IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

REBEKAH BERLINGER,
et al.,

Plaintiffs,

-vs-

MT. SINAI MEDICAL
CENTER, et al.,

JUDGE KILBANE
CASE NO. 94277

Defendants.

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Deposition of LEROY DIERKER, M.D., taken as if upon cross-examination before Pamela S. Greenfield, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at Cleveland Metro General Hospital, 3395 Scranton Road, Cleveland, Ohio, at 10:00 a.m. on Saturday, July 25th, 1987, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of Defendant
Robert Schwartz, M.D.

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LEROY 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 DTERKER, M.D.

BY MR. ILER:

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(Whereupon, Plaintiffs' Exhibit No. 1 was marked for purposes of identification.)

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MR. ILER: Let the record reflect that we're taking the deposition of Dr. Dierker as on cross-examination and pursuant to the discovery rules; that he appears to be an expert for the Defendant Mt. Sinai Hospital in this case.

MR. **GOLDWASSER:** I disagree with the comment as to cross-examination. That's for the record. It's a discovery deposition to be inquiring as to what Dr. Dierker will testify to on direct exam.

Q. Doctor, have you had your deposition taken before?

A. In this case?

Q. In any case?

A. Yes.

Q. If you find any tjme you don't understand one of my questions, tell me. I'll rephrase it and set. if we're together on it so that I'm sure that you've answered correctly,

We have a copy of your curriculum vitae. There is only one copy. The girl didn't make another one so I'll turn thjs over to Mr. Goldwasses then he can make a copy of it and we can attach it to the deposition later on, if you want.

MR. COLDWASSER: Fine.

I'm not going to take the time, doctor, at this time to run through an extensive and a very complete curriculum vitae with your education. It's not to slight you in any way. I think tha later on your attorney will probably take you through every detail of your education hut, I think we can just ask a few preliminary questions.

You are a physician?

A. I am.

Q. And you have been licensed to practice since

what year, approximately?

A. Licensed to practice since '68.

Q. You practice, I understand, in several stat
Iowa and Ohio?

A. Virginia.

Q. And you have been practicing medicine in Ohio
for how long now?

A. 11 years.

Q. I think you have confined your practice to a
specialty in medicine, am I right?

A. I have.

Q. Could you tell us what that is?

A. Maternal/fetal medicine.

Q. Internal fetal?

A. Maternal/fetal medicine.

Q. For the record, what is that?

A. High risk obstetrics.

Q. What do you mean by high risk? What's a high
risk?

A. Depends on the problem. Women who are at risk
for having either early deliveries which are
dangerous to them or to the baby.

Q. Later on we'll come back and we'll see if we can
engraft that term to Rebekah Berlinger and then
you can tell me whether or not you think she's

high risk; if she wasn't, why you think so, okay?

A. Okay.

Q. Insofar as giving a medical opinion in defense that before? Have you given opinions?

Have you done it or Mr. Goldwa er's firm before?

I have.

Q. How many times have you worked with that firm, Reminger & Reminger, on cases?

A. Giving depositions?

Q. Yes.

A. Maybe one.

Q. Have you advised them on other cases or given opinions t.o that firm on other cases?

A. I have.

Q. How many cases do you think you have worked with the firm Reminger & Reminger?

A. Two or three.

Q. Over the past year or two years, sir?

Correct.

Q. About that time?

A Yes.

Q. Have you ever testified in court?
A. I have.
Q. In Cleveland?
A. Yes.
Q. What case would that have been, do you recall?
A. It was Angerman versus somebody.
Q. Angerman?
A. Yes.
Q. Was that, did the Reminger firm hire you or who was the lawyer that you worked with on that case, do you remember?
A. I'm not certain, but I can get the name.
Q. Is it a local. firm in town?
A. Yes.
Q. Have you done any of this work, that is defending physicians in medical negligence suits in any other state, Iowa or Virginia?
A. No.
Q. The question is really what I'm trying to get from you is if you've given medical opinion before, written reports before, given deposition5 before and there is nothing wrong with all of that or you testified in trial before, I just want to know the number of times you have and if you remember specifically the

cases or the lawyers, it would help me.

A. I have testified in one legal case and that was this year. the case that I mentioned.

Q. The Angerman case?

A. Yes.

Q. Down in downtown Cleveland was it?

A. Correct.

Q. You don't remember the lawyers at this point or the firm?

A. It may have been Reminger. It may have been Arter & Hadden, I don't recall.

MR. GOLDWASSER: I don't think it was us; but if it was, I'd be happy to let you know. I just don't know the name of the case at all.

Q. How did it come to pass that the Reminger firm came to you for some advice for your opinion on some of these cases?

A. I'm not sure.

Q. Are you insured in medical negligence insurance? Do you have medical negligence insurance?

A. The hospital insures all the physicians.

Q. Do you know the name of the company that insures the hospital?

MR. GOLDWASSER: The hospital is self-insured.

A. I think it's self-insured.

Q. I have marked as Exhibit Number 1 a report of February the 7th, 1986 signed by yourself and a report of February 25th, 1986. Would you take a look at those? They are copies, doctor.

Doctor, the report of February the 7th, 1986, that's signed by yourself, is that correct?

A. Yes.

Q. And it concerns this case of Rebekah Berlinger versus Mt. Sinai Hospital and it's addressed to Attorney Gary Goldwasser, am I correct?

A. That's correct.

Q. Then the second report is dated February 25th of '86 once again to Attorney Goldwasser signed by yourself and of course both of these concern your opinion concerning the Rebekah Berlinger case?

A. Yes.

Q. What did you understand your task to be in reviewing the Rebekah Berlinger case?

A. To look at the records, the monitoring tracings and to render an opinion as to whether the care

was appropriate or not.

Q. Are you familiar with, have you heard the standard of care, that concept used before?

A. I've heard the term.

Q. You used the word appropriate and I just, want to know when you say appropriate care, do you mean that legal concept that we lawyers have to use, the standard of care? Is that the same thing in your mind?

MR. GOLDWASSER: Well, your statement suggests that he should know the legal definition.

MR. ILER: No. I just want to know if he knows.

A. I don't know.

Q. Well, what standard did you use when you say whether or not the people used the appropriate care? I mean, how do I know what standard you used to determine if they were above it, equal to or below the appropriate care which should have been rendered Rebekah? What do you use for that?

A. I would use if I thought a physician was acting in the best interest of the patient and by standard guidelines.

Q. Where would I find those guidelines?
A. Perhaps in textbooks.
Q. Which ones could I refer to?
A. You could refer to Creasy and Resnick.
Q. Wow do you spell that?
A. C R E A S Y and R E S N I C K.
Q. What's the name of the book?
A. Maternal/Fetal Medicine.
Q. Any other book that would give me some guidelines on this case?
A. Williams' Obstetrics,
Q. That's the old classic, I guess?
A. Yes.
Q. Do you consider it to he a reasonably good hook?
A. I think both of them are good books,
Q. From what I could read of your report of February 7th of '86 arid the other report of February 25th of '86, it appears to he addressed to Mr. Goldwasser's client, which is Mt. Sinai Hospital, am I correct on that?
A. It's addressed to Mr. Goldwasser,
Q. Yes. Rut you're not giving or are you giving an opinion as to Dr. Schwartz? He's a defendant in the case, too; or are you confining your opinion strictly to Mr. Goldwasser's clients who are Mt.

Sinai Hospital and Mt. Sinai employees?

MR. GOLDWASSER: Now, in fairness to Dr. Dierker, he doesn't know what I'm going to ask him on direct examination. We haven't, discussed that; but in fairness, Don, I would think that you can't hardly separate the standard of care of the obstetrics from that, of the labor room nurses, particularly as to the issues drawn by Dr. Abramson, it has to overlap, although I'm certainly concentrating on the hospital.

