o'clock to eight o'clock?
Q. Yes.
A. Who did the exam at 7:00, somebody else?
Q. Dr. Segal.
A. This isn't that accurate. He could come in say it's minus 1. It's just not something that is that accurate. If somebody says a patient is minus 3, that's really high. If it's around zero they call it minus 1, zero, plus 1, that is about the same place.

There is this much space in a pelvis, plus 3 on the perineum. If you argue a minus 1, zero, plus 1, they are almost the same thing. Three experienced obstetricians could come out with different measurements, wouldn't make one right and one wrong.

Q. Let set that aside.

When you are doing a vaginal exam, you are attempting to determine station, tell me how you do that.

A. Put your fingers in, based on how much you usually feel it's zero, the level of the spine. You feel from the spine, approximately where the head is, you want to measure the head, not caput.

Q. Is it important to be as accurate as you can?

A. No.

Q. Why not?

A. It's an approximation. We all know that is the best you can do.

Q. It's not important to be that accurate when you are doing that?

A. When you say that I feel you are trying to get me to say it's not important to be careful, not important to be accurate, that's not what I'm saying.

It doesn't lend itself to that kind of measurement. I'm trying to think of something that would make sense to you. It's the way we talk to each other. We know what we mean. We also understand that when I say minus 1, one partner goes in, says zero, we understand we may be talking about the same exam, not that somebody changed by a whole centimeter.

Q. I understand that.

Are you ever able to tell accurately --

A. Exactly --

Q. Wait a minute. Let me finish.

Are you ever able to tell accurately whether or not the station has changed 1 centimeter?

A. No, not 1 centimeter.

Q. When you are doing the vaginal exam, you are determining station, tell me what you do next, you feel and try to find the relationship with the spine to what?

A. The presenting part.

Q. Which is what?

A. The head.

Q. Which part of the head?

A. The bony part of the head, not the soft spot.
Q. What does caput and molding mean?
A. Caput is swelling. If you had your shoes on all day, you take them off, the upper part of your foot is a little swollen, that would be caput on the foot.
Q. It's a soft material that feels like --
A. Yes. Moms call their baby cone head. The soft top where the baby's head is.
Q. Explain molding.
A. Molding is an event that happens that allows us to get out big fat heads out of a little vagina. There are suture soft spots and the sutures overlap to get the head out or they wouldn't fit.
Q. Suture means it is the soft spot on the head?
A. That is back here. None of the bones are connected, those fuse later, after the baby is born. They are made to overlap. If they fused, no baby would ever fit out.
Q. If you are trying to determine station, doing the vaginal exam you reach up, feel bony presenting part of the fetal head; could that bony part that you feel be one of those bones that is pushed over the other on the top of the baby's head?

A. That is what you are feeling.
Q. That's what you are feeling?
A. Feel the sutures to see how the baby's head is directed, that kind of thing.
Are you confused?
Q. No, I'm thinking about what you said.
Obviously molding is something that is normal?
A. All babies do it except C-section babies.
Q. You expect to see molding?
A. On all babies, yes.
Q. You expect to see caput?
A. Yes.
Q. Would there ever be a reason to think positive molding, positive caput was abnormal?
A. If it were my clinical impression that the head itself was not descending, just getting longer, that would be a reason to be concerned.
Do you see what I'm saying?
Q. I hear you.
What about after the baby is born, a finding of positive caput and positive molding, would that ever been considered abnormal?
A. No.
Q. Ever?

A. No.
Q. Anything about it that would make it abnormal, the fact that it exists?
A. I can't think of anything. The vacuum makes them bigger.
Q. Pardon?
A. When you put a vacuum on the skull and the suction pulls into the cap, it tends to be exaggerated after the vacuum is used.
Q. Might be exaggerated after the vacuum is used?
A. Yes.
Q. Not abnormal?
A. NO.
Q. You expect to see it, wouldn't you?
A. Yes.
Q. Can you think of any other reason why you might observe a newborn and consider the caput and molding to be abnormal?
A. I can't think of any.
Q. When you are determining station, you feel the bones of the head, is it important to distinguish the bones you are feeling are part of that molded head? Do you follow what I'm saying?
A. No.

Q. Is it important to determine whether or not the baby's head is elongated when you are doing the vaginal exam to determine station?

A. It would be important to know that all you were feeling was the gradual swelling of this head, not the descent of the baby's head itself.

When the residents that are less experienced say to me it's descending, 1 reach in, say no, the head is higher than that.

Q. That's soft?

A. Yes. The first time you felt it, you might not appreciate the difference where as I have been doing it for a few years, I can appreciate what is what.

Q. Would it make any difference if the bones of the head you felt were part of that elongated top of the head that occurs during the molding process?

A. I would expect there would be molding. I guess the answer is no.

Q. Let's get back on the progress of labor chart, if we could.

MR. CULLERS: What is this?

MR. **NORCHI:** You know she wasn't there.

THE WITNESS: I wasn't there

until 7:30.

MR. CULLERS: I got you.

Q. This progress of labor chart does not indicate the station of the fetal presenting part at 8:35 or 8:30, does it?

A. No.

Q. Would it be important to have that on here?

A. It would be pertinent for the resident who is managing her to know that information, whether the nurses recorded it or not is sort of not as important to me.

Q. Would this progress of labor chart be something you would be interested in looking at in doing your job?

A. I don't always look at the nurses' notes as much as I do the resident notes if I'm actually involved in the care of the patient.

Q. This progress of labor chart would be a part of the nursing notes?

A. Yes, that is nursing.

Q. I would like you to look at the labor notes, I have them separately labeled as labor notes -- I'm sorry, nurses' notes. If you go to 3-14 at seven o'clock a.m.

A. I'm sorry. What time?

Q. Seven o'clock a.m., 3-14, starts Dr. Segal in; do you see that?
A. Yes.
Q. It indicates a 7:00 a.m. Dr. Segal did a vaginal exam, 7 to 8 centimeters dilatation and zero station; is that correct?
A. Yes, but Dr. Segal notes say plus 1. I say that is pretty much the same thing, so it doesn't bother me.
Q. His notes say 1 plus?
A. Yes. His notes says 1 plus, she says zero.
Q. So Dr. Segal's handwritten note of seven o'clock says plus 1 for station?
A. Yes.
Q. Dr. Krietsky at eight o'clock says zero to plus 1?
A. Yes.
Q. Can you look above Dr. Krietsky's eight o'clock note, please.
A. Yes.
Q. Who is that by?
A. Radkey.
Q. Can you read that note?
A. Subjective, comfortable, I think. NST 150 to 160, that would be the baby's heart rate is 150 to

160.

Q. stop.

What is right above that, starts with a C?

