

1 The State of Ohio,)
2 County of Erie.) SS:

3 IN THE COURT OF COMMON PLEAS

4 Trent J. Canfield, a minor, et al,
5 Plaintiffs,

6 vs.

Case No. 99-CV-507

7 Firelands Community Hospital,
8 etc., et al,

9 Defendants.

10 * * *

11
12 Deposition of DAVID M. BURKONS, M.D.,
13 called as a witness on cross-examination by the
14 Plaintiffs, taken before Kathleen A. Hopkins Durrant,
15 a Notary Public within and for the State of Ohio, at
16 the offices of University Suburban Gynecologists,
17 Inc., 1611 South Green Road, South Euclid, Ohio, on
18 Tuesday, the 12th day of August, 2003, at 5:35 p.m.
19 pursuant to agreement of counsel.

20
21 * * *

22  11/25/03

1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 Benjamin F. Barrett
4 Miraldi & Barrett Co., LPA
5 6061 S. Broadway
6 Lorain, Ohio 44053

7 On behalf of Defendant Firelands Community Hospital:

8 E. Thomas Maguire
9 Robison, Curphey & O'Connell
10 2332 Twin Eagles Drive
11 Traverse City, Michigan 49686

12 On behalf of Defendant Pediatric Associates
13 of Sandusky, Inc.:

14 James Sammon (via telephonic means)
15 Reminger & Reminger Co., LPA
16 237 W. Washington Row
17 Second Floor
18 Sandusky, Ohio 44870

19 On behalf of Defendant Dr. Stenzel:

20 George C. Ward (via telephonic means)
21 Cooper & Walenski Co., LPA
22 900 Adams Street
23 Toledo, Ohio 43624

24 On behalf of Defendant Dr. Visci:

25 Donald Switzer
Bonezzi, Switzer, Murphy & Polito Co., LPA
Leader Building
Suite 1400
526 Superior Avenue
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2 CURRICULUM VITAE MARKED PLAINTIFF'S EXHIBIT A FOR
3 IDENTIFICATION.

4 DR. BURKONS' REPORT MARKED PLAINTIFF'S EXHIBIT B
5 FOR IDENTIFICATION.

6 * * *

7 DAVID M. BURKONS, M.D.,
8 of lawful age, called as a witness by the
9 Plaintiffs, being first duly sworn as
10 hereinafter certified, was examined and
11 testified as follows:

12 CROSS-EXAMINATION OF DAVID M. BURKONS, M.D.

13 BY MR. BARRETT:

14 Q. Dr. Burkons, as you know, I'm Ben Barrett, and
15 I represent Trent Canfield and Christie Spring in
16 connection with this litigation.

17 You've provided a report to Mr. Switzer dated
18 March 6th, 2003, and I'm going to be asking you some
19 questions as you know today about yourself, your
20 practice and your opinions in this case.

21 You've been deposed before I know.

22 A. Yes.

23 Q. And if you would please, if you don't
24 understand the question, just indicate that you do not
25 understand it, and I will be glad to try to place it

1 in a way that we all understand what I'm asking.

2 MR. BARRETT: Let the record also
3 show that the time and place of this deposition has
4 been originally agreed to and then supplemented with
5 notice. And that counsel for all parties are present
6 either in-person or by conference call.

7 Q. Dr. Burkons, please begin by stating your name
8 and office address, please.

9 A. David M. Burkons, 1611 South Green Road, South
10 Euclid, Ohio, 44121.

11 Q. Dr. Burkons, I'm handing to you what has been
12 marked as Plaintiff's Exhibit A, which has been given
13 to me, purported to be your current curriculum vitae.
14 Can you state if that is current?

15 A. The only addition to this is I now am a member
16 of the House Officer Education Committee at Case
17 Western Reserve University School of Medicine and the
18 University Hospitals of Cleveland.

19 Q. What does that involve, house officer?

20 A. It's the committee that supervises the
21 residents. We call them residents. I guess they're
22 called house officers now, house officers in training
23 for the department of OB/GYN.

24 Q. How long have you had that appointment?

25 A. I was appointed to that around the first of

1 this year.

2 Q. What does that involve as far as your time?

3 A. The time, there is about every other month
4 there is an hour morning meeting, and then we as a
5 practice, our practice now conducts rounds with the
6 residents and students three mornings a week all year
7 long. We started that in July.