Q. The only reason I ask you that, see, my questions are really designed, I had anticipated that what you were doing was going to render a medical opinion concerning the appropriateness of care only for hospital people, see, and that Mr. Murphy has his own expert, Dr. Mann to testify as to the defendant, Dr. Sehwartz, okay?

A. Okay.

Q. I'm getting confused. So I don't know what to ask you.

Are you prepared to give an opinion for the hospital and Dr. Schwartz or just the hospital?

I don't know.

A. 1 could do either.

Q. You could do either?
A. I mean, I could.
Q. Well, let me get to the bottom. Let's take the hospital people first, okay?
A. Okay.
Q. Who would you include at the hospital that would encompass your opinion? Do you know what I mean by that?
A. Who would he involved in the hospital care?
Q. Yes. That you would address your expertise to which would you say, who at the hospital --

MR. GOLDWASSER: I think he understands the question.

A. Nurses and residents involved in the care.
Q. Why don't we start with that and we'll just take the nurses and the residents who were involved in the care of Rehekah Berlinger in 1984 when she was there, okay?
A. Okay.
Q. Then later on if you think you want. to give an opinion defending Dr. Schwartz, the OB/GYN, then we'll go to him, all right.?
A. All right.
Q. Now, insofar as your opinion is concerned, who specifically at the hospital at Mt. Sinai during

the month of July when Mrs. Berlinger was first. admitted are you expressing an opinion about? Would it be the admitting nurse, admitting doctor, intern? Is that. the kind of thing?

A. In the letter or --

Q. Well, I've got to know who you are defending.

A. Whoever you'd like me to address, I'd be glad to.

MR. GOLDWASSER: Just, so you know, I intend ta ask him on direct examination, 1 would assume, as to whether- or not the obstetrical care was appropriate, particularly addressing the issues of Dr. Abramson, your expert.. He's the one who has created the issues in the case and I am certainly going to concentrate on his statement that the labor room nurse failed to recognize suggestions of abnormal electronic fetal monitoring and failed to do the appropriate things to call it to Dr. Schwartz's attention. That's essentially what Dr. Abramson says.

MR. TLER: I thought that's what Dr. Dierker was going to do on that point.

MR. GOLDWASSER: No question about it.

MR. ILER: Then I get the feeling as though he's going to go beyond that.

MR. GOLDWASSER: Well, Don, I intend to ask him just as well, if I can help you get to the point, as to his interpretation of the electronic fetal monitoring strip because that clearly goes to what Dr. Abramson says.

Q. No question. I appreciate that because I was a little bit -- generally the doctors will say, "I'm here to defend Dr. A, Dr. B or Dr. C," or "I'm here to defend Nurse A, B or C," and then I know what questions to ask because I know then who they are involved with, so that helps me out. Yes, that's true, our physician did criticize the nurse.

So let us address ourselves then to the nurses who interpreted the external/internal monitor strips. Are you familiar with what they did in this case?

A. I think so. I didn't look at it specifically from the nursing standpoint. I looked at it from an overall care.

Q. Well, do you remember the nurses' names that were watching the fetal monitors?

A. No.

Q. Do you know when the monitors, do you know what kind of monitors were placed on Mrs. Herlinger?
A. I don't know the brand name; but I know this, that they were external and then they went to internal.
Q. Do you know when the external monitor was placed on her?
A. When she was admitted at nine.
Q. Do you know when an internal monitor was placed in Mrs. Herlinger?
A. Yes.
Q. Would that be the next morning?
A, Yes, seven or 8:00 in the morning.
Q. Do you know which hospital personnel had the responsibility to monitor both the external monitor and the internal monitor?

MR. **GOLDWASSER:** By name or generally speaking?

MR. ILER: Ry name.

A. I don't know that.
Q. Are you familiar with what nurses should be watching on an external monitor in a situation such as Mrs. Berlinger's?
A. Yes.
Q. What should they be doing?

A. They should he looking at the uterine contraction pattern and the heart rate patterns.
Q. For the baby?
A. Yes.
Q. And specifically what should they be looking for?
A. They should he looking for fetal stress or distress.
Q. What would those be?
A. A fall in the heart rate, bradycardia.
Q. Bradycardia, tachycardia?
A. Tachycardia, decelerations.
Q. I think there are several kinds of decelerations. There are late decelerations?
A. Correct.
Q. What other kind are there, for the record?

know the difference between a late deceleration and a variable deceleration, early deceleration?

A. Yes.
Q. Is that a requirement for them, nurses?
A. I would think so.
Q. Why?
A. They need to know patterns that are of concern.
Q. If during the time that Mrs. Rerlinger had the external monitor on, 1'11 ask you to make an assumption, assume there is an early deceleration that appears on the strip or appears, then what is your judgment on what the nurse should do about, that? Should she tell her supervisor, should she make a note in the record of the patient or should she call the OB/GYN, should she call a resident? What's the appropriate thing to do in such a situation?

MR. GOLDWASSER: Wait a minute. I need an explanation. Are you saying one single indication?

MR. ILER: Yes.

MR. GOLDWASSER: Just one?

Q. Right. We'll start with one and then work to a pattern and I will give you a chance to fully explain. I don't want to confine you,
A. Okay.
Q. Let's assume the first one appears. What's the

nurse supposed to do according to the standard of care?

A. If she notes early decelerations --

MR. GOLDWASSER: He's talking about one now in his question. One early deceleration.

Q. She sees the first one, let's assume.

A. Nothing.

Q. Is she supposed to mark it, down somewhere?

A. Not necessarily.

Q. Then is it important at the time the first-deceleration occurs, the time is unimportant or would a doctor or somebody like to know that the first one occurred at 10:30 a.m.? I mean that's the reason I'm asking you the question. Should somebody make a note about when the first one appears so that you can trace the length of time others may appear.

A. No.

Q. Let's assume that several late decelerations begin to appear?

A. Late?

Q. Yes. Late decelerations, they begin to appear in an external monitor situation on Mrs. Berlinger, should the nurse do anything about,

that; talk to anybody, say anything, write anything?

A. First they would, they might notify another physician or they might turn them on their side, see if it got better.

Q. From what I understand, turning on the side -- it's on the left side, I assume?

A. Correct.

Q. Kind of helps take the pressure of the baby off the mother's vein?

A. Yes.

Q. And then sometimes they will give the mother some oxygen?

A. They might.

Q. The first part of your answer where you say they might notify a doctor, say a resident or somebody, why would you do that, why is the nurse supposed to do that?

A. So they can evaluate the tracing.

Q. In what way?

MR. GOLDWASSER: Do you mean in what way to evaluate the tracing?

MR. ILER: Yes.

MR. GOLDWASSER: Now you are talking about the doctor evaluating the tracing.

Q. No. Before I get to the doctor, let's take a situation where some late decelerations occur in Mrs. Berlinger, I'm speaking hypothetically, and the nurse sees that, recognizes it and decides that she must advise somebody, a physician, a doctor about that and she does so. Why does she do that?

A. So that they could intervene if necessary.

Q. The physician?

A. Correct.

Q. Is it your judgment that the nurse without the consent of either a resident or the admitting physician can also take a patient. like Mrs. Rerlinger, put her on her left side to relieve some pressure on the veins and also administer some oxygen?

A. Yes.

Q. She doesn't need a doctor's consent to do that, I assume?

A. I don't think so.

Q. What is a late deceleration?

A. That's a fall in the heart rate which follows a uterine contraction.

Q. For purposes of the record, are we speaking about, to put that term late deceleration within

the framework of labor, I would assume what you're saying is that you have a contraction of the uterus and during that period of time, if there is a monitor, I assume an external monitor will show you a late deceleration, am I right?