A. I think that is a SOAP note.

Q. Can you read what that says next to the O?

A. I think referring to the blood pressure, saying it's okay. I'm not sure.

Q. Go down past 160 there.

A. Slight increase beat to beat variability with occasional moderate amount of variability. I think is what that says, could say recurrent variables, I don't know.

Q. Keep going.

A. Then says vag exam, 7 centimeters, zero to plus 1 maybe, I'm not sure. I can't read the rest of this.

Q. Go back up to the beat to beat variability, if you would. How is that significant, if at all?

A. It's a good assignment. A flat tracing is worrisome. There should be various shifts from each beat to the next beat.

Q. Have you given any consideration to the long-term beat to beat variability with this particular labor?

A. Have I?
Q. Yes.
MR. NORCHI: Do you understand the question, Doctor?
THE WITNESS: No.
Q. Do you know what the long-term beat to beat variability is for this particular labor?
A. I guess I'm not sure what you mean long-term beat to beat variability. Are you asking me is the tracing reactive?
Q. What I'm asking you is if considering the long-term beat to beat variability on this particular labor, if it's a good sign or bad sign?
A. Beat to beat variability is good. Accelerations of the heartbeat with movement or fetal scalp stimulation are good. Flat tracings are concerning. Decelerations are of concern.
So for example, at 8:30 when I see fetal heart tracing, the rate is up a little bit, 170, that worries me just a little bit. Fair beat to beat variability is good. Late decels, that bothers me.
Q. It's important to look at long-term beat to beat variability?
A. I don't know what you mean long-term beat to

beat variability.
Q. Not looking at one beat to beat variability reading, looking at them over time.
A. Yes.
Q. That's important?
A. Yes.
Q. Looking at this particular fetus' beat to beat variability over time, what does it look like to you as of 7:30?
A. The notes look like it's okay.
Q. Looks like it's okay?
A. Yes.
Q. You haven't reviewed the tracings?
A. No.
Q. Are you limiting your answer to your review of any particular notes when you tell me the overall --
A. The notes I'm looking at here, from Dr. Radkey, Dr. Krietsky, seven o'clock, at 8:30 which I have co-signed.
Q. Have you looked at any other notes prior to those three you just told me about when you were trying to figure out --
A. Right now, no.
Q. Can you look at the preceding physician's

progress notes.
A. There is a note here decrease beat to beat variability. There is concern throughout this is a fetus that's got heavy meconium. There are times the tracings are not reassuring, that is why we're getting scalp gases, which are the bottom line.
I would **say** this is not a real reassuring tracing. Looks like from whoever's note this is, Dr. Segal, poor beat to beat variability, things have perked up. Babies go to sleep sometimes, then things look better.
Q. Based on what you can tell looking at the progress of the beat to beat variabilities from the beginning of the progress notes until the time you come on 7:30 a.m., does it look positive?
A. At the time that I come on the beat to beat variability, based on the note that I'm looking at, looks like it was reassuring.
Q. What about the beat to beat variability over the course of some time starting with the first progress note, is it reassuring?
A. We're not seeing deterioration. Can get better as they go through labor. I don't really think so. It's stress.
Q. It's not something reassuring, it's just not

deteriorating over time?
A. Yes. I guess I would agree with what you just said.
Q. At the onset of labor is it important to try to arrive at the estimated fetal weight?
A. Arrive at?
Q. In other words, try to figure out what the fetus' weight is early on in the labor process?
A. On admission, something that is part of the physical exam, are we talking a little baby that may be compromised, average size baby, or talking about one a little big.
Q. Why is that an important factor?
A. To prepare for possible complications you may run across in the course of labor and delivery.
Q. Does the standard of care require a sonographic estimate of fetal weight?
MR. NORCHI: When, at admission?
Q. At the beginning of active labor?
A. No, wouldn't be possible.
Q. What about in the latent phase of labor?
A. No, it would be done antenatally.
Q. You wouldn't do a sonographic estimate of fetal weight at some point before active labor?

A. No.
Q. Why is it important at all to try to determine fetal weight early on?
A. Well, if you had a little growth retarded infant you would be much more concerned about placental insufficiency.

If you have a large infant, you need to be considering how much dystocia you are going to have as the baby delivers.
Q. Macrosomic babies yield a higher likelihood of dystocia?

MR. NORCHI: Likelihood for? I object to the term likelihood.
A. It would raise my index of suspicion. If I'm delivering a premature baby that weighs 3 pounds I'm not going to worry it, it's going to fall out.

A woman with a 9 pound baby I'm concerned; however, there are 7 pound babies that don't fit. That alone doesn't determine what we are going to do; likewise, people that deliver 11 pound babies, don't seem to breathe too hard.
Q. Statistically isn't it a macrosomic baby more likely to result in complications?

MR. NORCHI: 1 object to the term likelihood in relation to any statistics, it's

not shown anywhere.
Q. Let's me ask the question differently.
Is a macrosomic baby more likely to be involved in complications than a non-macrosomic baby?
A. No, not generally.
Q. In other words --
A. All complications, no.
Q. What about shoulder dystocia?
A. It's one of the factors, not the only factor.
Q. Is it a factor?
A. It's a factor.
Q. A macrosomic baby is more likely to be involved in a delivery that has the complication of shoulder dystocia than any non-macrosomic baby?
A. I'm not sure statistically speaking that is actually true. It's something we think about more, I'm not sure that statistically it would actually bear out.
Q. What is it about a big baby that causes you to think about it more?
A. Babies are supposed to have their heads bigger than their shoulders. As they get bigger their shoulders could be broader. The concern is

if the shoulder becomes lodged behind the fundus, that it would become a very difficult delivery.

To prevent that from happening, it's better to think about it ahead of time. If are you thinking about it, do what needs to be done to prevent it.

Q. Meaning what exactly?

A. Meaning that at the time of delivery, you want the appropriate number of people, appropriate level of experience with delivering multiple different size babies.

When the baby's head is delivered you don't sit there and suck the mouth out for the next minute while you let the shoulder fully turn to the A/P dimension. You have somebody ready to push down above the pubis to prevent the shoulder from getting lodged, get that baby out quickly.

Q. When you anticipate that the baby is macrosomic, do you worry about the possibility of fetal/pelvic disproportion?

A. If a baby is large, or the mom is small, it raises my concern that that baby isn't going to fit through that passage, yes.

Q. Is the fact that a mother has contractions, is 3 to 4 centimeters dilated, but the baby's head

has not engaged consistent with fetal/pelvic disproportion?

A. No.

Q. Why not?

A. I don't know how strong the contractions are. A lot of babies don't become engaged before active labor, that is not a diagnosis of fetal/pelvic disproportion, no.

Q. Just the fact that the baby's head isn't engaged, contractions begin, that doesn't necessarily indicate fetal/pelvic disproportion?

