

State Of Ohio,)
County of Cuyahoga.) SS:

IN THE COURT OF COMMON PLEAS

JACOB A. FIKTUS, etc.,)
et al.,)

Plaintiffs,)

vs.)

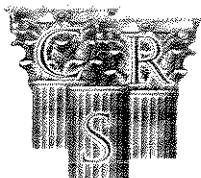
UNIVERSITY HOSPITALS OF)
CLEVELAND, et al.,)
Defendants.)



Case No. 430662
Judge Villanueva

- - - - -
THE DEPOSITION OF MICHAEL S. CARDWELL, M.D.
THURSDAY, MARCH 27, 2003
- - - - -

The deposition of MICHAEL S. CARDWELL, M.D., called by the Defendants for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Marcie S. Smith, a Registered Professional Reporter and Notary Public within and for the State of Ohio, taken at 3335 Meijer Drive, Toledo, Ohio, commencing at 2:20 p.m. day and date above set forth.



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On behalf of Defendants University OB/GYN
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Ricardo Loret de Mola, M.D.:

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- - - - -

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MICHAEL S. CARDWELL, M.D.

of lawful age, called by the Defendants for examination pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

EXAMINATION OF MICHAEL S. CARDWELL, M.D.

BY MS. ROLLER:

Q Doctor, my name is Jan Roller, and I represent University Hospitals of Cleveland in the lawsuit that's been brought by the Fiktus family. And we're here so that Joe Farchione and I can take your discovery deposition.

Would you please first just state your full name for the record.

A Michael S. Cardwell, M.D.

Q And, Dr. Cardwell, I'm aware that you're familiar with the deposition process because I was with you just a couple weeks ago doing the same thing, correct?

A Yes.

Q You have in front of you documents. Could I just see what you have?

A Yes.

Q And perhaps maybe it would be quickest if I just

1 looked over your shoulder and you can read into
2 the record what it is that makes up part of your
3 file.

4 A My October 23, 2002 report, expert letters of
5 Dr. Turrentine, and that's two of those.

6 Q There's two what?

7 A Expert reports from Dr. Mark Turrentine.

8 Q Oh, yes. Okay.

9 A Expert report from Nurse Lupe, L-U-P-E; expert
10 report from Dr. Weinstein, the nursing policy
11 from University Hospitals of Cleveland
12 concerning the use of Pitocin, a stack of fetal
13 monitor strips from the last hospital admission
14 and delivery of November 24 -- 23-24, 1997, and
15 some strips of prior admissions to the hospital
16 on October 29, 1997 and November 3, 1997, and
17 November 22, 1997, the deposition of Dr. Ricardo
18 Loret de Mola.

19 Q You have to open that one.

20 A Dr. Mary McHugh, M.D., Dr. -- or excuse me,
21 James Fiktus, F-I-K-T-U-S; deposition of Kelly
22 Fiktus, deposition of Dr. Neil Friedman,
23 depositions of nurses, including Nurse Sandra
24 Lucarelli, Tracy Arbertha, and Julie Haas,
25 various medical records of Jacob Fiktus after

1 delivery.

2 Q Do you know from what locations those records
3 come?

4 A Cleveland Clinic Foundation and looks like
5 University Hospitals.

6 Q Do you know if there are sources other than
7 those two institutions?

8 A It looks like records from a pediatric
9 orthopaedic surgeon.

10 Q And Vocare?

11 A Vocare. Records from Cleveland Clinic
12 Foundation, records from the Rehabilitation
13 Services Commission Bureau, Disability of Ohio;
14 various records and letters from Dr. Neil
15 Friedman, M.D., records of Kelly Fiktus from
16 Pitt County Memorial Hospital, Greenville, North
17 Carolina; and the hospital records of the
18 pregnancy in question from University Hospitals
19 of Cleveland concerning the mother and the baby,
20 records from Wayne Memorial Hospital, North
21 Carolina. These are records prior to her
22 arrival in Ohio.

23 And neonatal records of the baby after
24 delivery from University Hospitals of Cleveland,
25 records from Dr. Kelly Kinston, K-I-N-S-T-O-N,

1 Dr. Kiwi, and more fetal monitor strips.

2 Q And how about this stuff (indicating)?

3 A And depositions of Dr. Josephine Wang, fetal
4 heart rate tracings of November 24, 1997. And
5 this is a group of letters, correspondence from
6 the Becker & Mishkind law firm.

7 Q Let me just look at those just for a second.

8 And, Doctor, these letters that you've
9 just handed me appear to be in chronological
10 order. And the first is dated December 31,
11 2001. Does that sound about right?

12 A I think so.

13 Q Okay. Is that the first time you were contacted
14 about this case?

15 A Let's see. The record was initially sent to me,
16 I believe, in the summer of 2001, and I received
17 a phone call prior to that.

18 Q Who sent them to you, if you know? Was it
19 Attorney Mishkind's office or was it a different
20 law firm?

21 A No. Attorney Mishkind's office.

22 Q You say that was in the summer of 2001?

23 A I believe so.

24 Q Do you have any correspondence relating to that?

25 A If it's not in there, I don't.

1 Q Well, what happened in the summer of 2001
2 relating to this matter?

3 MR. MISHKIND: Objection.

4 Q With respect to any contact you had with
5 Attorney Mishkind's office, you said you got
6 records at that time?

7 A Records and telephone conversation. There might
8 have been more than one telephone conversation.

9 Q Who is the person that you spoke with from
10 Attorney Mishkind's office?

11 A I think Attorney Mishkind.

12 Q Okay. And what were you asked to do at that
13 time?

14 A I was asked to review the records and see if
15 this was a meritorious case as far as any
16 medical negligence is concerned.

17 Q And you have authored one report in this matter;
18 is that correct?

19 A Yes.

20 Q And what's the date of that?

21 A October 23, 2002.

22 Q I note among all the documents that you just
23 described, I do not see any notation, any notes
24 of any type from you; is that correct?

25 A That's correct.

1 Q You've never written a note on any of the
2 materials that you've reviewed nor on a separate
3 piece of paper about anything you've signed in
4 this case?

5 A That's correct.

6 Q And you simply dictated the report of October
7 23, 2002?

8 A No.

9 Q What did you do?

10 A I typed it myself.

11 Q You typed it yourself, okay.

12 Do you have any prior drafts of that
13 report?

14 A No. I typed it myself. No need for drafts.

15 Q From all of the stuff -- all of the things you
16 just told me that you have in front of you, have
17 you reviewed anything else for this case?

18 A Yes.

19 Q What's that? You're handing me some things.

20 A I reviewed four sources. The first source would
21 be the monogram or monograph from Awhonn,
22 A-W-H-O-N-N, entitled Fetal Heart Monitoring,
23 Principles and Practices, which was printed in
24 1994.

25 And then I reviewed Williams Obstetrics,

1 20th edition, which was published 1997. And you
2 have the pages in front of you.

3 Q The articles here are pages -- well, one page,
4 page 431?

5 A Yes.

6 Q Okay.

7 A I reviewed also the textbook Neurology of the
8 Newborn by Dr. Volpe, V-O-L-P-E. And I copied
9 that and you have in front of you page 415.

10 Q Thank you.

11 A And lastly I copied pages from a textbook
12 entitled Human Labor and Birth, 3rd edition,
13 published in 1975. And you would have pages 476
14 and 477 in front of you.

15 Q Okay. And you provided me with copies of each
16 of those?

17 A Yes.

18 Q Thank you very much.

19 Other than these four sources of
20 information, have you reviewed any other
21 literature for purposes of this case?

22 A No.

23 Q Doctor, I have a copy of your curriculum vitae.
24 I'd like to mark it as Exhibit A, but before I
25 do, let me show it to you so you can tell me

1 whether or not it's current.

2 A Yes, this is my most current CV.

3 MS. ROLLER: Why don't we
4 mark that as Exhibit A.

5 - - - - -

6 (Defendant's Exhibit A was marked.)

7 - - - - -

8 MS. ROLLER: Thank you.

9 Q Doctor, in order to save time, I asked you a
10 number of questions three weeks ago on February
11 22, 2003 about your background.

12 Has anything changed regarding your
13 background since then?

14 A No.

15 Q All right. Let me ask a few follow-up questions
16 that I wouldn't have asked you then.

17 Have you ever been retained to serve as an
18 expert by anyone from Attorney Mishkind's
19 office, including himself, before this case?

20 A Yes.

21 Q On how many other occasions?

22 MR. MISHKIND: Are you talking
23 about me or the firm?

24 MS. ROLLER: The firm. The
25 firm.

1 MR. MISHKIND: Okay.

2 A And your question was?

3 MR. MISHKIND: I'm sorry.

4 Q How many other cases other than this one?

5 A Probably about -- I would say at least half a
6 dozen.

7 Q Okay. And who were the other lawyers in his
8 firm that have retained you?

9 A Mike Becker. And I seem to recall years ago
10 there might have been a John Lancione.

11 THE WITNESS: Am I correct?

12 MR. MISHKIND: That's correct.

13 Q Junior?

14 MR. MISHKIND: Yes.

15 Q Okay. Yes. Are those the only other two other
16 than Mr. Mishkind himself?

17 A Yes, directly retained me. John Burnett has
18 attended a deposition in lieu of Mike Becker on
19 one or two occasions.

20 Q And I didn't mean to assume anything.

21 Has Howard Mishkind himself retained you
22 before this case?

23 A Yes.

24 Q How many times has Howard retained you?

25 A I believe this is his second one.

1 Q Okay. And then with respect to John Lancione,
2 Jr., and Mike Becker, how many times have they
3 each retained you?

4 A Attorney Lancione, I believe only once; and the
5 remainder would be Mike Becker.

6 Q Have you testified in any case, whether it would
7 be by videotaped deposition or in live
8 appearance, for a case that went to trial where
9 the plaintiffs were represented by anyone from
10 Attorney Mishkind's firm?

11 A Yes.

12 Q How many times has that occurred?

13 A Once for Attorney Mishkind several years ago, I
14 believe, and once or twice for Mike Becker.

15 Q All right. Tell me what those cases involved.
16 First, the three that did go to trial, the two
17 for Mike Becker.

18 A One of his cases involved an incompetent cervix
19 case. And I believe there might have been a
20 fetal distress case. It's been quite a number
21 of years.

22 Q That was the same case or a different case?

23 A A different case.

24 Q Okay.

25 A And Attorney Mishkind's case was a group B strep

1 case.

2 Q And do you recall what the other three cases
3 involved?

4 A No. I'm sure some obstetrical issue, but I
5 don't remember the exact issue.

6 Q Did any of the cases you've previously been
7 retained by the Becker, Mishkind firm involve
8 cerebral palsy as an outcome?

9 A The fetal distress case probably did.

10 Q When was that case? When did you testify in
11 that case?

12 A I think that was the first case I was engaged by
13 the law firm. That must have been maybe eight
14 or ten years ago.

15 Q And do you recall the outcome of those three
16 cases that went to trial?

17 A I know the outcome of one. The one with
18 Attorney Mishkind was a verdict in favor of the
19 plaintiff. I'm not sure about the other two.

20 Q And when was that case?

21 MR. MISHKIND: My case?

22 A The group B strep case?

23 Q Yes.

24 A It had to have been four, five, six years ago.

25 Q Where was that case tried?

1 A Cleveland.

2 Q Okay. Your CV lists a number of publications,
3 Doctor. Do you believe that any of them are
4 relevant to the issues that are present in this
5 lawsuit?

6 A No.

7 Q You previously told me that you have been a
8 defendant in a lawsuit seven times and three
9 were pending as of February 21, 2003.

10 Is that still the case, that three are
11 pending?

12 A Yes.

13 MR. MISHKIND: Let me show an
14 objection to any questions as it relates to any
15 claims against the doctor.

16 You've already answered the question, but
17 I'll just show a continuing line of objection.

18 Q Of those seven cases, can you tell me the nature
19 of the allegations against you, what was the
20 problem in the case?

21 MR. MISHKIND: And may I have a
22 continuing objection --

23 MS. ROLLER: Absolutely.

24 MR. MISHKIND: -- just so I
25 don't have to interrupt you?

1 MS. ROLLER: Absolutely.

2 A I can tell you the ones that have been
3 dismissed. I don't think I can go in too much
4 detail of the three that are pending. And I'm
5 not sure I even counted this one in the seven.

6 One I was misnamed as a defendant. It was
7 a Dr. Calwell and not a Dr. Cardwell.

8 Q Okay.

9 A Another case involved rupture of a uterus from a
10 cornual ectopic pregnancy.

11 Another case involved a placenta previa
12 baby who was delivered at term and died from
13 some kind of congenital neurological problem
14 about a year after.

15 Another case involved a baby who died from
16 choriomeningitis after the patient was
17 transported and sitting in an outreach hospital
18 for two weeks for ruptured membranes. That was
19 dismissed.

20 And I think there might have been another
21 case. That is four.

22 Q That's four.

23 A I don't recall any others. I think that's --
24 that is four counting the misnamed one?

25 Q It is including the misnamed one.

1 A Another case I was dismissed. The baby received
2 thermal injuries in a neonatal intensive care
3 unit. They named everybody; they dropped me. I
4 don't know what the allegations are -- or were.

5 Q You're saying in each of the cases that you've
6 just made reference to you were dismissed from
7 those cases?

8 A Yes.

9 Q And then there are three pending cases?

10 A Yes.

11 Q Let me ask you: On the three pending cases, do
12 any of the babies in those cases suffer from
13 cerebral palsy?

14 A I don't think so, but I haven't had an
15 opportunity to review the medical records on
16 those babies, so I'm not certain one way or the
17 other.

18 Q Knowing the nature of the allegations against
19 you in those cases, is it possible that they may
20 include a claim that the baby has cerebral
21 palsy?

22 MR. MISHKIND: Let me just
23 object.

24 And I'm not instructing you not to answer,
25 I'm only cautioning you because it sounds like

1 these cases are fairly new. I'm not your
2 attorney, but what you say relative to these
3 issues may or may not impact your defense in
4 those cases. So I would just suggest to you
5 that you answer cautiously with regard to that.

6 And I think you can appreciate that?

7 MS. ROLLER: Yes.

8 Q And I'm simply asking of your knowledge.

9 A And I cannot tell you one way or the other.

10 Q Fine.

11 Of the three pending cases, did any of
12 them involve a C-section?

13 A No.

14 Q And are all three currently pending in Lucas
15 County?

16 A Yes.

17 Q You are board certified with the American
18 College of Obstetrics and Gynecology, correct,
19 sir?

20 A No.

21 Q You're not.

22 A I'm board certified through the American Board
23 of Obstetrics and Gynecology. That's separate
24 from the college.

25 Q Okay. Thank you.

1 You are a fellow with the American College
2 of Obstetrics and Gynecology?

3 A Yes.

4 Q When did you become a fellow?

5 A I became a junior fellow during my residency.
6 And once I became board certified, I then
7 converted from a junior fellow to a fellow. So
8 that would have been approximately 1987.