8 Q. And where is that done?

9 A. At University Hospitals.

10 Q. And is that the hospital at which you are
11 affiliated at this time?

12 A. Yes.

13 Q. Are you affiliated with any other hospitals at
14 this time?

15 A. No.

16 Q. Tell me about your medical practice at this
17 time. Are you still practicing obstetrics?

18 A. No. As of October 30th, 19, or 2002, we are no
19 longer practicing obstetrics.

20 Q. Was the reason for that is that the additional
21 insurance premium for obstetrical practice exceeded
22 what you wanted to pay in view of your practice?

23 A. I think that's, we had a, the very thing that
24 made our practice very attractive both for us and our
25 patients is that we didn't do a large OB volume. It

1 sounds like a lot, 200 deliveries a year, but in this
2 day and age where you, no matter what you charge you
3 get what the insurance company pays you, we paid the
4 same premiums as if we had done 500 deliveries a year.
5 And since we did a lot of gynecology, we figured it
6 wasn't, with what rates were happening, we were told
7 what was going to happen to our rates, it didn't make
8 any sense for us to continue doing obstetrics.

9 Q. Then tell us about your practice at this time.

10 A. It's a, what you might call a full range
11 gynecology practice. We do take care of early
12 obstetric care of people, we confirm their
13 pregnancies, take care of them through the first
14 couple of visits, obviously if they have a
15 miscarriages we take care of that. We do infertility,
16 we do urogynecology, we do oncology. And that's, you
17 know, pretty much the full range of gynecology.

18 Q. Do you, I notice that you advertise for laser
19 hair removal?

20 A. Yes, we do that also. And we do the spider
21 veins now too.

22 Q. I had an opportunity before we started to
23 review what has been indicated to be your file.

24 To be short, it would appear that you did have
25 access to all of the prenatal and the obstetrical

1 records of Christie Spring?

2 A. Yes.

3 Q. And you have reviewed the various reports of
4 experts that I have provided, as well as I believe
5 deposition transcripts of each of the experts who have
6 been deposed thus far, is that accurate?

7 A. Yes.

8 Q. And deposition testimony of the parties to the
9 case?

10 A. Yes. It seems when I was reading your nurse's
11 deposition, I can't think of her name.

12 Q. Mary Jo Chapla?

13 A. I thought she mentioned some nurses'
14 depositions which I hadn't seen, but maybe I was wrong
15 about that. There was a number of nurses'
16 depositions. There was some names that I didn't
17 recognize.

18 Q. Nurses that may have been involved in the care
19 of Christie Spring or on the Code Pink Team?

20 A. Something like that. There are several in
21 there. I think there were about four nurses, but I
22 thought there were some names that I didn't recognize.

23 Q. Well, maybe we'd better cover the nurses that
24 you do have.

25 A. I have Margo Lawton, Jill Wagner, Deborah

1 Wicker. I think those are the three I have.

2 Let me see who this is. That's the three
3 nurses that I have.

4 Q. Do you recall, do you have access to identify
5 for us when you first received this assignment from
6 Mr. Switzer's office?

7 A. I'm assuming it was, it was within about a
8 month before my report, I guess. I have from early,
9 my earliest thing I see is from February 14th, 2002,
10 but I think I was contacted before that. What's the,
11 what's the date on my report?

12 Q. Your report is March 6th, 2003.

13 A. So I was apparently contacted, because I have a
14 February 14th, 2002, so unless, unless that is, should
15 have been 2003, which I can't tell you.

16 Q. Okay. Was it Mr. Switzer who was the contact
17 from his office?

18 A. Yes, or it may have been his, initially been
19 his paralegal. I'm not sure.

20 Q. Had you known Mr. Switzer from prior dealings?

21 A. Yes.

22 Q. Had Mr. Switzer or his law firm ever defended
23 you previously in any litigation?

24 A. Yes.

25 Q. On how many occasions?

1 A. Twice.

2 Q. And when was that, please?

3 A. Well, their firm hasn't been around that long.
4 They both, within the past three or four years, they
5 were both cases that were dropped.

6 Q. Were they obstetrical cases?

7 A. One was obstetrical and one was gynecologic.

8 Q. Before Mr. Switzer became affiliated with his
9 present firm, he, of course, was affiliated with
10 Jacobson, Maynard who represented PIE.