A. Correct.

Q. That during the contraction of the uterus in the mother, that the baby's heart will give an indication, is that what you mean?

A. Could you rephrase it?

Q. Yes.

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

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A. The baby's heart will beat; and following the peak of the contraction, the heart beat would go down. That's the definition of a late deceleration.

Q. That's a late deceleration?

A. Yes.

Q. And when we say it goes down, is it so that what we're talking about is a fetal heart rate between 120 beats and 160 beats? Is that a normal fetal heart rate?

A. The normal range is between 120, 160.
Q. So in the case of a late deceleration as you have described it, the baby's heart rate would fall below 120, is that right?
A. Not necessarily.
Q. Could you still have a late deceleration at; 120 or 130 beats per minute for a fetus?
A. Yes.
Q. What's the criteria to use on whether the deceleration is late or normal?
A. Whether the onset of the deceleration follows the peak of the contraction,
Q. Normally when would the deceleration normally occur, at the beginning of the contraction?
A. With a late deceleration?
Q. No, with a normal.
A. You might not have any decelerations.
Q. You might not have any at all?
A. That's correct.
Q. Theoretically in your experience you could have a mother who's going through contraction, through labor and never exhibit at all on either an external or internal monitor any kind of decelerations, is that it?
A, It's possible.

Q. During the period of a late deceleration which occurs at the peak of a contraction in labor, why does the baby or the fetal heart rate drop, what makes it do that?

A. Low oxygen levels.

Q. How does that result? What causes a low oxygen level in the fetus because of a late deceleration?

A. The contraction.

Q. Why is that so physiologic? What happens? Can you explain that for us?

A. The contraction decreases the amount of blood flow to the fetus.

Q. By compressing what?

A. The spiral arterials.

Q. What, sir?

A. Spiral arterials.

Q. Those are arterial blood vessels that come from the mother?

A. Yes.

Q. Where are they found?

A. In the uterus, in the muscle.

Q. If I summarize incorrectly, please tell me.

During a contraction, then, we have a contraction of the uterine muscles which

compresses some of the arterial blood flow in the mother which decreases the amount of blood; therefore, the amount of oxygen which is given to the child, is that about right?

A. That's correct,

Q. There seems to be an importance medically to the amount of oxygen that goes from mother to the baby. I'm correct on that, am I not?

A. Yes.

Q. If the decrease of oxygen from the mother to the fetus or to the baby is severe enough or continuous enough, you can have a child who suffers brain damage, is that true?

A. True.

Q. Is that the reason in a case of late decelerations that people must be attentive to such an event as late decelerations?

A. Yes.

Q. In your professional judgment in the case of late decelerations, is that something which should be watched either by a nurses or by physicians continuously?

A. Yes.

Q. I have read, but I am not. sure you would agree with this, that in the case of late

decelerations, it is like a red flag warning to physicians and to nurses. Am I about right?

A. Correct.

Q. And what is being said by that sign is please pay attention to this woman's decelerations. See if they occur frequently or they occur, recur and do something about. them. Is that about right?

A. That's correct..

Q. I'm speaking generally. Are there other either decelerations or medical phenomena or occurrences in a patient such as Mrs. Rerlinger, you know, in for the first time for a baby, a premie, that can affect the amount of oxygen which gets from mother to the baby aside from the late decelerations? Are there any other medical events or conditions that can cause a lessening or diminution of oxygen to the fetus?

MR. GOLDWASSER: Let me just understand. Are you saying limited to a primigravida or any woman?

MR. ILER: Any premie.

MR. GOLDWASSER: You don't, mean premie. You mean primigravida.

MR. ILER: Yes, not premature,.

A. Yes.
Q. What would those be?
A. If the cord was occluded or compressed.
Q. That would be the umbilical cord?
A. The umbilical cord. A separation of the placenta. Low blaod pressure. Position of the mother.
Q. Of the baby?
A. Of the mother and the baby. Blood loss in the mother.
Q. Is there one way for the -- if you think of anything else, you can bring it in whenever you're ready.

When we're talking about the oxygen supply from mother to the child, there is only one way that is transmitted to the baby and that is through the blood, am I correct?
A. That's correct.
Q. We talked about some other kinds of decelerations. We talked about early decelerations. Are those in any way significant insofar as the oxygen supply to the child? Do they affect the oxygen supply to --
A. Not usually.
Q. Are they medically significant?

A. Not usually.
Q. And the early deceleration would start when, before the contraction begins?
A. Correct.
Q. Would precede the first contraction of the uterus?
A. No. It's concurrent with.
Q. Concurrently?
A. Yes.
Q. No medical significance to that or is these?
A. No, not usually.
Q. With a high-risk mother, let's assume Mrs. Herlinger was high risk --
MR. GOLDWASSER: We're going to object to that; but go ahead with your question.
Q. Assume that she was high risk just for my purposes. Would early decelerations have any medical significance insofar as the oxygen which is getting to the baby?
A. It might depend on how long they lasted and how low they went; but generally speaking they're not.
Q. We spoke about variable decelerations?
A. We didn't.

Q. We didn't., but. I think we used that. term someplace. What is a variable deceleration?

A. It's a deceleration or lowering of the heart heat of the fetus which occurs at different times in response to contractions.

Q. How is it different than the late or early deceleration?

A. The early deceleration is a uniform deceleration that occurs with each contraction and begins early in the contraction, tends to reach its nadir at. the peak of the contraction and recover by the end of the contraction.

Late decelerations tend to begin after the peak of the contraction. The nadir follows the peak of the uterine contraction and the recovery may be later.

Variable decelerations may occur at any time or intermittently with contractions.

Q. Is there any medical significance to a labor such as Mrs. Herlinger was going through on July the 10th and the 11th of a variable deceleration?

A. Would there be any significance to it?

Q. Yes.

A. It might imply some cord occlusion or

entanglement.

Q. When we talk about an external monitor, for purposes of the record, is there a permanent record made of those?

A. Yes.

Q. How are they -- it just appears on a strip?

A. Yes.

Q. Then the strip is either reviewed by the nurse or the doctor?

A. Correct.

Q. In the Berlinger case, when the external and the internal monitor was applied to her, assume that the nurse that was watching the monitor, that would be external and then internal, did not know the difference between an early deceleration or a late deceleration or a variable deceleration. In your judgment would that be below the standard of care?

MR. GOLDWASSER: Objection. You may answer.

A. Yes.

Q. You've read the records of Mt. Sinai Hospital, both for mother and child, I assume?

A. Yes.

Q. If you find at any time you want to refer to

anything in that record, go ahead and do it and if you can't find it, one of us will get it for you.

A. Okay.

Q. Would you consider Mrs. Rerlinger to be a high-risk patient. while she was at the hospital and before delivery?

A. When?

Q. Well, we know that she came to the hospital for the first time on July the 9th of '84. She thought she was starting labor, from a review of the records, I guess, and she was looked at and sent back home. Okay?

A. Yes.

Q. And then a couple hours later she came hack and was admitted at this time?

A. Correct.

Q. From that point where she gets admitted to the Rerlinger a high risk obstetrical case?

A. Yes.

Q. What is your judgment as to the very earliest. time that Mrs. Rerlinger became a high-risk patient?

A. When some late decelerations were noted.
Q. What tjme do you fix that to he? What date and time?
A. I'd have to review the records.
A. Around Panel 90, 91, 92.
Q. When we speak about Panel 91 and 92, we are talking about the fetal monitoring strip, am I correct?
A. That's correct.
Q. Would it he the external for the internal strip?
A. The internal.
Q. And what date and time would that. be, for the record, please?
A. The date is the 10th of July. The time is difficult to tell.
Q. Is there any way to tell?
A. It says 1400 or 1410 on the record printed by the machine. That may not be correct.
Q. I think the. time aspect can change as to whether or not the machine is shut off *os* not.. Is that the point of it.?
A. Not usually.
Q. It should be running continuously, I assume?
A. It should have a battery backup *so* that the clock continues to run.