9 Q What does it mean to be a fellow of the American
10 College of Obstetrics and Gynecology?

11 A To become a fellow, the doctor must be board
12 certified within obstetrics and gynecology,
13 submit an application to the American College,
14 meet other criteria, and then he or she is voted
15 in or out.

16 Q Doctor, what publications do you regularly
17 review in your profession?

18 A American Journal of Obstetrics and Gynecology,
19 The Green Journal, or also known as Obstetrics
20 and Gynecology; The Contemporary OB/GYN, OB/GYN
21 Management, JAMA, or Journal of American Medical
22 Association; Journal of the American College of
23 Legal Medicine, several throwaways, OB/GYN News,
24 two ultrasound journals. I think that's about
25 it.

1 Q Okay. Do you review the publications of ACOG?

2 A Yes.

3 Q Do you plan to appear as a live witness at the
4 trial in this case, which is scheduled to begin
5 on April 23rd, sir?

6 A If I'm asked, if I'm available, I intend to.

7 Q And I understand that if you do appear as a live
8 witness, your charge for appearance that day
9 will be \$12,000?

10 A Yes.

11 Q Doctor, would you agree that the duties and
12 responsibilities of nurses differ from that of
13 physicians in caring for a patient in labor?

14 A No. I would not entirely agree with that. It
15 depends on the issue that is being looked at.

16 Q Okay. What issues, then, would you say are
17 those that are the responsibility of the nurses
18 as opposed to the physicians?

19 A Well, the nurses generally have nursing
20 responsibilities, which means taking vital
21 signs, recording the vital signs and following
22 the physician's orders. But there are
23 overlapping areas in which the duties of the
24 nurse would more or less be coinciding with the
25 physician's duties.

1 Q What are those duties that you're referring to?

2 A For example, when a patient is to be given
3 Pitocin for augmentation or induction of labor,
4 it's -- it is both the nurse's duty and the
5 physician's duty to monitor the patient and to
6 watch for any evidence of a nonreassuring fetal
7 heart rate pattern, or any evidence that Pitocin
8 is having ill effects. That's the duty both of
9 the nurse and the doctor.

10 Q Can you give me any other overlapping
11 responsibilities in this case that relate to
12 this case?

13 A Interpretation of fetal monitor tracings and
14 performing intrauterine resuscitative maneuvers,
15 if necessary. That would be an overlapping
16 function. Preparation of the patient for a
17 cesarean section would be an overlapping
18 function. Performing a C-section, of course,
19 would be a physician function.

20 Q Okay. When a nurse and a doctor are both
21 present, whose responsibility is it to determine
22 the appropriateness of the administration of
23 oxytocin?

24 A It's an independent duty. Both the nurse has an
25 independent duty to the patient and the doctor

1 also. Most of the time the duties are
2 complimentary.

3 Q When a nurse and a physician are both present
4 and they disagree on a particular point, must
5 one defer to the other?

6 MR. MISHKIND: Objection, but
7 you can answer.

8 A In some cases, yes; in some cases, no.

9 Q Okay. Regarding the administration of oxytocin
10 with that example, same question.

11 A If there's --

12 MR. MISHKIND: Show an
13 objection, please, but go ahead.

14 A If there's a conflict between a nurse and the
15 doctor concerning the administration of Pitocin,
16 then the nurse would have an independent duty to
17 the patient, who would have to access the chain
18 of command if she thought there was a conflict
19 between her interpretation or her concept of the
20 situation versus the doctor's.

21 Q And to access the chain of command in that
22 situation would be to do what, Doctor? What
23 would the nurse have to do?

24 A Depends on the institution. But usually the
25 labor/delivery nurse would go to her supervisor.

1 If her supervisor would have to go to someone
2 else, it may be the chairman of the department,
3 it may be the house supervisor, or it ultimately
4 could even go up to the administrator.

5 Q I take it you have never worked as a nurse?

6 A No.

7 Q And you've never attended nursing school?

8 A No.

9 Q Have you ever taken any nursing courses?

10 A I have not taken nursing courses.

11 Q Have you ever taught any nurses?

12 A I have given lectures to student nurses.

13 Q On what topics?

14 A On high risk obstetrics, fetal monitoring.

15 Q Anything else that relates to this case?

16 A No.

17 Q Have you ever written on the topic of nursing
18 standard of care?

19 A No.

20 Q Dr. Cardwell, was a Bandl ring present in this
21 case?

22 A Yes. At a time of cesarean section it was found
23 to be present.

24 Q Okay. Do you differentiate in any way regarding
25 uterine rings? Do you make any distinction or

1 classification of rings found in the uterine
2 wall?

3 A I don't. The one article I gave you, Human
4 Labor and Birth, they try to make a distinction
5 between a pathologic retraction ring, also known
6 as a Bandl ring, versus a constriction ring, but
7 I do not make a distinction.

8 Q Thank you.

9 What is the basis of any knowledge you
10 have regarding -- and for our purposes, since
11 you do not make a distinction, I'll just call it
12 a Bandl ring. So the question -- is that all
13 right with you since you don't make a
14 distinction?

15 A Yes.

16 Q We'll just call a retraction ring, we'll call it
17 a Bandl ring.

18 So the question is: What is the basis of
19 any knowledge you have of the condition of a
20 Bandl ring?

21 A The basis?

22 Q Yes. Of your knowledge.

23 A Well, that's one reason why I brought this
24 particular article. I first learned about a
25 Bandl ring, or pathological retraction ring,

1 when I was a resident.

2 In one of the references that I used when
3 I was a resident was this book, Human Labor and
4 Birth, which I gave you a copy of the relevant
5 pages. And that was published in 1975. So I
6 started my residency in 1979, and so I have had
7 knowledge of this particular condition since I
8 was a resident. So about 20 some -- 20-plus
9 years, 25 years.

10 Q So you're telling me you first heard of a Bandl
11 ring back in 1975 when you were a resident; is
12 that correct?

13 A Yes.

14 Q Okay. Other than hearing of it at that time --
15 and did you read this portion of the Human Labor
16 and Birth on a Bandl ring at that time?

17 A I'm sure I did.

18 Q Okay. Other than that, I'd like to understand
19 better your knowledge and experience with a
20 Bandl ring.

21 So let me ask you specifically: Have you
22 ever managed a pregnancy where one occurred?

23 A When I was a resident. And that was the last
24 time.

25 Q Okay. And you were a resident during what

1 years?

2 A From 1979 to about 1982.

3 Q Okay. So I take it then -- well, I should ask:
4 In that particular matter that you're referring
5 to, were you present for delivery, if you can
6 recall?

7 A Yes.

8 Q All right. And what --

9 A Probably on several occasions I can recall, not
10 specifically, but several times that we ended up
11 doing a C-section for, quote, CPD and it was
12 actually a Bandl ring that was causing the
13 problem.

14 Q Where did you do your residency?

15 A University of Illinois, Peoria, at the
16 St. Francis Medical Center.

17 Q How many cases did you -- how many different
18 pregnancies was there a Bandl ring when you were
19 a resident?

20 A Probably at least two or three, or maybe more.
21 Back then we did not use Pitocin like Pitocin is
22 being used now. We also used buccal Pitocin. I
23 don't know if you know what that is.

24 Q No. What's that?

25 A Buccal Pitocin is Pitocin pills in which they

1 are placed within the cheeks of the mother. You
2 would give her three, four, five, six.
3 Sometimes she even looked like a chipmunk.

4 Q I was going to say, "Which cheeks, Doctor?".

5 Mouth. Okay. I'm sorry.

6 A But that practice has long been gone.

7 MR. MISHKIND: Off the record.

8 (Off the record.)

9 A And let me finish my answer.

10 And also back when I was a resident, we
11 did not really use internal monitoring because
12 it was not really available to us back at that
13 point in time.

14 Q Okay. So of the two or three or maybe more
15 Bandl ring cases that you were aware of when you
16 were a resident, the specific question is: Were
17 you ever present for delivery? You said you
18 recall one where there was a C-section; is that
19 correct?

20 A One or more.

21 Q One or more.

22 Do you have any specific memory of the
23 other one that was a C-section?

24 A I think they were all C-sections because we had
25 ended up doing a C-section and we thought we

1 were doing a C-section for a cephalopelvic
2 disproportion, but it was actually for a Bandl
3 retraction ring.

4 Q Do you have a memory of actually seeing the
5 rings?

6 A I have an impression. I don't have an exact
7 memory of the particular patient.

8 Q You have not written on the topic, correct?

9 A Correct.

10 Q And so it's fair for us to understand that you
11 have not managed a patient in your private
12 practice who went on to have a Bandl ring at the
13 time of delivery. That's a fair statement?

14 A That's correct.

15 And just like what Williams Obstetrics
16 said, it's very unusual to even see this unless
17 the labor has been obstructed.

18 Q Have you ever attended a seminar on the topic?

19 A No.

20 Q How rare, then, is it, Doctor, a Bandl ring?

21 A It's very unusual to see any nowadays. I want
22 to say -- nowadays, I'm talking within probably
23 the last ten, 15 years. The cases I mentioned
24 to you when I said as a resident, it was, I
25 would think, fairly common. And not one percent

1 but, I mean, it would not be unusual in a large
2 hospital to see a case of that type during a
3 period of a year.

4 Q Are you saying at that period of time or now?

5 A At that period of time.

6 Q Okay. When you were a resident?

7 A When I was a resident.

8 Q Where was the Bandl ring located in Kelly
9 Fiktus, if you know?

10 A Just above the lower uterine segment.

11 Q When did it develop?

12 A When?

13 Q Yes.

14 A Progressively during the course of her labor. I
15 don't know if you want me to get into it now, or
16 I don't know if you want me to go through the
17 strips later or whatever but --

18 Q I want to know to the best that you're able to
19 tell me, and if you can't tell me, then tell me
20 that as well, but if you have opinions as to
21 when the Bandl ring developed, I want to know
22 when you believe that occurred.

23 A Well, let me put it this way: A Bandl ring
24 develops over a course of a period of time. I'm
25 fairly certain that the ring was not present

1 before the start of the Pitocin.

2 Q What's your basis for saying that?

3 A Because there was no evidence of
4 hyperstimulation, hypertonus prior to that. And
5 one of the causes of a pathologic retraction
6 ring is the use of Pitocin causing
7 hyperstimulation and hypertonus. And we knew
8 that back in 1975. That's also included in that
9 reference.

10 Q You've just held up, again, two pages from the
11 Human Labor and Birth, 3rd edition. And can you
12 tell me, and point it out to me, if you would,
13 where it says here that either Pitocin and/or
14 uterine hyperstimulation causes a Bandl ring?

15 A On page 476, bottom of the page. Causes
16 include: One, intrauterine manipulation.

17 Q I want to make sure I'm with you, Doctor. I'm
18 looking here at this paragraph (indicating).

19 A Yes.

20 Q Okay. It says, The constriction ring grips the
21 fetus tightly and prevents its descent. Then
22 it's dark on the page. What does it say next?

23 A No. No. Before that. There's four causes
24 which is listed.

25 Q Okay.

1 A Which are listed. One, intrauterine
2 manipulation; two, failed forceps; three, the
3 use of oxytocin when a uterus is hypertonic; and
4 four, spontaneous constriction ring which
5 usually occurs in a colicky uterus.

6 Q What's a colicky uterus?

7 A A uterus which is hyperirritable, having a lot
8 of uterine activity.

9 Q Okay. Other than this source that you're
10 referring to, have you ever seen it written
11 anywhere else that the use of oxytocin when a
12 uterus is hypertonic can cause a Bandl ring?

13 A The use of oxytocin? Not necessarily the use of
14 oxytocin, but when there's an obstructed labor.

15 Q Well, let's go back to my question. The
16 question is: Other than this one article from
17 Human Labor and Birth, I'm asking you have you
18 ever seen it written anywhere in the literature
19 that the use of oxytocin when the uterus is
20 hypertonic can be a cause of a Bandl ring?

21 A Other than this one, no.

22 Q And you've never personally experienced it
23 yourself?

24 A Not since I was a resident, no.

25 Q And when you were a resident, you didn't use

1 Pitocin?

2 A No. We used Pitocin. We used it differently
3 than we do nowadays.

4 Q You called it Buck Pitocin?

5 A Buccal, B-U-C-C-A-L, Pitocin. Also, we used IV
6 Pitocin but not with the method that we now use.

7 Q Well, how is it different? You said IV Pitocin
8 but it's different. How is it different?

9 A It would have been very unusual. We did not use
10 internal monitors to monitor a patient who is
11 being induced, or augmented Pitocin or Pitocin.

12 Our protocol usually started at one
13 milliunit, double the dose every ten minutes.
14 So we have had patients on 80 milliunits, 160
15 milliunits. That was standard back then to give
16 Pitocin, which nowadays it's not.

17 Q You're saying in the past they used to put
18 patients on 180 milliunits of Pitocin?

19 A They would -- what we would do is start at one
20 milliunit, double it every ten minutes until the
21 uterus is contracting every two to three
22 minutes.

23 Q And it could go as high as 180 milliunits?

24 A I've seen it real high.

25 Q Okay. Okay.

1 Would you agree with me that the cause of
2 a Bandl ring is not well understood in the field
3 of obstetrics and gynecology, in medicine in
4 general?

5 A No, I wouldn't say that.

6 Q Why do you say that it is? Do you think it's
7 well understood?

8 A I think it's well understood that uterine
9 hyperactivity, either hyperstimulation or
10 uterine hypertonus, or a combination thereof,
11 result in the ring, particularly if there's any
12 other reason for the labor being obstructed.

13 Q Are you making a differentiation between
14 hyperstimulation and hypertonus?

15 A They are two different ways to describe uterine
16 activity.

17 Q Okay. And the uterine activity that you're
18 referring to is what?

19 A Contraction and the resting tone in between the
20 contractions.

21 Q So you believe it's well understood as to the
22 cause of a Bandl ring in today's medical
23 literature?

24 A I think -- I think the Williams Obstetrics, in
25 their one paragraph, more or less summarizes

1 that idea.

2 Q All right. Let's turn to that. Can you point
3 that out to me, Doctor? Under which paragraph?

4 A Under the paragraph, Pathologic retraction ring.

5 Q Yes.

6 A And I can read this into the record. It's
7 pretty short. Very rare that localized rings of
8 constriction of the uterus develop an
9 association with prolonged labors. The most
10 common type is the pathologic retraction ring of
11 Bandl, an exaggeration of the normal retraction
12 ring described in Chapter 11. It is often the
13 result of obstructed labor with marked
14 stretching and thinning of the lower uterine
15 segment.

16 In such a situation, the ring may be seen
17 clearly as an abdominal indentation and
18 signifies impending rupture of the lower uterine
19 segment. Localized uterine constrictions are
20 rarely seen today because prolonged, obstructed
21 labor is unacceptable.

22 These may still occur occasionally as
23 hour-glass constrictions of the uterus following
24 birth of the first twin. In such a situation,
25 they can sometimes be relaxed and delivery

1 effective, if appropriate general anesthesia,
2 but occasionally prompt cesarean delivery offers
3 a better prognosis for the second twin.

