

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.PAGE

Cross-examination by Mr. Cullers

4

(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,

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

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

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

7 A. Um-hum.

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

10 A. Okay.

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

14 A. Yes.

15 Q. Is this your signature here?

16 A. Yes.

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

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

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

1 you adopt that as --

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

5 Q. That's what I wanted to know.

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

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

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

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

20 Q. That is your signature?

21 A. That's my signature.

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

1 A. Yeah, I imagine I read it over.

2 Q. By your signature do I take that to mean this
3 accurately describes what occurred during the
4 operative procedure?

5 A. Yes.

6 Q. The first thing I want to ask you about is on
7 the operative note, pre-operative diagnosis
8 indicates intrauterine pregnancy at 40-2/7 weeks
9 with a fetal distress, macrosomia; do you see that?

10 A. I see it, yes.

11 Q. What is macrosomia?

12 A. I wouldn't agree that, that this baby is
13 macrosomic.

14 Q. What is macrosomia?

15 A. I would say macrosomia is 4500 grams or
16 greater.

17 Q. The postoperative diagnosis indicates
18 macrosomia as part of the postoperative diagnosis?

19 A. I see that.

20 Q. You disagree with that?

21 A. I would disagree with that in this case.

22 Q. Is there a reason why you didn't indicate
23 that you disagreed with that finding --

24 A. I was ~~~signing.

25 Q. I know. Excuse me, I need you to let me

1 finish the question. Sorry.

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

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

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

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

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

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

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

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

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

9 MR. NORCHI: Ask any
10 question you want.

11 MR. CULLERS: I understand.

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

14 A. Technically speaking, no.

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

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

19 Q. You disagree this was a macrosomic baby?

20 A. Right.

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

24 MR. NORCHI: Objection.

25 Asked and answered. You can answer again, Doctor.

1 A. I looked it over generally, this is a
2 reasonable reflection, this is her dictation, not
3 mine, she doesn't have to agree with everything I
4 say. I would not say this is macrosomia, a
5 4100 gram baby. It was not a significant enough
6 thing for me to page her, say redo your dictation.

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

9 Q. If it would have been your patient?

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

12 Q. What is the difference?

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

17 Q. You were considered to be the attending?

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

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

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

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

24 A. 3-14-95 apparently.

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

1 A. It looks like it was Dr. Sogor.

2 Q. You indicated that macrosomia is **4,500** grams
3 or greater?

4 A. Yes.

5 Q. Therefore are you saying that a baby that is
6 **4,000** grams or greater is not macrosomic?

7 A. I would say it's a large baby.

8 Q. Wouldn't meet the definition of macrosomic?

9 A. Wouldn't meet mine, no.

10 Q. Did you ever have any discussion with
11 Dr. Krietsky your not feeling this was a macrosomic
12 baby?

13 A. No, not that I remember.

14 Q. You said likely it wouldn't have been
15 something you would have discussed with her?

16 A. Not likely.

17 Q. When you came on at **7:30** on **3-14**, what is the
18 process that you went through to find out what the
19 status of this labor and delivery was?

20 A. I don't remember specifically.

21 Q. What do you typically do?

22 A. Typically at **7:30** we meet for OB rounds. At
23 that time patients that are currently active are
24 reviewed, ongoing antenatal care. It's a rounds
25 meeting with the residents largely for teaching

1 purposes.

2 Q. Do you review the chart at all?

3 A. No.

4 Q. You don't do any of that?

5 A. No, the charts are with the patients.

6 Q. Do you review the charts?

7 A. No, the residents present the patients.

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

10 A. That's correct.

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

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

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

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

22 A. Yes.

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

1 suspected?

2 A. I'm aware of that.

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

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

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

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

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

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

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

1 have in here, we were not expecting a baby over
2 4500 grams. We were not surprised to see one 4100,
3 which I would still agree is a big baby.

4 Q. Why is that?

5 A. Why?

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

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

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

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

1 Q. Under what circumstances?

2 A. Now we're getting off the subject of this
3 particular case, not under these circumstances.

4 Q. Under what circumstances would you make that
5 recommendation?

6 A. If the baby were clearly over 4500 grams by
7 estimated fetal weight using a good ultrasound, I
8 was concerned by my clinical impression of the size
9 of the woman's vagina, I might discuss with her the
10 option of a C-section.

11 Q. The determination obviously of estimating
12 fetal weight is important in determining how you
13 are going to manage labor and delivery?

14 A. Yes.

15 Q. You're aware from your review of the records
16 that this was a gestational diabetic pregnancy?

17 A. Diet controlled.

18 Q. Pardon?

19 A. Controlled with diet, mild.

20 **a.** Was this a gestational diabetic pregnancy?

21 A. Yes.

22 Q. It was controlled by diet?

23 A. Right.

24 Q. Could you refer to the discharge summary,
25 please. If you look down at the laboratory data,

1 if you would; do you see that?

2 A. Um-hum.

3 Q. I need you to answer.

4 A. Yes.

5 Q. There is information contained in there about
6 the values from the glucose tolerance tests; do you
7 see that?

8 A. Yes.

9 Q. Do those values that are contained within the
10 last three sentences of that paragraph captioned
11 laboratory data meet the definition of gestational
12 diabetes?

13 A. Yes.

14 Q. Gestational diabetes is a factor that can
15 result in macrosomia?

16 A. Yes.

17 Q. Do you have any information about this
18 patient's fundal height on her presentation?

19 A. I have it in the record here, I think.

20 MR. NORCHI: Romney, is
21 this --

22 MR. CULLERS: Off the record.

23 -----

24 (Discussion had off the record.)

25 -----

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

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

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

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

11 A. No.

12 Q. It is not?

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

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

20 A. I wouldn't think so, no.

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

24 A. I don't remember.

25 Q. Do you know if a sonographic estimated fetal

1 weight was ever done?

2 A. I don't know.

3 Q. I would like to ask you to assume that the
4 patient arrived on 3-13-95 at 12:44.

5 MR. NORCHI: After midnight.

6 Q. 12:44 p.m., was 3 to 4 centimeters dilated.

7 A. You are talking about noon the day before?

8 Q. Yes.

9 Then she did not progress beyond
10 that dilatation until some hours later. She left,
11 she went home. I would like you to assume also
12 that on 3-13-95 when her cervical dilatation was
13 3 to 4 centimeters, she was at a high station,
14 minus 2 to minus 3; do those facts indicate that
15 the baby's head is not engaged?