A. No.

Q. It isn't inconsistent with a fetal/pelvic disproportion?

A. No.

Q. If the mother is 3 to 4 centimeters dilated, the presenting part of the fetus is in high station, that's consistent with fetal/pelvic disproportion?

A. Equally fetal/pelvic disproportion or not, I don't think it's indicative of it.

Q. I'm not asking indicative.

A. It's not inconsistent with it.

Q. Is consistent with it?

A. Explain to me what you mean consistent with.

MR. NORCHI: Sounds like it means diagnostic of, that is the concern with the word you are using.

Q. If the mother presents 3 to 4 centimeters dilated, she has contractions, and the presenting part of the fetus is at high station, meaning minus 2 or minus 3, is that scenario consistent with fetal/pelvic disproportion?

A. I don't think I start thinking about it too much at that point. Depends on a lot of different things. It is more important to me in this particular case when the lady pushed she brought that baby down rather quickly.

Q. Let me ask you this question, please assume the following: That the mother has contractions, she is 3 to 4 centimeters dilated, the presenting part of the fetus is at a high station, meaning minus 2 or minus 3 and macrosomia is suspected; is that scenario consistent with fetal/pelvic disproportion?

MR. NORCHI: Objection. Asked and answered. Objection to the hypothetical. You can go ahead and answer.

A. Ultimately what matters is how the baby and the mother do in labor. I can suspect all kinds of

things, ultimately she is due a trial of labor.

I think this lady made adequate progress, did well. When she had to push, she brought her baby down to plus 3 station without any assistance over 25 minutes, as I remember looking at this.

I don't think she had a protracted active phase of labor. She also didn't have a protracted second stage of labor. She was full two hours to push that baby out. In 25 minutes she made a heck of a lot of progress.

Q. There was intervention also?

A. No. She pushed it down to plus 3. The intervention comes in there.

Q. In fact, you don't know that the labor would not have lasted an hour if not for the intervention?

A. Given the tracings, the choice at that point was to get this baby delivered before deterioration could occur. He was a healthy baby by that point by fetal scalp gases, the tracings were not reassuring, she brought it rapidly down to plus 3, this is not CPD, she's gotten him down, she made it through the labor, plus 3, this is not a baby that is not going to deliver.

Why let him go through another hour and a half of labor before she probably would push him under the symphysis, which is the tough part of getting the baby out finally.

Q. Based on review of the pattern of descent and dilatation with this particular patient, had there not been an operative intervention do you believe it was likely that in fact her second stage of labor would have lasted two hours?

A. No, I don't think it would have.

Q. You don't think it would have?

A. I think it would have lasted -- I think it would have lasted maybe another hour.

Q. Maybe another hour after she pushed to plus 3?

A. Yes. I think she would have used the whole time.

The other thing is she had an epidural. Patients with epidurals don't push as well as patients without epidurals. If she hadn't had an epidural, looking at this, I don't remember, the urge to push is incredible, given how fast that baby came down when she started pushing, if she didn't have the epidural she would have blown the baby out in the time we had given. With the

epidural, I think the Mighty Vac delivery was prudent.

Q. Is it important that the baby was at plus 3 at the moment that the Mighty Vac was applied?

MR. NORCHI: As opposed to?

A. Can the Mighty Vac be applied at a higher station, yes. As I look at this tracing, I say to myself is there any time, any point we should have considered a C-section. That was not a consideration at any point in here.

My answer is no, there was never an indication for that. Part of that is does this baby look like he's going to have a protracted second stage, the answer is no.

Q. I'm not sure I heard the answer to my question which was can you appropriately use a Mighty Vac by intervening at a point where the station is higher than plus 3?

A. Yes, you can.

Q. How much higher station?

A. Generally plus 1.

Q. You can use the Mighty Vac even if the baby is plus 1?

A. Yes. So for example, if for some reason mom can't push, mom has a cardiac lesion, she shouldn't

be pushing, once the baby is down that far, it's safe to put traction with a vacuum, bring them yourself.

Q. Safe at even plus 1?

A. Generally speaking, yes.

Q. What about with a macrosomic infan ?

A. I still think that under the appropriate situations, let's say we had a baby who is clearly in distress, compromised, scalp gas is dropping, we need to get the baby out, you can still make the decision based on the exam we're going to deliver vaginally with a vacuum.

In this particular case as I'm looking backwards, I don't know what the thought process was, I can't remember, as I look backward it validates the decision to deliver a baby vaginally by vacuum to say that the course of the descent during pushing was moving so quickly. She wasn't push, push, pushing for a half an hour, making no progress. Would that have changed what we did, I would have to guess to tell you that.

Q. Based on your testimony, you are of the opinion that the fetal presenting part does not have to be descended to plus 3 before it's appropriate to intervene with the vacuum?

MR. **NORCHI:** Objection. Go ahead.

A. In all circumstances, no. You can use a vacuum at higher stations, under circumstances that you feel it's necessary to intervene.

Q. Would it be appropriate to use a vacuum at a higher station, meaning higher than plus 3, in a situation where you suspected that it was a macrosomic infant?

A, In a situation where I thought that the reason that the baby was not descending was because the baby was too big, I would not pull on it.

Q. Period?

A. When I put everything together, right, I wouldn't pull on that baby.

Q. If you suspect that the baby was -- I'm sorry.

A. Not just based on estimated fetal weight.

Q. Tell me what else.

A. Course of labor, my exams, how much molding there was, all of those things would go together to tell me whether this baby was fitting out.

The real problem was the power behind the labor was not adequate. The mother's pushing was not adequate, not the pelvis was too

small or the baby too large. Many things go into that judgment.

Q. Let me think about what you said for a minute.

I would like you to go to the nurses' notes to 7:21 a.m., are you there?

A. Yes.

Q. It says 7:21 scalp gas 7.23?

A. Yes.

Q. You agree that is a borderline value?

A. Yes.

Q. That is the second consecutive borderline value?

A. That's one.

Q. If you look straight above at seven o'clock you see another one?

A. I was looking at the operative note because that had all of them together.

Q. Yes, it does.

A. Yes, I can see that is the second one.

Q. At that point, 7:21, I take it that the fetal heart tracings were not reassuring; is that correct?

A. It says in the nursing notes repetitive late decelerations.

Q. In fact prior to that point the scalp pH of 7.23 was reported, that was a test done because of concern on the fetal tracings; is that right?
A. Yes.
Q. What is a bradycardia?
A. Slow heart rate over a prolonged period of time.
Q. What are the danger of bradycardia for a fetus?
A. It's not so much how low but the pattern.
Q. This fetus became bradycardic, did it not?
A. You have to show me where it says that.
Q. If you look here at 8:46 a.m., variable deceleration to 90's, you see that?
A. Yes.
Q. Does that meet the definition of bradycardia?
A. Not the way I think of it, no.
Q. Tell me.
A. What I said was bradycardia is the baby's heart rate drops down, doesn't come back up. A variable decel it goes down and stays down, comes back up. The return to baseline is what makes me not call that bradycardia.
Q. Could you refer to your operative note, please, in the second line the reference to the

fetal bradycardia, the fact that occurred; do you see that?

