IN THE COURT OF COMMON PLEAS

HURON COUNTY, OHIO

ANGELIA FORTNER, ADM., ETC.,

Plaintiffs,

-vs- CASE NO. CVA-96-756

FISHER-TITUS MEDICAL CENTER, ET AL.,

Doc. 15

Defendants.

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Deposition of LeROY J. DIERKER, M.D., taken as if upon cross-examination before Linda A. Astuto, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, Seventh Floor, 113 St. Clair Building, Cleveland, Ohio, at 9:00 a.m. on Wednesday, May 6, 1998, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant
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On behalf of the Defendant
Ralph May, M.D.

LeROY J. DIERKER, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF LeROY J. DIERKER, M.D.

BY MS. EKLUND:

Q. Doctor, I am Claudia Eklund. I represent Angelia Fortner and the Estate of Ciara Renee Sams in this case.

I'm going to ask you some questions. I assume you've been deposed before.

You understand the ground rules, correct?

A. Yes.

Q. I have in front of me a copy of your curriculum vitae which I assume is current?

A. It looks current.

Q. Okay. Would you state your name for the record.

A. LeRoy Joseph Dierker.

Q. Would you spell it?

A. D-i-e-r-k-e-r.

Q. And you are a medical doctor specializing in OB/GYN?

A. Yes.

Q. And you're presently associated with which hospital?
A. MetroHealth Medical Center.
Q. How long have you been with MetroHealth?
A. Twenty-two years.
MR. TATTERSALL: Pardon me?
A. Twenty-two years this summer.
Q. Do you hold any titles at MetroHealth?
A. Professor at Case Western Reserve and Director of Obstetrics and Internal Fetal Medicine at MetroHealth.
Q. How long have you been director at MetroHealth?
A. Since 1983.
Q. Are you a full professor at Case Western Reserve?
A. I am.
Q. What do you teach there?
A. Obstetrics.
MS. SANDACZ: I'm sorry?
A. Obstetrics.
Q. Is that classroom teaching or in hospital training?
A. It varies. We have largely in-house training with students that rotate through our service. But on occasion lectures to the first and second year students.

Q. In terms of your professorship at Case Western Reserve, when was the last time you were in a classroom instructing at the university?
A. About two years at the university.
Q. And I assume you've maybe given lectures at MetroHealth?
A. Yes.
Q. And that would have been to residents rotating through your service?
A. Students and residents but mainly students from Case.
Q. Do you have privileges at any other area hospitals?
A. I have privileges at Cleveland Clinic Foundation.
Q. Do they have an obstetrics ward at Cleveland Clinic?
A. Yes, they do.
Q. Do you admit patients at the Cleveland Clinic?
A. No.
Q. Okay.
A. Consultative.
Q. Do you have a private practice in addition to your hospital appointment and teaching responsibilities?
A. Yes.

Q. Where is your office located?
A. At Metro.
Q. And is your private practice divided between obstetrics and gynecology?
A. Yes.
Q. Is the majority of your patient work in obstetrics?
A. Majority.
Q. Can you divide it in any percentage?
A. 70/30.
Q. Are you in partnership with anyone?
A. No.
Q. In the curriculum vitae which we have, there are a number *of* articles listed, chapter review, things of that nature.

Do any of these articles deal with pre-term labor?
A. No.
Q. Have you ever written on the subject of pre-term labor?
A. No.
Q. For how many years have you been doing medical/legal consultation?
A. Probably about 15.
Q. And how many cases a year do you review?

A. My guess is six to ten.

Q Okay You previously primarily on behalf of defendants?

A. Primarily

Q When was the last time that you can recall that you reviewed a case on behalf of a plaintiff?

A. Two weeks ago.

Q When was the last time that you testified on be al of a plaintiff?

A. I don't recall

Q When was the last time you testified on behalf of a defendant?

R TAMMERSALL: You mean in a deposition?

Q deposition or in court

A. I think earlier this year, January or February

Q Was that in court or in deposition?

A. deposition

Q Do you recall who the attorney was in that case?

A. No, I don't.

Q. Do you recall the attorney who retained you in that case?

A. I'm not sure.

Q. Do you recall the name of the case?

A. I'm not sure

Q. I could have guessed that.

Have you testified in any cases involving spontaneous rupture of membranes and pre-term labor?

A. I don't think so. I don't think that was the focus of the case. I may have been involved in a pre-term labor case, it might be part of the process but I don't think where that was the focus.

Q. Have you been involved in pre-term labor cases?

A. I'm sure I have.

Q. Any that you recall the names of the attorneys involved?

A. No.

Q. What do you charge for your services?

A. $300 an hour.

Q. Is that for review of records?

A. Uh-huh. Yes.

Q. Is that for deposition testimony?

A. Yes.

Q. Is that for trial testimony?

A. Yes.

Q. Have you testified at Mr. Tattersall's request before?

A. Yes.

Q. Can you tell me how many times you've worked with him in a case?
A. I think once.
Q. Do you recall what that case was about?
A. I believe it was a shoulder dystocia.
Q. Have you worked with other members of Mr. Tattersall's firm?
A. I don't think so.
Q. What about the law firm of Reminger & Reminger? Have you worked with attorneys from that firm?
A. Yes, I have.
Q. Do you recall who you worked with?
A. If you give me a list, I can tell you.
MS. SANDACZ: It wasn't me.
Q. Do you know many attorneys here, is that fair to say?
A. Several.
Q. Were these all in birth cases?
A. I think largely.
Q. Do you recall any cases in which you testified in a courtroom setting?
A. For --
Q. Any party.
A. I remember several, yes.
Q. Do you remember the names of the cases?