4 Q I appreciate you reading that paragraph, but is
5 it your testimony that it is well understood as
6 to what occurs in obstructed labor to cause a
7 Bandl ring?

8 A I think this paragraph lays it out pretty well.

9 Q Could you answer that question, sir? Could you
10 repeat it for me?

11 A Yes.

12 Q And what is it that occurs in obstructed labor
13 to cause an -- -

14 A An exaggeration of the normal retraction ring.
15 That's what it states.

16 Q And what is it that causes an exaggeration of
17 the normal retraction ring? What is well
18 understood in medicine today to cause that?

19 A An obstructed labor.

20 Q And what is it about an obstructed labor that
21 causes the Bandl ring?

22 A Increased uterine activity, either
23 hyperstimulation, hypertonus, or both.

24 Q Isn't it your testimony that a Bandl ring will
25 always occur when there is a prolonged labor?

1 A No.

2 Q And it's very rare for that to occur, as a
3 matter of fact, isn't it, for a Bandl ring to
4 occur?

5 A It would be very unusual, yes.

6 Q Now, it's your testimony that Kelly Fiktus'
7 Bandl ring was detectable at any time?

8 A No. That's not my testimony.

9 Q Okay. Let's me see if I have your opinions
10 correct regarding the cause of Jacob Fiktus'
11 cerebral palsy.

12 From reading your report, am I
13 understanding you to say, and I'm just taking
14 this right from your report, and I want to make
15 sure I have your testimony understood, the use
16 of oxytocin, or in the form of Pitocin, caused
17 uterine hyperstimulation which, in turn, caused
18 an umbilical cord compression which, in turn,
19 caused an intrauterine hypoxia and ischemia; is
20 that correct?

21 A Yes.

22 Q Okay. Do you believe that the intrauterine
23 hypoxia and ischemia was an acute, intrapartum
24 hypoxic event sufficient enough to cause
25 cerebral palsy?

1 A No.

2 Q What caused the cerebral palsy?

3 A The ischemia from the umbilical cord compression
4 and a traumatic injury to the baby from the
5 ring.

6 Q Together?

7 A Together.

8 Q Okay. So the ischemia, you believe, contributed
9 to the cerebral palsy. What caused the
10 ischemia?

11 A Umbilical cord compression.

12 Q So that I have your testimony clearly, you're
13 saying that the umbilical cord compression
14 together with the Bandl ring caused an
15 intrapartum hypoxic event sufficient enough to
16 cause cerebral palsy?

17 A No. No.

18 Q Then please explain it to me. I thought I took
19 it right from your report.

20 A No. It is my opinion that the injury to the
21 baby was not the cause of intra -- not a result
22 of intrauterine hypoxia. The result of the
23 baby's injury was from the ischemia and the
24 pathologic retraction ring.

25 Now, on the fetal monitor, the baby had

1 evidence of intrauterine hypoxia, which was
2 temporary, and the heart rate came back to
3 normal. But I'm not saying the baby had hypoxic
4 injury intrapartum.

5 Is that clear?

6 Q Let me see. Hold on one minute.

7 A Let me read it to you again. And I know you
8 have it in front of you.

9 Q Hold on. Actually, I don't.

10 A This is from my report.

11 Q Okay. Go ahead. The second paragraph?

12 A Yes. The uterine hyperstimulation caused
13 umbilical cord compression. This caused
14 intrauterine hypoxia and ischemia resulting in a
15 nonreassuring fetal heart rate tracing. There
16 were several episodes on the strip of
17 bradycardia from cord compression and transient
18 hypoxia.

19 The uterine hyperstimulation also caused a
20 pathologic uterine retraction. The Bandl ring,
21 the pathologic retraction ring, contributed to
22 the baby's injuries as evidenced from the
23 medical records.

24 And maybe it was not clear. I'm not
25 contending that this baby had hypoxic injury

1 from intrapartum hypoxia. The cord gases were
2 normal. The Apgar, which was, I believe seven,
3 was reassuring. But the distinct injury that
4 the baby had was from trauma and from ischemia,
5 or a combination thereof, not from hypoxia.

6 Q How are you defining ischemia?

7 A Ischemia is decreased blood flow to the baby.
8 And the blood flow that goes to the baby could
9 be well oxygenated, it's just that the amount of
10 blood flow, like from a cord compression, is not
11 sufficient to give the baby enough blood to
12 abstract enough oxygen. Not hypoxia.

13 Q Well, did the cord compression cause any injury
14 to Jacob?

15 A I believe that the baby had injuries. And I'm
16 probably going to defer specifically to a
17 pediatric neurologist on this, but I think the
18 combination of the cord compression and the
19 pathologic retraction ring resulted in injury to
20 the baby.

21 As a basis for that opinion, I refer to
22 Volpe's Neurology of the Newborn, 3rd edition,
23 1995, on page 4715.

24 Q Okay. Where?

25 A Let me direct you to under the paragraph, Labor

1 and delivery.

2 Q Yes.

3 A About eight, nine lines down. There's a
4 sentence which starts indeed?

5 Q Yes.

6 A And I'll read that into the record. Indeed, the
7 deleterious effects of labor appear to be most
8 pronounced in a most premature infant. The
9 skull deformation can lead to obstruction of
10 major venous sinuses and presumably increased
11 venous pressure. Then they go on. I won't read
12 the rest of the paragraph. It's very wordy.
13 There's a connection between that type of injury
14 to the baby and intraventricular hemorrhage.

15 Q Now, tell me, though, what is your basis for
16 saying that the first -- tell me what your basis
17 is for saying there was a cord compression.

18 A The fetal heart rate tracing.

19 Q What is your basis for saying that the fetal
20 heart rate tracing is a result of cord
21 compression as opposed to solely the presence of
22 the Bandl ring?

23 A If it was just the Bandl ring itself, that would
24 not show up on the fetal monitor tracing as any
25 nonreassuring fetal heart rate tracing.

1 Q Why do you see that? What's the basis of that?

2 A Because there is -- retraction ring is on the
3 baby's head. It's not insufficiency. It's not
4 umbilical cord compression. Those two things --
5 uteroplacental insufficiency may result in
6 repetitive, late decelerations. Cord
7 compression would result in variable
8 decelerations.

9 Just having a retraction ring would not
10 give you either one of those unless there was
11 something else, such as cord compression. And
12 if there's enough uterine activity which causes
13 the retraction ring, eventually, and even in
14 normal labors, you would get some cord
15 compression.

16 The sudden drop in the fetal heart rate,
17 as evidenced on the fetal monitor tracing, is,
18 in my opinion, secondary to cord compression.

19 Q Because you're saying it has to come from the
20 umbilicus. That has to be the tracing that you
21 see.

22 Can the only source of the tracing, the
23 resulting tracing that we see, is the only way
24 that that can be demonstrated is a cord
25 compression?

1 A That's correct. Because, in general, there's
2 two types of decelerations that we see the a
3 course of a labor: Late decelerations, which
4 reflect uteroplacental insufficiency, and that's
5 not evidenced here; and variable decelerations,
6 which reflect umbilical cord compression.

7 Q So to go back. With respect to your opinion, I
8 still want to make sure that I understand what
9 you're saying with respect to what you believe
10 was a cord compression and as to any causative
11 effect it had on Jacob with respect to his
12 cerebral palsy.

13 Are you saying that cord compression
14 existed and that it caused his cerebral palsy?

15 A That would be a question to direct to a
16 pediatric neurologist.

17 Q Okay.

18 A I'll give my obstetrical causation opinions. As
19 far as specifically the injuries to the baby, I
20 would direct that to a pediatric neurologist.

21 Q So by what you just said, you are not offering
22 an opinion in this matter as to whether or not
23 the cord compression, which you believe did
24 occur in this case, whether or not that caused
25 Jacob -- or contributed to Jacob's cerebral

1 palsy?

2 A It could have, it may not, but I would defer
3 that to a pediatric neurologist.

4 Q So to that extent, you're not offering an
5 opinion on that matter?

6 A That's correct.

7 Q Okay. As an OB/GYN and a maternal-fetal
8 medicine physician, then, let me ask you the
9 other side of the causation question, which is
10 the Bandl ring. Because you said before this
11 cord compression and there's also obviously the
12 presence of the Bandl ring.

13 What, in your opinion, if any, injury did
14 the presence of the Bandl ring cause to Jacob?

15 A Well, I don't have any opinions on that because
16 I think the medical records speak clearly to
17 that issue.

18 From my interpretation in reading the
19 medical records, it appears that the
20 intraventricular hemorrhage, and other injuries
21 which occurred to the baby, was a direct result
22 of the Bandl retraction ring.

23 I believe Dr. Friedman has said that in
24 several letters. It's written in the medical
25 records. There are diagrams of the baby that

1 the neonatologist, and other members, actually
2 drew in the chart to show the effect of the ring
3 on the baby's head.

4 Q Well, with respect to when you say the
5 intraventricular evidence, I want to ask you
6 specifically so that I understand, what
7 resulting injuries are you saying was caused by
8 the presence of the Bandl ring?

9 A I think -- I mean, from my interpretation of the
10 pediatric records, all the injuries of the baby
11 was a result either/or, or a combination
12 thereof, of the Bandl ring and umbilical cord
13 compression as a contributing factor.

14 Q Have you seen the MRI of 1998, October 1998? He
15 was about ten months old at the time.

16 A No.

17 Q You've not actually seen the film?

18 A No, I have not.

19 Q Did you read the report?

20 A I probably did if it's in my records.

21 Q A letter of Dr. Friedman includes a finding that
22 Jacob suffers from PVL, periventricular
23 leukomalacia. I believe it's an October 16th
24 letter. In the first paragraph.

25 A I see it.

1 Q Can you turn to the CAT scan that was taken on,
2 I believe, the 24th or 25th of 1997 in your
3 records there?

4 A Without me going through 1,000 pages --

5 Q Do you want me to see if I can help?

6 MR. MISHKIND: To save some
7 time.

8 MS. ROLLER: Yes. Sure.

9 Q I'll put it in front of you, Doctor.

10 A Yes, I've seen that.

11 Q Okay. Would the findings of Dr. Friedman
12 relate -- that he sees from the MRI brain scan,
13 including the periventricular leukomalacia, be
14 consistent with the findings on the CAT scan?
15 And I make note that there was found global
16 decreased attenuation within the white matter of
17 the cerebral hemisphere.

18 MR. MISHKIND: Objection.

19 A You are asking me a question outside of the
20 scope of my expertise.

21 Q Okay. You can't say one way or the other?

22 A I'm not an expert on reading MRIs or CT or
23 interpreting the reports.

24 Q All right. Fine.

25 Were there hypoxic events or hypoxia

1 occurring during Kelly's labor for the fetus?

2 A As I mentioned previously, there was, I believe,
3 two or three episodes of fetal bradycardia that
4 reflected hypoxia at that time, but it was a
5 short-term event, the baby's heart rate
6 recovered back to normal baseline. And I do not
7 believe the fetus sustained any injury from
8 that, or those episodes from hypoxia.

9 Q I guess to be specific, do you have the tracings
10 in front of you, Doctor?

11 A Yes.

12 Q You believe uterine hyperstimulation occurred in
13 this case, correct?

14 A Yes.

15 Q Okay. There's two things I want you to do for
16 me, and if we can do them at the same time,
17 that's fine; if not, let me know. I'd like you
18 to tell me when the uterine hyperstimulation
19 occurred and when you believe those two to three
20 episodes of hypoxia occurred.

21 A Okay. I can -- probably the best way to do this
22 is I can just take you through the strip --

23 Q Okay.

24 A -- verbally.

25 Q And I'd like you to use -- and I brought an

1 extra copy of the tracings. If you could mark
2 it just with the yellow marker for me, we'll
3 mark these tracings as Exhibit B.

4 A I usually don't mark on the strips.

5 Q No. This is an extra copy.

6 A I usually don't mark on any strips. I'm giving
7 you my verbal testimony concerning the tracings.

8 Q Okay. How about -- well, we'll go along and if
9 you tell me something, I'll put a yellow line on
10 the strip.

11 A That's fine.

12 MR. MISHKIND: Okay.

13 MS. ROLLER: Let's mark this
14 Exhibit B, please.

15 - - - - -

16 (Defendant's Exhibit B was marked.)

17 - - - - -

18 Q First, with respect to either one, I don't care,
19 the period of hyperstimulation or the period of
20 hypoxia.

21 A What I'm going to do, I'm just going to take you
22 chronologically for each strip. It might be
23 easier. Starting at about 1:00 when the Pitocin
24 was started.

25 Q Are you going to be using military time or you

1 said 1:00.

2 A Let's use military time.

3 Q Okay. Let me make sure I'm on the same page as
4 you. Does it start -- yeah.

5 A So I'm looking at the strip starting at 1251 on
6 11-24, 1997.

7 Q All right.

8 A And the Pitocin was started at approximately
9 1300.

10 Q All right.

11 A At 1300, when I look at the strip, I see a
12 reassuring fetal heart rate tracing. I see
13 uterine contraction occurring approximately
14 every -- about every four minutes, but this is
15 an external monitor, both for the uterine
16 contractions and for fetal heart rate activity.

17 The first place that I can see uterine
18 hyperstimulation on the strip is starting at
19 approximately 1355.

20 Q Okay.

21 A There are contractions occurring about every
22 minute. This would meet the criteria for
23 uterine hyperstimulation, either -- using the
24 criteria of uterine contraction, less than every
25 two minutes or more than five in a ten-minute

1 window.

2 At this point in time -- by at least this
3 point in time, the doctor, doctors, and/or the
4 nurses, or both, should have instituted internal
5 monitoring consisting of the intrauterine
6 pressure catheter and the fetal scalp electrode.

7 MR. FARCHIONE: I'm sorry to
8 interrupt. I did not catch that. You defined
9 hyperstimulation. I think you said contractions
10 less than every two minutes and something else.

11 THE WITNESS: Or more than
12 five contractions between -- within a ten-minute
13 window.

14 MR. FARCHIONE: I thank you very
15 much. I'm sorry to interrupt.

16 Q Okay. Go ahead. You said you felt an IUPC
17 should have been --

18 A And fetal scalp electrode in order to gauge the
19 uterine activity in response to the fetus.

20 And if that was done, it's my opinion not
21 only would we affirm uterine hyperstimulation,
22 but we would also see uterine hypertonus. And
23 uterine hypertonus is defined as a resting
24 baseline of more than 20 millimeters of mercury
25 when the mother is on oxytocin.

1 So it would have been, on impression, by
2 approximately 1400, or 2:00 in the afternoon,
3 that there was both hyperstimulation and uterine
4 hypertonus.

5 Q How is that 20 millimeters of mercury measured?

6 Do you use the IUPC?

7 A The intrauterine pressure catheter.

8 Q Okay.

9 A And it's my opinion if that would have been
10 verified at that point in time, the Pitocin
11 should have been discontinued.