Q. So it's your judgment, anyhow, at Panels 91, 9% on July the 10th of 1984 on what appears to he on the record at 1410 hours, which would be something like 2:10 in the afternoon or so, assume that is the correct time, is when you would consider this child and the mother to be at high risk, is that it?

A. To be at some risk.

Q. From your review of the record, is that the first time you found decelerations that would incline you towards this patient being a high risk?

MR. GOLDWASSER: He said some risk.

Q. Some risk?

MR. GOLDWASSER: Go ahead.

A. Yes.

Q. What makes you say that?

A. They appear to be late decelerations.

Q. If late decelerations appeared earlier than that, would you then place the time in your mind earlier than that when the patient was at some risk? I'm trying to get your criteria for the time.

a. It would depend on whether they persisted and

whether there was variability.

Q. When you say persisted, what would make your mind up on that point? How persistent would the late decelerations have to be?

A. Several consecutive contractjons.

Q. Over what period of time?

A. Depends on the frequency. If they're occurring every five minutes, then it may be 15 minutes.

Q. Okay, Now, I just want to be plain. Can I rely that your opinion is this lady, Mrs. Berlinger, was at high risk when Panels 91 and 92 appear?

MR. GOLDWASSER: He said some risk.

Q. Well, everybody is at some risk. T'm looking for that high-risk point in your mind. I want to get that from you, if T can.

A. Well, I'm not sure what you mean by high risk.

Q. Okay. Let's go back and see if we can get that. What do you consider a high risk obstetrical case to be?

Now, we talked about hypotension in a patient. We talked about where the umbilical cord or the placenta may be involved. We have a placenta that slipped down, could be causing a problem. That's a high-risk patient?

A. Yes.
Q. You probably would consider a cesarean section right away?
A. Correct.
Q. Then we talked about some other things; but now in Mrs. Berlinger's case, what would you consider to be a high-risk situation for her, just late decelerations?
A. That might be a risk.
Q. Would you consider this lady to be at high risk medically at any point in time prior to her delivery?
A. She is at increased risk with the uterine -- when she has late decelerations.
Q. When we say increase, is that synonymous with high? I don't want to get tangled up in the term.
A. Well, there are patients who have diabetes and hypertension and who have triplet contributory pregnancy and have predate infants and postdate infants and some are at risk but some are higher than others; so high is just a --
Q. It's a relative term?
A. Yes, it's a relative term.
Q. Let's do this: Let's use your word increased

risk. And can we do this? Is it your opinion that Mrs. Rerlinger and the baby are at increased risk at Panels 91, 92 on 7/10/84?

A. There is risk there that needs to be evaluated.

Q. What is the risk?

A. Decreased oxygen supply to the baby.

Q. Which could result in what?

A. Damage.

Q. To the baby's brain?

A. Right.

A. Correct.

Q. So what. medically should he done for Mrs. Berlinger and her baby when late decelerations occur on Panel 91 and 92 that normally would not be done for a normal pregnancy and labor? What additional things, if any, in your judgment should be done for Mrs. Berlinger at that point in time?

turn her on her side; and if the pattern persists, she may need oxygen.

Q. Then after, if those things are done, say she's turned on her left side and oxygen is administered and then assume that the late

decelerations continue, and I think they did in this case, did they not, or do you know?

A. They resolved for a while and then recurred at a later time.

Q. What is your judgment as to when they occurred the second time, these late decelerations? Can you look at the monitoring strip?

A. She has a couple on Panel 100.

Q. What time would that be, then?

A. It. says 1450 printed on the record.

Q. She has two then or how many would you estimate?

A. There are two an that. panel.

Q. Two on Panel 100?

A. Yes.

Q. Are there some more or not. after Panel 100?

A. They resolve for several minutes and there. are a couple more on Panel 103.

Q. Two more?

A, *Yes.*

Q. What time would those late decelerations have, occurred on Panel 103?

A. The time printed is 1510.

Q. Did you find some more late decelerations after Panel 103?

A. There is one on 104.

Q. What would the time be on that panel, doctor-?
A. Oh, that might be the same one. That's the same one that I was referring to. The copying technique --
Q. We'll withdraw the 104.
A. -- there is overlap on the copy.
Q. When is the next one?
A. I'm not sure what type of a deceleration is on Panel 107.
Q. Either late, early or questionable, variable?
A. Correct.
Q. What do you want to do with that? Eliminate it as a sign of caution or concern or do you want to include it as something that would increase the risk?
A. It's hard to tell from this tracing.
Q. Are there more decelerations?
A. There are more decelerations, certainly.
Q. Are they late?
A. They seem to he mixtures, combined patterns.
Q. Would that be late, a mixture of lates, earlies and variable decelerations? Is that what you mean?
A. It's hard to say for sure. There is some variable component and some suggestion of a late

component.

Q. In your report. of February the 7th of '86, do you have a copy of that? You might want to refer to it.

A. Yes.

Q. In the first report you indicate that, down the second last paragraph, you indicate, "My impression from reviewing this data," that sentence, "they were treating suspicious tracings appropriately."

What do you mean by suspicious tracings?

A. I did not have the tracings at that time, so I was just reading the intrapartum notes. They were acting on what they saw.

Q. The fact is that when you rendered your medical opinion through your report of February the 7th of 1986, wherein you concluded medically that the care in monitoring was appropriate for Mrs. Berlinger, am I right?

A. Right.

Q. That's what you said on February 7th of '86 in writing. It also is true that on February 7th, 1986 when you wrote this report, you did not have the monitoring strips to review, true?

A. That's correct. They couldn't find them.

Q. I'm back to the point where you have, we started with Panel 91, 92 and then you gave us a few more decelerations.

Now, as those decelerations occur, late decelerations occur, should the physician be advised of those late decelerations as you saw them on the strip?

A. What page are you on? Did I mention on 91?

Q. You had 91 and 92 were the first panels we talked about. Then we had a couple of late decelerations on Panel 100 and also on 103 and that's where we stopped, I think; but on those three occasions where there are late decelerations, should the doctor he advised ox somebody be advised?

A. Well, the patient should be managed and then the doctor notified.

Q. If the doctor is not notified by the nurse who is watching the monitoring, is that a breach of the standard of care?

MR. GOLDWASSER: Objection. You may answer.

A. If the pattern persists and worsens, it certainly would be.

Q. Well, here we have a situation with Panel 91/92,

we found a couple late decelerations. We have discussed Panel Number 100 where we had two late decelerations and then we had Panel 103 that was two lates at 1510.

Now, based on just that short period of time or that period of tjme, would it he below the standard of care if the nurse does not advise either the resident or a physician, a medical doctor about these late decelerations?

MR. GOLDWASSER: Objection. You may answer.

A. I don't. think so.

Q. Do you practice obstetrics here at Cleveland Metro?

A. I do.

Q. You see patients?

A. Yes.

Q. How is your nursing staff advised here about this kind of a situation? Do you want to know when your patient has gone through late decelerations? Do you want the nurses to call you and say, "Doctor, your patient has had six late decelerations"? Do you want. to know that?

A. I would want to know.

Q. Do you instruct your nurses to tell you, to call

your if your patient does experience that os do they already know that that's what you want?