16 A. Yeah. If the exam is accurate, yeah. I have
17 a note from 3-11-95 that says that she was 3 to 4,
18 minus 1, by somebody else's exam.

19 Q. Can you turn to the next page, see if that
20 continues to 3-13. She came back on 3-13?

21 A. This is a screening room flow sheet that is
22 two days before.

23 Q- Is it true that normally the baby's head will
24 be at zero station --

25 A. No.

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

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

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

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

11 A. No.

12 Q. You don't usually find that?

13 A. Often, yes. Usually, no.

14 Q. Not necessarily something you expect to find?

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

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

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

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

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

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

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

11 A. Which ones?

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

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

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

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

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

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

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

14 A. She was in latent labor.

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

19 MR. CULLERS: Correct.

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

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

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

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

8 Q. If you look down further in that same note on
9 3-13-95.

10 A. Back in the nursing notes?

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

12 A. I'm back where you were.

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

15 A. Yes.

16 Q. It indicates that the vaginal exam shows 4 to
17 5 centimeters dilatation; does it not?

18 A. Um-hum.

19 Q. Is that true?

20 A. That is what is written here, yes.

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

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

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

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

5 Means 4 and 5 obviously.

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

8 Q. Between 4 and 5 it means?

9 A. Yes.

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

12 A. Um-hum.

13 Q. I need you to answer.

14 A. Yes.

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

17 A. That is an estimate.

18 Q. Between zero and plus 1?

19 A. Correct.

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

23 A. Yes.

24 Q. By Dr. Griffith?

25 A. Yes.

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

3 A. Yes.

4 Q. Does that change your opinion about whether
5 or not this patient is in active labor as of
6 2:07 a.m.?

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

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

12 A. Yes.

13 Q. Can you show me what time that is?

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

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

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

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

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

9 Q. Which is what time?

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

16 Q. Let me stop you there.

17 Between three o'clock a.m. and
18 **5:30** a.m. --

19 A. Between those two.

20 Q. Let me finish my question, please.

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

24 A. That's correct.

25 Q. You say that based partially on your

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

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

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

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

17 Q. What we're talking about --

18 A. IUPC fetal scalp electrodes, **3:30**.

19 Q. What are you referring to?

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

22 Q. **3:30** a.m.

23 A. Yes.

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

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

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

10 A. I'm making an assumption.

11 Q. I thought you looked --

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

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

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

23 The intrauterine goes inside the
24 uterus, sits in the amniotic fluid, measures the
25 pressure by the contraction of the uterus.

1 Q. Is that recorded somewhere in the notes,
2 results of that testing?

3 A. No.

4 Q. Is that something can you watch on the
5 monitor as it's happening?

6 A. Yes.

7 Q. The values that are shown by the testing
8 aren't recorded somewhere?

9 A. It's just on the tracing.

10 Q. It's on the tracing?

11 A. Yes.

12 Q. On the tracing?

13 MR. CULLERS: Off the
14 record.

15 -----

16 (Discussion had off the record.)

17 -----

18 Q. By the way, have you reviewed the tracings in
19 this case?

20 A. No.

21 Q. While we're talking about dilatation, I want
22 to ask you some questions about the progress of the
23 labor chart you had out earlier.

24 I was asking you about when you
25 believe that her active phase of labor began, you

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

4 A. Yes.

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

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

10 Q. Is station recorded?

11 A. It's recorded once.

12 Q. Isn't it recorded twice?

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

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

17 A. Yes.

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

22 A. No.

23 Q. It doesn't?

24 A. No.

25 Q. What is the definition of protracted descent?

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

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

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

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

19 MR. NORCHI: Do you
20 understand the question?

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

24 Q. That is not protracted descent?

25 A. No.

1 Q. The reason I ask, I'm looking at the bottom
2 of the chart, the progress of labor chart. If you
3 look down where it says descent; do you see that?

4 A. Um-hum.

5 Q. In the center, protracted descent, do you see
6 that?

7 A. I see it, I don't agree with that.

8 Q. Let me ask you if this is what it means: Does
9 the word -- first of all, let me ask you this.
10 Strike that.

11 Does this say protracted, in
12 parenthesis less than 1 centimeter per hour?

13 A. That's what it says. It says what you think
14 it says, but let me say she has come in early, the
15 patient comes in zero, plus 1, plus 2, I would say
16 all those things are normal.

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

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

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

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

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

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

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

14 Q. Is what I'm saying true, that the reason **you**
15 don't think that was protracted dilatation is
16 because you didn't think she was in active labor
17 until some later point after she is more than
18 5 centimeters dilated?

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

24 Q. 8:35.

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

1 that is a centimeter an hour.

2 Q. It doesn't matter during that time station
3 has remained static at least up until 7:00?

4 A. Not to me.

5 Q. Doesn't?

6 A. No.

7 Q. First of all, who is doing this chart, who is
8 making this chart?

9 A. Nurses.

10 Q. Do they record station and the level of
11 dilatation as it's happening?

12 A. As it's reported to them by a resident,
13 whoever does the exam.

14 Q. That is what I mean. They don't take this,
15 later go back?

16 A. No, it's recorded as it's done.

17 Q. Is there any reason why station isn't
18 recorded again after seven o'clock a.m.; do you
19 know why?

20 A. I don't know why.

21 Q. Wouldn't the appropriate course be to record
22 that on the progress of labor chart?

23 A. I don't know what the nurse's standard is.

24 Q. We know that at eight o'clock, if you look at
25 the progress notes, if you look at --

1 A. Nurse's or doctor's?

2 Q. Dr. Krietsky's progress note, if you look at
3 that. Dr. Krietsky records fetal presenting part
4 at zero to plus 1; is that right?

5 A. Yes.

6 Q. Again, zero to plus 1, that is somewhere
7 between zero and plus 1, right?

8 A. Yes.

9 Q. So if we look at this progress of labor chart
10 again at seven o'clock, station is charted at zero,
11 then we rely on Dr. Krietsky's vaginal exam to show
12 where station is, approximately an hour later, it's
13 something less than 1 centimeter?

14 MR. NORCHI: Objection. Go
15 ahead, Doctor.

16 A. I'm confused by what you are asking me.

17 Q. I'm asking between seven o'clock a.m. and
18 eight o'clock a.m. station has changed a centimeter
19 or less?

20 A. No, because this is not that kind of a
21 measurement. This an estimate. So what I say this
22 shows is that the head was coming down, that's all
23 it would tell me.

