THE STATE OF OHIO :
: SS:
COUNTY OF CUYAHOGA.

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IN THE COURT OF COMMON PLEAS

ZACHARY HAMMON, et al.,
plaintiffs, :
vs. : Case No. 209957
MARYMOUNT HOSPITAL,
et al.,
defendants. :

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DOC 134

Deposition of LEROY DIERKER, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Bruce A. Matthews, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, on Wednesday, April 28, 1993, at 2:10 p.m., pursuant to notice.

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I N D E X

WITNESS: LEROY DIERKER, M.D.

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(NO EXHIBITS MARKED.)

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(FOR KEYWORD AND OBJECTION INDEX SEE APPENDIX.)

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LEROY DIERKER, M.D.

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

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CROSS-EXAMINATION

BY MR. MELLINO:

Q. Would you state your name, please.

A. Leroy Dierker.

Q. What is your address?

A. 2410 Derbyshire, Cleveland Heights.

Q. Before we got started, you showed me your file in this case. I just want to get on the record everything that you reviewed before today's deposition, okay?

A. Yes.

Q. I'll just go a little faster to identify it. If I'm wrong about something, point it out.

The first thing is the infant's records from Marymount Hospital, correct?

A. Yes.

Q. Dr. El-Malewany's deposition?

A. Yes.

MR. KALUR: Office records.
A. Office records of El-Malewany.
Q. Dr. Redline's report?
A. Yes.
Q. Dr. Wiznitzer's report, Dr. Edelberg's report and his deposition, and the mother's chart from Marymount Hospital, correct?
A. Yes.
Q. Also, we have here in a bag the fetal monitor strips?
A. Yes.
Q. Those include the nonstress tests that were done?
A. They do.
Q. You've also made some notes from --
A. From my reading of this.
Q. Could I take a look at those?
A. Sure.
Q. You said in your report that you reviewed some University Hospital records. I didn't see those in there.
A, They were in the baby's records. I don't think I had any hospital records.
Q. From University?
A. I don't think I did.

Q. How many times have you testified before as an expert witness?

MR. KALUR: In depositions or in court or both?

MR. MELLINO: Both.

A. I'm not sure. Maybe ten to 12.

Q. How many of those times have been in court as opposed to deposition?

A. Two or three times in court.

Q. How many of those times have been for Mr. Kalur?

A. The testimony in court?

Q. Sure.

A. Maybe all three times.

Q. How about the depositions?

A. Probably half a dozen.

Q. How many cases total has he retained you to review records in?

A. Probably -- him personally?

Q. Yes.

A. Probably about a half a dozen.

Q. How about his firm?

A. Probably twice that many.

Q. Twice that many?

A. Yes. That's an estimate.

Q. How long have you been doing medical-legal reviews?
A. Probably about ten years.
Q. Do you have any idea of how many you've done in that period?
A, No.
Q. Do you have any idea how many you do in a year?
A. Maybe half a dozen.
Q. Do you have any idea of the percentage you testify for plaintiffs as opposed to defendants?
A. Testifying?
Q. Review cases, not testify.
A. About a quarter of the time for plaintiffs.
Q. What textbooks or journals do you consider authoritative on the subject of obstetrics?
A. I don't think any of them are authoritative, but all of them have some advice you use and some information that you don't.
Q. I see from your CV that you've written a couple articles that deal with midforceps deliveries.
A. Yes.
Q. Do you consider those relevant to the subject matter of this case?

A. Potentially.
Q. Are there any other articles that you've written or that are listed in your CV that would be potentially relevant?
A. Not that I know of.
Q. Are you familiar with the textbook Modern Instrumental Delivery?
A. Who is the author?
Q. Dr. O'Grady?
A. Heard about it.
Q. Have you read it?
A. No.
Q. So you don't know whether that's authoritative or not?
A. That's correct.
Q. Do you know Dr. O'Grady?
A. Yes, I do.
Q. Do you know what his expertise is in instrumental deliveries?
A. He wrote a book.
Q. Is shoulder dystocia an event that can cause asphyxia?
A. Yes.
Q. Did it in this case?
A. Probably.