11 A. Right.

12 Q. I notice from prior depositions that you were
13 an insured of PIE for some period of time?

14 A. Yes.

15 Q. And what period of time was that would you say?

16 A. I'm going to say, you know, probably, I really
17 don't know, but I'm going to say maybe ten years until
18 they went bankrupt.

19 Q. During that period of time, that ten year
20 period of time, did you serve as an expert witness for
21 the firm in which Mr. Switzer was --

22 A. No. The only thing I ever, I think twice I
23 served on their, they had this committee which would
24 meet to review cases, but I never was an expert for
25 anybody who was actually, who was at Jacobson, Maynard

1 at that time.

2 Q. And during that ten year period of time did the
3 firm which Mr. Switzer was affiliated, Jacobson,
4 Maynard, provide defense to you in cases?

5 A. Yes.

6 Q. And how many occasions?

7 A. I'm going to say probably two.

8 Q. Did Mr. Switzer represent you in those cases?

9 A. No.

10 Q. In connection with your Medical-Legal review,
11 let's just touch on that, please.

12 For what period of time have you been reviewing
13 cases as an expert witness in medical malpractice
14 matters?

15 A. I'm going to say 18, 20 years.

16 Q. And about how many cases have you reviewed each
17 year would you say?

18 A. Well, in the early, probably through most of
19 the 1980's it was very few, some years none, some
20 years two or three. I would say it's probably been
21 since about 1990 that it's, you know, picked up. And
22 I would say that I probably, you know, average one,
23 probably three, one to two cases a month, maybe three
24 cases every two months, new cases that I review or are
25 asked to review.

1 Q. Are those cases coming to you primarily from
2 the defense?

3 A. I would say now I'm doing at least a third to
4 maybe two/fifths plaintiff work.

5 Q. And for what period of time has that been?

6 A. Actually mostly, I've always done an occasional
7 plaintiff's case, but I'd say through most of the
8 '90's I've been doing plaintiff's work. I would say
9 probably starting in the latter, after 1995 it's, you
10 know, picked up.

11 Q. Are you currently involved in serving as an
12 expert witness or have agreed to serve as an expert
13 witness for plaintiff's counsel on an obstetrical
14 case?

15 A. Yes.

16 Q. And how many?

17 A. Well, I know I just did a deposition last week
18 for a Plaintiff's case. And I have one, a deposition
19 the last week of the month.

20 Q. And who was the plaintiff's lawyer in
21 connection with that case that you did last week?

22 A. Well, it was the firm of McKeen and Associates
23 in Detroit. It wasn't, it was one of his associates
24 that actually did the deposition.

25 Q. Is your plaintiff's work generally confined to

1 out of state counsel?

2 A. I've done at least two cases here in Cleveland.
3 And I have one that is, I reviewed, I mean, I'm acting
4 as an expert now. It's been sort of dormant for a
5 while.

6 Q. What are your charges for your review?

7 A. I charge for actual review of records \$300 an
8 hour.

9 Q. And for deposition time?

10 A. \$500 an hour with a minimum of three hours.

11 Q. I'm not planning on taking that long.
12 With reference to trial time?

13 A. What I charge is \$3,000 per half day away from
14 the office.

15 Q. Now, I'd like to ask you some questions
16 generally.

17 In this case did you notice at any time that
18 the fetal heart rate base line became tachycardic?

19 A. It certainly got, you know, I guess it depends
20 on the definition of tachycardia, but, you know, I'm
21 not going to beat around the bush, I mean, it got up
22 into the 160's and 170's, which to me is a relative
23 tachycardia. Some people say over 180. Once it gets
24 above 160, I certainly consider that it's somewhat
25 tachycardic. And there certainly were areas where it

1 was over 160 and sometimes over 170.

2 Q. In general, would you agree that the most
3 common cause of fetal tachycardia is one of two
4 things, either fetal exhaustion or fetal infection,
5 those are by far the most common reasons for fetal
6 tachycardia?

7 A. The most common, yes, I would say that's true.

8 Q. And you have testified to that previously?

9 A. I may have. I mean, there are probably more
10 pathologic reasons. I mean, for instance fetal
11 anemia, if the fetus has somehow or the other has
12 hemorrhaged, the fetus will get that. That's probably
13 more pathologic, but it's nowhere near as common.

14 Q. In this case is there any evidence of fetal
15 anemia?

16 A. No.

17 Q. So that can we agree that fetal exhaustion or
18 fetal infection would be the most likely cause of the
19 tachycardia?