24 Q- I understand that.

25 If station is changed I'm asking at

1 least a centimeter between seven o'clock a.m. and
2 eight o'clock a.m.?

3 A. It's changed, coming down, that's all I could
4 say for sure from those notes.

5 Q. You can't say it's changed a complete
6 centimeter?

7 A. I can't say that. I can't say it has not
8 changed by 2 centimeters. It's just come down.

9 Q. If you look **at the** progress and labor you
10 assume station is accurately recorded at zero at
11 seven o'clock a.m., then you referred to
12 Dr. Krietsky's note; isn't it fair to conclude
13 station has not changed at least 1 centimeter
14 during that one hour period?

15 A. What time are we talking about, seven o'clock
16 to eight o'clock?

17 Q. **Yes.**

18 A. Who did the exam at 7:00, somebody else?

19 Q. Dr. Segal.

20 A. This isn't that accurate. He could come in
21 say it's minus 1. It's just not something that is
22 that accurate. If somebody says a patient is
23 minus 3, that's really high. If it's around zero
24 they call it minus 1, zero, plus 1, that is about
25 the same place.

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

7 Q. Let set that aside.

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

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

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

16 A. No.

17 Q. Why not?

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

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

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

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

9 Q. I understand that.

10 Are you ever able to tell
11 accurately --

12 A. Exactly --

13 Q. Wait a minute. Let me finish.

14 Are you ever able to tell
15 accurately whether or not the station has changed
16 1 centimeter?

17 A. No, not 1 centimeter.

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

22 A. The presenting part.

23 Q. Which is what?

24 A. The head.

25 Q. Which part of the head?

1 A. The bony part of the head, not the soft spot.

2 Q. What does caput and molding mean?

3 A. Caput is swelling. If you had your shoes on
4 all day, you take them off, the upper part of your
5 foot is a little swollen, that would be caput on
6 the foot.

7 Q. It's a soft material that feels like --

8 A. Yes. Moms call their baby cone head. The
9 soft top where the baby's head is.

10 Q. Explain molding.

11 A. Molding is an event that happens that allows
12 us to get out big fat heads out of a little
13 vagina. There are suture soft spots and the
14 sutures overlap to get the head out or they
15 wouldn't fit.

16 Q. Suture means it is the soft spot on the head?

17 A. That is back here. None of the bones are
18 connected, those fuse later, after the baby is
19 born. They are made to overlap. If they fused, no
20 baby would ever fit out.

21 Q. If you are trying to determine station, doing
22 the vaginal exam you reach up, feel bony presenting
23 part of the fetal head; could that bony part that
24 you feel be one of those bones that is pushed over
25 the other on the top of the baby's head?

1 A. That is what you are feeling.

2 Q. That's what you are feeling?

3 A. Feel the sutures to see how the baby's head
4 is directed, that kind of thing.

5 Are you confused?

6 Q. No, I'm thinking about what you said.

7 Obviously molding is something that
8 is normal?

9 A. All babies do it except C-section babies.

10 Q. You expect to see molding?

11 A. On all babies, yes.

12 Q. You expect to see caput?

13 A. Yes.

14 Q. Would there ever be a reason to think
15 positive molding, positive caput was abnormal?

16 A. If it were my clinical impression that the
17 head itself was not descending, just getting
18 longer, that would be a reason to be concerned.

19 Do you see what I'm saying?

20 Q. I hear you.

21 What about after the baby is born,
22 a finding of positive caput and positive molding,
23 would that ever been considered abnormal?

24 A. No.

25 Q. Ever?

1 A. No.

2 Q. Anything about it that would make it
3 abnormal, the fact that it exists?

4 A. I can't think of anything. The vacuum makes
5 them bigger.

6 Q. Pardon?

7 A. When you put a vacuum on the skull and the
8 suction pulls into the cap, it tends to be
9 exaggerated after the vacuum is used.

10 Q. Might be exaggerated after the vacuum is
11 used?

12 A. Yes.

13 Q. Not abnormal?

14 A. NO.

15 Q. You expect to see it, wouldn't you?

16 A. Yes.

17 Q. Can you think of any other reason why you
18 might observe a newborn and consider the caput and
19 molding to be abnormal?

20 A. I can't think of any.

21 Q. When you are determining station, you feel
22 the bones of the head, is it important to
23 distinguish the bones you are feeling are part of
24 that molded head? Do you follow what I'm saying?

25 A. No.

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

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

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

10 Q. That's soft?

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

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

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

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

22 MR. CULLERS: What is this?

23 MR. NORCHI: You know she
24 wasn't there.

25 THE WITNESS: I wasn't there

1 until 7:30.

2 MR. CULLERS: I got you.

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

6 A. No.

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

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

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

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

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

20 A. Yes, that is nursing.

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

25 A. I'm sorry. What time?

1 Q. Seven o'clock a.m., 3-14, starts Dr. Segal
2 in; do you see that?

3 A. Yes.

4 Q. It indicates a 7:00 a.m. Dr. Segal did a
5 vaginal exam, 7 to 8 centimeters dilatation and
6 zero station; is that correct?

7 A. Yes, but Dr. Segal notes say plus 1. I say
8 that is pretty much the same thing, so it doesn't
9 bother me.

10 Q. His notes say 1 plus?

11 A. Yes. His notes says 1 plus, she says zero.

12 Q. So Dr. Segal's handwritten note of
13 seven o'clock says plus 1 for station?

14 A. Yes.

15 Q. Dr. Krietsky at eight o'clock says zero to
16 plus 1?

17 A. Yes.

18 Q. Can you look above Dr. Krietsky's
19 eight o'clock note, please.

20 A. Yes.

21 Q. Who is that by?

22 A. Radkey .

23 Q. Can you read that note?

24 A. Subjective, comfortable, I think. NST 150 to
25 160, that would be the baby's heart rate is 150 to

1 160.

2 Q. stop.

3 What is right above that, starts
4 with a C?

5 A. I think that is a SOAP note.

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

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

9 Q. Go down past 160 there.

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

14 Q. Keep going.

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

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

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

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

1 A. Have I?

2 Q. Yes.

3 MR. NORCHI: Do you
4 understand the question, Doctor?

5 THE WITNESS: No.

6 Q. Do you know what the long-term beat to beat
7 variability is for this particular labor?

8 A. I guess I'm not sure what you mean long-term
9 beat to beat variability. Are you asking me is the
10 tracing reactive?