Q. Did the shoulder dystocia and asphyxia that occurred contribute to produce Zachary's injuries in this case?
A. Probably had an effect.
Q. Does the standard of care require that an obstetrician who is delivering an infant to estimate the size of the baby?
A, I'm not sure what you mean.
Q. What part don't you understand?
A, You mean do you have to write it down, do you mean -- I'm not sure what you mean by consider the size of the infant.
Q. Well, did Dr. El-Malewany estimate the size of the baby in this case?
A. I didn't see him write it down.
Q. Do you have an understanding one way or another whether he did or not?
A. In reading his deposition, I think he mentioned that he thought the baby was nine to nine and a half pounds. That's the only notation that I recall.
Q. Getting back to my question, is that one of the things that a prudent obstetrician does, estimate the size of the baby before delivery?
A. Sure.

Q. You're saying he doesn't necessarily have to write that down in the chart?
A. That's correct.
Q. So if he didn't estimate the size of the baby, then that would be below the standard of care?
A. I don't think he had to write it down on the chart.
Q. I understand that. But he has to do it?
A. Sure,
Q. If he didn't do it, that's the below the standard of care?
A, Well, I think you always -- well, I think any time you are doing an operative delivery, you estimate the size of the baby.
Q. You do or you should?
A. I do.
MR. KALUR: There's no question he should. We'll stipulate, so we don't need to play games. He should have. Any competent, prudent physician should attempt to estimate the fetal weight before attempting an operative delivery. Okay? We agree to that.
Q. Do you agree with the statement that there's no such thing as a large baby which cannot go

through the birth canal?
A. I don't know in what context that was made and where it comes from.
Q. So you can't agree or disagree?
A. It's taken out of context. I need to know in what context it was taken.
Q. Well, the statement is that there's no such thing as a large baby which cannot go through the birth canal.
Aren't there instances where the baby can be too large for the birth canal?
A. Sure.
Q. Do you differentiate between the terms postdates and post-term?
A. I use the terms interchangeably,
Q. How do you use them?
A, Beyond 42 weeks gestation.
Q. How about a large for gestational age and macrosomia?
A. Distinction,
Q. What's the distinction?
A. Macrosomia is an absolute birth weight. Large for gestational age refers to the gestational age at the time the weight is taken.
Q. What would be a large for gestational age

baby at term?
A. Depends a little bit on the age of the infant, whether it's 38 or 42 weeks, but generally over nine pounds would be a large for gestational age infant.
Q. How would that be different if it was 41 or 42 weeks?
A. The curves continue to go up, and so if you have good curves, you may be able to show a difference in weight between 38 and 42 weeks.
Q. If you had a nine or nine and a half pound baby at 41 or 42 weeks, would that be large for gestational age?
A. Both of those would be large.
Q. Then how do you define macrosomia?
A. Over 4500 grams.
Q. How do you define a midforceps delivery?
A. Just like the American College does.
Q. Which is what?
A. An instrumental delivery of an infant that's above plus 2.
Q. So plus 1 then would be midforceps?
A. That's correct.
Q. A low forceps would be below plus 2?
A. Plus 2 and below.

Q. If there's molding, would that factor into whether you're doing a mid or a low forceps?
A. Probably wouldn't.
Q. Does it make it a difficult as opposed to a regular mid or low forceps?
MR. KALUR: Make what difficult, the delivery or assessment of stage of descent, which one?
MR. MELLINO: Let me try again.
Q. Is there a definition known as a difficult midforceps or don't you use that term?
A. That's a modifier that you might use if you did it, but I don't know that it's a definition.
Q. Does molding make it difficult to assess the station?
A, It makes it more difficult, sure.
Q. Is it a sign that there's fetopelvic disproportion?
A, Not necessarily.
Q. How about cephalopelvic disproportion?
A. Not necessarily.
Q. Is there some correlation though?
A. Sure.
Q. If you see molding, that's one of the things

you have to at least think about?
A. Sure.
Q. What were the indications for the use of forceps in this case?
A. It appears that the mother had been complete and pushing for about an hour and the fetus and mother had a fever, and there was evidence of chorioamnionitis.
Q. What was the evidence of chorioamnionitis?
A. Fever, fetal tachycardia.
Q. Anything else?
A. She had leucocytosis, but I think that was identified later.
Q. Did you say that there was a fetal fever?
A. I said the mother had a fever. It was a fetal tachycardia.
Q. You're saying those were indications for use of the forceps?
A. Yes.
Q. Or are those indications that the baby needed to be delivered?
A. It was an indication for delivery.
Q. What's the treatment if you suspect that the mother has an infection?
A. Antibiotics and/or delivery.