12 Q At what time?

13 A At 1400, or thereabouts.

14 And I continue to look at the monitored
15 tracing, because there was not an intrauterine
16 pressure catheter at that point in time, I
17 cannot tell you if there was uterine hypertonus,
18 but more likely than not it probably was
19 present.

20 Q Well, let me ask you this: You said, if I am
21 recalling your testimony correctly, you felt
22 that uterine hyperstimulation began around 1355?

23 A Yes.

24 Q Do you see it ending after that point?

25 A No.

1 Q At any time?

2 A Later on in the strips when the Pitocin was shut
3 off, the uterine activity, the contractions
4 appeared to be decreasing.

5 Q All right. When do you see that occurring?

6 A The first time I can see that occurring after
7 the Pitocin was initiated would have been around
8 2005.

9 Q It's your --

10 A And I'm talking about uterine hyperstimulation.

11 Q It's your testimony that Kelly Fiktus had
12 uterine hyperstimulation from 1355 to 2005
13 without interruption?

14 A Yes.

15 Q Did it recur, uterine hyperstimulation? And let
16 me back up and sort of withdraw that question.

17 You're using the definition that you
18 already put on the record for uterine
19 hyperstimulation. And you're saying that
20 occurred throughout that period of time?

21 A Yes.

22 Q Okay.

23 A And then starting at approximately 2115, there
24 appears to be a return of uterine
25 hyperstimulation. And that continues to the end

1 of the strip.

2 Q The last time that you have on the end of the
3 strip is what, Doctor?

4 A 2244.

5 Q Okay. I think it's on the next page, 2245?

6 A 2245.

7 Q Okay. Again, using that same definition for
8 uterine hyperstimulation, you believe it was
9 occurring from 2115 to 2245?

10 A Yes.

11 Q Okay. Now, how about the fetal heart rate
12 tracings in this strip that you have in front of
13 you that we've marked Exhibit B, do you see
14 periods of -- the term you used was hypoxia
15 earlier. I mean, do you see that occurring in
16 this tracing?

17 A I believe I said there was two or three episodes
18 of bradycardia which reflects transient hypoxia
19 at that stage.

20 Q Let's use bradycardia.

21 First of all, let's put your definition of
22 bradycardia on the record.

23 A A baseline below 110 beats per minute.

24 Q For how long?

25 A Baseline can be -- I've seen various

1 definitions. Three minutes, five minutes, at
2 least.

3 Q Did Jacob Fiktus' baseline change at any time?

4 A From the tracing that we have it appears to.

5 Q Okay. First, let's do that. Let's --

6 A Can I interrupt you?

7 Q Sure. Of course.

8 A Are we going to come back to uterine activity
9 because we're not done with that.

10 Q Okay. I thought you had indicated throughout
11 this tracing where you saw --

12 A Uterine hyperstimulation, but I did not talk
13 about uterine hypertonus.

14 Q All right.

15 A We can do that now or we can do it later.

16 Q Since we're talking about it, let's do it now.

17 Where do you see uterine hypertonus?

18 A The uterine hypertonus can only be detected --
19 you can sense it clinically, but if you want to
20 objectively define it, the patient would have to
21 have an intrauterine pressure catheter placed.
22 And she had an intrauterine pressure catheter
23 placed at approximately 1600.

24 Q And from that can you determine whether or not
25 uterine hypertonus occurred?

1 A And from that point in time until almost the
2 entire strip, the resting tonus exceeded 20
3 millimeters of mercury for the great majority of
4 the time.

5 Q Can you show that to me and point that out to me
6 as I'm looking over your shoulder here?

7 A This line is 25 millimeters of mercury and it
8 never dips, except occasionally, below that
9 level, except for occasionally. If you look at
10 the majority of the strip, it's above 20
11 millimeters of mercury.

12 Q And is there a time measurement for hypertonus?
13 You know, in order to qualify as hypertonus, it
14 has to be greater than 20 millimeters of mercury
15 for three to five, ten minutes?

16 A No. Hypertonus is the resting baseline in
17 between contractions that exceeds 20 millimeters
18 of mercury.

19 Q Okay.

20 A And now you want me to do the fetal heart rate?

21 Q Would you, please, for bradycardia.

22 And though we are jumping around a little
23 bit, I had asked you if the baseline changed at
24 any time. You said you thought it did. Can you
25 tell me what it was and when it changed?

1 A Well, the baseline changed when it goes from
2 normal baseline to bradycardia. You're asking
3 me at those points, right?

4 Q Did it change at any other time other than when
5 it was at bradycardia?

6 A Not significantly. The baby's heart rate, if
7 it's between 110, 160 baseline, that's a normal
8 baseline.

9 Q So the only time you believe that it changed the
10 baby's --

11 A Changed significantly when it went from normal
12 baseline to bradycardia. And it appears to be
13 at around 1920, 25. There appears to be a drop
14 to bradycardia.

15 Q Is it that period of time that you're referring
16 to 1920 to 1925?

17 A Starting at that period of time.

18 Q Well, wait a minute. That's several minutes.
19 When are you saying the period of bradycardia
20 starts?

21 A Well, I can't give you precisely because this is
22 an external monitor and it's not tracing the
23 fetal heart rate, but it appears -- the start of
24 it appears to be somewhere between 1921 and
25 1925. Some of the tracing is missing. And then

1 the baseline appears to be about 90 to 100 beats
2 per minute. From that time until it returns to
3 the baseline, the normal baseline, at around
4 1936.

5 Q Is there another period of bradycardia that you
6 see, Doctor?

7 A And then at around 2100, the fetal heart rate
8 drops. And it appears to be a baseline of about
9 90 to 100 beats per minute.

10 Q From 2100 until when, Doctor?

11 A Until about 2118. And there appears to be
12 another episode starting at approximately 2143,
13 and the baseline is returned by 2150.

14 Q Any other periods of bradycardia that you see?

15 A No.

16 Q Okay.

17 MS. ROLLER: Just let the
18 record reflect I've just put a hash mark on
19 those times that you've called out as when you
20 see fetal bradycardia.

21 MR. MISHKIND: And the record
22 should reflect that you're doing it independent
23 of -- you're doing things and he's telling you,
24 so it's not that you're working like a
25 well-tuned machine.

1 MS. ROLLER: So we'll make
2 sure that occurs.

3 Q Doctor, you indicated uterine -- we'll go back
4 to uterine hyperstimulation.

5 You said it began at 1355. And I put a
6 "UT" there. Do you see that? Do you see the UT
7 in yellow?

8 A Yes.

9 Q Until 2005. And I put that down here with a
10 hash mark to indicate UT. Do you see that I've
11 just written that in yellow?

12 A Yes.

13 Q And then on 215 -- I'm sorry. 2115, another
14 hash mark down at the mother's tracings. Do you
15 see that?

16 A Yes.

17 Q And you said until the end, until 2245, correct?

18 A Yes.

19 Q And that's right at the very end. And I put
20 another UT there, correct?

21 A Yes.

22 Q And then of course with the fetal bradycardia,
23 just to go through it, you said it began at 1921
24 through 1936. And it began somewhere between
25 1921 and 1925. And I put a yellow hash mark

1 right there, correct?

2 A Yes.

3 Q Indicating it went from that period through, as
4 you indicated, 1936?

5 A Yes.

6 Q Okay. And then the next time was 2100. And we
7 put that at the top of the strip to indicate
8 that period of time, correct?

9 A Yes.

10 Q To 2118. I put a line there to indicate the
11 ending point --

12 A Yes.

13 Q -- for that period.

14 And then the last one was 2143 through
15 2150 you indicated.

16 A Yes.

17 Q Okay. So does Exhibit A -- excuse me. Exhibit
18 B reflect the period of uterine hyperstimulation
19 and fetal bradycardia that you see in this
20 tracing --

21 A Yes.

22 Q -- as indicated by the yellow markings on it?

23 Other than the tracings, the fetal heart
24 rate tracings, do you have any other evidence of
25 cord compression?

1 A I believe there's some notation of the fetal
2 heart rate dropping in the nurse's notes and in
3 the progress notes.

4 Q But my question, I guess, relates not so much as
5 to other notations of the fetal heart rate
6 tracings, but other than the fetal heart rate
7 tracings and notations about the fetal heart
8 rate tracings, do you have any other independent
9 basis for your opinion that there was a cord
10 compression?

11 A Other than my knowledge, my training, my
12 experience, no.

13 Q Okay. Regarding the standard of care in this
14 case, who, in your opinion, breached the
15 standard of care owed to Kelly Fiktus and/or
16 Jacob?

17 A The attending staff. And that would be Dr. Kiwi
18 and Dr. Loret de Mola. The resident staff,
19 which would include Dr. Wang, Dr. McHugh, and
20 the labor and delivery nurses attending to the
21 patient during the relevant period of time.
22 That's, in my opinion, from 1:00 in the
23 afternoon of delivery until time of delivery.

24 Q I'll get back to ask you specific questions
25 about them. But let me ask you in general, did

1 Kelly Fiktus reach the active phase of the first
2 stage of labor?

3 A If you -- it's hard to define in a patient who's
4 premature because she was 34-plus weeks. In a
5 term patient, once she reaches four centimeters
6 dilated, she is considered to be in active
7 phase.

8 To my knowledge, there's no defined
9 criteria for pregnancies which are not term, but
10 she did reach four to five centimeters dilated
11 in the afternoon of, I believe, the 24th.

12 Q So your testimony is that she did reach the
13 active phase?

14 A Yes.

15 Q Let's be a little more precise. Can you tell me
16 when that was by the records in this case?

17 For convenience sake, I have an extra copy
18 of the labor flow sheet if you just --

19 MR. MISHKIND: He's got it.

20 Q You've got it?

21 MR. MISHKIND: Yes.

22 A Yes.

23 MR. MISHKIND: What was your
24 question now?

25 MS. ROLLER: When did she

1 reach the active phase?

2 A Some time between, using the usual definition,
3 some time between 1935 and 2113.

4 Q And you're basing that on the labor flow sheet?

5 A Yes.

6 Q Okay. Doctor, do you agree that the term
7 failure to progress is not a precise term?

8 A Yes.

9 Q When I say "ACOG", you know what I mean, right?
10 American College of Obstetrics and Gynecology?

11 A Yes.

12 Q ACOG has concluded the more practical
13 classifications are protraction disorder and
14 arrest disorder. Do you recognize those terms?

15 A Yes.

16 Q And protraction disorder means slower than
17 normal process and arrest disorder is cessation
18 of the process. Do you use those terms?

19 A I have in the past, yes.

20 Q Do you agree the woman must be in the active
21 phase of labor to diagnose either of those
22 conditions, either protraction disorder or
23 arrest disorder?

24 A A term patient would have to be in active labor.

25 Q What about a preterm patient?

1 A I don't think it's well-defined.

2 Q It's not well-defined?

3 A No.

4 Q So does that mean you cannot say one way or the
5 other as to whether a woman must be in the
6 active phase of labor if she is preterm in order
7 to diagnose her as having a protraction disorder
8 or an arrest disorder?

9 A I don't think we know.

10 Q Okay. Is it your testimony that Kelly Fiktus
11 had either a protraction or arrest disorder in
12 her labor in this case?

13 A She had some type of obstructed labor, either
14 from a fetopelvic disproportion or from
15 dysfunctional uterine activity, or a combination
16 thereof.

17 Q You said from cephalopelvic disproportion?

18 A Fetopelvic disproportion.

19 Q Excuse me.

20 Or from?

21 A Or a dysfunctional uterine activity.

22 Q But you would not call her labor pattern either
23 protraction or arrested. Fair to say?

24 A I would say that.

25 Q Do you see anywhere where Kelly Fiktus'

1 contraction pattern reached 200 Montevideo units
2 for more than a ten-minute period?

3 A I did not calculate that.

4 Q Take your time, Doctor.

5 A But I'm sure there are places that, if you count
6 the boxes, it would meet that type of criteria.

7 For example, not to belabor the point, but
8 you can only do it once the pressure catheter
9 had been placed.

10 Q Let's take it after that point then.

11 A And it was placed about four -- or 1600 in the
12 afternoon. If you look at that part of the
13 strip, starting at about 1603.

14 Q All right.

15 A It looks like, if you're just eyeballing the
16 series of three or four uterine contractions, it
17 appears that would meet 200 Montevideo units.

18 Q For a ten-minute period?

19 A Yes.

20 Q So tell me specifically where you're referring
21 to then.

22 A From 1603, for the ten minutes thereafter.

23 Q Okay. Any other time? I guess I should ask,
24 Doctor, at a point after which she had reached
25 four centimeters.

1 Let's go with any point after she reached
2 four centimeters, did she have 200 Montevideo
3 units for ten minutes or more? And as you said,
4 that period of time was 1935 to 2113.

5 A Perhaps at 2116 and in a ten-minute window
6 thereafter.

7 Q Until when, Doctor? Do you see it?

8 A From 2116 to ten minutes thereafter. So it
9 would be 2116 to 2126. But she's also having
10 uterine hyperstimulation and uterine hypertonus.

11 Q Any other period?

12 A And if you look at 2202, probably until 2226,
13 technically she would have had 200 units,
14 Montevideo units, but we have uterine
15 hyperstimulation and uterine hypertonus.

16 Q So you're saying from 2202?

17 A From 2202 until about 2226. Technically it's
18 probably 200 units, but realizing she has
19 uterine hyperstimulation and uterine hypertonus
20 occurring at the same time.

21 Q What significance is that to you?

22 A If the patient is having uterine
23 hyperstimulation and/or uterine hypertonus, it's
24 irrelevant concerning the issue of how many
25 Montevideo units are occurring.

1 Q Because?

2 A Because it's uterine hyperstimulation and
3 uterine hypertonus.

4 Q And why does that negate the consideration of
5 the strength of the contraction measured by
6 Montevideo units?

7 A Because the units are used to gauge if the
8 Pitocin is being effective and providing uterine
9 activity sufficient enough to have normal labor.
10 But in the presence of uterine hyperstimulation
11 and/or uterine hypertonus, the fact it's 200
12 units, it's nonsensical, because what's
13 important is the fact there's uterine
14 hyperstimulation and uterine hypertonus.

15 Q All right. Is it your opinion that Kelly Fiktus
16 should have been delivered earlier by C-section
17 than she was?

18 A It's my opinion that within the hour or so, I
19 believe I said around 2:00 in the afternoon, or
20 1400, when there appears to be uterine
21 hyperstimulation on the external monitor, the
22 doctors, the nurses, should have inserted the
23 internal monitors, they should have discontinued
24 the Pitocin and seen what occurred, or to affirm
25 there's uterine hyperactivity.

1 I have no problem stopping the Pitocin at
2 that point in time and restarting it at a much
3 smaller dose. But if after each initiation of
4 Pitocin, there's still hyperstimulation,
5 hypertonus at, say, one milliunit or a half
6 milliunit, this mother is not tolerating the
7 Pitocin. Therefore, we have two options: One
8 option is to allow her to labor spontaneously,
9 second option would be to deliver by cesarean
10 section.