11 Q. What I'm asking you is if considering the
12 long-term beat to beat variability on this
13 particular labor, if it's a good sign or bad sign?

14 A. Beat to beat variability is good.
15 Accelerations of the heartbeat with movement or
16 fetal scalp stimulation are good. Flat tracings
17 are concerning. Decelerations are of concern.

18 So for example, at 8:30 when I see
19 fetal heart tracing, the rate is up a little bit,
20 170, that worries me just a little bit. Fair beat
21 to beat variability is good. Late decels, that
22 bothers me.

23 Q. It's important to look at long-term beat to
24 beat variability?

25 A. I don't know what you mean long-term beat to

1 beat variability.

2 Q. Not looking at one beat to beat variability
3 reading, looking at them over time.

4 A. Yes.

5 Q. That's important?

6 A. Yes.

7 Q. Looking at this particular fetus' beat to
8 beat variability over time, what does it look like
9 to you as of 7:30?

10 A. The notes look like it's okay.

11 Q. Looks like it's okay?

12 A. Yes.

13 Q. You haven't reviewed the tracings?

14 A. No.

15 Q. Are you limiting your answer to your review
16 of any particular notes when you tell me the
17 overall --

18 A. The notes I'm looking at here, from
19 Dr. Radkey, Dr. Krietsky, seven o'clock, at 8:30
20 which I have co-signed.

21 Q. Have you looked at any other notes prior to
22 those three you just told me about when you were
23 trying to figure out --

24 A. Right now, no.

25 Q. Can you look at the preceding physician's

1 progress notes.

2 A. There is a note here decrease beat to beat
3 variability. There is concern throughout this is a
4 fetus that's got heavy meconium. There are times
5 the tracings are not reassuring, that is why we're
6 getting scalp gases, which are the bottom line.

7 I would **say** this is not a real
8 reassuring tracing. Looks like from whoever's note
9 this is, Dr. Segal, poor beat to beat variability,
10 things have perked up. Babies go to sleep
11 sometimes, then things look better.

12 Q. Based on what you can tell looking at the
13 progress of the beat to beat variabilities from the
14 beginning of the progress notes until the time you
15 come on 7:30 a.m., does it look positive?

16 A. At the time that I come on the beat to beat
17 variability, based on the note that I'm looking at,
18 looks like it was reassuring.

19 Q. What about the beat to beat variability over
20 the course of some time starting with the first
21 progress note, is it reassuring?

22 A. We're not seeing deterioration. Can get
23 better as they go through labor. I don't really
24 think so. It's stress.

25 Q. It's not something reassuring, it's just not

1 deteriorating over time?

2 A. Yes. I guess I would agree with what you
3 just said.

4 Q. At the onset of labor is it important to try
5 to arrive at the estimated fetal weight?

6 A. Arrive at?

7 Q. In other words, try to figure out what the
8 fetus' weight is early on in the labor process?

9 A. On admission, something that is part of the
10 physical exam, are we talking a little baby that
11 may be compromised, average size baby, or talking
12 about one a little big.

13 Q. Why is that an important factor?

14 A. To prepare for possible complications you may
15 run across in the course of labor and delivery.

16 Q. Does the standard of care require a
17 sonographic estimate of fetal weight?

18 MR. NORCHI: When, at
19 admission?

20 Q. At the beginning of active labor?

21 A. No, wouldn't be possible.

22 Q. What about in the latent phase of labor?

23 A. No, it would be done antenatally.

24 Q- You wouldn't do a sonographic estimate of
25 fetal weight at some point before active labor?

1 A. No.

2 Q. Why is it important at all to try to
3 determine fetal weight early on?

4 A. Well, if you had a little growth retarded
5 infant you would be much more concerned about
6 placental insufficiency.

7 If you have a large infant, you
8 need to be considering how much dystocia you are
9 going to have as the baby delivers.

10 Q. Macrosomic babies yield a higher likelihood
11 of dystocia?

12 MR. NORCHI: Likelihood
13 for? I object to the term likelihood.

14 A. It would raise my index of suspicion. If I'm
15 delivering a premature baby that weighs 3 pounds
16 I'm not going to worry it, it's going to fall out.

17 A woman with a 9 pound baby I'm
18 concerned; however, there are 7 pound babies that
19 don't fit. That alone doesn't determine what we
20 are going to do; likewise, people that deliver
21 11 pound babies, don't seem to breathe too hard.

22 Q. Statistically isn't it a macrosomic baby more
23 likely to result in complications?

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

1 not shown anywhere.

2 Q. Let's me ask the question differently.

3 Is a macrosomic baby more likely to
4 be involved in complications than a non-macrosomic
5 baby?

6 A. No, not generally.

7 Q. In other words --

8 A. All complications, no.

9 Q. What about shoulder dystocia?

10 A. It's one of the factors, not the only
11 factor.

12 Q. Is it a factor?

13 A. It's a factor.

14 Q. A macrosomic baby is more likely to be
15 involved in a delivery that has the complication of
16 shoulder dystocia than any non-macrosomic baby?

17 A. I'm not sure statistically speaking that is
18 actually true. It's something we think about more,
19 I'm not sure that statistically it would actually
20 bear out.

21 Q. What is it about a big baby that causes you
22 to think about it more?

23 A. Babies are supposed to have their heads
24 bigger than their shoulders. As they get bigger
25 their shoulders could be broader. The concern is

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

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

7 Q. Meaning what exactly?

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

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

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

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

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

1 has not engaged consistent with fetal/pelvic
2 disproportion?

3 A. No.

4 Q. Why not?

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

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

12 A. No.

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

15 A. No.

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

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

22 Q. I'm not asking indicative.

23 A. It's not inconsistent with it.

24 Q. Is consistent with it?

25 A. Explain to me what you mean consistent with.

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

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

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

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

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

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

1 things, ultimately she is due a trial of labor.

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

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

12 Q. There was intervention also?

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

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

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

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

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

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

11 Q. You don't think it would have?

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

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

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

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

1 epidural, I think the Mighty Vac delivery was
2 prudent.