A. Yes, I see that.

Q. Can you tell me when that happened?

A. I can't, but I can tell you when it would likely have happened, it may be in the notes, I can't find it right now, I haven't seen it.

As babies descend there are a lot of compressions on the head. Frequently what is called terminal bradycardia. Doesn't mean the baby is about to die. It happens to a lot of babies as they are about to deliver, the heart rates slows down as their head is squeezed.

Q. You can't tell me by looking at the nurses' notes where this occurred? I'm talking about the fetal bradycardia that is referred to in the operative note.

A. Let me see if it says anything under doctor's notes.

Based on Dr. Krietsky's notes, she writes **plus** 1, the next thing the patient is plus **3**, I would suspect that in the process of descending rapidly, that is when it happened. I don't see it written. Let me look at the nurses' notes.

Fetal heart rate with persistent variable decels to 90 with pushing. Goldfarb and Krietsky at bedside, peds present. Fetal heart rate 130 with pushing and contraction, Dr. Austin present.

I guess that what she is talking about is the heart rate is dropping low with pushing. I'm not too excited about that, that wasn't a critical issue in the decision to deliver.

Q. I'm just wondering when it occurred.

MR. NORCHI: If you don't know.

A. Between 8:30 and when we delivered. The nurse is describing the fetal heart coming down to 130. Dr. Krietsky describes that as bradycardia, Probably has to do with how long it stayed down, her impression versus the nurse's impression.

Q. No way to tell me?

A. There is not a decel, the baby's heart rate drops to *60*, never comes back up, that doesn't happen; that would be recorded in the nurses' note if it had.

Q. Can we be certain fetal bradycardia occurred?

A. I would believe Dr. Krietsky when she said that, since she apparently dictated this as the

patient was being discharged.

I guess what I'm saying is you are getting a subjective recitation of her impression of how things are happening and the nurse's, which is the same thing, the nurse describes them as decels with pushing, she described them as bradycardia. I would guess I would agree with the nurse.

Q. In any event, the fetal bradycardia wasn't a reason to go ahead and expedite the delivery?

A. Not as I see it represented in the nursing notes.

Q. How about reviewing your operative note, can you tell me whether or not fetal bradycardia is a reason that the delivery may have been expedited?

A. I can only interpret what I'm seeing here. As I would put this together, I would say we've got a baby that's now been scalp gassed five times, which is a lancet to his little scalp with blood being drawn to watch a scalp pH. They are not getting worse, they are not getting better. Good progress second stage, the baby is down to plus 3, we can deliver the baby. The decelerations are getting worse, that is what I would say.

I said to you it's not so much how

deep, it's the pattern. So the depth isn't as big an issue to me as the fact that the pattern has been a little bit worrisome all along.

Q. Is fetal bradycardia the reason for expediting the delivery?

A. I don't know, this is Dr. Krietsky, I would ask her if she has a recollection what she meant when she said this. I don't remember this case, I don't see it represented in the nurses' note, I can't tell you that.

If there were a bradycardia by my definition that would have been a reason. I agree with you I can't see it represented in the nursing notes. I can't say that was part of it. I wouldn't need it to say it's prudent not to scalp this baby again in 20 minutes, but get the little guy out of there.

Q. Can you go to the discharge summary, please.

A. Yes.

Q. The last three lines on that page. We had patient begins to push; however, the patient develops bradycardia so at that point operative vaginal delivery was performed?

A. Then I would say that was part of Dr. Krietsky's reason, that is probably what

happened.

I would still say had I been asked as an attending should we keep scalp gasing, the lady keep pushing, given the sequences of events and scalp gases I would have said no. I don't know what happened here.

Based on Dr. Krietsky's dictation I would say they encouraged her to say come on, let's gets this baby out. The nurses don't reflect in their notes, I don't know if they didn't include it because they were getting ready for delivery, there are lots of other things going on.

MR. NORCHI: Do you know?

A. I don't know.

MR. NORCHI: That suffices.

A. I didn't need that to say that this is a baby who should be delivered now.

Q. I want to go back to your operative note, at the last paragraph on the first page, I have a question about; are you there?

A. First page?

Q. Yes.

A. Yes.

Q. I was called to room, who is "I" there, is that you?

A. No, that would be Dr. Krietsky.
Q. So she is purporting to prepare this for you, meaning "I" was called to the room?
A. No, this thing of her for me is something that the dictating people do.
Q. I was called to the room, that means Krietsky was called to the room?
A. Krietsky, she is dictating for herself, I.
Q. I was called to the room means Krietsky was called to the room?
A. Yes.
Q. On the nurses' delivery notes I notice that at 8:53 indicates you were present for delivery?
A. Yes.
Q. I didn't see anywhere in the notes your presence prior to that time; is that accurate?
A. There is a cosignature.
Q. Where is that?
A. In the doctor's notes, patient progress, at 8:30 the decision to allow the patient to push, consider vaginal delivery, the cosignature would not have been at the time. I don't have to cosign their notes like I do op notes and discharge, that means I was there.
Q. You would have been there at 8:30?

A. Yes.
Q. Is this your signature down here on an angle by the X?
A. Yes.
Q. What is all this, the X about?
A. The X means don't write there anymore. Probably I signed there, then decided that I agreed with what she said, right underneath her name put an X so nobody would put anything between my two signatures, that is my guess.
Q. Were you in the room from 8:30 up until the point of delivery?
A. I don't know, What does the nursing note say?
Q. Nursing note says Dr. Austin present at 8:53?
A. At 8:35 says Dr. Austin aware. I would suspect the reason they know I'm aware is because I'm standing around there, but I don't know. I had to have been here to sign the chart.
Q. Is it likely you would have stayed there the whole time?
A. There were other things going on at the same time, I may have been walking around doing other things as well.
It is our custom that the attending

is here for vacuum and forcep deliveries.
Q. Why is that?
A. Seems like a good idea. In this particular situation this is March, you've got a pretty experienced resident, you've got the chief there, I don't think it would have been a dangerous thing by any means for me not to be there.
On the other hand, I'm the most experienced physician on the floor, it's appropriate that I be there, unless my attention is needed somewhere else.
Q. Based on what you can see here in the notes, 8:35 and 8:53 notes, that makes you feel comfortable indicating you were there from 8:35 to 8:53?
A. No. All I can say for certain is at 8:53 when she applied the vacuum I was there. Vacuum assist Dr. Austin could mean the nurse notified me they were getting ready for the vacuum, to come down. Since I signed here, I don't know. I'm not sure what that means.
Maybe they called me at 8:30, said we're considering vacuum, come down, help us look at this, in which case I walked down, discussed it, co-signed the note, the nurses wrote I was aware.