11 In a premature baby at 34 weeks, we do not
12 want that baby's head pounded through the birth
13 canal with hyperstimulation and uterine
14 hypertonus because it can cause intraventricular
15 hemorrhage from trauma just from the excess
16 uterine activity. It can cause the presence of
17 Bandl retraction ring. It could cause a
18 nonreassuring fetal heart rate tracing either
19 from cord compression or uteroplacental
20 insufficiency. It may cause problems to the
21 mother, may cause rupture of the uterus because
22 of hyperstimulation, uterine hypertonus. All
23 those things are foreseeable. So if she could
24 not spontaneously labor on her own, then it may
25 have been necessary to do a cesarean section.

1 Q Okay. Thank you for all that, and I do
2 appreciate that. You've said a lot. But I
3 still need to go back and get an answer to my
4 question.

5 A See, I can't answer your question because the
6 doctors and the nurses did not do what the
7 standard of care required them to do.

8 If they had put the internal monitors in
9 at 2:00, it's my opinion that the uterine
10 hyperstimulation and uterine hypertonus would
11 have been affirmed, and the doctors and nurses
12 had two options at that period of time: Stop
13 the Pitocin, restart it at a much slower dose
14 and see what happens. If it reoccurs, then the
15 decision tree would either be to don't use
16 Pitocin or do a cesarean section.

17 But since they didn't do what the standard
18 of care required them to do, you know, I have to
19 make my opinion based upon that period of time.

20 Q Now, there was a point in time when an IUPC was
21 inserted?

22 A Yes. At 1600. Which was about three hours
23 after Pitocin was started.

24 Q All right. It seems that your opinion here is
25 based upon the absence of an IUPC, that you said

1 I'm not able to say -- you're not able to answer
2 my question when I asked you should Kelly have
3 been delivered earlier. You said I can't say
4 because she didn't have an IUPC in when she
5 should have.

6 A Yes.

7 Q Once she had the IUPC inserted, is it your
8 opinion that Kelly Fiktus should have been
9 delivered by C-section earlier than she was?

10 A Same thing. At that point in time, when they
11 insert the pressure catheter, they should have
12 also inserted a fetal scalp electrode, they
13 should have stopped the Pitocin. They could
14 restart the Pitocin in a much lower dose. But
15 if hyperstimulation and/or hypertonus recur at a
16 much lower dose, two decision points, again,
17 either labor, no Pitocin; or do a C-section. It
18 has to be one or the other.

19 Q At that point in time when the decision --
20 you're saying you would have two options: Labor
21 without Pitocin or C-section?

22 A At that point in time.

23 Q What point in time are you referring to?

24 A Well, you asked me when the pressure catheter
25 was placed. I want to make it clear, I'm not

1 saying if they did it at -- if they put the
2 pressure catheter in at 1600, and put the scalp
3 electrode in, and did what I say the standard of
4 care -- I'm not saying they met the standard of
5 care at that time. They should have done it
6 three hours earlier because we had three hours
7 of continuous hyperstimulation and hypertonus
8 that contributed to the development of the Bandl
9 retraction ring.

10 Q Are you able to say, with any degree of
11 certainty, as to when injury occurred to Jacob
12 which resulted in his cerebral palsy?

13 A When the retraction ring occurred.

14 Q Are you able to say, with any degree of
15 certainty, as to when the retraction ring
16 occurred?

17 A Well, I can say this with a fair degree of
18 medical certainty. If the doctors and the
19 nurses would have inserted the internal monitors
20 at the appropriate time, no later than 2:00,
21 they would have determined that there's
22 hyperstimulation and hypertonus. And had they
23 acted accordingly, it's my opinion, even at that
24 point in time, the ring had not developed.

25 Now, the longer this process goes, the

1 more likely the ring is going to develop. And
2 because we don't have X-ray vision, I can't say
3 exactly when the ring developed. You can't see
4 inside the patient. But we know that it's a
5 result of an obstructed labor, or excess uterine
6 activity.

7 Q Doctor, I'm going to go back to my original
8 question. You see the records before you as to
9 what occurred in this labor, both with the
10 mother's contraction pattern and the fetal heart
11 tracing.

12 Based upon that evidence before you, is it
13 your opinion that based on what was occurring,
14 Kelly Fiktus should have been delivered, before
15 the time she was, by cesarean section?

16 A I thought I answered that.

17 Q I didn't get an answer.

18 A Let me -- I'll reiterate what I just said. The
19 standard of care for the doctors and the nurses
20 is to, at least by 2:00 p.m. in the afternoon,
21 to insert the pressure catheter and the fetal
22 scalp electrode. That's the standard of care.

23 Had they done that, it's my opinion they
24 would have seen that there is uterine hypertonus
25 and would have affirmed what the external

1 monitor showed, that there is uterine
2 hyperstimulation.

3 Seeing that, they should have discontinued
4 the Pitocin. And the option at that point in
5 time would have been to restart the patient on a
6 very low dose of Pit, or oxytocin; or deliver
7 her by cesarean section, or allow her to labor
8 spontaneously without Pitocin.

9 Q All right.

10 A The fact that they continued the Pitocin is what
11 caused the pathologic retraction ring. Had they
12 did the appropriate things at 2:00, we would
13 never have gotten to the point in time that the
14 ring developed.

15 Q Again, I appreciate what you're saying. And
16 you've added your analysis of causation with
17 respect to you think the Bandl ring occurred
18 after 2:00 and, therefore, none of this problem
19 would have occurred, in your opinion.

20 But, again, we see what did occur. You do
21 agree with me that the Pitocin was stopped and
22 was started and stopped three times. You agree
23 with that?

24 A Yes.

25 Q Okay. So you've indicated that the IUPC and the

1 fetal scalp electrode should have been placed
2 earlier than what they actually were. That's
3 your testimony?

4 A Much earlier, yes.

5 Q But you do agree that a decision was made to
6 stop Pitocin for a period of time, the first
7 time. And let's go to that.

8 When is that first time? 13 -- or 1730.
9 Do you see that?

10 A Yes.

11 Q Okay. So the Pitocin is turned off at that
12 time, correct?

13 A At 1730.

14 Q And, by the way, let me just ask you a couple
15 questions about Pitocin while we're talking
16 about this topic.

17 Was it appropriate to start Kelly Fiktus
18 on Pitocin when she was first started at 1355?

19 A Yes.

20 Q Do you have any quarrel with the dose at which
21 she was started?

22 A No.

23 Q Agree that's a low dose?

24 A Yes.

25 Q And you agree that low dose regimens have been

1 associated with lower incidents of uterine
2 hyperstimulation?

3 A Yes.

4 Q And certainly each patient's reaction to
5 oxytocin augmentation is different. You would
6 agree with that, wouldn't you?

7 A Yes.

8 Q Once the administration of Pitocin is stopped,
9 how long usually does it take until the Pitocin
10 no longer has an effect?

11 A Well, there's a half life, a very short half
12 life. But depends on the dose that was given at
13 the time and also depends on the individual
14 patient.

15 Technically, a half life is three minutes
16 but the activity may continue, the uterine
17 activity caused by the Pitocin may continue for
18 a much longer period of time after that.

19 Q Do you agree that if it's necessary to
20 discontinue Pitocin it may be restarted once the
21 fetal heart rate and uterine activity return to
22 acceptable levels?

23 A Yes.

24 Q Do you believe there was a breach in the
25 standard of care regarding the administration of

1 Pitocin in this case?

2 A Yes.

3 Q How, in particular?

4 A I'm not critical of the fact that Pitocin was
5 initiated. I'm not critical of the initial
6 dose. But I am critical of the nurses and the
7 doctors continuing the Pitocin when there is
8 evidence of uterine hyperstimulation and even
9 later on uterine hypertonus.

10 Q So the Pitocin was turned off at 1730, as we've
11 talked about. Was it inappropriate after 1730
12 to turn it back on?

13 A Well, I'm not saying because they turned the
14 Pitocin off at 1730 they met the standard of
15 care.

16 Q I understand. I understand.

17 But at 1730 it was turned off, correct?

18 A It was turned off, but I'm not saying that met
19 the standard of care. It would have been turned
20 off much earlier than that.

21 Q I understand.

22 But once it was turned off, do you have --
23 I want to know what your thoughts are regarding
24 turning it back on, which was at 1830.

25 A At 1830 they should not have restarted Pitocin.

1 Q Why?

2 A Because we have had hours and hours of uterine
3 hyperstimulation. We have had fetal bradycardia
4 episodes from that. The patient was not making
5 progress. This is a premature baby.

6 Q Okay.

7 A The better route is, and standard of care
8 mandates, that the patient be delivered by
9 cesarean section.

10 Q I think we're getting back to the question that
11 I had originally asked you.

12 My question was: Based upon the records
13 you have in front of you, is it your testimony
14 that there was a point at which Kelly Fiktus
15 should have been delivered by C-section at a
16 different time than what she was?

17 A There's a point, but the point is it doesn't
18 meet the standard of care. They should have
19 done it hours earlier.

20 MR. MISHKIND: You're right,
21 Doctor. But what she's saying is forget about
22 what they should have done earlier.

23 MS. ROLLER: Absolutely.

24 MR. MISHKIND: Is there a point
25 that a C-section should have been done given

1 what they did or didn't do before that?

2 MS. ROLLER: Right.

3 MR. MISHKIND: Correct?

4 MS. ROLLER: Right.

5 Q Based on this record.

6 A That's when they turned the Pitocin off the
7 first time. It should not have been
8 reinstigated. They should have delivered her by
9 cesarean section at that point in time.

10 Q All right. You had told me earlier that you
11 feel that the options would have been to turn
12 the Pit off and permit spontaneous labor or
13 C-section; is that correct?

14 A Are we talking about at 2:00 or 1400 in the
15 afternoon?

16 Q I want to talk about when they turned the
17 labor -- the Pitocin off, which was at 1730.

18 A At that point in time the only option is to do a
19 cesarean section.

20 Q Is it your testimony that a cesarean section
21 should have been performed before 1730?

22 A Yes.

23 Q When do you think a cesarean section should have
24 been done in this case?

25 A Well, I'll give you the same answer as I did

1 previously. At 1400 in the afternoon, they
2 should have put the internal monitors in and
3 more likely than not we would have seen
4 hyperstimulation, hypertonus even if they
5 restarted Pitocin at a very low dose.

6 And probably at that point in time,
7 somewhere around 2:00, or maybe from 2:00 to
8 3:00, the decision should have been made to do a
9 cesarean section. It depends on what showed up
10 after they turned off the Pitocin and did those
11 other things outlined earlier.

12 Q Okay. So that I understand, at that point in
13 time you're saying the IUPC and the fetal scalp
14 electrode should have been placed. When do you
15 think the decision for C-section should have
16 occurred?

17 In other words, if they had been inserted
18 at the time you think they should have, which is
19 about 2:00, what readings would you believe it
20 would indicate the need for C-section at that
21 time?

22 A If they did that at 2:00, they should have
23 discontinued Pitocin and then they could have
24 restarted the Pitocin at a lower dose. But it's
25 my opinion that even at a low dose, we would

1 have a return of hyperstimulation and hypertonus
2 even if they gave her a half milliunit.

3 And at that point in time, and that could
4 have been at 2:30, or 1430 or 1500, they would
5 probably have seen a need to do a cesarean
6 section because recurrence of the
7 hyperstimulation and hypertonus.

8 Q So it's your testimony that there was hypertonus
9 and hyperstimulation occurring at 2:00. If they
10 stopped the Pitocin, if they had the IUPC in,
11 the fetal scalp electrode in place and saw it
12 recur, a C-section should have been done at that
13 time?

14 A Yes.

15 Q Okay.

16 A And the only other option is, as I said, they
17 could see if she would labor spontaneously
18 without the use of any obstetrical agent. But
19 more likely she probably would not have labored.

20 Q How long would you have let her go, without
21 showing signs of progress, if she had labored
22 without Pitocin, stopping the Pitocin at about
23 2:00?

24 A If there's no increased uterine activity and the
25 fetal heart rate is suitable, several hours.

1 Q What's "several hours"?

2 A Two, three hours, see if she made any progress.

3 Q Okay.

4 MS. ROLLER: Let's take a
5 break.

6 MR. MISHKIND: Take a
7 couple-minute break, Joe.

8 (Recess taken.)

9 MS. ROLLER: Can you read
10 back the last question?

11 (Record was read.)

12 Q Doctor, Kelly Fiktus was a private patient on
13 Dr. Kiwi's service; is that correct?

14 A Yes.

15 Q And Dr. de Mola was part of that service?

16 A That's my understanding.

17 Q Who had the ultimate responsibility to make the
18 decision of when to have a C-section on this
19 patient?

20 A The attending physicians, either Dr. Kiwi or
21 Dr. Loret de Mola.

22 Q Could a C-section have been performed on Kelly
23 Fiktus without either Dr. Kiwi or Dr. de Mola's
24 approval?

25 A Probably not.

1 Q Okay. Does uterine hyperstimulation occur at
2 times in the absence of Pitocin?

3 A Yes.

4 Q What are some other reasons for the development
5 of uterine hyperstimulation in a patient?

6 A Unknown etiology. Other drugs with oxytoxic
7 properties, methergine, cocaine.

8 Q Does it occur without the use of any medication
9 at times?

10 A Yes.

11 Q How frequently does uterine hyperstimulation
12 occur in patients?

13 MR. MISHKIND: With or without?

14 Q Let's break that down. Let's say first without
15 oxytocin, or oxytocin agents.

16 A It would be very unusual.

17 Q And can you give me any sense of how frequently
18 that would be other than to say "very unusual"?

19 A Absent placental separation or abruption, it
20 would be very unusual to see uterine
21 hyperstimulation other than maybe an isolated
22 episode or two.

23 Q And how about when a patient does take oxytocin
24 or is on oxytocin augmentation, how frequently
25 does uterine hyperstimulation occur?

1 A I don't think there's any dose. Frequently it's
2 dose-dependent, patient-dependent.

3 Q You would agree with me at all times Kelly
4 Fiktus was on a low dose of Pitocin?

5 A Yes.

6 Q How do you know that Kelly Fiktus' uterine
7 hyperstimulation wasn't caused by the -- by a
8 naturally occurring Bandl ring?

9 A Because prior to the initiation of Pitocin, on a
10 strip it will not appear to be uterine
11 hyperstimulation.

12 Q Do you have any other reason other than that?

13 A Well, more less cause and effect. A drug is
14 initiated, it's known to increase uterine
15 activity. And a complication of administration
16 of Pitocin is uterine hyperstimulation or
17 hypertonus. I mean, it's pretty clear.

18 Q You would agree that a Bandl ring can occur in
19 cases where the patient has not been taking
20 Pitocin?

21 A Yes.

22 Q And do you have any knowledge about the rate of
23 incidents for that situation?

24 A I have not seen any rates quoted.

25 Q One way or the other, whether a Bandl ring --

1 how frequently it occurs when a patient has
2 taken Pitocin as opposed to when the patient
3 hasn't taken Pitocin, do you have knowledge or
4 information on either one of those categories?