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

5 MR. NORCHI: As opposed to?

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

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

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

19 A. Yes, you can.

20 Q. How much higher station?

21 A. Generally plus 1.

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

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

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

4 Q. Safe at even plus 1?

5 A. Generally speaking, yes.

6 Q. What about with a macrosomic infant?

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

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

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

1 MR. NORCHI: Objection. Go
2 ahead.

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

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

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

13 Q. Period?

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

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

18 A. Not just based on estimated fetal weight.

19 Q. Tell me what else.

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

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

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

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

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

7 A. Yes.

8 Q. It says 7:21 scalp gas 7.23?

9 A. Yes.

10 Q. You agree that is a borderline value?

11 A. Yes.

12 Q. That is the second consecutive borderline
13 value?

14 A. That's one.

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

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

19 Q. Yes, it does.

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

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

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

1 Q. In fact prior to that point the scalp pH of
7.23 was reported, that was a test done because of
3 concern on the fetal tracings; is that right?

4 A. Yes.

5 Q. What is a bradycardia?

6 A. Slow heart rate over a prolonged period of
7 time.

8 Q. What are the danger of bradycardia for a
9 fetus?

10 A. It's not so much how low but the pattern.

11 Q. This fetus became bradycardic, did it not?

12 A. You have to show me where it says that.

13 Q. If you look here at 8:46 a.m., variable
14 deceleration to 90's, you see that?

15 A. Yes.

16 Q. Does that meet the definition of bradycardia?

17 A. Not the way I think of it, no.

18 Q. Tell me.

19 A. What I said was bradycardia is the baby's
20 heart rate **drops** down, doesn't come back up. A
21 variable decel it goes down and stays down, comes
22 back up. The return to baseline is what makes me
23 not call that bradycardia.

24 Q. Could you refer to your operative note,
25 please, in the second line the reference to the

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

3 A. Yes, I see that.

4 Q. Can you tell me when that happened?

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

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

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

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

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

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

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

10 Q. I'm just wondering when it occurred.

11 MR. NORCHI: If you don't
12 know.

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

18 Q. No way to tell me?

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

23 Q. Can we be certain fetal bradycardia occurred?

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

1 patient was being discharged.

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

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

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

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

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

25 I said to you it's not so much how

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

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

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

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

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

19 A. Yes.

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

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

1 happened.

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

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

13 MR. NORCHI: Do you know?

14 A. I don't know.

15 MR. NORCHI: That suffices.

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

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

21 A. First page?

22 Q. Yes.

23 A. Yes.

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

1 A. No, that would be Dr. Krietsky.

2 Q. So she is purporting to prepare this for you,
3 meaning "I" was called to the room?

4 A. No, this thing of her for me is something
5 that the dictating people do.

6 Q. I was called to the room, that means Krietsky
7 was called to the room?

8 A. Krietsky, she is dictating for herself, I.

9 Q. I was called to the room means Krietsky was
10 called to the room?

11 A. Yes.

12 Q- On the nurses' delivery notes I notice that
13 at 8:53 indicates you were present for delivery?

14 A. Yes.

15 Q. I didn't see anywhere in the notes your
16 presence prior to that time; is that accurate?

17 A. There is a cosignature.

18 Q. Where is that?

19 A. In the doctor's notes, patient progress, at
20 8:30 the decision to allow the patient to push,
21 consider vaginal delivery, the cosignature would
22 not have been at the time. I don't have to cosign
23 their notes like I do op notes and discharge, that
24 means I was there.

25 Q. You would have been there at 8:30?

1 A. Yes.

2 Q. Is this your signature down here on an angle
3 by the X?

4 A. Yes.

5 Q. What is all this, the X about?

6 A. The X means don't write there anymore.
7 Probably I signed there, then decided that I agreed
8 with what she said, right underneath her name put
9 an X so nobody would put anything between my two
10 signatures, that is my guess.

11 Q. Were you in the room from 8:30 up until the
12 point of delivery?

13 A. I don't know, What does the nursing note
14 say?

15 Q. Nursing note says Dr. Austin present at 8:53?

16 A. At 8:35 says Dr. Austin aware. I would
17 suspect the reason they know I'm aware is because
18 I'm standing around there, but I don't know. I had
19 to have been here to sign the chart.

20 Q. Is it likely you would have stayed there the
21 whole time?

22 A. There were other things going on at the same
23 time, I may have been walking around doing other
24 things as well.

25 It is our custom that the attending

1 is here for vacuum and forcep deliveries.

2 Q. Why is that?

3 A. Seems like a good idea. In this particular
4 situation this is March, you've got a pretty
5 experienced resident, you've got the chief there, I
6 don't think it would have been a dangerous thing by
7 any means for me not to be there.

8 On the other hand, I'm the most
9 experienced physician on the floor, it's
10 appropriate that I be there, unless my attention is
11 needed somewhere else.

12 Q. Based on what you can see here in the notes,
13 **8:35** and **8:53** notes, that makes you feel
14 comfortable indicating you were there from **8:35** to
15 **8:53**?

16 A. **No.** All I can say for certain is at **8:53**
17 when she applied the vacuum I was there. Vacuum
18 assist Dr. Austin could mean the nurse notified me
19 they were getting ready for the vacuum, to come
20 down. Since I signed here, I don't know. I'm not
21 sure what that means.

22 Maybe they called me at **8:30**, said
23 we're considering vacuum, come down, help us look
24 at this, in which case I walked down, discussed it,
25 co-signed the note, the nurses wrote I was aware.

1 I don't know.

2 Q. As you mentioned, that doesn't mean that you
3 were there that whole time between 8:35 and 8:53?

4 A. No, doesn't mean that.

5 Q. You see that Dr. Krietsky cut the cord and
6 clamped the cord in the 9:01 note?

7 A. Yes.

8 Q. Does that mean she is the one who delivered
9 the child?

10 A. It implies that she is since she is the one
11 that then handed the baby to the pediatrician,
12 yes.

13 The reason I hesitated, sometimes
14 if the cord is around the neck another person will
15 do the clamp and cut while someone else delivers
16 but since she hands it off.

17 Q. Since she hands the baby to the pediatrician
18 she probably did the delivery?

19 A. Handed off to peds, I think that means
20 Dr. Krietsky did it, that would make sense.

21 Q. If you are trying to determine fetal weight
22 prior to delivery, is there any way you can
23 accurately do that to the extent you can tell if
24 the fetus is more than 4,000 grams but less than
25 4,500 grams?

1 A. Probably the most accurate thing would be
2 ultrasound.

3 Q. Does that have any percentage of error?

4 A. I'm sure it does, I can't tell you what it
5 is. Probably is dependent on the person doing it.

6 Q. It's about 10 percent error?

7 A. At least. I would imagine from one person to
8 the next it's going to vary.

9 Q. That's the same thing as a sonographic
10 estimate of fetal weight?

11 A. Yes.

12 MR. NORCHI: Can we take
13 another break?

14 -----

15 (Recess had.)