A. I don't.
Q. Or the attorneys involved?
A. I have done some with PIE. I remember Jerry Kalur. And Bill Bonezzi. I think I have done some with Les Spisak.
Q. Now, Mr. Bonezzi is a defense attorney, correct?
A. Correct.
Q. And Jerry Kalur was a defense attorney?
A. That's correct.
Q. And Les Spisak is a defense attorney?
A. Yes.
Q. He is with Reminger & Reminger?
A. Yes.
Q. Do you know any of the physicians involved in the Angelia Fortner case?
A. No.
Q. Have you met any of them?
A. No.
Q. Have you ever had privileges at Fisher-Titus Medical Center in Norwalk?
A. No.
Q. Have you ever been to that facility?
A. No.
Q. Do you know any of the other experts involved in this case?

A. I don't know them personally, no.
Q. Have you heard of any of them?
A. Fields.
Q. What have you heard of Dr. Fields?
A. I've just read his testimony in previous cases.
Q. And was that provided to you in regards to this particular case?
A. I have his deposition.
Q. From this case?
A. From this case.
Q. Is that the deposition you're making reference to?
A. Yes. I have read other depositions of his in other cases.
Q. But you don't know of him personally?
A. No.
Q. What about Dr. Walentik who happens to be from St. Louis?
A. I don't know.
Q. W-a-l-e-n-t-i-k. And Dr. Nowicki from Columbus?
A. Don't know him.
Q. N-o-w-i-c-k-i. In teaching your medical students, do you teach them the basics of labor and delivery?
A. Yes.

Q. Do you refer to any particular medical texts as a teaching aid?
A. There are several that we use.
Q. Which ones?
A. We use Williams Obstetrics. We use Creasy & Resnik. C-r-e-a-s-y, R-e-s-n-i-k.
Q. Those are the two basic ones?
A. And others. Journals as well.
Q. And you are a member of the American College of Obstetrics and Gynecologists?
A. I am.
Q. And they publish --
A. Technical bulletins.
Q. I call them guidelines but you would disagree with that?
A. They're called technical bulletins.
Q. And do you use those technical bulletins also as a teaching aid with your students?
A. Yes.
Q. You use them yourself in your practice?
A. Yes. I refer to it.
Q. Have you ever been involved in a lawsuit as a party?
A. I was named in one that was subsequently dropped.
Q. What type of a case was that?

A. It was a stillbirth.
Q. How long ago was that?
A. 13, 14 years.
Q. Do you recall who defended you in that case?
A. It never came about. I never gave a deposition. The hospital.
Q. You didn't have personal counsel?
A. No.
Q. The case was just dropped?
A. Yes.
Q. You never testified at deposition or anything like that?
A. Correct.
Q. Doctor, can you give me a textbook or a classroom definition of labor?
A. Uterine contractions that result in cervical change.
Q. And what type of cervical change are we talking about?
A. Effacement and/or dilatation.
MR. TATTERSALL: What was the other?
A. Effacement and/or dilatation.
Q. Do you need both effacement and dilatation to have labor?

A. No. Either or.
Q. Either or. Does Williams define labor as including the presence of cervical dilatation?
A. I'm not sure how Williams defines it.
Q. Do you know how Creasy and Resnik define it?
A. I'm not sure of their specific definition.
Q. Would you agree that you cannot diagnose labor on the basis of the presence *of* contractions only?
A. Correct.
Q. Do you agree that contractions have to be producing change in the cervix?
A. In order to make a definite definition, yes.
Q. And in order to determine whether there's been a change in the cervix, you have to observe the effects of the contractions over some period of time, is that fair?
A. It depends on the situation. It may be that when you examine them, there is perceived change from what you would anticipate the cervix being.
Q. That may or may not be a change, is that something you would still have to observe to see if that is a continuing process?
A. To make the definite definition, probably so.
Q. Can you tell me how you distinguish false labor

from true labor?

A. False labors are irregular in frequency and intensity and do not result in cervical change.

Q. Do they result in cervical dilatation?

A. No.

Q. And true labor?

A. Results in cervical change, effacement and/or dilatation.

Q. Is it true that in a normal term pregnancy, cervical effacement begins to occur before active labor occurs?

A. It depends on how you are using specific definitions. At mature labor, active labor being the cervix being four to five centimeters, if you're using that as a specific framework, then usually there is effacement concurrent with dilatation.

