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

IN THE COURT OF COMMON PLEAS

Trent J. Canfield, a minor, et al,

Plaintiffs,

vs. Case No. 99-CV-507

Firelands Community Hospital, etc., et al,

Defendants.

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

* * *

11/25/03

APPEARANCES:

On behalf of the Plaintiffs:

Benjamin F. Barrett
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On behalf of Defendant Firelands Community Hospital:

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

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On behalf of Defendant Dr. Stenzel:

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On behalf of Defendant Dr. Visci:

Donald Switzer
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CURRICULUM VITAE MARKED PLAINTIFF'S EXHIBIT A FOR IDENTIFICATION.

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

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DAVID M. BURKONS, M.D.,

of lawful age, called as a witness by the Plaintiffs, being first duly sworn as hereinafter certified, was examined and testified as follows:

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

BY MR. BARRETT:

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

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

You've been deposed before I know.

A. Yes.

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

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

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

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

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

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

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

Q. What does that involve, house officer?

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

Q. How long have you had that appointment?

A. I was appointed to that around the first of

this year.
Q. What does that involve as far as your time?
A. The time, there is about every other month there is an hour morning meeting, and then we as a practice, our practice now conducts rounds with the residents and students three mornings a week all year long. We started that in July.
Q. And where is that done?
A. At University Hospitals.
Q. And is that the hospital at which you are affiliated at this time?
A. Yes.
Q. Are you affiliated with any other hospitals at this time?
A. No.
Q. Tell me about your medical practice at this time. Are you still practicing obstetrics?
A. No. As of October 30th, 19, or 2002, we are no longer practicing obstetrics.
Q. Was the reason for that is that the additional insurance premium for obstetrical practice exceeded what you wanted to pay in view of your practice?
A. I think that's, we had a, the very thing that made our practice very attractive both for us and our patients is that we didn't do a large OB volume. It

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

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

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

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

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

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

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

records of Christie Spring?
A. Yes.
Q. And you have reviewed the various reports of experts that I have provided, as well as I believe deposition transcripts of each of the experts who have been deposed thus far, is that accurate?
A. Yes.
Q. And deposition testimony of the parties to the case?
A. Yes. It seems when I was reading your nurse's deposition, I can't think of her name.
Q. Mary Jo Chapla?
A. I thought she mentioned some nurses' depositions which I hadn't seen, but maybe I was wrong about that. There was a number of nurses' depositions. There was some names that I didn't recognize.
Q. Nurses that may have been involved in the care of Christie Spring or on the Code Pink Team?
A. Something like that. There are several in there. I think there were about four nurses, but I thought there were some names that I didn't recognize.
Q. Well, maybe we'd better cover the nurses that you do have.
A. I have Margo Lawton, Jill Wagner, Deborah

Wicker. I think those are the three I have.

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

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

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

Q. Your report is March 6th, 2003.

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

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

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

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

A. Yes.

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

A. Yes.

Q. On how many occasions?

A. Twice.
Q. And when was that, please?
A. Well, their firm hasn't been around that long. They both, within the past three or four years, they were both cases that were dropped.
Q. Were they obstetrical cases?
A. One was obstetrical and one was gynecologic.
Q. Before Mr. Switzer became affiliated with his present firm, he, of course, was affiliated with Jacobson, Maynard who represented PIE.
A. Right.
Q. I notice from prior depositions that you were an insured of PIE for some period of time?
A. Yes.
Q. And what period of time was that would you say?
A. I'm going to say, you know, probably, I really don't know, but I'm going to say maybe ten years until they went bankrupt.
Q. During that period of time, that ten year period of time, did you serve as an expert witness for the firm in which Mr. Switzer was --
A. No. The only thing I ever, I think twice I served on their, they had this committee which would meet to review cases, but I never was an expert for anybody who was actually, who was at Jacobson, Maynard

at that time.

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

A. Yes.

Q. And how many occasions?

A. I'm going to say probably two.

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

A. No.

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

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

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

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

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

Q. Are those cases coming to you primarily from the defense?
A. I would say now I'm doing at least a third to maybe two/fifths plaintiff work.
Q. And for what period of time has that been?
A. Actually mostly, I've always done an occasional plaintiff's case, but I'd say through most of the '90's I've been doing plaintiff's work. I would say probably starting in the latter, after 1995 it's, you know, picked up.
Q. Are you currently involved in serving as an expert witness or have agreed to serve as an expert witness for plaintiff's counsel on an obstetrical case?
A. Yes.
Q. And how many?
A. Well, I know I just did a deposition last week for a Plaintiff's case. And I have one, a deposition the last week of the month.
Q. And who was the plaintiff's lawyer in connection with that case that you did last week?
A. Well, it was the firm of McKeen and Associates in Detroit. It wasn't, it was one of his associates that actually did the deposition.
Q. Is your plaintiff's work generally confined to

out of state counsel?

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

Q. What are your charges for your review?

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

Q. And for deposition time?

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

Q. I'm not planning on taking that long.

With reference to trial time?