20 A. I would think that be would be correct, yes.

21 Q. Is there any sign of fetal infection in this
22 case?

23 A. None that I'm aware of.

24 Q. With reference to beat to beat variability,
25 Doctor, would you agree that the brain of the fetus

1 controls beat to beat variability?

2 A. I think, yeah, it's generally, it's generally
3 felt that that's, that that's true.

4 Q. And with reference to the fetus who, which may
5 be stressed, isn't it a fact that when the fetus
6 senses it isn't getting enough oxygen, the natural
7 reaction is to try to pump faster, the heart pumps
8 faster?

9 A. Well, it either can be that or I suppose under
10 any kind of stress, I mean, that happens to all humans
11 under stress, the heart tends to pump faster.

12 Q. Right.

13 And this does result in a rising base line, if
14 there is a monitor, does it not?

15 A. Yes.

16 Q. And you often see a tachycardia and a loss of
17 beat to beat variability in those circumstances?

18 A. Correct.

19 Q. Doctor, if the status of this baby in utero had
20 been compromised before this mother went into labor,
21 wouldn't you expect that the fetal monitor tracing
22 would show decreased beat to beat variability and/or
23 late decelerations from the time the tracing started?

24 A. It depends on how, when the insult or the
25 compromise occurred. If the compromise occurred

1 somewhat remotely, you know, a couple, three days
2 before, you can see a perfectly normal tracing. If
3 the compromise occurred just before or very close to
4 when the person went into labor, then you would expect
5 to see either beat to beat variability, decreased beat
6 to beat variability, or decelerations right from the
7 beginning.

8 Q. Is that the manner in which you have constantly
9 testified?

10 A. I don't know if I've ever been asked that
11 specifically. I mean, I have been asked questions for
12 instance where, and I can tell specific instances,
13 where right from the get-go, the first time the
14 patient hit the floor where there was a very bad
15 tracing, and I said, well, it's unlikely that the
16 tracing just happened to get bad five minute ago.

17 But I can tell you from my own personal
18 experience, when you are talking about lawsuits, one
19 of the suits that Mr. Switzer's firm defended me on
20 was a case, absolutely normal tracing, normal
21 delivery, good Apgars, and about seven or eight hours
22 later the baby crashed. And it turned out that it had
23 had a middle cerebral artery stroke. And all the
24 experts, and that's why it was dropped, because the
25 plaintiff's attorney got his experts to say that, that

1 had reviewed the films said the same thing, that this
2 had occurred at least 48 hours before delivery had
3 occurred. I don't know how they tell that, but the
4 radiologists apparently know how to tell it. And the
5 baby had an absolutely normal tracing.

6 So when insults occur somewhat remotely, the
7 tracing at the time of the delivery or of labor may be
8 normal.

9 Q. Would you agree that when this baby came into
10 labor and the fetal monitor was applied, that the
11 tracings did appear to be normal?

12 A. Yes, I would agree with that.

13 Q. And it was sometime later, after the
14 administration of the Cytotec, rupture of the
15 membranes and then the Pitocin began, that the
16 tracings became somewhat tachycardic, as you've
17 indicated, the base line rose?

18 A. That is correct.

19 Q. And would you agree that those tracings
20 demonstrate that the beat to beat variability became
21 reduced at about the same time the tracings rose?

22 A. Yes, yes.

23 Q. Speaking of beat to beat variability, what is
24 your definition of a normal beat to beat variability?

25 A. Well, I mean, to me, you know, you get into all

1 the little definitions, is it five, is it six. It's
2 one of those things that you look at it and you sort
3 of know it if you see it. And it also, it has to do
4 with how it looked before. I mean, the technical
5 definition that I always was taught is you like to see
6 variance of at least five beats, but I've seen other
7 people say seven. I don't know how you measure the
8 difference between seven and five. And it's the kind
9 of thing, that you know when you see it, you know it's
10 decreased.

11 I mean, my feeling is if you have to argue a
12 whole lot about whether it is or it isn't, it probably
13 is decreased.

14 Q. Would you agree that it is, there are portions
15 of time that the beat to beat variability is decreased
16 in this, these strips?

17 A. Yes, I would agree with that.

18 Q. Would you agree the beat to beat variability is
19 an important measure of the fetal central nervous
20 system's well-being?