Q. Pardon?
A. Antibiotics and/or delivery.
Q. How soon do you have to effect delivery?
A. Depends on the condition.
Q. What would make delivery more necessary, what are the factors?
A. Higher fever or sign of a more serious infection.
Q. What's the range of fever that you would look for?
A, Well, I think if you had a temperature of 38 degrees, 100.4, that would be a relatively mild fever. If you had a fever like this woman, who was 102 to 103, it's a more serious indication and more suggestive of a more serious infection.
Q. So how soon would you need to deliver the baby?
A. I think that you have probably some period of hours; usually one to two would be preferable.
Q. What are the contraindications to a forceps delivery?
MR. KALUR: In this case or in general?
MR. MELLINO: In general,
MR. KALUR: Can you answer

that this afternoon?
A. In general, the indications would be a high fetal station, anticipated difficulty with or potential for injury with the case due to position or size, not being familiar with the technique; those would be the primary indications.
Q. Can forceps deliveries cause shoulder dystocia?
A. They can contribute to it.
Q. How does that happen?
A. If you have an infant who is large for gestational age or macrosomic and labor is prolonged, then instrumental delivery may raise a risk of shoulder dystocia,
Q. What would be prolonged labor?
A, Usually second stage of over two hours.
Q. What is an arrested descent?
A. It's when the fetus stops coming down the pelvis usually for a period of one to two hours,
Q. What are the risk factors for shoulder dystocia?
A, Big baby, small pelvis, diabetes.
Q. Any others?
A. Well, as we mentioned, instrumental delivery with a prolonged second stage and a large baby.

Q. How about this being the mother's first delivery?
A. Minor risk factor.
Q. What are some of the things you look for as an obstetrician to tell you that there's potentially a large baby?
A. Fundal height, high presenting station, abnormal labor, arrest of descent.
Q. How about being 42 weeks gestation?
A. That would increase the risk.
Q. You said high station, What station would that be?
A. If she came into labor and the station was minus 2 or minus 3, that would also be a relative sign.
Q. What about excessive maternal weight gain?
A. Minor risk. It depends more on her initial weight than gain,
Q. What would be excessive weight gain?
A. Depends on the size of the mother.
MR. KALUR: He's saying her weight before she got pregnant would be the bigger factor.
MR. MELLINO: I understand.
MR. KALUR: That's what the

books say, too.

MR. MELLINO: Thanks.

Q. What about her case, did you notice her size and weight gain?

A. Yes.

Q. What was it?

A. She went from about **125** to about 160-something. **127** to **188** -- no, it's to **179**.

Q. 127 to **179?**

A. Yes, **51** pounds.

Q. Would that be an excessive weight gain?

A. It would be an unusual amount.

Q. Would that be an indication of the potential for a large baby?

A. Not in itself. I'd be more concerned about a mother who would start out at a heavier weight, weighed 160 and gained **50** pounds.

Q. If she started out at a heavier weight --

A. And gained that much weight, it would be much more of a risk.

Q. So you don't think the weight gain in this case should have been an indication of a large baby?

A. Probably not. The fundal height measurements were all pretty consistent with her dates.

Q. You point out in your report that there's good variability on the fetal monitor strips throughout her labor. What's the significance of that?

A. It's usually a good sign, oxygenation.

Q. Does it tell you anything about the status of the baby?

A. It suggests that it's doing well.

Q. While we're talking about the mother's size, was she a small woman?

A. Yes.

Q. Is there a correlation between her size and the size of her pelvis?

A. Variable.

Q. Even though it's variable, is that something that the obstetrician should think about; if he has a small mom, that the pelvis may be small?