Q. When does effacement begin in a normal pregnancy? Let's try that.

A. First or second, it depends whether it is a first pregnancy or second pregnancy.

Q. First pregnancy.

A. Characteristically, usually the cervix effaces starting around a 37, 38 week pregnancy. And then dilatation will typically follow. But

that's not present in all cases.
Q. Okay. In some cases does cervical effacement begin earlier?
A. It could.
Q. Would effacement begin -- strike that.
A first trimester abortion followed by a second pregnancy, would there be any change in the rate of effacement?
A. I wouldn't expect so.
Q. Can you distinguish for me the difference between pre-term labor and labor?
A. Pre-term labor is labor occurring prior to 37 weeks. Labor is that which occurs 37 weeks on out.
Q. Is 37 weeks the cut-off point for a pre-term child and a term child?
A. Yes.
Q. In pre-term labor, what is the percentage of labors that can be arrested with the use of tocolytic agents?
A. It depends on the circumstances and the degree of prematurity and the degree of dilatation.
Q. I don't know if you have all of these answers in your head, but if there is rupture of membranes with pre-term labor at let's say 34 weeks with

one centimeter dilatation, what is the success of tocolytics in those situations?

A. We don't use tocolytics in that situation.

Q. Why not?

A. Because of the risk of infection.

Q. And the risk of infection is present because of the rupture of membranes?

A. Correct.

Q. What is the standard of care in a situation with 34 weeks rupture of membranes and one centimeter dilatation?

A. There is no standard of care.

MR. TATTERSALL: I'm sorry, I didn't hear that.

A. There is no standard of care.

Q. How would you care for such a patient if she was presented at your emergency room or hospital for treatment?

A. Contracting?

Q. Mild.

A. She's having mild contractions, we would observe her.

MS. SANDACZ: I'm sorry?

A. We would observe her.

Q. Is that, that is called expectant management?

A. Yes.
Q. What are you observing it for?
A. Any signs of infection or progression of contractions.
Q. What would be a sign of infection in a patient such as that?
A. Fever, uterine tenderness, fetal tachycardia, elevated white count.
Q. If there was no sign of infection such as you've just mentioned, what would you do in terms of treatment of that patient?
A. We would observe her.
Q. Would you hydrate the patient?
A. We would start an IV.
Q. And that would just be fluids?
A. Yes.
Q. And what is the purpose of IV fluids in that situation?
A. To give the mother some fluids. Generally when they might be going into labor, we prefer them not to eat or drink because of aspiration should delivery or surgery be needed.
Q. So that would prevent dehydration?
A. It helps, yes.
Q. How long would you observe a mother in that

situation?
A. At 34 weeks?
Q. Yes.
A. Probably 24 hours.
Q. And if labor hadn t commenced in 24 hours, would you do anything?
A. We would induce her.
Q. And you would induce her whether or not there was any sign of infection?
A. If we were sure of our dates we would.
Q. If you were sure it was a 34 week baby?
A. Yes.
Q. Would you induce if you had no information as to lung maturity?
A. Yes.
Q. Would there be a risk to that infant to induce labor if the lungs are not mature?
A. Sure.
Q. Why wouldn't you test for lung maturity in a 34 week infant before inducing labor?
A. If our dates are good, our data shows that delivery beyond, at 34 weeks and beyond carries minimal risk to the fetus whether you deliver them or whether you observe them.
Q. And the risk that you're speaking of has to do

with lung maturity?

A. Infection versus lung maturity. Those two things. Those are the things that you are weighing.

Q. Is there a simple test to test for lung maturity?

A. There are several tests you can use.

Q. Can they be done in a hospital setting?

A. Yes.

Q. Do you do them at Metro?

A. We do them.

Q. How quickly can you get an answer?

A. Within an hour.

Q. Are you telling me you don't test for lung maturity because it really makes no difference?

A. At 34 weeks we generally do not test for lung maturity and we would induce in 24 hours if the dates are good.

Q. And how do you know if your dates are good?

A. If we know last menstrual period, early observation of the pregnancy, ultrasounds to correlate the dates.

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(Thereupon, a discussion was had off the record.)

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Q. When you are expectantly managing a patient in the situation we have described, would you do a vaginal exam?
A. Not if she's not contracting. We would do -- not a digital exam. We would do a speculum exam to confirm rupture of the membranes.
Q. That would preserve the sterile environment?
A. It would minimize the risk of infection.
Q. A digital exam would enhance the risk of infection?
A. Probably.
Q. Have you heard of labor defined as regular contractions with progressive change in the cervix which includes cervical dilatation of two centimeters or more and cervical effacement of at least 80 percent?
A. I'm not sure what specific definition you're using.
Q. Can you tell me what Braxton Hicks contractions are?
A. Uterine contractions which do not result in cervical change.
Q. Are those present throughout pregnancy?
--
Q. Do they tend to increase in intensity and

frequency as the pregnancy nears term?
A. As labor approaches.
Q. Are Braxton Hicks contractions frequently misdiagnosed as active labor?
A. In using the phrase active labor specific. I use the phrase active labor very specifically. And so what do you mean by active labor?
Q. I'll rephrase my question.
Are Braxton Hicks contractions frequently misdiagnosed as labor?
A. The patients often come in to have it evaluated and sometimes it is misdiagnosed as labor.
Q. Is there an intensity level that is consistent with the beginning of labor?
A. It tends to be painful. With time, it does progress.
Q. What about the measurement of the uterine pressure? Is there a range of values you would expect to find?
MR. TATTERSALL: On pain you mean?
MS. EKLUND: No.
A. Of uterine pressure? It is highly variable.
Q. So there's no minimum level of uterine pressure to diagnose labor pains?
A. Not that I'm aware of.