21 A. I mean, I think it certainly is a, it's
22 something that you look at, but most of the time
23 decreased beat to beat variability has little say on
24 the outcome. And there are other times that it is a
25 very big prognostic factor, but most of the time it

1 doesn't seem to matter a whole lot.

2 Q. At what time is it a very big prognostic
3 factor?

4 A. You know, to me, to me it seems, particularly
5 if you start, the ones that seem the most important to
6 me is when you start having decelerations, and
7 particularly late decelerations, and then the late
8 decelerations start to disappear and then you have
9 very little beat to beat variability because the fetus
10 has lost all its ability to respond to stress.

11 When I just see decreased beat to beat
12 variability remote from any kind of decelerations or
13 anything else, then I usually think it's due to
14 something like fetal exhaustion, fetal stress to the
15 fetus, or, you know, narcotic administration or
16 something like that.

17 Q. Well, would you agree that diminished or absent
18 beat to beat variability associated with a rising base
19 line is a nonreassuring fetal heart pattern?

20 A. You said absent. I mean, if there is
21 absolutely no variability, that's not, you know,
22 that's certainly a sign that you want to pay attention
23 to.

24 Q. Well --

25 A. But absent and decreased are two different

1 words.

2 Q. Let's just stick with diminished. You have a
3 diminished beat to beat variability coupled with a
4 rising base line into the tachycardia area, is that or
5 is it not a reassuring pattern?

6 A. It's not reassuring, but it doesn't necessarily
7 mean, it doesn't necessarily mean that it's an ominous
8 pattern, but it's certainly one that you would want to
9 pay attention to and be monitoring more closely than
10 if you didn't have those factors.

11 Q. Would you expect the clinician to take steps to
12 try to correct that pattern?

13 A. It would depend on, you know, the overall
14 situation. If the physician felt that delivery was
15 going to occur fairly soon, that's the best way to
16 correct it, is to get the baby delivered.

17 Q. Well, there would be other ways, perhaps the
18 use of oxygen, it may include administering oxygen,
19 changing the maternal position?

20 A. Yes.

21 Q. Discontinuing oxytocin?

22 A. Those are all things that can be done and
23 sometimes will have effect on those parameters you
24 were speaking of.

25 Q. With reference to hyperstimulation, would you

1 agree with the definition of hyperstimulation in
2 William's 20 Edition which states the definition,
3 which defines hyperstimulation as six or more
4 contractions in ten minutes for a total of twenty
5 minutes?

6 A. Well, I would say that's the definition, but I
7 would add that hyperstimulation per se is not
8 something that I consider necessarily bad. It's only
9 if hyperstimulation is causing compromise to the fetus
10 that I would be necessarily concerned about it. But
11 certainly that's a legitimate definition of it.

12 Q. Well, do you agree that hyperstimulation may
13 prevent appropriate uterine blood flow and fetal
14 oxygenation?

15 A. Yes, yes.

16 Q. Would you, when an obstetrician is inducing
17 labor through oxytocin administration, do you agree
18 that the obstetrician is obligated to follow the
19 written protocol for that procedure developed by the
20 Obstetric Department of that hospital?

21 A. I guess it would depend on, you know, on
22 exactly what the protocol, the protocol said. I look
23 at protocols as a guideline, but most protocols, most
24 protocols are set that if you feel that you want to do
25 more than that protocol or less than that protocol as

1 long as you're taking everything into consideration
2 it's okay.

3 I think protocols are a guideline and certainly
4 something that shouldn't be overridden by the nurses
5 without a physician saying so. For instance, at our
6 hospital the nurses are allowed to increase oxytocin
7 up to 20 milliunits. After 20 milliunits a physician
8 has to specifically come in and specifically in the
9 presence of the nurse say, okay, increase the Pitocin.
10 I mean, I've many times gone up to 40 milliunits, but
11 over 20, the nurses can't do it without the doctor.

12 So that's how the protocol -- so protocols are
13 meant as a guidelines. It doesn't mean that it is set
14 in stone.

15 Q. With reference to the use of Cytotec, when you
16 were performing or practicing obstetrical, obstetrics,
17 did you use Cytotec yourself?

18 A. Yes, very often.

19 Q. And what was the purpose of the use of Cytotec?

20 A. It was to ripen the cervix. And certainly once
21 it was, became available, it sort of supplanted all
22 the other things that we used to use, because it
23 seemed to work better, and from the hospital's point
24 of view was much, much less expensive than the other
25 things.