A. Sure.

Q. Were there signs of fetal distress in this labor?

A. There was a development of fetal tachycardia late in the record, but there are no other signs of fetal distress.

Q. So I take it then --

MR. KALUR: Are you saying

on the monitor or are you saying, in general, any signs of fetal distress? I didn't understand what your question was.

MR. MELLINO: I wasn't limiting it to the monitor.

MR. KALUR: Okay.

A. There was meconium, however.

Q. Did you see any late decelerations on the fetal monitor strip?

A, No.

Q. Did you see any decelerations?

A, Sure.

Q. At what times did you see decelerations?

A. Variable times.

Q. Well, I'd like you to be more specific and tell me what times you saw them.

A, There's a deceleration at 13:25, 13:10, 13:00, there's one at 12:42, but these are all minor variable decelerations of no consequence.

Q. Are there any others?

A. I'm sure if I looked over 12 hours. Here is one at 11:18, 10:01, 8:58, 9:48, 8:36. Do you want all of them? These are all minor, inconsequential decelerations.

Q. Are they all variable?

A. Yes, and mild,
Q. Would you agree that if the baby is potentially macrosomic, that you don't instrument the baby?
A. Yes.
Q. If the baby was at a plus 1 station when the forceps were applied, would this delivery then have been below the standard of care?
A. Yes.
Q. When did the mother become infected?
A. I think she began to show signs of infection around 10:00 o'clock in the morning.
Q. Whenever she had the fever?
A. No. When the fetal heart rate started to go up.
Q. Does that tell you when she became infected?
A. It's a clue. We have no other apparent cause for it.
MR. KALUR: He may be interpreting your answer to mean that at that moment in time she became infected.
A. I said that's when she started showing symptoms of it.
Q. Right. I understood your answer correctly, I guess I want to know if you can pinpoint it.

Do you have any evidence that she was infected before that time?

A. There's no clinical evidence aside from meconium that she was infected. At the time she came in, she had a white count elevation, I think, leucocytosis. I'm not sure what time that was drawn.

Q. Are you talking about after she delivered?

A. It was 17,000. I'm not sure when that was.

Q. Do you have an opinion one way or the other whether she was infected before 10:00 o'clock in the morning?

A. I think that the infection was developing certainly before 10:00 o'clock. That's when it began to manifest some symptoms.

Q. Do you have an opinion as to when it began developing?

A. Hours before that,

Q. How many hours?

A. I don't know.

Q. You don't know?

A. No,

Q. What are the consequences to the baby if the mother gets infected?

A. The baby may get infected.

MR. KALUR: 10:34 a.m., 1722 on the leucocytosis,

Q. What can be the consequences to the baby if the baby is infected?

A, The baby may have a very serious infection and it could kill the baby.

Q. Anything else?

A, It could cause almost anything short of that, pneumonia, shock, kidney damage, various serious injuries, brain infections.

Q. Did this baby go into shock?

A. I don't have the records for University.

Q. So you don't know one way or another?

A. Well, when it was born it was in shock, but I don't know how long it persisted after that.

Q. What do you mean by that, when it was born it was in shock?

A, It didn't have a heartbeat, no pressure.

MR. KALUR: Pretty shocking,

Q. Do you have an opinion as to what was the cause of that, the fact that it had no heartbeat or respiration?

A. Yes.

Q. What is that?

A. I think it was due to a combination of the infection in the infant and the delay in delivery, the shoulder dystocia.

Q. What leads you to conclude that the infection had a role in it?

A. The baby showed signs of infection with the elevation of the fetal heart rate, the foul smelling fluid at the time of delivery and the meconium, supported by the examination of the placenta; and the neonatal course, as I understand it, was protracted; and usually a shoulder dystocia of this duration is not associated with this degree of depression.