Q. And what is the uterine pressure measured in? What is the unit of measure?
A. Millimeters of mercury.
Q. In expectantly managing a patient, would you administer Bethamethasone?
A. It depends on the circumstances.
Q. In a 34 week infant?
A. Probably.
Q. And what is the purpose of the Betamethasone?
A. To accelerate pulmonary maturity.
Q. Do you feel that Betamethasone is effective in the majority of patients in whom you administer the drug?
A. I'm not sure about the majority. It certainly helps as a group those who receive it if they are pre-term, felt to be less than 34 weeks.
Q. I'm sorry, less than 34 weeks?
A. 34 weeks or less.
Q. And does Betamethasone need 48 hours to be effective?
A. It works in less than 48 hours.
Q. How much less?
A. It works less than 24 under some circumstances.
Q. What is the maximum benefit from the drug achieved?

A. Maximum is 48 hours.
Q. Would it be beneath the standard of care to induce labor in a 34 week pregnancy with spontaneous rupture of membranes in a patient who is not in labor?
A. No.
Q. Are you familiar with the level of care hospital that Fisher-Titus Medical Center is?
A. No.
Q. What level is MetroHealth?
A. III.
Q. And that means it is a full service facility?
A. Yes.
Q. In terms of your obstetrics department, you have a neonatology unit?
A. We do.
Q. Does a Level I typically have a neonatology unit?
A. No.
Q. Would you deliver a 34 week baby in a Level I setting?
A. I think that's acceptable.
Q. If you have an option as a physician to transfer that patient to a Level III facility, would you do it?
A. It depends on the circumstance, why the patient

needs to be delivered.
Q. Does there have to be a need for delivery?
A. To deliver a 34 weeker?
Q. Yes.
A. Sure.
Q. What circumstance would constitute need?
A. Infection, distress, sick mother.
Q. So you wouldn't just deliver a 34 week infant without a reason?
A. Not on purpose.
Q. Who asked you to review Angelia Fortner's matter?
A. Mr. Tattersall.
Q. Did he give you information about the case?
A. Yes.
Q. What, did he talk to you over the phone?
A. He described the case over the phone and then sent me some information.
Q. Did you take any notes regarding your telephone conversation with Mr. Tattersall?
A. No.
Q. Can you tell me what he sent to you?
A. He sent me the complaint, office charts, ultrasound reports, hospital record, some depositions of Carlson, Trippe, Fortner, I think May's, Fields and the pediatrician from St.

Louis.

Q. Can I see that pile that you have there, Doctor?

A. Sure. I think I got Kasten's, too.

Q. I don't see Dr. Field's deposition here.

A. I have it in my office.

Q. I'm just curious because I haven't got Dr. Field's deposition.

MR. TATTERSALL: I'm sorry?

MS. EKLUND: Did you get Dr. Field's deposition already?

MR. TATTERSALL: Yes.

Q. Doctor, this baby was not delivered by cesarean section, correct?

A. Correct.

Q. And did you find any evidence in the records that you have been provided with of the presence of a mucus plug?

A. Was I provided any evidence of what?

Q. A mucus plug?

A. Any evidence of it? No. I saw none.

Q. Do you have any opinions as to the cause of death of this infant?

MR. TATTERSALL: Objection.

MS. SANDACZ: Objection.

A. There seems to have been some difficulty in

resuscitation that led to a rather profound acidosis.

Q. Did this baby have a hyaline membrane disease?

MS. SANDACZ: Objection.

Q. Hyaline membrane disease.

A. I don't think so. He had some problems afterwards but I don't think he had much in the way of hyaline membrane disease.

Q. Do you have an opinion as to whether the infant's lungs were mature at delivery?

A. I think they probably were.

Q. Have you seen the x-ray films of the infant's lungs?

A. No.

Q. Would that be important in determining whether the infant's lungs were mature at delivery?

A. Not necessarily. It depends on the resuscitation and the events that occurred around delivery.

Q. So if the resuscitation is not successful, you may see results in the lungs that were caused actually by the failure of resuscitation?

A. Well, abnormal lung x-rays, I'm not a pediatrician, so I probably shouldn't even testify about it. I'll just leave it alone.

Q. You don't have an opinion?

A. No.

MR. TATTERSALL: He's not going to testify on the matter of resuscitation. Only as to the standard of care.

Q. Is that correct, you have no opinions as to the resuscitative effect, efforts on behalf of this infant?

A. That's correct.

Q. Do you teach resuscitation at MetroHealth?

A. I teach a portion of the class that is involved. I teach a portion of the obstetrical difficulties associated with it that might be encountered in the rendering of resuscitation. But not in the actual resuscitation.

Q. Do difficulties include difficulties with pre-term children?

A. Pre-term deliveries, yes.

Q. I take it you have not written any reports in regard to this case?

A. That's correct.

Q. Have you made any notes in the process of your reviewing the records or depositions?

A. No.

Q. I'll give this back to you, Doctor, because you may need to refer to that.

Doctor, do your materials include the fetal monitor strips for the child?