1 Q. It comes in what, a 100 mcg. pill?

2 A. Little tablet, yes.

3 Q. And would you break up the tablets?

4 A. Well, the nurses usually would. Their eyesight
5 is usually a little better than mine. They would take
6 a knife and break it into either fifty, or halves or
7 quarters.

8 Q. Would you insert it vaginally? Would it be
9 inserted vaginally then?

10 A. It can be. We sometimes would use it, not so
11 much for labor induction but for postpartum hemorrhage
12 we would often use it rectally, but for labor
13 induction we almost always use it vaginally.

14 One of my partners had a patient who had a
15 dead, it had endometritis, and she used it rather than
16 constantly putting her fingers into the vagina, would
17 do it rectally, so it works as well rectally. You can
18 do it orally too, but I'd say 98 percent of the time
19 for labor induction we did it vaginally.

20 Q. And was there a protocol at the hospital, at
21 University Hospital, for the use of Cytotec?

22 A. Yes.

23 Q. And what is that protocol?

24 A. The protocol was, usually we would start with
25 the first time, and if that didn't, and we had to

1 wait, in general, if the nurses were doing it, again
2 if we were there we could override it, but if the
3 nurses were doing it, it could be repeated every four
4 hours. And if you wanted to start oxytocin, it had to
5 be at least four hours after the last, after the last
6 insertion of Cytotec.

7 MR. WARD: Doctor, you're fading,
8 the doctor is fading out a little toward the end.

9 THE WITNESS: I will move closer
10 here.

11 MR. WARD: I can hear Ben very as
12 well.

13 THE WITNESS: How's that?

14 MR. WARD: That's much better.

15 MR. BARRETT: Thank you.

16 MR. WARD: Thank you very much.

17 Q. You would agree that one of the risks of the
18 use of Cytotec in this manner is uterine
19 hyperstimulation?

20 A. Yes.

21 Q. Do you agree that the use of Cytotec for
22 inducement make the uterus more responsive to
23 oxytocin?

24 A. I mean, that's, you know, whether it's ever
25 been proven or not I don't know. Certainly my

1 impression is that it does.

2 Q. In connection with the prenatal care prior to
3 labor in this case, do you find anything that is
4 problematic or would indicate to you that this child
5 would have a problem being delivered?

6 A. No. I mean, I think that Dr. Visci thought
7 that the baby was, you know, getting bigger and so
8 therefore that was his rationale for wanting to induce
9 a little bit early, because he thought if it got much
10 bigger there might be a problem.

11 Q. Did you see anything in connection with the
12 prenatal care that would indicate to you that the baby
13 did have a problem?

14 A. Problem in what way?

15 Q. Well, that something happened during the --

16 A. No. I think the prenatal -- apparently, as I
17 recall, there had been an abnormal either one or two
18 hours screen. I forget which one they did. And then
19 the three hour was okay.

20 Q. Okay.

21 A. Of the glucose tolerance test.

22 Q. Would that be the test that you would follow,
23 the three hour?

24 A. The only time you wouldn't is if you've got
25 somebody that has a markedly, markedly abnormal one or

1 two hours, say 220, 230, there would be no point in
2 even bothering, but most of them we get, they're
3 slightly elevated. In order for a test to be a good
4 screen, you are going to have, and eliminate all the
5 false positives, you are going to have a certain
6 percent of false positives. And I would say that
7 probably 25, 30 percent of our positives, of our
8 positives, we do one hour screens here, when we did
9 the three hour were normal.

10 Q. Is there anything about the screening in this
11 case that would be of a concern in view of the three
12 hour test?

13 A. No.

14 Q. You indicated that Dr. Visci induced because he
15 felt that the baby was getting large?

16 A. Well, he felt that the baby was getting larger
17 and her cervix from one exam to the next, nad I forget
18 how many days it was in between, had ripened up quite
19 a bit, so I think it had gone from a fingertip to now
20 it was two to three centimeters, that he felt that she
21 was ripe and he knew she was at term, and there was no
22 sense waiting and having the baby get any bigger.

23 Q. Do you believe that that's a valid and
24 acceptable reason for inducement?

25 A. Done it many times myself.

1 Q. Have you also induced for the convenience of
2 your own schedule?

3 A. Have I ever, and I suppose I took an oath to be
4 honest, absolutely. I mean, we always, we will tell
5 the patient that, but, I mean, sometimes it's for
6 patient convenience, sometimes it's for, sometimes
7 it's for our convenience, sometimes it for a
8 combination of both, but when you do that you're
9 honest with the patient.