Q. But all those things you just cited, you could have those in the absence of an infection, correct?

A. Probably not with the maternal fever. I mean, it would indicate an infection in the mother, but those signs of the foul smelling fluid, the high fetal heart rate and the maternal fever are very suggestive of an infection.,

Q. Well, the baby can be infected without it causing any brain damage, correct?

A. Sure.

Q. If there's an event that causes asphyxia

during the delivery, you could have the same signs and symptoms that this baby had, correct?
A. It would not usually be this protracted nor this severe in the absence of something else.
Q. But you still could have it?
MR. KALUR: Could have what?
Q. It might be unusual?
MR. KALUR: Don't answer that question until he gets specific on what he's talking about here. Make the question clear. Let's drop the pronouns.
Q. You could still have the same symptoms that this baby had when he was born --
MR. KALUR: If what?
MR. MELLINO: Why don't you let me finish the question.
MR. KALUR: I'm sorry. I thought you finished,
Q. You could still have the same symptoms this baby had when he was born with asphyxia alone, would that be correct?
A. What symptoms?
Q. No heart rate, no respirations.
A. Sure.

Q. There could also be a protracted neonatal course from just asphyxia alone, correct?
A. Sure.
Q. The baby can have tachycardia without having an infection, would that be true?
A, Yeah.
Q. What about foul smelling fluid, could you have that without the baby being infected?
A. The mother could have an infection without the baby growing bacteria from the blood, but the baby would probably have bacteria and infection superficially. This baby was infected.
Q. What do you believe to be the mechanism of brain damage from the infection?
A. From infection in general?
Q. No, in this case.
A. I'm not positive when the brain damage occurred, but if this baby was infected with bacteria in his bloodstream and had low blood pressure, had also sustained hypoxia from delayed delivery, that combination could be sufficient to cause a problem.
Q. Well, I'm not sure if I asked this question before, but do you believe that the infection in this case coupled with the hypoxia -- did you call

it hypoxia or anoxia?
A. I didn't, I don't think.
Q. Do you believe that the infection in this case coupled with the asphyxia that occurred during the delivery caused brain damage to Zachary?
A. I don't know, I think that the combination of the infection plus the delayed delivery caused the baby to be depressed at birth,
Q. But you don't have an opinion one way or the other as to whether that caused permanent brain damage?
A. That's correct.
Q. Have you ever had a case where an E. coli organism or an infection that's caused by E. coli has caused brain damage to an infant?
A. Death, number of deaths,
Q. How about brain damage?
A, Brain dies when the baby dies.
Q. Well, has the infant lived but had brain damage?
A, Sure, sure.
Q. With E. coli?
A, Yes.
Q. How many cases?
A. I don't know. E. coli is a common cause of

meningitis, and that causes brain damage, too. That's one of the problems with E. coli sepsis, it affects many organs.

Q. So would the baby have to have meningitis to get brain damage from E, coli?

A. No, not necessarily, You just asked if I had somebody that had brain damage.

Q. I'm not trying to argue with you. Have you had any cases where there hasn't been meningitis, but you've had brain damage in a living infant from E. coli?

A. I think so,

Q. Can you give me any number of cases?

A. A few, It would be easier to ask a neonatologist, because they see more than I do.

Q. Do you know the mechanism of brain injury in those cases?

A. I suspect shock has something to do with it.

Q. How do you define shock?

A, Insufficient pressure and oxygenation to oxygenate the tissue.

Q. Did I hear you say before that you don't know when the brain damage occurred in this case?

A. That's correct.

Q. Did it occur after delivery?

A. I don't know.
Q. If the infection were causing some injury to the baby's brain in utero, wouldn't that be exhibited by the monitor strips?
A. It did show tachycardia.
Q. Is tachycardia a sign of decreased oxygenation?
A. It might be.
Q. If the infection were causing some type of brain injury to the baby in utero, wouldn't you expect to see late decelerations on the monitor strip?
A. You might.
Q. Aren't those a better sign of decrease in oxygenation?
A, A decrease in oxygenation, correct,
Q. If the infection was causing a brain injury, would you also expect to see a decrease in the beat-to-beat variability?
A. Not necessarily. I don't know what you would see if you had a brain infection or a generalized infection of the body, a sepsis.
Q. You don't know how that would exhibit itself on a fetal monitor?
A. Initially, you may only see an increase in