5 A Well, only what's inferred in that.

6 Q That one article?

7 A That one article I gave you that is associated
8 with use of Pitocin.

9 Q That was one of four situations where it has
10 been thought to occur?

11 A Yes.

12 Q I'm just going to run down some things, Doctor.

13 Do you agree that transient and repetitive
14 episodes of hypoxia, a hypoxic event at the
15 level of the central nervous system, are
16 extremely common during normal labor and are
17 generally well tolerated by the fetus?

18 A Yes. Let me just clarify. Are you talking
19 about a term fetus?

20 Q You would agree with that with respect to a term
21 fetus?

22 A Yes.

23 Q What about with a preterm fetus?

24 A Preterm fetuses are, in general, more
25 susceptible.

1 Q With respect to that topic that I just
2 described, can you put any figures or numbers or
3 percentages on that?

4 A No. I think the literature just seems to
5 indicate they're more susceptible, more
6 susceptible than term infants, for example.

7 Q Would you agree that each time you made
8 reference to bradycardia occurring in the fetal
9 heart rate tracings for Jacob Fiktus, that
10 subsequent to those episodes, accelerations in
11 the fetal heart rate were seen?

12 A Yes.

13 Q And the accelerations in the fetal heart rate
14 are virtually always reassuring and almost
15 always confirm the fetus is not acidotic at the
16 time?

17 A Yes.

18 Q Do you agree that an acceleration before or
19 after a variable deceleration is seen only when
20 the fetus is not hypoxic?

21 A That's a controversial point. I have seen
22 literature that suggests that elevation in the
23 fetal heart rates are reassuring with a variable
24 deceleration. And I've seen articles that say
25 they are not reassuring.

1 Q So it's controversial?

2 A Yes.

3 Q Going back to what we were saying, I just want
4 to make sure, again, I understand your
5 testimony.

6 From looking at the tracings, is there any
7 point in time when you believe, just looking at
8 the tracings, that a physician should have
9 determined that an immediate C-section was
10 warranted?

11 A Just looking at the tracings?

12 Q Yes.

13 A And not looking at any other factors?

14 Q Yes, sir.

15 A No.

16 Q Then let me ask you the same thing with respect
17 to the contraction pattern shown for Kelly
18 Fiktus.

19 Is there any point in time, looking at
20 that contraction pattern, that you believe that
21 a physician should have said, "We need to have
22 an immediate C-section"?

23 A Just looking at contraction pattern?

24 Q Yes, sir.

25 A No.

1 Q A fetal scalp electrode was placed in this
2 patient, correct?

3 A Yes.

4 Q What is it about the evidence in this chart that
5 you believe that it should have been placed
6 earlier, the fetal scalp electrode?

7 A It's my opinion, when Pitocin is being given,
8 that the fetus needs to be monitored directly,
9 when feasible, with a scalp electrode, and the
10 uterine activity should be monitored with
11 intrauterine pressure catheter, particularly
12 when there is evidence of uterine
13 hyperstimulation or uterine hypertonus. Because
14 in those situations, the baby is more likely to
15 show nonreassuring heart rate patterns. The
16 most precise way of determining if a fetus is
17 not hypoxic is to look at a short-term
18 variability, which only can be looked at using a
19 fetal scalp electrode.

20 Q With respect to the management of this patient's
21 labor, is there any particular text that you
22 would rely on to support the opinions you've
23 stated with respect to, for instance, monitoring
24 the fetus, fetal scalp electrode, placement of
25 the IUPC?

1 A I think probably Williams Obstetrics had a
2 chapter or so on fetal monitoring that would
3 support it. Probably the one I cited to you
4 from Awhonn, A-W-H-O-N-N, the Fetal Heart
5 Monitoring Privileges, Principles and Practices
6 would also have information concerning that
7 particular issue.

8 Q That was A-W-H-O-N-N?

9 A Yes.

10 Q How about with respect to management of the
11 uterus when uterine hyperstimulation and
12 hypertonus occurs, what text would you rely on
13 for guidance?

14 A Probably the same ones that I gave you, plus
15 there may be several ACOG technical bulletins on
16 that point.

17 Q Okay.

18 A There's an ACOG technical bulletin on induction
19 of labor, there's a bulletin on fetal
20 monitoring. Those would be two additional
21 sources.

22 Q I think you've already stated that you do not
23 believe that Jacob Fiktus, as a fetus, was
24 exhibiting signs of hypoxia which were
25 sufficient to indicate an intrapartum event

1 capable of causing cerebral palsy?

2 A That's correct.

3 Q And you've also said that you do not believe
4 that there was evidence from the fetal heart
5 rate tracings to indicate a prior need for
6 C-section until the time the C-section actually
7 did occur?

8 MR. MISHKIND: Objection.

9 A I believe you asked me to look in isolation only
10 at a fetal heart rate tracing, just looking at
11 heart rate tracings, nothing else. It's my
12 opinion there was no indication to do a
13 C-section other than when it was done. That he
14 was out a lot of other findings.

15 Q Specifically the contraction pattern?

16 A That, plus the fact that we're dealing with a
17 premature baby. And the other historical risk
18 factors previously, premature baby, patient had
19 been in the hospital for 24 hours prior to
20 initiation of Pitocin. All these things.

21 Q But you would agree with respect to determining
22 the timing of a C-section, you do not consider
23 time as a factor until the patient has reached
24 the active phase of labor?

25 A No, that's not necessarily true. You have to

1 look at the fetus -- you can have fetal strips
2 and the patient's only two centimeters dilated.
3 You can have a nonreassuring heart rate tracing
4 and a patient not even in labor.

5 Q I appreciate that.

6 So let's take the situation other than
7 showing a fetal heart rate tracing that is
8 nonreassuring. You don't consider time as a
9 factor for having a C-section until the patient
10 has reached the active phase of labor?

11 A In general you're asking me?

12 Q In general.

13 A In general, no. But you have to look at
14 specific cases, for example.

15 Q Was that in general, no, or were you agreeing
16 with me?

17 A In general, that's true.

18 Q Okay.

19 A But under certain other specific situations,
20 like prolonged premature ruptured membranes, you
21 don't want to wait too long; patient gets
22 infected, if there's a breech presentation in
23 the patient in labor, you don't want to wait
24 hours and hours before you do the C-section. I
25 mean, those specific situations.

1 Q Did any of those occur here?

2 A We did have premature ruptured membranes. And
3 as time was passing -- she ruptured in the
4 morning, but we wouldn't want her to have
5 prolonged ruptured membranes more than 18 hours
6 because then the fetus would be at increased
7 risk of an infection.

8 Q There was no indication of infection, though,
9 was there?

10 A No.

11 Q I don't need, then, to ask you about ACOG's
12 recent report regarding the four criteria for --
13 that establishes -- four criteria were
14 established for causation from hypoxia and an
15 intrapartum event as the cause of cerebral
16 palsy.

17 A That's not applicable here.

18 MR. MISHKIND: Saved an entire
19 page of questions.

20 MS. ROLLER: It certainly
21 did. It certainly did.

22 Q I am cutting out a lot, so let me just take a
23 moment here, Doctor.

24 Do you have criticisms, specific
25 criticisms of the residents in this case,

1 Dr. Wang, Dr. McHugh?

2 A The same criticisms that I have for the nurses
3 and the attendings also apply to the residents.
4 Remember I told you the nurses and the doctors,
5 the attending physicians, have independent
6 duties? Also the residents have an independent
7 duty to the patient.

8 Q All right. And specifically, then, so that
9 before I leave I know what you are specifically
10 saying how they breached the standard of care,
11 tell me how the residents, and I understand
12 you're saying it's the same for the nurses and
13 the attendings, tell me --

14 A Same thing. I mean, to save time, it's exactly
15 the same thing.

16 At 1400 in the afternoon, the residents
17 who were following this patient, Dr. Wang,
18 Dr. McHugh, should have realized that there's
19 hyperstimulation and did the appropriate
20 maneuvers, the application of internal monitors,
21 all of that that I went into great detail --

22 Q Yes.

23 A -- prior.

24 Q You think the IUPC and the fetal scalp electrode
25 should have been placed?

1 A Yes.

2 Q And it would have led to the scenario --

3 A And they should also discontinued the Pitocin.

4 Q Okay.

5 A And then with the residents, they also had a
6 duty to report to their superiors, which would
7 be Dr. Kiwi, Dr. --

8 Q De Mola.

9 A -- de Mola.

10 Q Do you have any evidence at all that the nurses
11 and/or residents did not report their findings
12 to one of the attending physicians?

13 A No. The attendings were in-house.

14 Q At one point we know Dr. Kiwi left and
15 Dr. de Mola took over?

16 A Yes.

17 Q Okay. Have you told me all of the conduct in
18 this case that, in your opinion, breached the
19 standard of care?

20 MR. MISHKIND: Let me just show
21 an objection to the general question. I think
22 he's answered your question -- let me just
23 finish. I'm not saying that he hasn't given you
24 the answers because every conduct, I mean, there
25 may be some derivation that I ask, but note my

1 objection.

2 You can go ahead and answer the question.

3 Q Before I leave, I want to know what you're
4 saying the nurses and residents did that
5 breached the standard of care.

6 And you've told me that at 1400 they
7 should have done some things that were not done,
8 specifically placed the IUPC and the fetal scalp
9 electrode. And, as a result, you think certain
10 things would have happened. And you have not
11 told me anything more specifically with respect
12 to their conduct afterward.

13 MR. MISHKIND: Well, objection.
14 I don't think that's quite an accurate
15 statement, but go ahead.

16 Q I say that to the extent I am not aware of any
17 other specific conduct after 1400 that you are
18 critical of other than the fact they didn't do
19 certain things back at 1400 hours.

20 MR. MISHKIND: Objection.

21 Q Go ahead.

22 A I think I gave you all my opinions concerning
23 that.

24 Q All right. Well, Doctor, if you have any new or
25 modified opinions between now and trial, I'd ask

1 that you notify Attorney Mishkind so he can
2 communicate those to me. Will you do that?

3 A Yes.

4 Q Otherwise, is it fair for me to assume that the
5 opinions you expressed here today cover the
6 opinions you will express at trial?

7 A Yes.

8 Q All right.

9 MS. ROLLER: Joe, with that.

10 MR. MISHKIND: Joe, before you
11 begin --

12 MR. FARCHIONE: Yes.

13 MR. MISHKIND: First, I want to
14 make sure you're still there, and you are,
15 correct?

16 MR. FARCHIONE: Yes, sir, I am.

17 MR. MISHKIND: Let me just note
18 on the record that obviously I have not had an
19 opportunity to depose Dr. Kiwi. And I don't
20 know, even as we're sitting here now, whether we
21 have a date and time firm between our offices.

22 MR. FARCHIONE: We do.

23 MR. MISHKIND: I'm sorry?

24 MR. FARCHIONE: We do.

25 MS. ROLLER: Could you tell

1 me when that is?

2 MR. FARCHIONE: I don't know off
3 the top of my head. My computer is off.

4 MS. ROLLER: The reason --
5 and I do want this on the record. I have asked
6 that I be kept in the loop on the timing of
7 these depositions. Dr. Weinstein's deposition
8 was set at a time that I am not available. In
9 that situation, being as it is, I can send
10 someone else, but Dr. Kiwi's, I must be present.

11 MR. MISHKIND: Do you know when
12 that is, Joe? All I knew was that --

13 MR. FARCHIONE: Let's just get
14 to the point of it so we can get the doctor out
15 of there.

16 MR. MISHKIND: Sure. That's
17 fine. I'm just noting an objection on the
18 record. And to the extent that when I take his
19 deposition, if there's additional information
20 that I gather from the deposition, which
21 obviously I've not been able to provide to
22 Dr. Cardwell, to the extent that it modifies or
23 adds to his opinions, you'll be the second
24 person to know, okay?

25 MR. FARCHIONE: Well, I'll just

1 put on the record also that it was my
2 understanding Dr. Kiwi was not going to be in
3 the case and, in fact, Dr. Cardwell's report has
4 no criticism of Dr. Kiwi. So right now is the
5 first time that I heard criticism of Dr. Kiwi in
6 this case. So we'll explore that with the
7 doctor right now.

8 MR. MISHKIND: But, Joe, I
9 think you would agree that I have been
10 requesting Dr. Kiwi's deposition for quite some
11 time.

12 MR. FARCHIONE: I would agree
13 with that. And you would also agree you've
14 indicated that the criticism was going to be
15 after Dr. Kiwi left and not before. And that's
16 reflected in Dr. Cardwell's report.

17 MR. MISHKIND: Well, it all
18 depended upon what I learned from Dr. Kiwi as to
19 whether or not he was or was not going to be a
20 party at the time of trial, and I've indicated
21 that to you.

22 EXAMINATION OF MICHAEL S. CARDWELL, M.D.

23 BY MR. FARCHIONE:

24 Q Dr. Cardwell, this is Joe Farchione. Can you
25 hear me okay?

1 A Yes.

2 MR. MISHKIND: Joe, are you
3 there?

4 MR. FARCHIONE: I'm waiting to
5 hear from the doctor.

6 MR. MISHKIND: He said yes to
7 your question.

8 MR. FARCHIONE: I said, Why is
9 there no criticism in his report of Dr. Kiwi?

10 MR. MISHKIND: Oh. We didn't
11 hear that, and the court reporter didn't hear it
12 either.

13 MR. MISHKIND: You must have
14 blanked out.

15 MR. FARCHIONE: I'll do it this
16 way.

17 Q Doctor, can you hear me okay?

18 A Yes.

19 Q Here's the question, Doctor. Why is there no
20 criticism of Dr. Kiwi in your report?

21 A At the time I did my report, October 23rd, I did
22 not have his deposition available to me.

23 Q You did not have his deposition and, therefore,
24 you had no criticism of him?

25 A At that point in time.

1 Q So I take it that it would be fair to state,
2 based on the medical records, what you did
3 review, at that time you had no criticism of
4 Dr. Kiwi?

5 A No. At the time I was not certain of when the
6 various doctors switched, as far as care of the
7 patient is concerned. I think the medical
8 records are more or less -- I'm not saying
9 incomplete, but the medical records did not
10 indicate when the shift from Dr. Kiwi or
11 Dr. de Mola occurred.

12 Q Well, you read Dr. de Mola's deposition, did you
13 not?

14 A Yes.

15 Q Did you read it in its entirety?

16 A Yes.

17 Q Read it carefully?

18 A I read it carefully, but I also read six other
19 depositions and I don't have them all memorized.

20 Q I understand.

21 But there were two attendings involved in
22 this case, correct?

23 A Yes.

24 Q You understood that at the time you wrote your
25 report, correct?

1 A Probably not completely because I did not have
2 the other attending, Dr. Kiwi's, deposition.

3 Q How do you know there were two attendings today
4 then?

5 A Because since that time I've been provided other
6 depositions and other medical records, and a
7 re-review indicated to me that, after looking at
8 all these other materials, that Dr. Kiwi was
9 involved until he left, I believe, some time in
10 the afternoon, 5:00 or so.