A. Yes.

Q. And do you agree that this was a 34 week pregnancy at the time of admission?

A. I don't disagree with that

Q Do you agree that there was no testing of lung maturity done by the physician in this case?

A. I don't think there was

Q Doctor, from your review of the record, was there any indication which required induction of labor for Angelia Fortner?

A She was having regular contractions She had been examined And under those circumstances we would probably deliver.

Q Would you deliver because she had been digitally examined?

A. Plus the fact that she had ruptured membranes and was contracting every few minutes, that combined with the digital exam, we would deliver.

Q So once Dr. Kasten performed a digital examination, it was necessary to induce labor?

A. I don't know that it was absolutely necessary but I think it was indicated.

Q That would be the standard of care?

A. I think that most people would do that
Q When she was admitted to the hospital at 5:30 PM, her contractions are really listed as merely an ache and it's in quotation marks
A. Yes.
Q. In your opinion, does that constitute labor?
A. It might be the beginning of it It depends where they're located, if you can palpate it
Q Dr. Kasten orders Pitocin for this woman at 7:30 PM at which point her contractions are described as only mild
Is that an appropriate order?
A I think after an examination and physical impression she was going into labor or if she would have an infection it would have
Q Is there any basis for Dr. Kasten to believe there was an infection?
A. I don't know.
Q. Was there any temperature?
A. Did she have a fever? Specific
Q I have children and I say fever.
Did she have fever?
A. No.
Q. Did she have uterine tenderness?
A. I don't think so.

Q. Did she have any fetal tachycardia?

A. No. Not that I saw.

Any elevated white blood count?

I don't recall what her white count was on admission.

Q. As far as you remember now there was no sign of infection?

A. No.

Q. And from -- let's see. According to the chart, her membrane ruptured at 7:00 a.m.?

A. What page are you on?

Q. I don't know which page. But it's the first page of the labor process.

MS. SANDACZ: What date?

MS. EKLUND: It's 5/20/95.

Q. It's probably in here. It starts with 5/20/95 at 6:30. You're getting close. Got it?

A. Yes.

Q. Okay. All right. Doctor, we're on the same page.

A. Uh-huh.

Q. The records would reflect at 7:00 a.m. she had a spontaneous rupture of membranes with clear fluid, is that right?

A. There's a notation of spontaneous ruptured

A. There's a notation of spontaneous ruptured

membranes at 6:30.

Doesn't it say questionable? Do you read it that a way?

Questionable at 5:30. She came to the hospital with ruptured membranes, I think.

So you don't interpret the 7:00 a.m. note to mean that they ruptured at that time?

It says mom with ruptured membranes. I'm not sure. I thought they ruptured at 5:30.

If they ruptured at 5:30, would there still be the presence of clear amniotic fluid?

There may be.

And you could still do the Nitrazine testing at that point?

Uh-huh.

Q. Did Dr. Kasten allow enough time to determine whether or not this woman was in true labor before ordering Pitocin?

A. That's a subjective decision based on whether the contractions are perceived by him and if he felt that labor was beginning.

Q. He'd have to have some basis to believe that labor was beginning, wouldn't he?

A. Uh-huh.

Q. He would have to have some basis to believe that

the mild contractions, which are described in the nurses' notes, were causing cervical changes, correct? I mean

A. Well, he would talk to the patient, too. would go he wouldn't just read nurses' notes. He in and talk to patients.

Q. Based on what you know of this case, including his deposition in the record, what was his basis for believing that labor had begun?

A. I have to look at the records to see what specifically. I'm not specifically sure what you're referring to.

Q. Based upon the hospital chart, what is the indication that labor has commenced?

She has ruptured membranes. She's having uterine contractions.

Uterine contractions could be pre-term labor?

A. That's corre

Q. And they may not be true labor:

A. Pre-term labor is true labor.

Q. But it may also be that it's not true labor:

A. That's possible.

Q. And what you need to determine in a 34 week pregnancy is is this really labor or is this something that won't stop?

A. Persistence of contractions and cervical change.
Q. To determine that, you have to observe the effects of those contractions over a period of time?
A. Part of your evaluation of the change is whether the cervix has changed. So you have to examine the patient to feel that change.
Q. What was her condition of her cervix before she was admitted into the hospital on 5/20/95?
A. I don't know what it was before.
Q. Okay. So when you are examining the patient on 5/20/95, you don't know the prior state of her cervix so you don't know whether these contractions have caused any changes or not?
A. That's correct.
Q. So you would have to observe from the time of your examination what occurs, how these contractions are affecting the cervix?
A. Sure. If you're watching for cervical change under these circumstances and you do an exam because you have to palpate the effacement and palpate dilatation, then you need to do an exam. You do an exam, if your clinical suspicion is raised sufficiently, you do a visual exam.
Q. Can you do a speculum exam and determine cervical

effacement?

A. No.

MR. TATTERSALL: What was your question?

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

Q. In your hospital you wouldn't do a digital exam until you were sure that labor had in fact commenced?

A. If we were concerned and suspicious that labor had commenced, we might do a speculum examination or we might do a digital examination. It depends on the circumstance.

Q. In a patient presenting such as Angelia Fortner with what you see appearing in her hospital chart, would you do a digital exam on this patient?