16 -----

17 BY MR. CULLERS:

18 Q. When you were talking about being present in
19 the delivery room, you were talking about the chief
20 resident was there, the resident was there; do you
21 recall that testimony?

22 A. Yes.

23 Q. What is the general way the delivery is
24 handled, meaning who is there in the room?

25 A. That way. The primary resident gives the

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

3 Q. He's the fourth year resident?

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

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

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

11 Q. Right.

12 A. Yes.

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

15 A. Yes.

16 Q. Is a certified nurse midwife always in
17 attendance?

18 A. No.

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

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

24 Q. Did Dr. Anthony give suprapubic pressure?

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

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

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

6 A. No.

7 Q. She I mean --

8 A. The intern?

9 Q. The intern.

10 A. No.

11 Q. She was just training?

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

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

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

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

1 A. I don't know what the circumstances were.

2 The labor and delivery nurses can give suprapubic
3 pressure as well. I can.

4 Q. There is no particular reason why a certified
5 nurse midwife would be called in this instance?

6 A. No.

7 Q. I was asking you earlier about the progress
8 of labor chart and pattern of descent and
9 dilatation, there is a question I didn't ask that I
10 want to ask, but to ask the question I've got to
11 tell you what I asked you before, okay?

12 MR. NORCHI: Objection. Go
13 ahead.

14 Q. I asked you before about whether or not the
15 fact that there wasn't descent of at least
16 1 centimeter per hour after active labor started
17 constituted protracted descent, you said it didn't;
18 do you recall that?

19 A. Recall our discussion.

20 Q. I want to ask you a specific question about
21 that, if you refer to the progress of labor chart.

22 A. I can't find it. What section is it in?

23 MR. NORCHI: We have
24 different sections.

25 Q. With the labor notes in my chart anyway.

1 Here's mine.

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

4 A. Yes.

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

8 A. Yes.

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

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

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

22 Q. Plus 2 what?

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

25 Q. Right.

1 A. What I'm saying there minus 3, minus 2, minus
2 1, zero, plus 1, plus 2, plus 3, there is only
3 6 centimeters, you can't make a whole centimeter
4 per hour, most labors last longer than six hours.

5 Q. Progress of less than 1 centimeter per hour
6 in descent between 7:00 and 8:00 doesn't constitute
7 protracted descent?

8 A. Based on this piece of paper it does. I say
9 it's irrelevant. It didn't mean anything in terms
10 of her progress in labor.

11 Q. When you referred to this piece of paper, I
12 need to clarify what it was you are referring to.

13 A. Intrapartum problem record.

14 Q. The part you are referring to, part where it
15 says descent, right next to protracted, is that
16 what you are referring to?

17 A. Yes.

18 Q. Information contained less than 1 centimeter
19 per hour?

20 A. I showed you how there aren't enough
21 centimeters for anybody to do that.

22 Q. I'm trying to understand. I'm trying to make
23 a record what you are referring to.

24 A. That is what I'm referring to.

25 Q. That's something that defines parameters

1 taken from the Friedman curve?

2 MR. NORCHI: Objection.

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

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

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

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

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

18 MR. CULLERS: No.

19 A. Let me answer the question differently.

20 I guess my point is let's assume
21 she did not descend by a full centimeter between
22 7:00 and eight o'clock, which I said I don't know
23 whether that happened or not, none of these
24 measurements are accurate to tell me for sure.

25 & e At least based on --

1 A. Based on the data available. Let's say she
2 was at zero and plus 1. I don't believe that
3 constitutes an abnormal progress of labor.

4 Q. That's because of the rate of dilatation?

5 A. Yes.

6 Q. You don't make any distinction about the fact
7 that descent doesn't change -- strike that. Never
8 mind.

9 Looking at your or Dr. Krietsky's
10 note of 8:30, it indicates there that operative
11 vaginal delivery was going to be considered,
12 something of that nature, would you refer to that?

13 A. Yes.

14 Q. Is that what that said?

15 A. Yes.

16 Q. You co-signed on that note?

17 A. Yes.

18 Q. Do you recall the thought process that you
19 went through when that note was co-signed?

20 A. No.

21 Q. Can you tell by reviewing that note, other
22 information in the chart, what factors would
23 indicate an operative vaginal delivery in this
24 situation?

25 MR. NORCHI: Objection, it's

1 been asked and answered. Go ahead.

2 A. The reason for the operative delivery was the
3 status of the fetus based on the scalp tracings and
4 scalp gases.

5 Q. Looking forward from **8:30**, is your testimony
6 the same?

7 A. Yes.

8 Q. In considering operative vaginal delivery may
9 be attempted, is it important at all for you as the
10 attending to confirm station before anyone
11 intervenes with the vacuum?

12 A. No.

13 Q. You feel comfortable relying on the resident
14 and/or the chief resident to do that?

15 A. Yes.

16 Q. Can you return to the labor/delivery notes.
17 I would like you to go to **8:53**, where it indicates
18 Dr. Austin present for delivery.

19 A. Yes.

20 Q. The first thing that happened at **8:53** is
21 push/pull with vacuum?

22 A. Push means the patient pushed, the pull means
23 the vacuum pulled at the same time.

24 Q. That is the first time any pulling with the
25 vacuum occurs; is that true?

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

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

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

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

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

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

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

23 A. Yes.

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

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

3 MR. NORCHI: Is it in the
4 progress notes?

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

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

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

13 A. Yes.

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

17 A. Yes.

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

21 A. I see that.

22 Q. Do you agree with that?

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

25 Q. You would have put large baby, shoulder

1 dystocia was anticipated?

2 A. Yes.

3 Q. You agree with that?

4 A. Yes.

5 Q. If the shoulder dystocia is anticipated, why
6 wouldn't the episiotomy be cut through to the
7 rectum?

8 A. I don't think this shoulder ever was
9 impacted.

10 Q. You don't think this shoulder was ever
11 impacted?

12 A. No, I don't.

13 Q. Why do you say that?

14 A. I'm taking it only from what I read here and
15 the fact I have no memory of this case, because
16 impaction doesn't happen that often I ought to
17 remember.