11 Q Well, Doctor, in your report of October 23,
12 2002, you say you've reviewed various
13 depositions, correct?

14 A Yes.

15 Q What depositions, what various depositions did
16 you review?

17 A I believe I reviewed, at the time, the
18 deposition of Mary McHugh, M.D., Dr. de Mola,
19 and I believe the -- and Dr. Wang, and maybe the
20 nurses.

21 Q Just a second. Dr. Kiwi is mentioned 11 times
22 in the deposition of Dr. McHugh. Did you miss
23 the 11 times that he was mentioned in there?

24 A As I said, I don't recall specifically every
25 deposition. I read all the information. I read

1 several -- lots of depositions.

2 Q Well, obviously it would be very important to
3 know who the attending physicians were in this
4 case, would it not?

5 A Yes. But it's obvious the purpose of this
6 discovery deposition is to get all my opinions.
7 And I am not held to the opinions in my letter
8 of October 23rd, true?

9 Q Is that a legal opinion or a medical opinion,
10 Doctor?

11 A Take it either way you want to.

12 Q Well, Doctor, I took it you were asked to write
13 a report that reflected all of your opinions in
14 the case, correct?

15 A All my opinions that I had at that point in time
16 with the materials I was asked to review.

17 Q And we can certainly agree that Dr. Kiwi is not
18 mentioned in the October 23, 2002 report,
19 correct?

20 A Yes.

21 Q Have you filed or given Mr. Mishkind a
22 subsequent report that talks about your
23 criticism of Dr. Kiwi?

24 MR. MISHKIND: Joe, I'll
25 stipulate he hasn't done that. The report says

1 what it does, and I do not have any supplemental
2 report from him.

3 MR. FARCHIONE: Okay.

4 Q Doctor, when did you develop this opinion about
5 Dr. Kiwi?

6 A Probably after I wrote my October 23, 2002
7 letter.

8 Q When after the October 23, 2002 letter?

9 A I can't be more specific than that.

10 Q What other information did you obtain that
11 caused you to think, Wait a minute, there's a
12 Dr. Kiwi involved in this?

13 A I received other depositions, as I mentioned,
14 prior to that, and other medical records.

15 Q What other depositions did you read -- or
16 receive, rather?

17 A The plaintiffs, Dr. Friedman. Those.

18 Q And it was from those depositions that you found
19 out there was a Dr. Kiwi involved?

20 A No.

21 Q Where did you get the information about
22 Dr. Kiwi?

23 A What information?

24 Q What I'm trying to find out what stimulated your
25 mind to think about Dr. Kiwi, or what brought to

1 your attention that there was a Dr. Kiwi
2 involved following the October 23, 2002 letter
3 from --

4 A From my review of additional materials and
5 re-review of the records.

6 Q The re-review of the records and review of
7 additional materials. The additional materials
8 were the depositions of the parents, correct?

9 A Yes.

10 Q Dr. Friedman?

11 A Yes.

12 Q Was it based on the review of those depositions
13 that you found out that Dr. Kiwi was involved?

14 A No.

15 Q What subsequent records?

16 A I received records, including letters, from
17 Dr. Friedman, records of the baby after
18 delivery.

19 Q So could you tell me which one of the records
20 you were going through is the one that told you
21 that Dr. Kiwi was involved?

22 A Well, I can't tell you that. I knew Dr. Kiwi
23 was involved. I didn't have his deposition.
24 When I did my preliminary report of October
25 23rd, I did not include him. Subsequently,

1 after reviewing the records and reviewing the
2 records and reviewing the other materials, I
3 came to a conclusion that he is also negligent.

4 Q What is your understanding, based on the
5 records, then, of Dr. Kiwi's involvement?

6 A He was her attending physician until about 5:00
7 or 5:30, 1700, 1730 the day of delivery.

8 Q And your opinion, as related to standard of
9 care, specifically for Dr. Kiwi, is what?

10 A More or less exactly what I told the other
11 attorney, but I will reiterate.

12 Q You don't have to reiterate. It's the same
13 thing you already said?

14 A Yes.

15 Q At the time you had specified before, measures
16 should have been taken to stop the Pitocin and
17 monitor the child more closely with a fetal
18 scalp electrode?

19 A At 2:00, or 1400 in the afternoon, yes.

20 Q Doctor, if this child had been delivered at
21 10:00, do you have an opinion, to a probability,
22 whether the outcome would have been different?

23 A 10:00 p.m. that night?

24 Q Yes.

25 A In my opinion, the outcome would have been the

1 same.

2 Q If this child had been delivered at 9:00 p.m.
3 that night, would the outcome have been
4 different, to a probability?

5 A Probably the same.

6 Q As we go back, is there a point in time where
7 you can state, to a probability, that the
8 outcome would have been different?

9 A No. Because as I told the other attorney, it
10 takes a period of time, and it is progressive,
11 for the Bandl retraction ring to develop and to
12 have the adverse effect on the fetus.

13 Q So if I were to ask you at 5:00 p.m., Doctor, to
14 a probability, if the child was delivered right
15 then and there at 5:00 p.m., would the outcome
16 have been different, you would not be able to
17 answer that question?

18 A That's correct.

19 Q At 4:00 p.m., if I were to ask you, to a
20 probability, would the outcome be different, you
21 would not be able to answer that question?

22 A You're correct.

23 Q What about 3:00 p.m., Doctor, to a probability,
24 would the outcome have been different if the
25 child had been delivered at that time?

1 A In my opinion, yes. And I said this previously.
2 I said if the baby was delivered by a C-section
3 within a couple hours after the initiation of
4 the hyperstimulation and the hypertonus, more
5 likely than not there would not have been a
6 Bandl retraction ring.

7 Q So it's that two-hour window, between 2:00 in
8 the afternoon and 4:00 p.m. in the afternoon,
9 where we reach that point of no return?

10 A No. That's not what I said. All I said is if
11 the patient was delivered by C-section by that
12 time, --

13 Q Right.

14 A -- it's my opinion that it would not have been a
15 retraction ring. That's all I can say.

16 Q You can't say whether the outcome would have
17 been different?

18 A If the baby had been delivered by 3:00 or 4:00,
19 the outcome would have been different. I can't
20 say after that time, however.

21 Q Okay. After 4:00 you can not say, to a
22 probability, if this child had been delivered by
23 section we would have a normal child today?

24 A That's correct.

25 Q What was Dr. Kiwi's, at least based on the

1 records and the depositions you've read,
2 involvement between 2:00 and 4:00?

3 A He was the attending.

4 Q Do you know, based on these records, if he had
5 any involvement directly with the patient during
6 that time frame?

7 A Well, he was in-house at the time, so I assume
8 he had direct involvement. It was a private
9 patient.

10 Q Well, I understand that. But if you have a
11 private patient and you're in-house, are you
12 required to see that patient every half hour?

13 A No.

14 Q You can rely on the residents and nurses to
15 report abnormalities that are going on?

16 A Well, you can delegate that responsibility, but
17 ultimately you are responsible.

18 Q Sort of the captain-of-the-ship argument?

19 MR. MISHKIND: Objection.

20 A No. A delegation argument. If you're going to
21 delegate the responsibility, which is
22 appropriate, you also take the responsibility of
23 any of the outcome.

24 Q So let's say you examine a patient at,
25 hypothetically, 1:00 and you leave to make

1 rounds. The nurses are keeping track of what's
2 going on but they miss a pattern of late
3 deceleration. You come back at 4:00, see the
4 late deceleration and order cesarean section.

5 Are you, as the obstetrician, responsible
6 for the nurse's failure to see the late
7 decelerations?

8 A Am I in-house or do you have to leave the
9 hospital?

10 Q You're doing rounds in the hospital.

11 A If I'm in the hospital, I would be responsible.
12 If I'm not, I would not unless there was
13 something pre-existing.

14 Q How can you be responsible just because you're
15 in the house, if you're off making rounds
16 between 1:00 and 4:00, and the nurse fails to
17 pick up a pattern of late decelerations?

18 A Because Dr. Kiwi was the --

19 Q I'm talking in general. I'm talking in general.

20 A It depends if you are required to be in the
21 house. If you are paid to be in the house or if
22 you are to supervise residents in the house, you
23 are responsible for things that occur during
24 your watch.

25 If you're a private attending and you're

1 not required to be in the house, you can rely
2 upon the nurses and the residents to give you
3 adequate information, assuming there was no
4 pre-existing, nonreassuring event occurring, to
5 your knowledge, prior to your leaving the
6 hospital.

7 Q And prior to 2:00, we do not have any such event
8 in this case, do we?

9 A No.

10 Q Now, this was a private patient of Dr. Kiwi and
11 his group, correct?

12 A Yes.

13 Q So in terms of relying on the nurses, if I
14 understood what you just said, he would have the
15 ability to rely on the nurses and if an error
16 was made by the nurse, which I'm not saying one
17 was, but if an error was made, then Dr. Kiwi
18 would not automatically be responsible for that?

19 A No. That's not what I said previously.

20 Dr. Kiwi was the in-house physician. He was
21 required to be in-house until 5:00, 5:30 or so.

22 Q Okay.

23 A He would then be responsible. It's a different
24 situation.

25 Q I guess I don't understand. Are you saying that

1 an attending, in order to be on the safe side,
2 would have to be with the patient the entire
3 time she is in labor?

4 A No. Let me explain it to you again. It's one
5 thing to be a private attending and have a
6 private patient and not be directly responsible
7 for supervising their in-house residents as
8 opposed to being required to be in-house for a
9 specified time period. That's two different
10 situations.

11 Q Well, is it your understanding that Dr. Kiwi or
12 Dr. de Mola were supervising the residents
13 during this time frame?

14 A Yes.

15 Q So it's your position that whether they're
16 standing there at bedside, or they're delivering
17 another patient, or checking on another patient,
18 whatever happens in that room is their
19 responsibility?

20 A Yes.

21 Q So if they're delivering another patient and a
22 resident or a nurse breaches the standard of
23 care, then automatically Dr. Kiwi or Dr. de Mola
24 would be below standard of care?

25 A Well, you have to give me more specific

1 information. I mean, there can be a blatant
2 violation of a standard of care by a nurse or
3 the resident which is outside the usual conduct
4 of medical care in which the attending certainly
5 wouldn't be responsible for.

6 Q Well, let's say failure to recognize patterns of
7 late decelerations. Dr. Kiwi or Dr. de Mola are
8 performing a delivery that takes about an hour,
9 which I believe is what it took you to get to
10 the hospital and back here today, if they're
11 doing a delivery during that time frame and the
12 nurse fails to pick up a pattern of late
13 decelerations, or a resident fails to pick up a
14 pattern of late decelerations, are Dr. de Mola
15 and/or Dr. Kiwi automatically responsible for
16 that?

17 A Yes.

18 Q Doctor, do you deal with residents?

19 A Yes.

20 Q How often?

21 A I have one assigned to me every day, same one
22 for a month; and my office, and they also go to
23 the hospital to help me do deliveries,
24 C-sections, or other surgical procedures.

25 Q Do any of the lawsuits that have been filed

1 against you involve allegations of the residents
2 also, negligence for the residents also?

3 MR. MISHKIND: Objection.

4 A I can't tell you one way or the other.

5 Q For Dr. de Mola, what is your understanding of
6 his involvement with the patient? What
7 specifically did he do?

8 A He became the attending after Dr. Kiwi went off
9 call.

10 Q Okay. Do you have any criticism of him, his
11 conduct when he arrived at 1940, took a look at
12 the strips and what he did following that?

13 A Well, when he came on duty, he should have
14 realized, after reviewing the strip and the
15 course of the patient in labor, that Pitocin
16 should have been discontinued and the patient
17 should have been delivered by cesarean section.

18 Q That wasn't my question. My question was: Do
19 you have criticism of what he did from 1940 on?

20 A I thought I gave you my criticism.

21 Q I want to make sure that it's absolutely clear,
22 Doctor. From 1940 on, you have no criticism of
23 what Dr. de Mola did?

24 MR. MISHKIND: Objection. I
25 think he's just answered it, Joe.

1 MR. FARCHIONE: He's not
2 answered that question directly, Howard.

3 MR. MISHKIND: I'm sorry?

4 MR. FARCHIONE: He's not
5 answered that directly. He's criticized him for
6 5:00 when he came on. I'm asking from 1940 on.
7 I want to make sure he has no criticism of that.
8 I'll reask the question.

9 Q Doctor, do you have any criticism of what
10 Dr. de Mola did from 1940 on?

11 A Yes.

12 Q What is that criticism?

13 A Well, first of all, he came on call, I believe,
14 and you can correct me, around 5:00 or 5:30 in
15 the afternoon; is that right?

16 Q That's not my question, Doctor.

17 MR. FARCHIONE: Could the court
18 reporter please repeat that? I'm concerned with
19 the time frame of 1940 on.

20 A I'm trying --

21 MR. FARCHIONE: So, Court
22 Reporter, can you please repeat it?

23 A I know what the question is. I'm trying to
24 answer the question very clearly. He violated
25 the standard of care when he came on duty and

1 it's a continuing violation up until the time
2 the patient is delivered.

3 Q At 1940 he comes in. What action does he take,
4 Doctor?

5 MR. MISHKIND: You can take a
6 look at the record if you want to.

7 A At 1940 he comes in, examines the patient, he
8 places a fetal scalp electrode.

9 Q That was standard of care to do that?

10 A At that time?

11 Q Well, I understand you think it should have been
12 earlier, but given he put it on, at that time
13 that was appropriate to do that?

14 A Yes.

15 Q Go ahead.

16 A But he should have done it when he came on call.

17 Q Continue on, Doctor.

18 A You asked me a question in the meantime. What
19 was the original question?

20 Q The original question was: What is your
21 understanding of what Dr. de Mola did from 1940
22 on?

23 A At 1940, just to reiterate, he placed a scalp
24 electrode. He, I guess, approved that there was
25 an epidural. There was conversation of an

1 amnioinfusion but it was never done. And he was
2 going to monitor the patient carefully.

3 A little later on, the fetus had episodes
4 of bradycardia. Dr. de Mola did a scalp pH and
5 his plan was to proceed with amnioinfusion and
6 low dose Pitocin.

7 When he did a scalp pH and it came back
8 7.15, he decided to do a stat cesarean section
9 on the patient.

10 Q If those events you've just outlined had taken
11 place beginning at 5:00, would you have any
12 criticism of Dr. de Mola?

13 A No.

14 Q What was causing the abnormal strips beginning
15 around 10:00 p.m. and what we're seeing around
16 that time?

17 A Umbilical cord compression.

18 Q Did you hear that, Doctor?

19 MS. ROLLER: He didn't hear
20 you.

21 A Umbilical cord compression.

22 Q How does umbilical cord compression usually
23 present on a fetal monitor strip?

24 A A drop from the baseline.

25 Q Variable deceleration?

1 A Yes. Or a bradycardia.

2 Q Bradycardia that is not preceded by variable
3 deceleration?

4 A It can be, yes.

5 Q How does that happen, where you have a
6 bradycardic event from a cord compression
7 without variables before?

8 A It's a prolonged cord compression.

9 Q Would that mean prolonged contraction?

10 A It can be a prolonged contraction. It can be
11 simply a prolonged cord compression between the
12 baby and the uterine wall, or between parts of
13 the baby and the umbilical cord.