A. I probably would have if I thought that her contractions were getting stronger and uncomfortable for her.

Q. And can you locate the fetal monitor strips that are in the records that coincide with the admission? They start with 43624.

A. I got it.

Q. Now, the fetal monitor strip is attached right at the time of admission or shortly thereafter, correct?

A. I think so.

Q. And am I correct that the top strip measures the fetal heart rate?

A. Correct.

Q. And the bottom strip measures uterine contractions?

A. Yes.

Q. Do these fetal monitor strips from let's say 5:30 a.m. to let's say 7:00 a.m. show contractions consistent with labor?

A. Yes.

Q. Do they have the intensity of contractions consistent with labor?

A. You can't tell intensity from the tracing. All you can tell is frequency.

Q. From the monitor, what are the frequencies of her contractions?

A. It looks like every two to three minutes up until around 7:00. Then you can't really tell. And then at 7:50 it looks like they are occurring every two or three minutes.

Q. Now, by 7:50 she's received Pitocin, corr

A. I'm not sure of the time of the start of

Q. About 7:30.

So she was having contractions every two to three minutes.

Prior to 7:30.

Pardon?

Before 7:30.

A. Yes.

Q. And the Pitocin would have the effect of the contractions?

Yes.

Was the administration of Pitocin in the dosages which Dr. Kasten gave this woman throughout her labor appropriate?

A. They're reasonable, sure.

Q. When is it appropriate to administer Pitoc

A. To either initiate or augment labor.

Q. If you are using it to augment labor, do you have to have some basis to believe that the normal uterine contractions are not sufficient to produce the cervical changes required for delivery?

A. You don't have to. It depends on the

circumstance.

Q. What circumstance?

A. Well, if urgency was important, if you had signs of an infection, for example, which is not present in this case, then augmentation might be important to shorten the duration.

Q. Was there any indication of any urgency in Angelia Fortner's case?

A No.

Q Was there any indication for the administration of Pitocin?

A. She had ruptured membranes and he felt that it might be augmented. Clinically it is a judgment call.

Q. You, in reviewing this, find no basis for the decision to augment her labor?

MR. TATTERSALL: Objection.

A. I find no fault with augmenting the labor. If he examined her and felt that labor was beginning and he wanted to shorten the amount of time because of the dilatation of the cervix, then that's a very reasonable approach.

Q. What are you talking about with the dilatation of the cervix?

A. She is one centimeter dilated. If he foresaw it

might take a while, then augmenting would be reasonable. It's a judgment call of a physician.

Q. Do you have an understanding of what is meant by the standard of care?

A. I know what I think it is.

Q. What do you think it is?

A. It is reasonably appropriate under the majority of circumstances.

Q. Is it what a reasonable physician would do under the circumstances?

A. Yes.

Q. So it's not necessarily a judgment call what one physician does under the circumstances?

A. I don't understand the question.

Q. I guess your answers to me have been basically that it's a judgment call if Dr. Kasten felt that Pitocin was appropriate.

Is there a standard of care in regard to when it is appropriate to administer Pitocin?

A. I don't think there is a standard of care in this circumstance. We're dealing with 34 weeks, ruptured membranes. There certainly is with much more pre-term events and with much more term events. But 34 weeks, there is no standard of care.

Q. Is one centimeter of dilatation commonly found in a 34 week pregnancy?
A. Yes.
Q. Cervical dilatation occurs before the term is completed in the normal pregnancy?
A. With the first delivery it tends not to dilate until later in the pregnancy towards 38, 39 weeks. It is not unusual to find it but usually under the majority of circumstances, the cervix will be closed at 34 weeks gestation.
Q. And one centimeter of dilatation doesn't necessarily mean that labor is about to commence, does it?
A. It doesn't necessarily mean that.
Q. In reviewing the fetal monitor strips, did you see any evidence of fetal distress?
A. Just toward the end, there was some decelerations that would suggest distress just prior to the delivery.
Q. And this baby was born with good pH levels, correct?
A. I believe the cord pH was good.
Q. Does that indicate a baby that has survived the labor process in an intact condition?
A. In a non-asphyxiated condition.

Q. Did you see anything in the record which would explain the infant's inability to breathe upon birth?

A. No.

Q. Do you have any opinion as to why this infant couldn't breathe when she was born?

MR. TATTERSALL: Objection.

MS. SANDACZ: Objection.

A. No.

Q. Have you ever had a pre-term infant that you were unable to ventilate?

MR. TATTERSALL: Objection.

MS. SANDACZ: Objection.

A. I don't usually do the resuscitations of infants.

Q. Do you have a neonatologist present when you have a pre-term delivery?

A. It depends on the circumstances. Usually not.

Q. Who is usually in attendance?

A. It depends on the time of day. We usually have a neonatal nurse practitioner, perhaps a pediatric resident, another nurse.

Q. In teaching students and residents how to resuscitate a pre-term infant, do you tell them that you may need to use greater than normal pressures to ventilate?

MR. TATTERSALL: Objection.

MS. SANDACZ: Objection.

A. I don't teach the resuscitation.

Q. Okay. I thought that you said you did in difficult deliveries.

A. No. You asked if I participated in teaching resuscitation courses. I teach the portion that deals with the conditions in which you might be called upon to resuscitate.