10 Q. In this case you indicate a moderate shoulder
11 dystocia. What does moderate mean in connection with
12 that context?

13 A. Well, you know, as I said, I think when you
14 have to do more than like one maneuver, that's sort of
15 what I consider. In fact, a lot of times people go
16 how many percentage have shoulder dystocia. When
17 you've got a patient, the baby delivered, the head
18 was, you'd say, okay, do a McRobert's. And with a
19 McRobert's, I won't even check off shoulder dystocia,
20 although technically it was.

21 When you start having to do more than a simple
22 McRobert's maneuver, it's what I would call moderate.
23 When you really have to, when you're getting to the
24 point that you are, sort of the definition I use is
25 when you have to change your scrub shirt after the

1 procedure it's been a tough one. When you had to do
2 more than one or two maneuvers but you didn't have to
3 change your shirt, it was a moderate one. You know,
4 it's kind of hard to judge, but it's like one of my,
5 the late Mort Rosen used to say, well, how do you know
6 it was postpartum hemorrhage, he said when the blood
7 got in my shoes, then I knew it was a postpartum
8 hemorrhage.

9 Q. The McRobert's maneuver in this case apparently
10 was not successful in extracting the baby?

11 A. No, not in and of itself, no.

12 Q. And the Wood's screw maneuver likewise?

13 A. He tried suprapubic pressure, Wood's screw and
14 eventually went to deliver the posterior arm, which
15 is, I usually, everybody has their own technique, I
16 usually skip the Wood's screw and go to, that's, I
17 just feel more comfortable doing the posterior arm.

18 Q. And when you do the posterior arm, what does
19 that, explain mechanically what you do?

20 A. Well, essentially your problem is is that the
21 anterior shoulder is impinged underneath the symphysis
22 and you can't really get in to bring that shoulder
23 down. So the McRobert's maneuver, and as I was saying
24 we were doing the McRobert's maneuver before we knew
25 that's what it was. I mean, Dr. McRobert's whenever

1 he described it, you know, has his name on it, but we
2 were doing that for years. And the suprapubic
3 pressure, the same thing.

4 The Wood's screw maneuver is supposed to get
5 your hand in and change the axis of the baby to rotate
6 the baby so that now the posterior arm can come
7 underneath the symphysis. I find it in tough cases
8 difficult to do, so instead I put my hand in and I
9 take the posterior arm and sweep it out and that
10 essentially decreases the bulk of the baby and almost
11 always after that the anterior shoulder falls
12 underneath the symphysis and the baby delivers.

13 Q. In this case would you agree that the baby was
14 flaccid at the time of delivery?

15 A. Yes.

16 Q. Would you agree the baby was depressed at the
17 time of the delivery?

18 A. By the initial Apgars, yes.

19 Q. Was there ever any indication in your
20 impression that the oxytocin should have been slowed
21 or discontinued?

22 A. Well, I mean, the, both the nurses and the
23 doctor who were, the nurses who were there all the
24 time and the doctor who was there several times, felt
25 that even though the contractions were frequent, the

1 resting tone was good, and, you know, to me the
2 tracing isn't one that says you're getting
3 hyperstimulation here, I mean, the sequelae of
4 hyperstimulation. By strict definition there is
5 hyperstimulation here as far as the amount of
6 contractions, but to me hyperstimulation only matters
7 if it's affecting the fetus. If I was seeing big
8 decelerations and bradycardias, I would back off on
9 the Pitocin. Either they felt there was good
10 relaxation and resting tones in between, and so
11 therefore I don't see any reason, I think the most
12 they got to was what, 14.

13 Q. I think they got to 18 at least.

14 A. Eighteen. I didn't think there was any reason
15 that the baby was making progress to back off.

16 Q. Was, you know that there was never an internal
17 pressure catheter administered in this case?

18 A. Correct.

19 Q. That would enable, the clinician would be able
20 to determine the fetal, the tone, the uterine tone
21 between contractions with that?

22 A. Well, they'd be able to give a direct
23 measurement of it.

24 Q. Yes.

25 A. A direct measurement in, you know, whatever, in

1 Montivadeo units or milli, you know, depending on how
2 your machine is calibrated, but certainly you would be
3 able to get a direct actual thing, actual reading but
4 is it more accurate, it may more, something you can
5 quantitate more, but I don't know that it's more
6 accurate than an experienced person saying the uterus
7 is relaxed.