A. They would notify the resident usually.

Q. A medical doctor would he notified here at Cleveland Metro about that?

A. That's correct.

Q. Well, can we do this? In speaking about your report of February the 7th, 1986, it appears that the report was written without yau knowing how many late decelerations had occurred because you had not been given the monitoring strips to observe, is that right?

A. That's correct.

Q. Then would you say that the opinion rendered on February 7th, '86 in this case should be withdrawn by you because you did not have the actual, you were not given the actual monitoring strips to look at?

MR. GOLDWASSER: He wasn't given them because remember you had the originals and none of the other parties in this lawsuit had them until we discovered that you had the originals when you were taking Dr. Schwartz's deposition. I just did not want you to imply that we intentionally did not. give the doctor

the strips.

MR. ILER: I would not make that reference that way.

MR. GOLDWASSER: I know that's not what you meant but I don't want the record to show that.

A. This opinion was rendered based on the available evidence at this time. Additional evidence is available now.

Q. Well, let me put it this way: See, I'm trying to see from what it appears to me, but it's up to you, when I look at the report of February 7th, '86, I find out that you didn't have the monitoring strip for whatever reason, no fault. of your own, but you rendered a medical opinion which says that the care that was administered to Mrs. Berlinger and the baby by the nurses was okay and I'm saying, well, maybe that opinion was a little premature, based on the fact you didn't have the monitoring strips. Do you agree with that. or not?

A. That could be,

Q. Okay. Now, when we come to the report of February 25th, '86, you now have had an opportunity to actually look at the mon

strips and now see what was happening to mother and child and then impose your medical judgment with that additional evidence, the monitoring strip, am I right?

A. Okay.

Q. Now, have you seen Dr. David Abramson's report to me?

A. I have.

Q. Have you had a chance to look at his deposition?

A. Yes.

Q. Did you read what he was critical about?

A. Yes.

Q. I don't have it here, but I think you probably have an idea what the doctor is saying, how he criticizes medically the nurses who were doing the monitoring, both external and the internal monitoring, okay?

A. I don't recall. I would have to review his criticism of the nurses.

Q. At this point, today, this deposition today that you have given, can you tell me how many late decelerations there were that appeared on the external or the internal monitoring strip from the time the external/internal monitoring strip was placed on Mrs. Berlinger?

MR. GOLDWASSER: Over and beyond what he's told you already?

Q. Yes, in addition to what we've talked about.

A. There were six t.o eight that were apparently pure late decelerations that. occurred intermittently from Panel. 91 on and there were some other decelerations which occurred later, part of which could have been late in nature.

Q. Have you concluded as of this date the number of late decelerations that appeared on the monitor strip that were seen on the monitoring strip which you have reviewed?

MR. GOLDWASSER: You are talking about something he's already told you because. he went through each panel from 91 on. He reviewed each one.

Q. Well, let me ask you this: What I'm trying to get from you today is can you tell me today exactly how many late decelerations you found in the monitoring strip? I assume that this is -- what strip is that you have been looking at, the external or the internal?

A. The internal.

Q. Let's just stay with the internal. How many late decelerations did you find from the

monitoring strips which you were given to review from beginning to end, haw many lates did you find?

A. I didn't count them,

Q. Does that make any differenre to your opinion as to whether there were six late decelerations or 26 late decelerations? Does it make any difference to you?

A. Sure it would make a difference.

Q. Why?

A. It would indicate that there could a continuing problem with longer numbers.

Q. I notice you have made some notes for yourself, is that right?

A. Yes.

Q. Are those your own notes on that,?

A. Yes, these are mine.

Q. Can I have that marked? Is it written on both sides?

A. Yes.

- - - -

(Whereupon, Plaintiffs' Exhibit No. 2 was marked for purposes of identification.)

- - - -

Q. Doctor, I'm handing you what has been marked as

Exhibit Number 2. It's a yellow sheet both sides. What is this, doctor?

A. Those are notes that I made in reviewing the chart.

Q. When were these notes made? Is there a date on them or anything?

A. July 13th.

Q. July 13th of what year?

A. '87.

Q. Are these the only notes which you have made in reviewing the chart and rendering the fetter reports you did? Are there any other notes?

MR. GOLDWASSER: Handwritten notes, you mean?

Q. Yes.

A. I don't believe there are.

Q. Now, these notes which were'made on 7/13/87 are entitled, "Review"?

A. Yes.

Q. It's done in your handwriting, I take it?

A. That's correct.,

Q. You have "7/9/84, 39"?

A. "5/7ths".

Q. Then you have underneath that, "11:15 p.m." What does that. say?

A. "Contracts," contractions.
Q. "Since early evening"?
A. Yes.
Q. And then, "11:45," you have "FH" here. What's that?
A. "Stable."
Q. Fetal heart sate?
A. Yes.
Q. At 1:35 a.m. you have a "1.5 centimeters." What does that line say?
A. It's, "1.5 centimeters. 75 percent effaced. Minus one station. Fetal heart rate stable."
Q. On this document have you -- I assume you got this information from the medical records, the hospital charts -- made a little summary for yourself?
A. Correct.
Q. Then I see that at 2:35 you have, "MS Code 230." What is that?
A. Morphine sulfate.
Q. She was given medication?
A. Yes.
Q. Do you know why?
For sedation.
Q. Why did she need that?

A. I don't know.
Q. Make any difference to you?
A. Why she needed it?
Q. Yes.
A. She was probably tired.
Q. That was given to her at 2:55 in the morning?
A. 2:35.
Q. It was how much, dosage?
A. I don't have the dosage.
Q. The next line is what?
A. The exam at that time was two centimeters dilated.
Q. What's the next?
A. 75 percent effaced.
Q. Then after that you have, "fetal heart rate stable"?
A. "With accelerations."
Q. "With accelerations"? What do you mean by accelerations?
A. Increases in the heart heat.
Q. What do you attribute that to have been caused by at 2:35 in the morning?
A. Probably fetal movement..
Q. Nothing to be concerned about?
A. No.

Q. What's the MS mean?
A. Morphine sulfate.
Q. Then we have at 4 --
A. 35.
Q. 35 a.m. and this would be now on the 10th?
A. Yes.
Q. July 10th. What's your next note?
A. "Contractions irregular."
Q. What does that mean? What's happening here?
A. They've become spaced out.
Q. Nothing to be concerned about here?
A. No.
Q. Everything progressing okay so far --
A. Yes.
Q. -- with this lady and her baby?
A. Yes.
Q. Then we come to 0700. That would be 7:00 in the morning?
A. Correct.
Q. Of July the 10th, you have a note. What does it say?
A. "Three to four centimeters dilated. 90 percent effaced. Minus one station. Fetal heart rate variability returned."
Q. Returned? Where was it?

A. Apparently it had decreased.
Q. Well, that's what the resident put down in his note, didn't he?
A. I believe so.
Q. What was the trouble? I don't understand. What did you understand was occurring during the night before the resident made his note?
A. Decreased variability.
Q. Well, what was happening to this lady at. night, then?
MR. GOLDWASSER: He just told you. You are talking about to the fetus. He just said decreased variability.
Q. Well, how long had that gone on during the early morning of July the 10th. Do we know?
A. I'd have to review the records again.
Q. Is that a significant point.?
A. I don't believe so. She had had morphine sulfate which is a sedative and decreases the variability in the heart rate.
Q. What's your medical judgment? That was caused by the medication?
A. I would think so.
Q. What if it wasn't?
MR. GQLDWASSER: Objection. He

said it was.

Q. Hypothetically let's assume it wasn't caused by the medication. Then does it become a matter of concern or we still don't have to worry about it?

MR. GOLDWASSER: Objection. You can answer.