Q. You don't take it to the next step?

A. No.

Q. Do you have any opinion as to the percentage of 34 week infants that will have immature lungs?

A. Define immature lungs.

Q. Inability to breathe, will require resuscitation.

MS. SANDACZ: Objection.

A. You mean at the time of delivery?

Q. Yes.

A. How many will need to have ventilation immediately?

Q. Yes.

A. The vast minority, assuming that the indications associated with the delivery are not extreme such as rupture or bleeding problems, distress.

Q. Was there any point in the laboring process of

this child where you felt a cesarean section would have been appropriate?

A. No

Q. In expectantly managing a patient with pre-term labor, would you induce -- strike that.

The pathology on the placenta in this case showed a chorioamnionitis?

A. I believe it did.

Q. And that is an infection of the placenta?

A. It's an inflammation in the placenta.

Q. And that inflammation could have occurred as the result of 36 hours of labor and the vaginal exams that accompanied that?

A. It could have.

Q. Was there any sign of infection in the pathology afterbirth?

A. I'm not sure what you're saying.

Q. Did you review the pathology records from Toledo Hospital?

A. Yes

Q. Was there any sign of infection other than the chorioamnionitis?

A. I don't recall. I'd have to specifically review them again. But I don't recall any specifically.

Q. In --

MR. TATTERSALL: Are you referring to the mother or to the child or both?

MS. EKLUND: Either.

Q. In mothers who have a chorioamnionitis, isn't it true that a very small percentage of those babies will be affected by the chorioamnionitis?

A. A small percentage, yes, depending how you define that.

Q. Define what, chorioamnionitis?

A. Yes.

Q. How many different ways can you define it?

A. You can define it on the basis of an evaluation of the placenta, in which case you find it much more frequently and in the clinical presentation with fever and uterine tenderness.

Q. Doctor, is it true that pre-term labor can stop spontaneously on its own?

A. If it does, it is not pre-term labor.

Q. What is it, Braxton Hicks?

A. If there is no cervical change and it is just cervical change, it is just Braxton Hicks.

Q. Doctor, in your review of this record, was there any reason that you can see in the records for Dr. Kasten to have performed a digital exam at 7:30 a.m.?

A. That is really dependent upon the evaluation of the clinician at the time. In the majority of patients under this circumstance that are sent to us from the outside, they are examined prior to referral.

Q. That doesn't mean it's appropriate, does it?

A. It's the usual practice in the community.

Q. Does that make it appropriate?

A. It's not what we would prefer but that's the usual practice.

Q. So you're saying you would prefer that they not be digitally examined before they are sent over to you?

A. We would prefer that.

Q. You would prefer a sterile environment so that the expectant management can proceed?

A. If they are referred to us for expectant management we would.

Q. Doctor, I just want to understand, are you equating the standard of care with what is in fact done in the medical profession as opposed to what should be done?

A. No. Not necessarily.

Q. So the fact that referring physicians may digitally examine patients before sending them to

you for expectant management, that doesn't make it appropriate, does it?

A. Correct.

Q. And you would agree that the standard of care would be that they should not be digitally examined?

A. I think at 34 weeks, again, there is no clear standard as to how to manage these patients.

Q. What is the cut-off point for when there's a standard of care and when there isn't in terms of pre-term labor?

A. Generally from 33 weeks and below. 33 weeks and below, we would consider those significantly pre-term that we would prefer referral to a tertiary center, though there is no standard in Ohio.

Q. Is there a standard somewhere in the United States?

A. I'm sure there are. It may not be uniform. It may not be.

Q. Does the American College of Obstetrics and Gynecologists have guidelines?

A. They have guidelines.

Q. In regard to 34 week pre-term labor?

A. You mean the technical bulletin?

Q. Yes.
A. I presume. I've not read that one.
Q. Do the textbooks have guidelines or information as to 34 week pregnancy?
A. They have opinions.
Q. Does your department have a protocol as to 34 week pregnancies?
A. No.
Q. Does it have written protocol as to 33 week pregnancies?
A. No.
Q. Does it have any written protocol?
A. For?
Q. Pregnancy.
A. Yes. We have protocol for pregnancy.
Q. But not in regard to whether to induce or expectantly manage labor?
A. In pre-term rupture of the membranes, that's correct. That's with specific regard to inducing or not inducing.
Q. You have no written protocol as to that?
A. That's my understanding, correct.
Q. Well, you head the department, correct?
A. I head that division.
Q. You would know, I assume?

A. I would think I would

Q Do you consult with neonatologists in terms of whether or not to induce labor in a 34 week pregnancy?

A. No.

Q. You talked some things in your apparent review of the chart in this case.

Are any of those tabbed items important in terms of your opinions in this matter?

A. No. It just refers me to different areas of the chart where I can follow the labor.

Q Is it your opinion in this case that Dr. Kasten was exercising his clinical judgment in deciding to order Pitocin for Angelia Fortner and induce her l abor?

MR MAMMERSALL: Objection.

A. You mean to augment her labor.

Q did he augment her labor or i duce it?

A. My impression is he augmented it

Q Do you know from the chart what or he induced it or augmented it?

A. No, I don't.

MR. TAMMERSALL: What was your answer?