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

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

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

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

was over 160 and sometimes over 170.
Q. In general, would you agree that the most common cause of fetal tachycardia is one of two things, either fetal exhaustion or fetal infection, those are by far the most common reasons for fetal tachycardia?
A. The most common, yes, I would say that's true.
Q. And you have testified to that previously?
A. I may have. I mean, there are probably more pathologic reasons. I mean, for instance fetal anemia, if the fetus has somehow or the other has hemorrhaged, the fetus will get that. That's probably more pathologic, but it's nowhere near as common.
Q. In this case is there any evidence of fetal anemia?
A. No.
Q. So that can we agree that fetal exhaustion or fetal infection would be the most likely cause of the tachycardia?
A. I would think that be would be correct, yes.
Q. Is there any sign of fetal infection in this case?
A. None that I'm aware of.
Q. With reference to beat to beat variability, Doctor, would you agree that the brain of the fetus

controls beat to beat variability?
A. I think, yeah, it's generally, it's generally felt that that's, that that's true.
Q. And with reference to the fetus who, which may be stressed, isn't it a fact that when the fetus senses it isn't getting enough oxygen, the natural reaction is to try to pump faster, the heart pumps faster?
A. Well, it either can be that or I suppose under any kind of stress, I mean, that happens to all humans under stress, the heart tends to pump faster.
Q. Right.
And this does result in a rising base line, if there is a monitor, does it not?
A. Yes.
Q. And you often see a tachycardia and a loss of beat to beat variability in those circumstances?
A. Correct.
Q. Doctor, if the status of this baby in utero had been compromised before this mother went into labor, wouldn't you expect that the fetal monitor tracing would show decreased beat to beat variability and/or late decelerations from the time the tracing started?
A. It depends on how, when the insult or the compromise occurred. If the compromise occurred

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

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

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

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

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

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

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

A. Yes, I would agree with that.

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

A. That is correct.

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

A. Yes, yes.

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

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

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

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

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

A. Yes, I would agree with that.

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

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

doesn't seem to matter a whole lot.

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

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

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

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

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

Q. Well --

A. But absent and decreased are two different

words.
Q. Let's just stick with diminished. You have a diminished beat to beat variability coupled with a rising base line into the tachycardia area, is that or is it not a reassuring pattern?
A. It's not reassuring, but it doesn't necessarily mean, it doesn't necessarily mean that it's an ominous pattern, but it's certainly one that you would want to pay attention to and be monitoring more closely than if you didn't have those factors.
Q. Would you expect the clinician to take steps to try to correct that pattern?
A. It would depend on, you know, the overall situation. If the physician felt that delivery was going to occur fairly soon, that's the best way to correct it, is to get the baby delivered.
Q. Well, there would be other ways, perhaps the use of oxygen, it may include administering oxygen, changing the maternal position?
A. Yes.
Q. Discontinuing oxytocin?
A. Those are all things that can be done and sometimes will have effect on those parameters you were speaking of.
Q. With reference to hyperstimulation, would you

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

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

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

A. Yes, yes.

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

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

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

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

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

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

A. Yes, very often.

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

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

Q. It comes in what, a 100 mcg. pill?
A. Little tablet, yes.
Q. And would you break up the tablets?
A. Well, the nurses usually would. Their eyesight is usually a little better than mine. They would take a knife and break it into either fifty, or halves or quarters.
Q. Would you insert it vaginally? Would it be inserted vaginally then?
A. It can be. We sometimes would use it, not so much for labor induction but for postpartum hemorrhage we would often use it rectally, but for labor induction we almost always use it vaginally.

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

Q. And was there a protocol at the hospital, at University Hospital, for the use of Cytotec?
A. Yes.
Q. And what is that protocol?
A. The protocol was, usually we would start with 25 the first time, and if that didn't, and we had to

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

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

THE WITNESS: I will move closer here.

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

THE WITNESS: How's that?

MR. WARD: That's much better.

MR. BARRETT: Thank you.

MR. WARD: Thank you very much.

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

A. Yes.

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

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

impression is that it does.
Q. In connection with the prenatal care prior to labor in this case, do you find anything that is problematic or would indicate to you that this child would have a problem being delivered?
A. No. I mean, I think that Dr. Visci thought that the baby was, you know, getting bigger and so therefore that was his rationale for wanting to induce a little bit early, because he thought if it got much bigger there might be a problem.
Q. Did you see anything in connection with the prenatal care that would indicate to you that the baby did have a problem?
A. Problem in what way?
Q. Well, that something happened during the --
A. No. I think the prenatal -- apparently, as I recall, there had been an abnormal either one or two hours screen. I forget which one they did. And then the three hour was okay.
Q. Okay.
A. Of the glucose tolerance test.
Q. Would that be the test that you would follow, the three hour?
A. The only time you wouldn't is if you've got somebody that has a markedly, markedly abnormal one or

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

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

A. No.

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

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

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

A. Done it many times myself.

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

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

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

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

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

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

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

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

Q. And the Wood's screw maneuver likewise?

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

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

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

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

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

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

A. Yes.

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

A. By the initial Apgars, yes.

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

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

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

Q. I think they got to 18 at least.

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

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

A. Correct.

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Well, I would say --

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

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

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

A. No.

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

MR. MAGUIRE: I have nothing.

MR. SWITZER: Anybody on the phone have any?

MR. WARD: Ward has none.

MR. SAMMON: No questions.

MR. WARD: Is the Doctor going to read?

MR. SWITZER: Yes.

MR. BARRETT: Yes, he probably 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