heart rate.
Q. Doesn't beat-to-beat variability tell you something about the function of the baby's brain?
A. It tells you something about it.
Q. If there's good beat-to-beat variability, doesn't that tell you that there's good brain function?
A. It's a good sign. It doesn't tell you there's good function.
Q. Well, it would argue against there being any injury at that time, wouldn't it?
A. It would argue against it.
MR. KALUR: Would it win the argument?
THE WITNESS: It may show a sign of an ongoing problem.
Q. How severe does the infection have to be to cause brain injury?
A. Enough to damage tissue or cause decreased blood flow to it.
Q. You just don't know if that happened in this case because you --
A. I don't see any sign of brain damage in this child before delivery.
Q. Have you ever been an expert in a shoulder

dystocia case?
A. Yes.
Q. Was it in Cuyahoga County?
A. Yes.
Q. Was it for a plaintiff or a defendant?
A, For a defendant.
Q. Do you know the name of the case?
A, No.
Q. Was your deposition taken?
A, Yes, I think it was. I think so.
Q. Do you know who took your deposition?
A. No.
Q. Do you have some record that would tell you what the name of the case was?
A. I don't know that I do.
Q. Do you remember the patient's name?
A. No.
Q. Do you know who retained you in that case?
A, No.
Q. How long ago was it?
A. Several years.
Q. Have you ever been an expert in a forceps case?
A. As far as being deposed? Yes.
Q. Have you been deposed in one or retained in

one?
A. I've been deposed.
Q. Do you know the name of that case?
A. I don't remember the name.
Q. Who retained you in that case?
A. Kalur.
Q. Do you remember the name of the patient?
A. No.
Q. Was Mr. Kalur representing a doctor?
A. I think so.
Q. Do you know the doctor's name?
A. No, I don't.
MR. MELLINO: Do you know the name of the case?
MR. KALUR: I'm just scratching my head trying to remember it. I can't, Chris. I actually don't remember, seriously, what case he's talking about. The two I can recall didn't involve forceps.
Q. You don't keep any kind of records on these cases?
A. I might on that one.
MR. MELLINO: Could you guys come up with the name of that case?
MR. KALUR: If he's got the

records. I remember one I had him testify on was a premie case and one was a term kid where forceps weren't used out in Ashtabula. I don't remember the forceps, but if he's got it, we'll find it.

Q. What professional societies do you belong to? Are those on your CV?

A. I don't know. American College of Obstetricians and Gynecologists, Central Association of Obstetricians and Gynecologists, the Society of Perinatal Obstetricians and the Cleveland Ob. Gyn. Society.

Q. Do you know Dr. El-Malewany?

A. No.

Q. A nine or nine and a half pound baby is potentially macrosomic, isn't it?

A. A nine pound baby is not macrosomic.

Q. I said potentially macrosomic.

A. No.

Q. Nine and a half is macrosomic?

A. No.

MR. KALUR: 4500 grams is macrosomic. Nine and a half isn't 4500 grams.

Q. Nine and a half is potentially macrosomic?

A. No.

Q. Well, ten pounds is 4500 grams, right?

A. Bingo.
Q. Well, I mean, if you have a ten-pound baby, you're definitely macrosomic; the potential is removed, correct?
A. That's the definition.
Q. Would it be inappropriate to use instruments to deliver a large for gestational age infant?
A. No, not necessarily.
Q. If you do instrument large for gestational age babies, you certainly risk shoulder dystocia, correct?
A. You always risk shoulder dystocia.
Q. Well, you increase the risk of shoulder dystocia by instrumenting a large for gestational age baby, don't you?
A. It depends on the size of the baby.
Q. Well, I thought you already defined a large for gestational age baby,
MR. KALUR: He didn't already say he knew it was a large for gestational age baby before he puts the instruments on. How are you going to know that ahead of time?
Q. You're never going to know what size the baby is until you --
MR. KALUR: That's the

fallacy in your question. That's what I'm pointing out.

MR. MELLINO: I see.

Q. Would it be inappropriate to instrument a potentially large for gestational age baby?

A, It depends on the circumstances.