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

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

4 Q. Explain what you mean by impacted.

5 A. Stuck behind the symphysis.

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

8 A. I don't think.

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

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

14 MR. NORCHI: Let him ask the
15 question,

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

18 A. Yes.

19 Q. Nuchal cord times one reduced?

20 A. Yes.

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

23 A. Yes.

24 Q. You see where it says difficulty with
25 shoulder?

1 A. I do.

2 Q. You think they are referring to difficulty
3 with the nuchal cord?

4 A. No. I still don't think it was impacted.

5 Q. Did you think after the head was delivered
6 that there was a pause in the remainder of the
7 infant coming forth because of something having to
8 do with the shoulder getting caught on something?

9 A. I think that the baby was on the large side,
10 the shoulder was not a rapid delivery, so instead
11 of putting a lot of traction on the baby they
12 lowered the bed, pushed suprapubically. I don't
13 know that the baby was stuck.

14 Q. Why would they do suprapubic pressure and put
15 the bed down if the shoulder wasn't stuck?

16 A. To facilitate the easy delivery of the
17 shoulder, not pull too hard.

18 Q. You don't think that his shoulder was stuck
19 even for a few seconds?

20 A. We're talking about semantics. I don't think
21 this is an impacted shoulder. You say what do you
22 mean by impacted, maybe I should change it, say
23 really stuck.

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

1 on out. It's a very easy delivery.

2 Q. We're in agreement that the baby's shoulder
3 at least got hung up for some amount of time?

4 A. We're in agreement they felt some resistance,
5 therefore went through the appropriate maneuvers to
6 widen the delivery space. It happened with the
7 first steps, further steps were not necessary.

8 Q. Are we in agreement that the baby's shoulder
9 was hung up at least for some amount of time?

10 A. No.

11 Q. We're not?

12 A. "Hung up" is a word I wouldn't use.

13 Q. You used it, that is why I chose it.

14 A. Did I say that?

15 Q. I'm trying to figure out what happened. The
16 baby's head came out, the rest of his body didn't
17 come forward, did the shoulder delay the passing
18 through?

19 THE WITNESS: Can I explain
20 this?

21 MR. NORCHI: Sure.

22 A. If I have a shoulder that is on the wide
23 side, I pull, then I'm going to get an impacted
24 shoulder, then I'm going to have a problem.

25 If I start to deliver, this isn't

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

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

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

9 You said this was an easy delivery?

10 A. Relatively speaking, yeah.

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

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

16 Q. Your view this was a relatively easy
17 delivery?

18 A. Yes.

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

21 A. Right.

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

25 A. Right.

1 Q. Do you agree that his shoulder was prevented
2 from coming forth because it was prevented from
3 doing so by some part of the mother's anatomy?

4 A. I think it was a wide baby across the
5 shoulders, yes, it has to come under the symphysis,
6 by pushing it down it came right out.

7 Q. Do you think the baby's anterior shoulder got
8 hung up on the symphysis?

9 A. I think I've answered it the best I can. I
10 don't think it was impacted. I've attended a lot
11 of shoulder dystocias,, this was an easy delivery.

12 Q. Do you remember it?

13 A. This delivery, I see the description, see how
14 long it took, I see what maneuvers were necessary
15 to deliver this baby.

16 Q. You feel confident in reviewing this
17 information you know what maneuvers were done?

18 A. Yeah. I see the length of time they had to
19 do them in.

20 Q. Tell me about the suprapubic pressure, how
21 was that done?

22 A. I'm not sure what you are asking me. Are you
23 asking how suprapubic pressure is given?

24 Q. You said you can look at that, you can tell
25 that they did the appropriate maneuvers, I'm asking

1 what this one means.

2 A. Pressure is given straight down standing on a
3 stool, pushing straight down above the pubic bone
4 to push the shoulder or keep it from getting stuck
5 up there.

6 Q. What does bed down mean?

7 A. Means the bed is lowered, closer to the floor
8 so the person giving suprapubic pressure can be
9 straight above the symphysis.

10 Q. Is it important to put the bed down to
11 perform the McRobert's maneuver?

12 A. No.

13 Q. How is the McRobert's maneuver performed?

14 A. Like this.

15 Q- Can you tell from looking at the nurses' note
16 at nine o'clock whether the McRobert's maneuver was
17 done?

18 A. I don't remember where I read it.

19 Q. Nine o'clock?

20 A. She doesn't seem to record it.

21 Q. Is that something that you would expect the
22 nurse to record if it was done?

23 A. Not necessarily.

24 Q- Earlier you said in reviewing the nurses'
25 notes at nine o'clock and **9:01** you can tell this

1 was a relatively easy delivery?

2 A. I said reading the chart.

3 Q. I thought you were talking about reading the
4 chart.

5 A. I referred to when I read the whole chart to
6 get a feeling for what the delivery was. My
7 impression this was a relatively easy delivery.

8 Q. By reading the notes at nine o'clock and 9:01
9 there is no way for you to tell whether or not the
10 McRobert's maneuver was performed, is there?

11 A. No.

12 Q. Is that something that is required?

13 A. Something that's customary. It would have
14 been done.

15 Q. Earlier you were talking a little about the
16 resident, the resident's relationship to the chief
17 resident in the delivery process. I'm going to ask
18 you more about that.

19 In a vacuum delivery, who would be
20 doing what, if you can tell me as a matter of
21 custom?

22 A. As a matter of custom in March of a second
23 year residency, the second year resident would be
24 doing the vacuum. The chief would be supervising.

25 Q. When the chief is supervising what is he

1 doing hands-on?

2 A. Usually scrubbed, he's usually either
3 watching or checking the application, that kind of
4 thing.

5 Q. The resident is the one operating the vacuum?

6 A. Holding onto it.

7 Q. The second year resident?

8 A. You mean pulling on the vacuum, yes.

9 Q. Would there ever be a situation where the
10 chief resident would be the one who was pulling on
11 the vacuum, the second year resident was watching?

12 A. Be unlikely. A first year resident, the
13 chief might do it.

14 Q. What is the chief's role in supervising,
15 watching, what else?

16 A. I think you stated it pretty well.

17 Q. He's watching?

18 A. Supervising.

19 Q. I mean what does that entail, is he helping
20 by touching anything?

21 A. He might have done the exam before she
22 applied the vacuum. Vacuums are more forgiving
23 than forceps, the application is much easier.
24 Watching how well the baby is responding to
25 traction, direction of traction Dr. Krietsky

1 applied, that sort of thing.

2 Q. Would it have been important for the chief to
3 have confirmed the station of the fetal presenting
4 part before application of the vacuum?