I don't know.
Q. As you mentioned, that doesn't mean that you were there that whole time between 8:35 and 8:53?
A. No, doesn't mean that.
Q. You see that Dr. Krietsky cut the cord and clamped the cord in the 9:01 note?
A. Yes.
Q. Does that mean she is the one who delivered the child?
A. It implies that she is since she is the one that then handed the baby to the pediatrician, yes.
The reason I hesitated, sometimes if the cord is around the neck another person will do the clamp and cut while someone else delivers but since she hands it off.
Q. Since she hands the baby to the pediatrician she probably did the delivery?
A. Handed off to peds, I think that means Dr. Krietsky did it, that would make sense.
Q. If you are trying to determine fetal weight prior to delivery, is there any way you can accurately do that to the extent you can tell if the fetus is more than 4,000 grams but less than 4,500 grams?

A. Probably the most accurate thing would be ultrasound.
Q. Does that have any percentage of error?
A. I'm sure it does, I can't tell you what it is. Probably is dependent on the person doing it.
Q. It's about 10 percent error?
A. At least. I would imagine from one person to the next it's going to vary.
Q. That's the same thing as a sonographic estimate of fetal weight?
A. Yes.
MR. NORCHI: Can we take another break?

(Recess had.)

BY MR. CULLERS:
Q. When you were talking about being present in the delivery room, you were talking about the chief resident was there, the resident was there; do you recall that testimony?
A. Yes.
Q. What is the general way the delivery is handled, meaning who is there in the room?
A. That way. The primary resident gives the

care, which is Dr. Krietsky. The chief is her immediate source for assistance and direction.

Q. He's the fourth year resident?

A. Yes. He reports to me. It would be standard for the chief to be called to the room, and for the attending to be called.

Q. What about for the resident to be called to the room, is that normal?

A. Yes, because she is taking care of more than one patient. You mean Dr. Krietsky?

Q. Right.

A. Yes.

Q. You notice there is a certified nurse midwife there?

A. Yes.

Q. Is a certified nurse midwife always in attendance?

A. No.

Q. Do you know why she was there this time?

A. If she was the person who gave suprapubic pressure, based on the chart, might have come in to give suprapubic pressure since she is experienced with that.

Q. Did Dr. Anthony give suprapubic pressure?

A. Yes, she was an intern at that time, I

suspect she was working with Heather, the nurse midwife, we have the interns work with midwives to learn from them.

Q. There is no other reason why she was in the room?

A. No.

Q. She I mean --

A. The intern?

Q. The intern.

A. No.

Q. She was just training?

A. That is my best guess. I don't see any other role for her there.

Q. Would there be a reason why Heather Gerard would have been called to the room ahead of time because somebody knew she was going to be doing suprapubic pressure?

A. I think there is an indication we may have a baby that could have a shoulder dystocia, we will do what is necessary to prevent that from happening. Possibly she was there for that purpose, possibly not. I don't know why she was there.

Q. I wondered if it is an ordinary thing for a certified nurse midwife to be there?

A. I don't know what the circumstances were. The labor and delivery nurses can give suprapubic pressure as well. I can.
Q. There is no particular reason why a certified nurse midwife would be called in this instance?
A. No.
Q. I was asking you earlier about the progress of labor chart and pattern of descent and dilatation, there is a question I didn't ask that I want to ask, but to ask the question I've got to tell you what I asked you before, okay?
MR. NORCHI: Objection. Go ahead.
Q. I asked you before about whether or not the fact that there wasn't descent of at least 1 centimeter per hour after active labor started constituted protracted descent, you said it didn't; do you recall that?
A. Recall our discussion.
Q. I want to ask you a specific question about that, if you refer to the progress of labor chart.
A. I can't find it. What section is it in?
MR. NORCHI: We have different sections.
Q. With the labor notes in my chart anyway.

Here's mine.

We know that at seven o'clock the station is charted at zero; is that correct?

A. Yes.

Q. We know from reviewing Dr. Krietsky's note from eight o'clock that she had charted the station at zero to 1; do you recall that?

A. Yes.

Q. If there is less than 1 centimeter of descent that occurs between 7:00 and eight o'clock, does that constitute protracted descent?

A. I don't think in terms of protracted descent, in terms of the Friedman curve, in terms of dilatation. Descent counts, but not the same way as dilatation. I agreed with you about what this said I said, but clinically I don't use that. That doesn't mean anything to me.

If we go by everything I have Dr. Segal saying she's plus 2 at seven o'clock, Dr. Krietsky saying they tucked that baby back up to zero, I don't believe that happened.

Q. Plus 2 what?

A. Plus 1. Remember Dr. Segal notes plus 1, the nurses said zero?

Q. Right.

A. What I'm saying there minus 3, minus 2, minus 1, zero, plus 1, plus 2, plus 3, there is only 6 centimeters, you can't make a whole centimeter per hour, most labors last longer than six hours.
Q. Progress of less than 1 centimeter per hour in descent between 7:00 and 8:00 doesn't constitute protracted descent?
A. Based on this piece of paper it does. I say it's irrelevant. It didn't mean anything in terms of her progress in labor.
Q. When you referred to this piece of paper, I need to clarify what it was you are referring to.
A, Intrapartum problem record.
Q. The part you are referring to, part where it says descent, right next to protracted, is that what you are referring to?
A. Yes.
Q. Information contained less than 1 centimeter per hour?
A. I showed you how there aren't enough centimeters for anybody to do that.
Q. I'm trying to understand. I'm trying to make a record what you are referring to.
A. That is what I'm referring to.
Q. That's something that defines parameters

taken from the Friedman curve?

MR. NORCHI: Objection.

A. I don't think this is from the Friedman curve.

Q. When I referred to it you said something you don't follow part of it, I didn't understand.

MR. NORCHI: Objection. You can ask her a question, Romney, we're getting a little confused here.

Q. I'm asking whether or not -- what I was asking you about was whether the fact that descent of less than 1 centimeter between 7:00 and eight o'clock constituted protraction of descent, you said something about the Friedman curve, I didn't understand what you said.

MR. NORCHI: Do you want to know what the Friedman curve is?

MR. CULLERS: No.

A. Let me answer the question differently.

I guess my point is let's assume she did not descend by a full centimeter between 7:00 and eight o'clock, which I said I don't know whether that happened or not, none of these measurements are accurate to tell me for sure.