8 Q. You're able to determine that there is adequate
9 resting, you believe, by a nurse placing her hand on
10 the abdomen?

11 A. I mean, people did it for a long time before
12 there was monitors. If it's an experienced nurse.
13 The problem sometimes you run into today is a lot of
14 the nurses have never been trained to do that and
15 therefore don't know what they're feeling for. So
16 sometimes, you know, when somebody tells me something
17 I, same thing with residents, you judge on how
18 experienced they are, and if they are experienced,
19 some people you trust more than others.

20 Q. In an induced labor, when you were doing
21 obstetrics, did you generally use an internal fetal
22 monitor?

23 A. It would depend, you know, it would depend on
24 the, you know, the circumstances. Many times we would
25 use, we would use, certainly we would use the internal

1 scalp electrode more times than we use the internal
2 pressure catheter, just because it was easier to put
3 in and sort of less invasive, but maybe half the time
4 we would and half the time we wouldn't. It would
5 depend on the individual case.

6 And also would depend on how good your
7 readings, a lot would depend on how good your readings
8 were on the external monitor.

9 Q. I believe what you're saying is you agree that
10 by definition hyperstimulation was present throughout
11 periods of time in this case, but you do not believe
12 that what was shown or what was observed was
13 sufficient to discontinue the Pitocin or make any
14 changes in what was being done?

15 A. It was pointed out to me, because we used to
16 talk about that a lot of times particularly when I was
17 in training, and if some patient came in, and we had
18 patients, particularly if they may be having a small
19 abruption or something that come in and they can be
20 having a spontaneous pattern like this, as long as
21 there is no sign of significant fetal compromise, you
22 don't try to stop the labor, you say, good, they're
23 going to deliver quickly.

24 So, I mean, yes, it's hyperstimulation by
25 strict definition, but hyperstimulation per se is not

1 a bad thing. It's only if the hyperstimulation, for
2 instance, if it's a patient with a couple of previous
3 Cesarean scars, you would worry about that or if
4 you're having signs of significant fetal compromise
5 you'd worry about that. But you can say it the
6 opposite way, if you're having contractions every four
7 minutes but big decelerations with every contraction,
8 you're not going to say, okay, I'm going to up the
9 Pitocin, you're probably going to turn it down.

10 So it's a term, but unless it's causing a
11 problem per se it isn't a bad thing.

12 Q. And by causing a problem, you mean abnormal,
13 abnormal readings on the monitor strip?

14 A. I mean significant, you know, what you would
15 and I would consider or whoever is the attending
16 obstetrician or nurse, considers significant
17 compromise to the fetus or stress to the fetus.

18 Q. In your report you indicate that you were
19 requested to review these records and now these
20 depositions and make a determination if whether or not
21 the care provided by Dr. Visci during the pregnancy,
22 labor and delivery of Trent Canfield met acceptable
23 medical standards, was that your sole purpose in
24 reviewing?

25 A. Yes.

1 Q. Okay. Other than the standard of care issue as
2 it applies to Dr. Visci, will you be offering any
3 other opinions in this case?

4 A. Well, I would say --

5 MR. SWITZER: He is not going to
6 give any causation opinions, if that's what you're
7 getting at.

8 A. I mean, from the hospital or nurses' point of
9 view, I would say that I feel the care was adequate,
10 but from a causation point of view, no.

11 Q. You are not going to give any opinions on
12 causation in this case?

13 A. No.

14 MR. BARRETT: Fine. I have
15 nothing further tonight, Dr. Burkons. Thanks again.

16 MR. MAGUIRE: I have nothing.

17 MR. SWITZER: Anybody on the
18 phone have any?

19 MR. WARD: Ward has none.

20 MR. SAMMON: No questions.

21 MR. WARD: Is the Doctor going to
22 read?

23 MR. SWITZER: Yes.

24 MR. BARRETT: Yes, he probably
25 will.

C E R T I F I C A T E


The State of Ohio,)
) SS:
County of Lorain.)

I, Kathleen A. Hopkins Durrant, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DAVID M. BURKONS, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced by me to stenotype in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Elyria, Ohio, this 13th day of August, 2003.



Kathleen A. Durrant, Notary Public
My Commission expires 1-10-05
Recorded in Lorain County, Ohio

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