Q. Under what circumstances would it be inappropriate?

A. If it was macrosomic, if labor was not progressing normally and you had an arrest at the second stage, arrest of descent, then you run a risk of shoulder dystocia.

Q. Well, when you answered my question, you said it would be inappropriate if the baby was macrosomic. You wouldn't know that ahead of time, right?

A. You probably wouldn't. You may not know.

Q. So if you should have anticipated a macrosomic baby, then it would be inappropriate, correct?

A. If you anticipated a macrosomic infant and delivered instrumentally, you run the risk, a high risk of shoulder dystocia.

Q. Under those circumstances, would it be below the standard of care then to apply instruments to

deliver that baby?
A. It would run the risk of injury. It might depend on the circumstance.
Q. Well, once again, under what circumstances would that be inappropriate?
A. Inappropriate?
Q. Yes.
MR. KALUR: You mean what he said before, you want him to repeat it? Or is this a different question?
MR. MELLINO: This is a different question.
A. Could you repeat it, please?
Q. Sure. I'll rephrase it. If you anticipate that the baby is macrosomic, under what circumstances then would it be appropriate to do an instrumental delivery?
A. If delivery had to be done within a short period of time and provisions for C-section were not available.
Q. So C-section should be your first course of action?
A. It depends on the circumstance,
Q. Well, let's talk specifically about this case then. If Dr. El-Malewany anticipated that this

would be a macrosomic infant, would it be appropriate for him to do an assisted delivery?

MR. KALUR: Show an objection to that question,

A. Is that a hypothetical?

Q. Yes.

A. Yes.

Q. Yes, it would have been appropriate?

A. Under these circumstances.

Q. Just to take it one step further, if there were signs and symptoms that should have alerted him to the potential of a macrosomic baby so that he should have anticipated macrosomia, would it have been below the standard of care for him --

MR. KALUR: Objection.

A, Such as what symptoms?

Q. That she was at **42** weeks, there was an excessive maternal weight gain --

A. She wasn't **42** weeks.

Q. **So** you dispute the records from Marymount on that point then?

A. I'm saying she's not **42** weeks.

Q. Did you see in the record where it says all over that she's **42** weeks?

A. I saw where it was mentioned she was **42**

weeks, but her prenatal record does not show that.
Q. Records at Marymount have it in about five or six different places, don't they?
A. I saw it in one place.
Q. Dr. El-Malewany put it in there in a couple different places?
A, I'm not sure who put it in.
Q. In terms of trying to anticipate whether the baby is large or not, I mean if he thinks it's 42 weeks, then that should be a sign to him; I mean the fact that he's wrong about that, if he thinks it's 42 weeks, that should be something to alert him to the fact there's a big baby, correct?
A, That would be one thing, yes.
Q. Did you say before it was appropriate to treat a maternal infection with antibiotics?
A. I said that was one option.
Q. If you did that, would you allow labor to continue?
A. It depends on the circumstance, I think I mentioned,
Q. What does it depend on?
A. The symptoms. If the fever is high, you probably wouldn't want to wait as long. If the fever was lower, you probably got more time.

Q. Well, you give antibiotics and the fever comes down. Would that allow you to continue labor?
A. Fever doesn't usually come down when you give antibiotics under these circumstances,
Q. Should antibiotics have been given in this case?
A. No. I think it could have been delayed until after delivery as long as delivery was within a short period of time,
Q. How do you determine if you have a prolonged second stage when you interrupt the second stage with an instrumental delivery?
A. Your question doesn't make sense.
Q. You said when we were discussing the contraindications to a forceps delivery, I think you said that a prolonged second stage would be one of them,
A. You asked for indications, for contraindications to instrumental delivery.
Q. Right.
A. With a macrosomic infant.
Q. If forceps hadn't been used in this case, then she may well have had a prolonged second stage, correct?