A. Depends how long it went, how long it lasted.

Q. Your next note on this exhibit?

A. We were down to 7:00 a.m.

Q. Then you have, "fetal heart rate variability --"

A. "Returned."

Q. "Returned." What does the little note say here on the side, 50?

A. That's, "Demerol 50. 25 Phenergan at 8:30 in the morning."

Q. What do you have there, cord what?

A. "Cord pattern."

Q. What does that mean?

A. Variable decelerations.

Q. Were they just variables? Is that what, you came up with?

A. That was my impression.

Q. Did you get that information from the nurses' notes or what?

A. From reviewing the record.
Q. The monitor strips or just the record?
A. The monitoring strips, I believe.
Q. We are now at 8:00 a.m. and your note here says, "8:00 a.m. AROM"?
A. Artificial rupture of membranes. "Little amniotic fluid, show. Scalp electrode. Early uniform decelerations after Demerol."
Q. Now at 8:00 in the morning I think Dr. Schwartz ruptured the membranes?
A. Yes.
Q. And the fluid was clear?
A. Correct.
Q. At this point in time, this is 8:00, and after the doctor had ruptured the membranes, and the fluid had come out, do you believe at this point in time that the baby, Rebekah, has gone under no distress or stress?
A. No evidence from the, in the record.
Q. For an example, if we -- hypothetically speaking, when the doctor had broken the membranes at 8:00 and let's assume the green pea soup meconium comes out. Then we could assume that the child had undergone some stress prior to this time?

A. That would he a reasonable assumption.
Q. So at 8:00 in the morning on February the 10th, how would you assess the child?
A. Normal.
Q. And how would you assess the labor?
A. Normal.
Q. Wow far had the labor progressed from the beginning of labor until 8:00 in the morning on July the 10th? You said complete effacement, correct?
A. Yes.
Q. How about the stations? Where had that gone?
A. Minus one. Stayed the same.
Q. Stayed the same?
A. Yes.
Q. How long had the station remained the same?
A. Since the onset of labor it had dropped, 11:00 p.m. it was minus two and it had come down to minus one.
Q. So in a period of how many hours did it take to drop down?
A. Eight, nine.
Q. That's not normal, is it?
A. That's normal.
Q. So at this point you are satisfied with the

progress of labor and you are satisfied in your mind as a physician as to the stations of the child?

A. Correct.

Q. Now, 10:00 is your next note and can you tell me what you've written there and what it means?

A. "Four to five centimeters. 100 percent effaced. Minus one station. Fetal heart rate 155. Decreased variability.''

Q. What does decreased variability mean to you in this particular setting?

A. Decreased from normal.

Q. What's happening to the baby? Why is there a decrease?

A. My impression was medication.

Q. Was she given more medications, then, that caused that?

A. She still had the medication from an hour-and-a-halfbefore.

Q. If you didn't have medication and the decelerations were not caused by medication, would that raise a concern in your mind?

A. No.

Q. The next entry is at what time?

A. 11:00.

Q. In the morning?
A. A.m.
Q. What have you written there?
A. "Five to six centimeters dilated. 100 percent effaced. Zero station. Epidural. And Pitocin."
Q. Was Pitocin started then?
A. I'm not sure of the time. It's either 10:40 or 11:40.
Q. I think it is at that time, between 11 and 11:40.
MR. GOLDWASSER: The chart says 11:45 as I recall.
Q. Okay. What's a.n epidural?
A. It's a method of providing analgesia.
Q. For what purpose was it. given to Mrs. Berlinger?
A. To relieve pain.
Q. That's the only purpose of it?
A, Yes.
Q. Does it have any effect, on the labor?
A. It. may,
Q. In what way?
A. It may decrease contractions transiently.
Q. What effect. would that have on a labor?
A. It might slow it down.

Q. Is there a timing that should be used in epidural? In other words, should it he done at, certain times and not done at other times?

MR. GOLDWASSER: During the course of the labor, you're talking about?

Q. Yes, during the course of labor.

A. Not necessarily. Depends on the labor.

Q. I have read some literature which says that you have got to be careful when you do the epidural because what you can do is throw the whole labor pattern off?

A. Certainly.

Q. Did that epidural. have any effect on the labor pattern of this lady?

A. It doesn't appear to have.

Q. Now, at 11:00 the station is where now?

A. Zero.

Q. So at this point, 11:00, doctor, the baby has remained, hasn't really descended very well, has it?

A. It's at zero station.

Q. What do you think about that?

A. Normal.

Q. Normal?

A. Yes.

Q. You don't normally give Pitocin to someone who is progressing normally at labor, do you?
A. Her labor is on the slow side of average.
Q. Well, we know that Mrs. Rerlinger was given Pitocin, right?
A. Yes.
Q. Under what circumstances is it your judgment that you would give Pitocin to such a lady?
A. If the labor progress falls below normal.
Q. Well, did it fall below normal when Pitocin was administered to Mrs. Rerlinger?
A. By a stricter criteria, just barely.
Q. What are we saying now? What is your judgment here? What is Pitocin, first of all?
A. It's a hormone that causes uterine contractions.
Q. There are same benefits to this drug, Pitocin or oxytocin. It's the same thing, am I right?
A. Correct.
Q. I think she got oxytocin. Same thing?
A. Same thing.
Q. Rut this is a dangerous drug, isn't it, Pitocin?
A. All drugs are dangerous.
Q. Why is Pitocin dangerous to use in a lady such as Mrs. Berlinger?

MR. GOLDWASSER: Wel1, objection to

the conclusion that Pitocin was dangerous to Mrs. Berlinger. Rut you're asking why is it potentially dangerous? Is that your question?

Q. Yes, That's a good question. Thank you.

Why is it. potentially dangerous to Mrs. Rerlinger when it's given to her at. 11:00 on July the 10th?

A. Pitocin can be dangerous to any laboring patient..

Q. Why?

A. It could cause distress to the fetus.

Q. How?

A. Increasing the frequency of contractions so that there is decreased time for oxygenation to the baby.

Q. How does that occur?

A. We had mentioned that the contractions, the blood flow is between contractions and increasing the frequency so that there was no relief between contractions could be detrimental.

Q. By cutting off the blood supply to the baby?

A. Yes.

Q. Is it true that what Pitocin does is it makes the uterus contract a little stronger than a

normal labor contraction?
A. That's correct..
Q. Does Pitocin increase the frequency of contractions or the severity and length of the contraction?
A. It can do both.
Q. So what you can have, theoretically speaking, with the use of Pitocin is you can have a uterus contracting for a longer period of tjme than it normally would contract without Pitocin and thereby cut off the supply of oxygen to the fetus for a longer period of time than would normally be done if no Pitocin was used?
A. That's correct.
Q. What's your judgment on why Pitocin was used on this lady?
A. She had a protraction.
Q. What is that?
A. A slower than minimal rate of dilatation.
Q. Dilatation of what?
A. Cervix.
Q. And the baby's head was not descending into the canal. Is that true, too?
A. That's not. why. I don't. know why -- I don't. know if that was a factor in their decision.

Q. So the purpose of the Pitocin was to increase the dilatation of the cervix, right?

A. Increase the contractions to result in increased cervical dilatation.

Q. Now, is this true: That during a contraction, a normal contraction during the labor, it's the baby's skull which is projected forward or downward into the cervix?

A. Yes.

Q. And with the use of Pitocin, is that forceful downward movement of the head of the fetus during the contraction, is that increased?

A. Could be.

Q. Do you agree that when using Pitocin, the standard of care is that the physician or a doctor should he present from the time the Pitocin is started on the patient until the time the Pitocin is discontinued?

MR. GOLDWASSER: Are you talking about present at the patient's bedside?

MR. ILER: Yes.

MR. GOLDWASSER: Not in the hospital alone, but at the patient's bedside?