5 A. To say important, I wouldn't say important.
6 Dr. Krietsky was at the far end of her second year
7 of residency, she is capable of doing that.

8 Q. It's really not that significant for him to
9 do that?

10 A. No, but he might have.

11 Q. Why was it important for the senior resident
12 to be in attendance during delivery?

13 A. It's our protocol.

14 Q. Why is that?

15 A. Medical/legal reasons I suspect.

16 Q. What does that mean exactly?

17 A. I think that a second year resident is fully
18 capable of doing a vaginal delivery and in an
19 emergency would do an adequate job. When you have
20 a more experienced practitioner available it's
21 reasonable to have them available.

22 Q. In case something might happen that is
23 unusual?

24 A. Sure.

25 Q. There is no question in this situation --

1 THE WITNESS: Can I answer
2 this page?

3 MR. CULLERS: Sure.

4 -----

5 (Recess had.)

6 -----

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

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

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

16 A. When?

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

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

21 Q. No, that is not my question.

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

24 A. Yes.

25 Q. Did this delivery include the complication of

1 shoulder dystocia?

2 A. Yes.

3 Q. Is shoulder dystocia considered an
4 obstetrical emergency?

5 A. Emergency, not if appropriately managed. It
6 requires appropriate management. Does that answer
7 the question?

8 Q. No.

9 Is shoulder dystocia an obstetrical
10 emergency?

11 A. I wouldn't call it so.

12 Q. In this case with Michael Dixon you wouldn't
13 call this case involving shoulder dystocia an
14 emergency?

15 A. No.

16 Q. What is Erb's palsy?

17 MR. NORCHI: I object to a
18 neurologic diagnosis. You can answer the question
19 if you can.

20 A. Weakness in the arm resulting from damage to
21 the brachial plexus.

22 Q. Do you have an opinion as to whether Michael
23 Dixon sustained damage to his brachial plexus
24 during his delivery?

25 MR. NORCHI: I object. I

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

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

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

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

15 MR. CULLERS: Yes.

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

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

23 A. I was told that.

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

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

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

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

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

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

13 A. I'll make that assumption.

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

17 A. Repeat the question.

18 MR. CULLERS: Read it back.

19 -----
20 (Question read.)

21 -----
22 MR. NORCHI: I object to the
23 hypothetical and also the vague nature of the term
24 delivery because delivery is a long process.

25 If you have an opinion, care to

1 answer, you can, Doctor.

2 A. It could have.

3 Q. It could have?

4 A. Could have.

5 Q. Do you have an opinion as to whether it is
6 more likely than not that it did occur during his
7 labor and delivery?

8 MR. NORCHI: Objection. Go
9 ahead if you have an opinion.

10 A. I don't know what else happened with this
11 baby, this is only a portion, the experience I have
12 with him. Given the nature of the delivery I would
13 have said it was unlikely. I would have said it
14 unlikely based on what I read about the delivery,
15 so I don't know.

16 Q. At least you will concede it's a possibility?

17 A. I'll concede one of the things that can lead
18 to a brachial plexus injury is the process of
19 birth, of all births.

20 Q. Do you have an opinion as to whether a
21 brachial plexus injury can occur during the process
22 of birth having nothing to do with the medical
23 procedure?

24 A. Yes, I do.

25 Q. How could it be caused?

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

4 Q. Can you explain the physiological way that
5 occurs?

6 A. No, I can't.

7 Q. You can't because?

8 A. I'm not a neurologist.

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

12 A. That is correct.

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

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

20 MR. CULLERS: This is a
21 different question.

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

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

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

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

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

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

12 A. I don't have an opinion.

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

18 A. I don't know.

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

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

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

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

4 MR. NORCHI: That's
5 different.

6 MR. CULLERS: I know it's
7 different.

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

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

20 A. Been involved in a number, yes.

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

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

24 Q. Do you remember when that was?

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

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

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

6 A. It was a much more difficult delivery.

7 Q. You specifically recall that?

8 A. I remember everything about that.

9 Q. Did that case result in litigation?

10 A. Yes, it did.

11 Q. That has been resolved?

12 A. Yes.

13 Q. Do you remember the patient's name?

14 A. No.

15 Q. You were a named defendant in that case?

16 A. I was the attending.

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

19 A. Yes.

20 Q. Was that here at University Hospitals?

21 A. Yes.

22 Q. Who defended you in that case?

23 MR. NORCHI: Objection. If
24 you recall.

25 A. I don't remember.

1 Q. You don't remember who defended you?

2 A. No.

3 Q. Do you remember who the plaintiff's lawyer
4 was?

5 A. I don't remember.

6 Q. You said about eight years ago?

7 A. Um-hum.

8 Q. Since that time have you been involved in any
9 other cases where you were named in a malpractice
10 case as a defendant?

11 MR. NORCHI: Objection.

12 A. Not obstetrical. One when I was a Fellow.
13 Nothing that ever went to court.

14 Q. Were you involved in any situations where a
15 lawsuit was filed but was resolved short of going
16 to court?

17 A. I was dropped from the cases.

18 Q. Do you remember how many cases there were?

19 A. I only remember once because it was last
20 week. Let me think for a second. I had my
21 deposition taken twice before. Once for this, once
22 for something else. Does that answer your
23 question?

24 Q. No. What I want to know is how many times
25 you've been named as a defendant in a lawsuit that

1 was filed?

2 A. We get 180 day letters.

3 MR. NORCHI: Claims are
4 different.

5 A. Then I don't think there are anymore.

6 Q. Just the two cases you gave your deposition?

7 A. Three including this one, three.

8 Q. This is one, second when you were a Fellow,
9 third one about eight years ago?

10 A. The one when I was a Fellow was not an
11 obstetrical case, one shoulder dystocia, this one.

12 Q. The shoulder dystocia one was eight years
13 ago?

14 A. Approximately.

15 Q. Are you Board certified?

16 A. Yes.

17 Q. Obstetrics?

18 A. And reproductive endocrinology.

19 MR. CULLERS: That's it.

20 MR. NORCHI: You have the
21 right to waive signature. I suggest you read the
22 deposition transcript that will be prepared by the
23 court reporter so we know it's accurate.

24 THE WITNESS: Okay.

25 (Deposition concluded; signature not waived.)


1 The State of Ohio, .

2 County of Cuyahoga. CERTIFICATE:

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

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

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

21 
22 -----

23 Constance Campbell, Stenographic Reporter,
24 Notary Public/State of Ohio.

25 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

 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

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: 4

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