A. Don't know,
Q. I guess that was my point, there's no way to tell because the second stage was interrupted with the use of forceps?
A, Well, she was making normal and even good progress, so there's no reason to expect her to stop.
Q. Well, what progress did she make from 1:00 o'clock to the time the forceps were used?
A. At 12:55 or 1:00 o'clock, she was complete and zero station, and she was taken back for delivery at 1:00 o'clock.
MR. KALUR: 1:35.
A. At 1:35 she was plus 1 to plus 2, so she was making good descent.
Q. Where did you see at 1:35 that she was plus 1, plus 2?
A, In the chart,
MR. KALUR: Dr. El-Malewany's either operative delivery note or his typed op note. She reached full dilation plus 2, that's the time he put on the things.
MR. MELLINO: 1 was interested in a contemporaneous note.
MR. KALUR: We've got that

for you, too.

MR. MELLINO: Good. I'd like to see it.

A. 1:00 o'clock, had station zero; 1:05, had plus 1. That's written in the note.

Q. Right.

MR. KALUR: Contemporaneous progress notes, see?

Q. Sure, but is there a contemporaneous note that shows she went below plus 1?

A. It's not been dictated.

Q. The handwritten delivery note doesn't say anything about station of the head, correct?

A. It said plus 1.

MR. KALUR: He means the delivery note here. This doesn't say anything about it.

THE WITNESS: No. That's correct.

MR. KALUR: It's in his typed noncontemporaneous.

MR. MELLINO: The operative note, dictated operative note.

MR. KALUR: Yes. The discharge summary, too. You're quite correct,

those two were not dictated at the time, but later.

BY MR. MELLINO:

Q. There's nothing in the nurses' notes about the station of the head?

A. The nurses probably wouldn't examine her after that.

Q. But there's nothing in the notes from 1:00 to 1:47?

A. That's correct, from 1:05.

Q. I know you let me look at these notes, but I couldn't read your writing and I would appreciate if you would read those for me.

A. Where?

Q. The whole page.

A. "Beraradinelli Hammon versus El-Malewany, Kalur, not sure LMP. Ultrasound 2/1/88, 10.5 weeks. Due date 8/25/88. Ultrasound 4/18, about 22 weeks. 8/23/88, due date. Negative GTT. Fundal height equals dates. Presented 9/1/88, 41 weeks gestation. Labor onset 22:30 on 9/1. 3 to 4 centimeters at 8:30."

Q. That's just the tracking.

A. What don't you want me to read?

Q. You just tracked her progress from 8:30 to

12:35?
A. Right.
Q. You have here, "13:53, low forceps plus 2." What's that say in parentheses?
A. "For infection, Ped/Stork in attendance." I didn't know it was dictated on the same day.
MR. KALUR: He wants the exact minute.
A. He wrote the note afterwards.
Q. Go ahead. Finish reading that.
A. "Severe shoulder dystocia about five minutes, meconium, episiotomy, posterior shoulder, suprapubic pressure, notochord times two, foul smelling, shoulders above pelvis, neonatal blood positive for E. coli, present in placenta, 4750 gram male, brachial plexus and pyloric stenosis.''
Q. Where did you get the weight from?
MR. KALUR: It's in the UH chart. He must have had a discharge summary because it's noted in his report, too. I don't know what's happened to it here.
A. It may have been mentioned in here somewhere.
MR. KALUR: I don't think they weighed him while he was still there at

Marymount,

A. I don't know where I got it.

MR. MELLINO: Doctor, I don't have any other questions for you this afternoon. Thanks.

THE WITNESS: Okay.

MR. LITTLE: I don't have any questions.

MR. KALUR: We're done then.

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(Deposition concluded; signature not waived.)

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ERRATA SHEET

PAGE LINE

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

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LEROY DIERKER, M.D.

The State of Ohio, .
County of Cuyahoga. CERTIFICATE

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 3rd day of May, 1993.

Bruce A. Matthews, RPR-CM,
Notary Public/State of Ohio.
Commission expiration: June 24, 1993.

Look-See Concordance Report

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762 UNIQUE WORDS
386 NOISE WORDS
6,375 TOTAL WORDS

- - -

SINGLE FILE CONCORDANCE

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CASE SENSITIVE

- - -

EXCLUDES OCCURRENCES IN FIRST 3 PAGES

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