14 Q Is that more likely to occur as the fetus
15 descends as opposed to being high?

16 A It can occur any time.

17 Q When is it more likely to occur?

18 A It can occur any time. There's more variables
19 if the patient is pushing in the second phase as
20 the fetus is descending, but it can occur any
21 time.

22 Q It can occur any time, but you would agree with
23 me more often than not it occurs as the fetus is
24 descending and pushing?

25 A Yes.

1 Q Would you agree with me, more often than not,
2 compression or -- strike that.

3 Would you agree with me, more often than
4 not, a cord compression presents as a variable
5 deceleration rather than a deceleration -- or
6 bradycardic event, rather?

7 A Yes.

8 Q Do all hyperstimulation situations require
9 cesarean section?

10 A No.

11 Q Have women who will continue with a
12 hyperstimulation and you will allow that labor
13 to go forward if you cannot stop the
14 hyperstimulation?

15 MR. MISHKIND: Joe, could you
16 repeat the question? I think some of the words
17 just got cut off.

18 MR. FARCHIONE: Sure.

19 Q If you have a laboring mom and there is
20 hyperstimulation, and that hyperstimulation can
21 not be reversed, do you allow her to continue to
22 labor?

23 A Depends.

24 Q Depends on what?

25 A Depends on how far the patient is dilated at the

1 time, depends on the fetal heart rate tracing,
2 depends on the gestational age.

3 Q Is there really that much of a difference
4 between the gestational age of this fetus, which
5 was, I think, between 34 and 35 weeks, and a
6 full term?

7 A Yes. Six weeks premature.

8 Q How much of a difference does that make in terms
9 of outcome? What are the statistics between the
10 two?

11 A That's an overbroad question. What do you mean
12 "outcome"?

13 Q Are there statistics out there that you're aware
14 of that shows outcome of 34/35 weeks versus 38
15 to 40 week?

16 A Well, the more premature the baby, the more apt
17 for the baby to have prematurity complications,
18 including intraventricular hemorrhage, distress,
19 hypoglycemia, high bilirubin, ischemia.

20 Q Intraventricular hemorrhage can occur in a
21 premature infant absent a constriction ring or
22 Bandl ring, correct?

23 A Yes.

24 Q What is the percentage of time that that can
25 happen?

1 A Depends on the gestational age of the fetus.

2 Q 34 to 35 weeks.

3 A It would be unusual compared to, say, a
4 30-weeker or a 28-weeker.

5 Q How unusual at 34 to 35 weeks?

6 A I can't cite you specific statistics.

7 Q Where would I look to find those specific
8 statistics?

9 A Probably in a neonatal textbook.

10 Q Volpe's Pediatric Neurology, would that be a
11 source for it?

12 A Possibly. Maybe Avery's Neonatology textbook.

13 Q Any other neonatology textbook other than
14 Avery's?

15 A There are others. I can't think of the names.

16 MR. FARCHIONE: I'm kind of
17 going through notes here so I don't repeat
18 anything, so I apologize for the silence.

19 Q I take it, Doctor, it's your opinion -- strike
20 that.

21 Doctor, earlier in your deposition you had
22 made a distinction between rings. And I think
23 you said one was pathologic and I didn't catch
24 what the other one was. What were you
25 distinguishing?

1 A I was not making the distinction. I said that's
2 one article. There's a distinction between
3 constriction rings and pathologic retraction
4 rings.

5 Q What is the distinction that's made in that
6 article?

7 A Well, probably the best way to do this is just
8 attach it as an exhibit because it's a large
9 table.

10 MR. MISHKIND: Yes, I'll get
11 you a copy of the article, Joe.

12 Q Do you have an understanding that you can give
13 to me of the difference between the constriction
14 ring and the pathologic ring?

15 A Well, according to this table, I can point out
16 some major differences. For example, in a
17 constriction ring, the uterus never ruptures.
18 In a pathologic retraction ring, if uncorrected,
19 the uterus may rupture. With a constriction
20 ring, the fetus may be wholly or mainly above
21 the ring. With a pathologic retraction ring,
22 parts of the baby must be below the ring.

23 MS. ROLLER: Can we make a
24 copy of that before we leave?

25 MR. MISHKIND: You have a copy

1 of it.

2 MS. ROLLER: Are you reading
3 from portions that are not --

4 THE WITNESS: No.

5 MS. ROLLER: It's all
6 contained in the copy that we have?

7 MR. MISHKIND: Yes.

8 MS. ROLLER: Just hold up the
9 front of it so I can see what one that was.

10 Thank you.

11 MR. MISHKIND: Sure.

12 Q I take it, Doctor, that with hyperstimulation
13 and Pitocin, there's no way of predicting which
14 patient will have a ring, which will not have a
15 ring?

16 A Well, first of all, as I stated previously, and
17 I read from Williams Obstetrics, it is rare to
18 see a ring, retraction ring nowadays, unless the
19 labor is neglected.

20 Q Neglected in terms of how long?

21 A Or obstructed.

22 Q Okay. Just so I'm clear, how do you define
23 obstructed labor?

24 A How do I define it?

25 Q Yes.

1 A It's when there's no progress towards delivery
2 and the cervix may not dilate beyond a certain
3 stage, or the fetus may not descend beyond a
4 certain station.

5 Q Had she reached that definition between 2:00
6 and 4:00?

7 A Yes.

8 Q What's the basis for that, please?

9 A She was admitted to the hospital the day before
10 in labor, the labor continued. She had rupture
11 of membranes about 9:30 in the morning. She was
12 not making any progress so, therefore, the
13 Pitocin was started.

14 And from the time the Pitocin was started
15 until the time she was delivered, I believe she
16 went maybe from two centimeters at 1:00 in the
17 afternoon, and she was no more than four or five
18 centimeters when the C-section was done in the
19 evening.

20 Q What would you have liked to have seen between
21 2:00 and 4:00 to say she was making progress and
22 would not fall into this obstructed labor
23 definition?

24 A Well, first of all, I want to see no
25 hyperstimulation and no hypertonus. And then I

1 would want to see the contractions occurring
2 with a change and the effacement and the
3 station, and dilatation.

4 Q What effacement, what station, what dilation
5 would you want to see between 2:00 and 4:00
6 given how she had presented the day before and
7 where she was at heading into 2:00, where would
8 you have wanted to see her between 2:00 and
9 4:00?

10 A Well, this is her second baby. You would
11 expect a patient, if the labor is progressing
12 normally, a patient with her second baby would
13 dilate, let's say, one to two centimeters an
14 hour.

15 So in that two-hour period, you would
16 expect the cervix to change at least about a
17 couple centimeters. I would expect the cervix
18 to also thin out, or efface more.

19 Q You're saying one to two per hour. What is the
20 starting point for you?

21 MR. MISHKIND: I'm not sure I
22 understand what you mean "the starting point,"
23 Joe.

24 Q If you're saying one to two per hour, is that
25 when she was admitted to the hospital you want

1 to see that, or is that after the rupture of
2 membranes?

3 A When she's in labor with the Pitocin, the
4 Pitocin was started at 1300 and she was two
5 centimeters at 1300 when the Pitocin was
6 started. And at 1935, which is six, seven
7 hours later, she's only three centimeters
8 dilated.

9 Q I understand that. What I'm concerned about in
10 that two- to four-hour time period, the 2:00 to
11 4:00, you indicated that at 1:00 she was two
12 centimeters. What would you want to have seen
13 on vaginal exam to be comfortable with her
14 progress between 2:00 and 4:00?

15 A An increase in the dilatation by at least a
16 couple centimeters.

17 Q What if she was examined at, let's say, 2:30 by
18 the attending, what would you expect to see at
19 2:30, an hour-and-a-half after the two
20 centimeters?

21 A At 2:30, if she's having adequate contractions,
22 I would expect her, this would be in her second
23 baby, for the cervix to be dilated maybe another
24 centimeter.

25 Q Why did she not dilate?

1 A We don't know why she didn't dilate.

2 Q Why did she rupture her membranes prematurely?

3 A Because patients in premature labor tend to have
4 premature rupture of membranes at some point in
5 time.

6 Q The underlying cause of that being what?

7 A It could be mechanical from the uterine
8 activity.

9 Q And in this case, do you have an opinion, to a
10 probability, what caused the premature rupture
11 of membranes?

12 A Probably the premature labor.

13 Q You had mentioned earlier that the Bandl ring
14 contributed to the injury. What else
15 contributed to the injury, to a probability?

16 A The cord compression.

17 Q I thought you said the cord compression, which
18 would cause ischemia, hypoxia, did not cause any
19 permanent injury to this child.

20 A No. I didn't say that. I said the hypoxia from
21 the bradycardia did not cause any injury.
22 Ischemia from cord compression, in a premature
23 baby, can cause problems.

24 And I also mentioned previously I deferred
25 specific causation of the baby's injuries to the

1 pediatric neurologist.

2 Q So as far as the relationship of the umbilical
3 cord and ischemia, the ultimate injury you would
4 defer on?

5 A Yes.

6 Q The only thing you can say to a probability is
7 the Bandl ring contributed to the ultimate
8 injury?

9 A Yes.

10 Q What is the half life of Pitocin?

11 A The other attorney asked me that already, but
12 about three minutes.

13 MR. FARCHIONE: That is all I
14 have at this time other than, Doctor, if you can
15 give an updated CV to Mr. Mishkind, I'd
16 appreciate that.

17 MR. MISHKIND: We have one as
18 of three weeks ago that Jan marked as --

19 MR. FARCHIONE: She did mark
20 that, okay. I didn't hear that. I've got one
21 that goes back to January of 2002.

22 MS. ROLLER: Exhibit A.

23 THE WITNESS: That's the most
24 recent one.

25 MR. MISHKIND: The one Jan

1 marked as an exhibit was from three weeks ago.

2 MR. FARCHIONE: Okay.

3 MR. MISHKIND: You'll either
4 get that from Jan or it will be attached to the
5 copy of the transcript.

6 MR. FARCHIONE: Very good.

7 MS. ROLLER: I have a couple
8 other questions, Joe, if you're finished.

9 MR. FARCHIONE: Yes. Go ahead.

10 RE-EXAMINATION OF MICHAEL S. CARDWELL, M.D.

11 BY MS. ROLLER:

12 Q Dr. Cardwell, the labor of Kelly Fiktus, are you
13 of the opinion that this was a neglected labor,
14 as you use that term?

15 A Neglected in such that when the Pitocin resulted
16 in hyperstimulation and hypertonus, there was
17 negligence in the management. It was a
18 neglected labor.

19 Q Neglect or negligent?

20 A I'm using them interchangeably. I'm not saying
21 there's a difference.

22 Q Neglect and negligence, you're saying they're
23 the same words?

24 A I'm using them interchangeably in this case.
25 Neglect, negligence. Same route.

1 Q So your definition of a neglected labor is
2 what? That was a term you used earlier and I
3 just want to make sure I understand what
4 you're saying. How do you define a neglected
5 labor?

6 A Same as a negligent labor. It depends on the
7 circumstances. If Pitocin is being used
8 negligently, or if the patient is not being
9 monitored appropriately, it's a negligent labor.

10 Q The reason I'm asking you that is because you
11 would agree with me that this patient was
12 monitored closely, wouldn't you?

13 MR. FARCHIONE: What was the
14 answer?

15 MR. MISHKIND: She said, You
16 would agree with me that she was monitored
17 closely, wouldn't you?

18 A Not close enough. To be monitored closely, she
19 would have had to have internals in place by
20 2:00 in the afternoon.

21 Q You think different things should have been --
22 different things should have happened, but I'm
23 asking you with respect to the time and the
24 attention, maybe not the decision-making, but
25 with respect to time and attention, you would

1 agree with me that this labor was monitored
2 closely?

3 MR. MISHKIND: I'm going to
4 object to the question, but go ahead and answer
5 if you can answer it.

6 A Monitored closely with the exception that the
7 patient should have had internal monitors
8 placed.

9 Q All right. I asked you earlier whether you
10 felt this labor was either -- that it involved
11 either a protraction disorder or an arrest
12 disorder. And you said it did not?

13 A It did not because we do not have definitions
14 for a preterm labor.

15 Q But you believe this was an obstructed labor?

16 A I did not say that.

17 Q Well, do you think it was?

18 A Remember I told you the reason -- I believe you
19 asked me the reason the patient didn't deliver
20 or make progress. I said either from a
21 fetopelvic disproportion or a dysfunctional
22 labor?

23 Q All right. But in your opinion, does Kelly
24 Fiktus' labor qualify as an obstructed labor as
25 you use that term and how you've defined it?

1 A I didn't -- it was not -- I did not say it
2 was -- -- it was not an obstructed labor.

3 Q That is your opinion, it was not an obstructed
4 labor?

5 A Correct.

6 Q Okay. I think we finally got it.

7 Doctor, in your opinion, what was the
8 cause of the cord compression?

9 A Cord compression is usually from uterine
10 contraction. It could be from compressing
11 of the cord between the parts of the baby and
12 the uterine wall, or from the uterus itself, or
13 some other reasons. I don't know. It's
14 umbilical cord compression.

15 Q So you don't have any specific cause that you
16 assign for the cord compression that you believe
17 occurred in this case?

18 A No.

19 Q And do you have an opinion as to what caused
20 Kelly Fiktus' premature labor?

21 A No.

22 MS. ROLLER: That's all I
23 have. Thank you.

24 MR. MISHKIND: Okay.

25 MR. FARCHIONE: Nothing else for

1 me.

2 MR. MISHKIND: Okay. We will
3 read the deposition.

4 Let's see. We're four weeks from trial.
5 Two weeks?

6 (No response.)

7 - - - - -

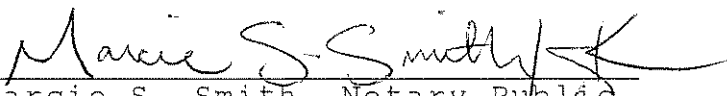
THE STATE OF OHIO,)
COUNTY OF CUYAHOGA.)

SS:

I, Marcie S. Smith, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that MICHAEL CARDWELL, M.D., was 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 by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, 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 in the foregoing caption specified. I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 31st day of March, 2003.



Marcie S. Smith, Notary Public
within and for the State of Ohio
My Commission expires April 20, 2004.

THE STATE OF _____)
)
 COUNTY OF _____) SS:

Before me, a Notary Public in and for said state and county, personally appeared the above-named MICHAEL CARDWELL, M.D., who acknowledged that he did sign the foregoing transcript and that the same is a true and correct transcript of the testimony so given.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at _____ this _____ day of _____, 2003.

 MICHAEL CARDWELL, M.D.

 Notary Public

My Commission expires: _____

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