&e At least based on --

A. Based on the data available. Let's say she was at zero and plus 1. I don't believe that constitutes an abnormal progress of labor.
Q. That's because of the rate of dilatation?
A. Yes.
Q. You don't make any distinction about the fact that descent doesn't change -- strike that. Never mind.
Looking at your or Dr. Krietsky's note of 8:30, it indicates there that operative vaginal delivery was going to be considered, something of that nature, would you refer to that?
A. Yes.
Q. Is that what that said?
A. Yes.
Q. You co-signed on that note?
A. Yes.
Q. Do you recall the thought process that you went through when that note was co-signed?
A. No.
Q. Can you tell by reviewing that note, other information in the chart, what factors would indicate an operative vaginal delivery in this situation?
MR. NORCHI: Objection, it's

been asked and answered. Go ahead.
A. The reason for the operative delivery was the status of the fetus based on the scalp tracings and scalp gases.
Q. Looking forward from 8:30, is your testimony the same?
A. Yes.
Q. In considering operative vaginal delivery may be attempted, is it important at all for you as the attending to confirm station before anyone intervenes with the vacuum?
A. No.
Q. You feel comfortable relying on the resident and/or the chief resident to do that?
A. Yes.
Q. Can you return to the labor/delivery notes. I would like you to go to 8:53, where it indicates Dr. Austin present for delivery.
A. Yes.
Q. The first thing that happened at 8:53 is push/pull with vacuum?
A. Push means the patient pushed, the pull means the vacuum pulled at the same time.
Q. That is the first time any pulling with the vacuum occurs; is that true?

A. Based on these notes, that's what it looks like.

Q. After the first push/pull, the episiotomy is then cut; is that true?

A. At 8:53 a push and pull, 8:56, two or three minutes later episiotomy is cut with the next push, that means that the head was coming firmly against the peritoneum so it's a good time to cut.

Q. Is there any particular reason that the episiotomy would be cut after the first push/pull -- strike that.

Is there any reason the episiotomy would be cut after the first pull with the vacuum?

A. Likely it was cut with the second contraction. The pushing and pulling would happen with the contraction, looks like it was cut with the second. Diminish bleeding from the episiotomy from the pressure of the head which was coming very easily.

Q. The diminished bleeding would be the reason the episiotomy would be cut at the point the vacuum was used to do a pull?

A. Yes.

Q. From looking at Dr. Krietsky's handwritten note it appears that the episiotomy was a second

degree episiotomy with a perirectal extension; do you see that?

MR. NORCHI: Is it in the progress notes?

Q. The operative notes, operative reports in my copy of the chart, immediately prior to the typed report. Do you see there second degree episiotomy cut?

A. No, where is it? I'm sorry. Yes.

Q. At the bottom lower left-hand corner, with perirectal extension as a further description and second degree episiotomy; do you see that?

A. Yes.

Q. Is that usual to cut a second degree episiotomy in a situation where the vacuum is being used?

A. Yes.

Q. I notice from looking at Dr, Krietsky's handwritten note indicates due to macrosomia shoulder dystocia was anticipated; do you see that?

A. I see that.

Q. Do you agree with that?

A. I would use the word large baby instead of the macrosomia.

Q. You would have put large baby, shoulder

dystocia was anticipated?
A. Yes.
Q. You agree with that?
A. Yes.
Q. If the shoulder dystocia is anticipated, why wou dn't the episiotomy be cut through to the rectum?
A. I don't think this shoulder ever was impacted.
Q. You don't think this shoulder was ever impacted?
A. No, I don't.
Q. Why do you say that?
A. I'm taking it only from what I read here and the fact I have no memory of this case, because impaction doesn't happen that often I ought to remember.

This baby is delivered, the head comes out, the shoulder is delivered, pressure is put, the shoulder is out. The time between the delivery of the head and delivery of the baby is less than a minute. It's not time for impaction to have occurred. They did all the things necessary to prevent that from happening, putting the legs back to create a little extra space. If the

shoulder was impacted they would need to put a scissors in, cut through the rectum, that has morbidity, you don't want to do that.

Q. Explain what you mean by impacted.

A. Stuck behind the symphysis.

Q. You don't think this baby's shoulder was stuck?

A. I don't think.

Q. Would you look at the nurses' notes again, nine o'clock. Do you see where it says difficulty with shoulder in the note?

A. I think they are talking about the nuchal cord.

MR. NORCHI: Let him ask the question.

Q. Do you see where it says nine o'clock head out, you see that?

A. Yes.

Q. Nuchal cord times one reduced?

A. Yes.

Q. Then says difficulty with shoulder, do you see that?

A. Yes.

Q. You see where it says difficulty with shoulder?

A. I do.
Q. You think they are referring to difficulty with the nuchal cord?
A. No. I still don't think it was impacted.
Q. Did you think after the head was delivered that there was a pause in the remainder of the infant coming forth because of something having to do with the shoulder getting caught on something?
A. 1 think that the baby was on the large side, the shoulder was not a rapid delivery, so instead of putting a lot of traction on the baby they lowered the bed, pushed suprapubically. I don't know that the baby was stuck.
Q. Why would they do suprapubic pressure and put the bed down if the shoulder wasn't stuck?
A. To facilitate the easy delivery of the shoulder, not pull too hard.
Q. You don't think that his shoulder was stuck even for a few seconds?
A. We're talking about semantics. I don't think this is an impacted shoulder. You say what do you mean by impacted, maybe I should change it, say really stuck.

It hung up a little bit, it was very easy to loosen things up, have the baby come

on out. It's a very easy delivery.
Q. We're in agreement that the baby's shoulder at least got hung up for some amount of time?
A. We're in agreement they felt some resistance, therefore went through the appropriate maneuvers to widen the delivery space. It happened with the first steps, further steps were not necessary.
Q. Are we in agreement that the baby's shoulder was hung up at least for some amount of time?
A. No.
Q. We're not?
A. "Hung up" is a word I wouldn't use.
Q. You used it, that is why I chose it.
A. Did I say that?
Q. I'm trying to figure out what happened. The baby's head came out, the rest of his body didn't come forward, did the shoulder delay the passing through?
THE WITNESS: Can I explain this?
MR. NORCHI: Sure.
A. If I have a shoulder that is on the wide side, I pull, then I'm going to get an impacted shoulder, then I'm going to have a problem.
If I start to deliver, this isn't

coming as easily as I think it should, put the bed down, suprapubic pressure, I avoid impaction.

You said got hung up a little bit, we're saying the same thing. The maneuvers the resident took to deliver this baby avoided a shoulder impaction.

Q. You said a couple of things I want to further ask you about.

You said this was an easy delivery?