MR. ILER: Yes.

MR. GOLDWASSER: You may answer,

doctor.

A. No.

Q. Do you believe somebody should be watching the patient as the Pitocin is being dripped into the mother's blood stream?

A. Sitting by the patient's side?

Q. I don't know. Anywhere?

MR. GOLDWASSER: Well, wait a minute. There is a difference. I mean she is obviously in a hospital.

MR. ILER: Yes. We know that.

Q. With Mrs. Berlinger, when the Pitocin was administered to her at 11:45 a.m. on July the 10th of '84, it's your medical opinion that a medical doctor should not be present as the Pitocin is run into -- let me finish.

You have testified, doctor, that a physician does not need to be present at the bedside of Mrs. Berlinger when the Pitocin is being administered and during the period of time the Pitocin is going into Mrs. Herlinger's blood stream, right?

A. That's correct.

Q. Is it your opinion that, somebody who is trained to know the effects of Pitocin should be at the

bedside of Mrs. Berlinger while the Pitocin is being administered and dripped into her blood?

A. The entire time?

Q. Yes.

A. No.

Q. Is this true: That the use of Pitocin causes the uterine contractions either to increase in severity or i.n length of time?

MR. GOLDWASSER: He's answered that already. Go ahead again, doctor.

A. That's correct.

Q. Isn't. this true: That if nobody is watching the contractions in the mother, like Mrs. Rerlinger, when Pitocin is being administered, then nobody knows how long the contractions are taking place because of the Pitocin and how severe the contractions are?

MR. GOLDWASSER: Objection. Are you talking about continuously? I object to the question. You may answer, doctor.

A. That's not what you said.

Q. Let me retry the question.

See, I think that either the doctor os a resident or a very well-trained nurse should he watching Mrs. Berlinger after the Pitocin is

started on her because you don't know what effect the Pitocin has on Mrs. Berlinger until you actually see with your eyes the contractions taking place. That's what I think, see? Do you agree with that?

A. I agree.

Q. Well, if nobody is watching, neither a resident nor a physician nor a trained nurse is watching the contractions during the time the Pitocin is being administered to Mrs. Berlinger, then nobody knows how long the oxygen is being cut off to Rebekah, the baby, during these contractions, is that right?

MR. GOLDWASSER: Objection. That's not the circumstances in this case. I object to the hypothetical.

Q. That's all right. Go ahead.

A. But that's not the question you asked me.

Q. Is that correct?

MR. GOLDWASSER: Hypothetically if that be the case, doctor, which I object to, if nobody was ever there to look.

Q. Yes.

A. You stated that a nurse or a physician must be at the bedside the entire time of administration

of oxytocin. My response was no.

Q. That's right,.

A. But I think that somebody needs to observe either the patient. or the monitoring tracings which need not be at the bedside but somewhere so that if increasing contractions are noted, they can be attended to.

Q. And the reason for that opinion is so that somebody is either watching the monitor strip while Pitocin is being administered or watching the patient· so that we do not get a prolonged cantraction which cuts off blood and oxygen to the fetus?

A. Sure.

Q. Now, would it be below the standard of care for the nursing staff not to be watching the monitor strip while Pitocin is being administered to Mrs. Berlinger?

MR. GOLDWASSER: Objection. You may answer.

A. You mean continuously sitting there looking at the strip?

Q. Observing it.

A. Well, they should abserve the strip for changes that are worse, yes.

Q. What would they be looking for; late decelerations, early decelerations or variables or what?

A. They would he looking for bradycardias, late decelerations, increasing frequency in tone of the, uterine contractions as being monitored or the mother complaining of something.

Q. Okay. Did you read the nursing nates during the period of time that Pitocin was being administered to Mrs. Berlinger?

A. I'd have to refer to the notes again. I did, but I don't recall what you're referring to.

Q. Here at Cleveland Metro, is it a requirement. of the nursing staff in such a situation where Pitocin is being administered to one of your patients to record in the medical records what is happening to the patient and what indications are on the monitor?

A. To interpret the monitoring tracings?

Q. Yes.

A. Yes.

Q. Do you tell your nurses here to do that?

A. Yes.

Q. Why?

A. So that they note changes that are worrisome.

They usually note abnormal patterns.

Q. And that would be, what, late decelerations?

A. Late decelerations, bradycardia.

Q. Did you find, when you reviewed this case, did you have your mind on this particular point as to who was monitoring the monitor strip or Mrs. Berlinger during the period of time the Pitocin was being administered to her? Did you have that in your mind?

A. No.

Q. Does it make any difference to you in your opinion as to whether the nursing staff comported with the standard of care in Mrs. Berlinger's case as to whether or not they were watching the monitoring strip or Mrs. Rerlinger during the use of Pitocin?

A. I'm not sure I understand.

MR. ILER: Can you read it back?

- - - -

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

- - - -

MR. GOLDWASSER: Object.

A. I still don't understand your question. It's not clear.

MR. GOLDWASSER: I don't understand your question, either.

Q. You have opined that you believe that the nursing staff that was watching Mrs. Berlinger, taking care of her during this labor time comported with the standard of care, right?

A. I have opined that?

Q. Yes.

A. I did not review the record specifically looking at the nursing care.

Q. You're not making an opinion as to that standard of care for those nurses, then?

MR. GOLDWASSER: Oh, no. On direct examination I may well ask the doctor in view of his experience working with nurses, whether the nurses in this case complied with acceptable standards. I just don't want you to be misled. He doesn't know what I'm going to ask him on direct examination. I haven't discussed it with him, yet.

MR. ILER: Maybe I'm taking this deposition prematurely, then.

MR. GOLDWASSER: No, you're not.

MR. ILER: Do you want to talk with him?

MR. GOLDWASSER: No. You go ahead and proceed. In fact, you're doing quite well. I'm not objecting to you taking the deposition.

In fairness to you I'm telling you something probably a lot of lawyers wouldn't even mention to you.

MR. ILER: I know. See, I've got to get ready for this thing. What I'm trying to get from the doctor --

MR. GOLDWASSER: Well, then, ask the doctor the question.

- - - -

(Thereupon, a recess was had.)

- - - -

Q. Have you reviewed the medical records made by the nurses who were attending Mrs. Rerlinger?

A. Yes.

Q. Did you find from the notes, the nurses' notes themselves, that they reported to Dr. Schwartz all the significant signs, that is decelerations or variabilities or beat-to-beat variabilities or any other clinical problems that may have occurred during the period of time of labor? Did you find from the records that these nurses did report such conditions to Dr. Schwartz?

may answer that hypothetical.

A. Is this --

MR. GOLDWASSER: Wait a minute. Doctor, I contend that that is absolutely contrary to what is recorded in the nurses'

know that; but you can indicate that in the hypothetical if they didn't know.

A. Did I state that?
Q. I'm sorry?
A. Did I state that?
Q. I assume that's what you are going to state.
MR. GOLDWASSER: Then why don't you ask him if he has that opinion? Do you have an opinion that the nurses comported with the standard of care from your review of the record. I assume that's what you want to know.
MR. ILER: That's what I want to know.
MR. GOLUWASSER: Well, you've got the cart before the horse. You didn't ask him that question.
A. I don't think the opinions that I have are strictly with regard to a nursing care standpoint.
Q. Specifically with regard to the letters of February 7, '86 and February 25, '86 from yourself to Mr. Goldwasser, did those opinions include the nurses that attended Mrs. Berlinger during her labor?
A. It was the entire case.
Q. Including the nurses?
A. The entire case was my opinion.

Q. Now, let's stay with the nursing staff for a moment, and upon what facts do you base your opinion that is contained in your report of February 7th and February 25th that the nurses who were monitoring, observing and watching Mrs. Berlinger from the time of labor until the time of delivery acted in accordance with the standard of care? What facts do you base that on?