A. I can't tell She was hawing contractions wit

rupture of the membrane every three minutes and he made them stronger and closer.

Q. But you can't tell just because she's having contractions with ruptured membranes whether or not she's in labor or not?

A. My impression from somebody who is having their first child, if she's 34 weeks and one centimeter dilated, contracting every three minutes after rupturing the membranes would mean that she was in labor. That would be my initial impression.

Q. Would you act on that initial impression or would you wait and see how that labor progresses?

A. I think there is no standard of care on how you approach that. My personal plan would be to observe her for a little bit longer. If she's not changed in about six hours, then we would add Pitocin at that time.

Q. You would add Pitocin after six hours?

A. Yes. If she was still contracting.

What if she stopped contracting?

A. We might observe her. If she had been examined, we probably would have done Pitocin.

Q. If she had not been examined?

A. Probably watch for 24 hours and then induce.

Q. I want to get back to your opinions.

You have no criticism of Dr. Kasten's decision to administer Pitocin in this case?

A. That's correct.

Q. Do you have any criticism of Dr. Kasten's digital examination of this case?

A. It depends on the circumstance and what his impression was when he saw the patient. So I don't have any specific criticism if his impression was she was in labor.

Q. If she was not in labor, you would be critical of that decision?

A. If she was not contracting, I would prefer him not to do that.

Q. How about if she's not in labor?

A. You don't know if she's in labor unless you examine her.

Q. You have no criticism of Dr. Kasten's failure to perform a lung maturity test?

A. Correct.

Q. You have no criticism of Dr. Kasten's decision to deliver this pre-term infant in a Level I hospital setting?

A. That's correct.

Q. And you have no criticism of the resuscitation of this infant?

MS. SANDACZ: Objection.

MR. TATTERSALL: Say that again, please?

Q. No criticism of the resuscitation of the infant?

MR. TATTERSALL: Objection.

MS. SANDACZ: Objection.

A. I can't discuss that as a criticism.

Q. You have no opinions?

A. I have no opinion.

Q. Are there any other opinions you have in regard to this case that we have not discussed or I have not mentioned?

A. Like what?

MR. TATTERSALL: If you have any questions to ask him, I think he's covered the waterfront as far as his opinions that I'm going to ask him on direct examination.

You might ask him something on cross which you haven't done today that he might have an opinion on. But you got the essence of it.

Q. I'm trying to understand if I've covered all of the opinions that you intend to express at trial, as far as you know?

A. I've responded to all your questions. I don't

know if you ask me a different question or you might ask something differently If you ask me these questions that you did here, that's fine

Q You, I assume, have no opinions as to the care that was rendered at Meleod Hospital?

MR TATTERSALL: Objection.

A. No opinion.

MS EKLUND: I have nothing further for you.

MR TATTERSALL: I want to make one correction in the record You asked him what he reviewed by way of records and he read off a list of depositions

I don't know whether he listed Mr. Kasten's deposition but that is included in the list

A. I did

MS EKLUND: No further questions

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CROSS-EXAMINATION OF LeROY J. DIERKER, M.D.

BY MS. SANDACZ:

Q As I introduced myself, I am Beverly Sandacz I represent, I represent Dr. May

With regards to your comments about the cord blood gases upon delivery, you indicated that

were within the expected or normal range --

A. That's my recollection.

Q. -- at the time of delivery.

And you indicated that that would indicate that the baby was not born in an asphyxiated condition?

A. That's my impression, correct.

Q. Is it fair to say that the existence of cord gases within normal limits does not eliminate the possibility that the neonate might have suffered some distress during the pregnancy or during the prenatal period?

MS. EKLUND: Objection.

A. That's correct.

Q. Or that the baby suffered some fetal asphyxia prior, during the prenatal period?

MS. EKLUND: Objection.

A. Prior to this observation period, it could be, yes.

Q. And in fact if there are low apgar scores as noted, in this particular case, that could be explained by some fetal asphyxia during the prenatal period?

MS. EKLUND: Objection.

A. It's possible.

Q. And just so I'm clear, you don't have any opinions regarding the basis or the reason for any kind of non-compliance or the resistance that was met during the resuscitative effort of this baby?

A. That's correct.

MS. SANDACZ: That's all I have.

MR. TATTERSALL: Anything further?

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CROSS-EXAMINATION OF LeROY J. DIERKER, M.D.

BY MS. EKLUND:

Q. A baby who had suffered some event during pregnancy, would you expect to see some evidence of distress in the fetal monitoring during labor?

A. Not necessarily. Not necessarily.

Q. Would you probably see some distress?

A. I don't know that you would see distress. I guess it would depend on the degree and type of injury.

But I saw no sign of it in this case.

MS. EKLUND: Okay. Thank you.

MS. SANDACZ: We're done.

MR. TATTERSALL: Doctor, this deposition will be transcribed. Would you like to look at it and sign it?

THE WITNESS: I'll read it.

MR. TATTERSALL: There will be no waiver of signature.

_____

LeROY J. DIERKER, M.D.

CERTIFICATE

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

I, Linda A. Astuto, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named LeROY J. DIERKER, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____ A.D. 19 __

_____

Linda A. Astuto, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 25, 2002