A. Relatively speaking, yeah.

Q. You think whoever wrote difficulty with shoulder thought this was an easy delivery?

MR. NORCHI: Objection to what Mandy Young was thinking. You want to ask her. He'll ask another question.

Q. Your view this was a relatively easy de1ivery?

A. Yes.

Q. You are of the opinion that the baby's shoulder was not impacted?

A. Right.

Q. You are of the opinion that the baby's shoulder did not come forth easily right after his head was born?

A. Right.

Q. Do you agree that his shoulder was prevented from coming forth because it was prevented from doing so by some part of the mother's anatomy?
A. I think it was a wide baby across the shoulders, yes, it has to come under the symphysis, by pushing it down it came right out.
Q. Do you think the baby's anterior shoulder got hung up on the symphysis?
A. I think I've answered it the best I can. I don't think it was impacted. I've attended a lot of shoulder dystocias,, this was an easy delivery.
Q. Do you remember it?
A. This delivery, I see the description, see how long it took, I see what maneuvers were necessary to deliver this baby.
Q. You feel confident in reviewing this information you know what maneuvers were done?
A. Yeah. I see the length of time they had to do them in.
Q. Tell me about the suprapubic pressure, how was that done?
A. I'm not sure what you are asking me. Are you asking how suprapubic pressure is given?
Q. You said you can look at that, you can tell that they did the appropriate maneuvers, I'm asking

what this one means.
A. Pressure is given straight down standing on a stool, pushing straight down above the pubic bone to push the shoulder or keep it from getting stuck up there.
Q. What does bed down mean?
A. Means the bed is lowered, closer to the floor so the person giving suprapubic pressure can be straight above the symphysis.
Q. Is it important to put the bed down to perform the McRobert's maneuver?
A. No.
Q. How is the McRobert's maneuver performed?
A. Like this.
Q. Can you tell from looking at the nurses' note at nine o'clock whether the McRobert's maneuver was done?
A. I don't remember where I read it.
Q. Nine o'clock?
A. She doesn't seem to record it.
Q. Is that something that you would expect the nurse to record if it was done?
A. Not necessarily.
Q. Earlier you said in reviewing the nurses' notes at nine o'clock and 9:01 you can tell this

was a relatively easy delivery?
A. I said reading the chart.
Q. I thought you were talking about reading the chart.
A. I referred to when I read the whole chart to get a feeling for what the delivery was. My impression this was a relatively easy delivery.
Q. By reading the notes at nine o'clock and 9:01 there is no way for you to tell whether or not the McRobert's maneuver was performed, is there?
A. No.
Q. Is that something that is required?
A. Something that's customary. It would have been done.
Q. Earlier you were talking a little about the resident, the resident's relationship to the chief resident in the delivery process. I'm going to ask you more about that.

In a vacuum delivery, who would be doing what, if you can tell me as a matter of custom?
A. As a matter of custom in March of a second year residency, the second year resident would be doing the vacuum. The chief would be supervising.
Q. When the chief is supervising what is he

doing hands-on?
A. Usually scrubbed, he's usually either watching or checking the application, that kind of thing.
Q. The resident is the one operating the vacuum?
A. Holding onto it.
Q. The second year resident?
A. You mean pulling on the vacuum, yes.
Q. Would there ever be a situation where the chief resident would be the one who was pulling on the vacuum, the second year resident was watching?
A. Be unlikely. A first year resident, the chief might do it.
Q. What is the chief's role in supervising, watching, what else?
A. I think you stated it pretty well.
Q. He's watching?
A. Supervising.
Q. I mean what does that entail, is he helping by touching anything?
A. He might have done the exam before she applied the vacuum. Vacuums are more forgiving than forceps, the application is much easier. Watching how well the baby is responding to traction, direction of traction Dr. Krietsky

applied, that sort of thing.
Q. Would it have been important for the chief to have confirmed the station of the fetal presenting part before application of the vacuum?
A. To say important, I wouldn't say important. Dr. Krietsky was at the far end of her second year of residency, she is capable of doing that.
Q. It's really not that significant for him to do that?
A. No, but he might have.
Q. Why was it important for the senior resident to be in attendance during delivery?
A. It's our protocol.
Q. Why is that?
A. Medical/legal reasons I suspect.
Q. What does that mean exactly?
A. I think that a second year resident is fully capable of doing a vaginal delivery and in an emergency would do an adequate job. When you have a more experienced practitioner available it's reasonable to have them available.
Q. In case something might happen that is unusual?
A. Sure.
Q. There is no question in this situation --

THE WITNESS: Can I answer this page?

MR. CULLERS: Sure.

(Recess had.)

Q. There is no question in this situation there was evidence of shoulder dystocia?

A. I'm lost. The last thing I knew we were talking about Dr. Krietsky and Dr. Goldfarb and their relationship, what Dr. Goldfarb would be doing.

Q. We're off that, I want to ask you this question: There is no question that shoulder dystocia was present?

A. When?

Q. At nine o'clock a.m.?

A. In the process of the delivery was the shoulder broad and required special maneuvers to deliver?

Q. No, that is not my question.

At 9:01 delivery of a male infant with shoulder dystocia, do you see that?

A. Yes.

Q. Did this delivery include the complication of

shoulder dystocia?
A. Yes.
Q. Is shoulder dystocia considered an obstetrical emergency?
A. Emergency, not if appropriately managed. It requires appropriate management. Does that answer the question?
Q. No.
Is shoulder dystocia an obstetrical emergency?
A. I wouldn't call it so.
Q. In this case with Michael Dixon you wouldn't call this case involving shoulder dystocia an emergency?
A. No.
Q. What is Erb's palsy?
MR. NORCHI: I object to a neurologic diagnosis. You can answer the question if you can.
A. Weakness in the arm resulting from damage to the brachial plexus.
Q. Do you have an opinion as to whether Michael Dixon sustained damage to his brachial plexus during his delivery?
MR. NORCHI: I object. I

don't know if you've seen records, I don't know what the basis for such an opinion would be. You haven't been identified as an expert, If you have an opinion I'm not going to prevent you from rendering it.

A. If I were given this chart to review, asked if this baby sustained a brachial plexus injury, my answer would be no.

Q. I would like you to take a look at a page from the baby's chart which contains a note prepared by Nurse Young, the same one doing these notes.

MR. NORCHI: Do you want her to read it?

MR. CULLERS: Yes.

MR. NORCHI: I'11 stipulate to what the record says. She never examined the baby, she has no expertise what the neurologic impairment of the baby is, I don't have any records after 1995.

Q. You are aware that the baby was noted to have poor movement in his left arm after delivery?

A. I was told that.

Q. Do you have any reason to believe he sustained a brachial plexus injury that resulted in

the difficulty he was observed having in moving his left arm after birth?

MR. NORCHI: I object. I don't think she has the knowledge base to provide that. We can get that elsewhere in the chart.

MR. CULLERS: She can tell me if she doesn't have an opinion.

A. No, I don't have an opinion about that.

Q. I would like to ask you to assume that immediately after birth the baby was found to have a left-sided Erb's palsy which persisted for some time; can you make that assumption?

A. I'll make that assumption.

Q. Do you have an opinion as to whether or not that condition could have resulted from trauma that he sustained in his delivery?

A. Repeat the question.

MR. CULLERS: Read it back.

(Question read.)

MR. NORCHI: I object to the hypothetical and also the vague nature of the term delivery because delivery is a long process.

If you have an opinion, care to

answer, you can, Doctor.
A. It could have.
Q. It could have?
A. Could have.
Q. Do you have an opinion as to whether it is more likely than not that it did occur during his labor and delivery?
MR. NORCHI: Objection. Go ahead if you have an opinion.
A. I don't know what else happened with this baby, this is only a portion, the experience I have with him. Given the nature of the delivery I would have said it was unlikely. I would have said it unlikely based on what I read about the delivery, so I don't know.
Q. At least you will concede it's a possibility?
A. I'll concede one of the things that can lead to a brachial plexus injury is the process of birth, of all births.
Q. Do you have an opinion as to whether a brachial plexus injury can occur during the process of birth having nothing to do with the medical procedure?
A. Yes, I do.
Q. How could it be caused?

A. I think that babies are born precipitously at home without anyone in attendance can have brachial plexus injuries.

Q. Can you explain the physiological way that occurs?

A. No, I can't.

Q. You can't because?

A. I'm not a neurologist.

Q. It's your understanding a brachial plexus injury can be an injury which is not an iatrogenically caused injury?

A. That is correct.

Q. In this case you don't have an opinion whether or not he has a brachial plexus injury that is a non-iatrogenically caused injury?

MR. NORCHI: I object. She doesn't know enough about his subsequent care. She already answered the hypothetical that you gave, now you are trying to supply different facts.

MR. CULLERS: This is a different question.

MR. NORCHI: Try it again, maybe we missed it.

Q. I'm trying to figure out if you have an opinion how this baby ended up with a brachial

plexus injury. You said it could have happened during birth. You said based on your review of the chart you would have considered it to be unlikely?

MR. NORCHI: She doesn't know if the baby has Erb's palsy or a brachial plexus injury.

Q. I asked you to assume Erb's palsy, I asked you -- I don't remember what I asked.

I'm trying to find out if you have an opinion what caused the brachial plexus injury, if anything?

A. I don't have an opinion.

Q. The reason I'm asking this is so later at trial you don't have an opinion about what caused the brachial plexus injury, that is why I'm asking. I need to find out now if you formulated such an opinion.

A. I don't know.

Q. By your saying that, I understand that to mean that you don't have an opinion that the brachial plexus injury that existed in this child was a result of some process other than an iatrogenically caused injury?

A. I'm not sure what you are asking me.

Q. I'm asking if you have an opinion that this

baby's Erb's palsy and/or brachial plexus injury was caused as a result of some congenital deformity?

MR. NORCHI: That's different.

MR. CULLERS: I know it's different.

A. I know nothing about this baby. I never examined him. I know nothing else. The only thing I can tell you given the description of this delivery, I'm very surprised if this delivery would have resulted in a brachial plexus injury. What happened during labor, I don't know that, that could have involved it. I don't know what other myriad of things may have resulted in it.

Q. Good. You indicated earlier you had been involved in many cases of delivery of an infant with a complication of shoulder dystocia; do you recall that?

A. Been involved in a number, yes.

Q. Have you ever been involved in any that also had an accompanying brachial plexus injury?

A. I've been the attending on one other.

Q. Do you remember when that was?

A. I would have -- I remember the name of the

chief resident. I would have to go back, find out what year he finished. It was probably eight years ago.

Q. Do you remember anything at all about the circumstances of that situation?

A. It was a much more difficult delivery.

Q. You specifically recall that?

A. I remember everything about that.

Q. Did that case result in litigation?

A. Yes, it did.

Q. That has been resolved?

A. Yes.

Q. Do you remember the patient's name?

A. No.

Q. You were a named defendant in that case?

A. I was the attending.

Q. Were you named in the lawsuit as a defendant in that case?

A. Yes.

Q. Was that here at University Hospitals?

A. Yes.

Q. Who defended you in that case?

MR. NORCHI: Objection. If you recall.

A. I don't remember.

Q. You don't remember who defended you?
A. No.
Q. Do you remember who the plaintiff's lawyer was?
A. I don't remember.
Q. You said about eight years ago?
A. Um-hum.
Q. Since that time have you been involved in any other cases where you were named in a malpractice case as a defendant?
MR. NORCHI: Objection.
A. Not obstetrical. One when I was a Fellow. Nothing that ever went to court.
Q. Were you involved in any situations where a lawsuit was filed but was resolved short of going to court?
A. I was dropped from the cases.
Q. Do you remember how many cases there were?
A. I only remember once because it was last week. Let me think for a second. I had my deposition taken twice before. Once for this, once for something else. Does that answer your question?
Q. No. What I want to know is how many times you've been named as a defendant in a lawsuit that

was filed?
A. We get 180 day letters.
MR. NORCHI: Claims are different.
A. Then I don't think there are anymore.
Q. Just the two cases you gave your deposition?
A. Three including this one, three.
Q. This is one, second when you were a Fellow, third one about eight years ago?
A. The one when I was a Fellow was not an obstetrical case, one shoulder dystocia, this one.
Q. The shoulder dystocia one was eight years ago?
A. Approximately.
Q. Are you Board certified?
A. Yes.
Q. Obstetrics?
A. And reproductive endocrinology.
MR. CULLERS: That's it.
MR. NORCHI: You have the right to waive signature. I suggest you read the deposition transcript that will be prepared by the court reporter so we know it's accurate.
THE WITNESS: Okay.
(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.

_____

CYNTHIA AUSTIN, M.D.

The State of Ohio, .
County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, CYNTHIA AUSTIN, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 10th day of February, **1998**.

Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

Look-See Concordance Report

- - -

UNIQUE WORDS: 1,335
TOTAL OCCURRENCES: 5,293
NOISE WORDS: 385
TOTAL WORDS IN FILE: 16,724

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SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

PHRASE WORD LIST(S):

- - -

NOISE WORD LIST(S): NOISE.NOI

- - -

COVER PAGES = 4

- - -

INCLUDES ONLY TEXT OF:
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

- - -

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- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE FORMS ON

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: 4

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LIST OF THRESHOLD WORDS:

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