A. My written opinion on February whatever was based on the overall care and attention given to monitoring and intervention as I felt reviewing the record both from a nursing, physician, anesthesia standpoint.

I did not review them specifically from either individual point, but I can review the nursing records, if you'd like.

The heart rate was noted every 15 minutes on the intrapartum record, noting that, they were at least observing the record.

Q. In the letter of February 7th of '86, this appears near the bottom of the second last paragraph, "This relieves much of my concern about the absence of written clinical notes following the notation of 12:30."

What occurred at 12:30 that seemed to he a point to you?

A. Can I refer to the record?

Q. Oh, yes.

MR. GQLDWASSER: I think you are talking about the progress note of 12:30. Doctor, it's the clinical notes in the index I sent you.

A. Okay. In the clinical notes of 12:30.

Q. That would be on July?

A. 10th, I believe.

Q. Okay. At 12:30 what occurred?

A. The observation of the cervix was seven centimeters, completely effaced, zero station. The fetal heart rate showed mild late decelerations. She was given oxygen and turned on her left side.

Q. Now, apparently from your letter report, that incident of late decelerations and then so forth at 12:30 raised some concern in your mind, am I right,, from your letter?

A. Yes.

Q. What was your concern?

A. There were no further notations until 3:30 p.m. on that --

MR. GOLDWASSER: Notations in the clinical notes?

A. Right.

Q. There should have been, I assume?

A. At Metro, the nursing notes and physician notes are simultaneously on the same sheet, so I am accustomed to seeing nurses' notes in there, as well.

Q. Do you find any nursing notes at all in Rebekah Berlinger's case -- Mrs. Berlinger's case that occur after 12:30 up to 3:30?

A. Not physician notes.

MR. GOLDWASSER: He is asking about nurses' notes. He didn't ask about physician's notes.

Q. Nurses' notes I'm asking for. I think what, you indicated was there was a nurse's note at 12:30 and the next one appeared at 3:30?

A. I think that's a physician note.

Q. Why don't you take a look at it.

MR. GOLDWASSER: Thad's a resident in obstetrics.

Q. Let's go back over it again.

There appears to be no physician's note after 12:30 on 7/10/84 until 3:30. Three

hours. There is no doctor's note, is that right?

A. That's correct,.

Q. Insofar as the nursing notes are concerned during that, period of time, what do we see there?

A. I'll have to refer to the nursing notes. Just observation of the heart rate.

Q. What time?

A. And decreasing slightly with contractions at 3:00.

Q. When is the note, any nurse's note before 3:00 on July 10th?

MR. GQLDWASSER: You are excluding the hospital form. You are just talking about the narrative form?

Q. The narrative form.

A. I'm sorry. What was the question?

Q. You just read a note which apparently was as 3:00?

A. There is a note at 3:00 where they mention the heart rate.

Q. Okay. Before that,, 2:30, 2:00, 1:30, 1:00 are there any notes?

A. There are notes.

Q. Who has signed those notes, do we know?
A. They are not signed. Or they are signed down lower, I guess, B. Thomas.
Q. What has Nurse Thomas reported at 12:30 on her note?
A. "12:25, Exam per Dr. Auld,"
MR. GOLDWASSER: A U L D?
A. "7 centimeters. Comfortable. Talkative. 1:15 Dr. Schwartz here. Nine cm's."
Q. At 9:15 what, sir?
A. Dr. Schwartz here.
Q. What else does it say?
A. Nine cm's.
Q. Then your next note?
A. "At 1:30 patient allowed to push. Has no feeling in peroneal area."
Q. Then what?
A. 2:00 p.m. is noted but I'm not sure of what's there,
Q. You can't read it?
A, There is nothing there.
Q. Then what's after that.?
A. "3 continuous pushing. Fetal heart tones, 140 to 160. Decreasing slightly with contractions. Dr. Schwartz examine. No progress. Will do

C-section."

Q. What's the last part? C-section?

A. " Willdo C-section."

A. 1:30 till when?

Q. 3:30?

A. There are heart rate decelerations noted.

Q. That's late decelerations?

A. It doesn't say.

Q. But are there any specific references during that period of time, 1:30 to 3:30 of late

t you

MR. GOLDWASSER: For after, when it. started and then stopped, you say?

MR. ILER: Yes.

MR. GOLDWASSER: I object. You may answer, doctor.

A. When did labor stop? When did progress in labor stop?

Q. Yes, progress

A. No change after 1:00. 1:00 p.m.

Q. And at 1:00 p.m., where is your note on Exhibit Number 2 for for 1:00 p.m.?
A. "1530. Complete zero/minus one since 1300."
Q. So at 1:30 in the afternoon, July 10th, would you say the progress stopped for Mrs. Rerlinger in her labor?
A. After when?
Q. 1:30?
A. There was no progress from 1:00 on.
Q. From 1:00 on, there is no progress?
A. That's correct.
Q. Is that the time to do the cesarean section?
A. When?
Q. 1:30?
A. No.
Q. You want to let her -- she's still on Pitocin at 1:30?
A. Yes.
Q. She had been on Pitocin for how long now, from 11:45 to 1:30, maybe a couple hours or so?
A. Couple hours.
Q. You can let her run on Pitocin?
A. Yes.
Q. What's going to make your mind up as to when you are going to do a cesarean here or aren't you

she is not doing very well pushing?

A. She's not able to push too well,

Q. What. time was that note reflected?

Q. "After"?

A. "IV Demerol."

Q. And then your next, note says what? "Off

A. "Off monitor 11:05 for epidural."

Q. This is the external?

MR. GOLDWASSER: Off the external monitor, you mean?

Q. Yes. Or the internal? We don't know?

A. Well, she was on internal from 7:00 a.m.
Q. So then at 1350 you've got a note? What does that mean, doctor? Can you read it for me then tell me what it means?
A. "Fetal heart rate 150 to 160 with minimal variability."
Q. The next line is "1400"?
A. "1400 to 1410. Four light decelerations. 10 beats per minute. 160 to 150."
Q. What time would that be?
A. 1410.
Q. That would be about. 2:10 or so?
A. As noted on the tracing.
Q. Do you think you should be doing a cesarean right now?
A. No.
Q. Is the child, just taking it up to this note in your record of 1400 to 1410, when you say four late decels, okay?

From this point backwards has Rehekah Rerlinger, the baby, been placed under any distress os stress?

A. I'm not sure about these times because, as we noted, there is a question of the times being printed and the times as they actually were,

so --

Q. Rut up till this point, 2:00 in the afternoon of July the 10th of 1984, has this baby gone under any stress?

A. I don't believe so.

Q. Has she gone under any distress?

A. None we have observed on the tracing.

Q. Then your next note is 1420, something is resolved?

A. Yes.

Q. What resolved?

A. The late decelerations.

Q. And then the baseline?

A. 160.

Q. And what's your next note?

A. "Mild intermittent lates."

Q. The lates have come back again?

A. Apparently. That's what we mentioned earlier.

Q. Yes, I think you did.

So now is this based upon your analysis at this point in time, taking the 1420, where mild intermittent lates returned, okay?

From the summary of your sheet that you have here, this yellow sheet, how many times have late decelerations occurred up to this

point of 2:20 or 1420?

A. Two episodes.

Q. And then your next note is at 1500. That's 3:00, right?

a. On the tracing.

Q. What's happened on the tracing then?

A. "Regional variability, decelerations."

Q. Your next note?

A. "Pushing. Cord pattern. Normal variability. 1640 variable decelerations. Good variability. Baseline 150."

Q. What's your last?

A. "I would not have gotten scalp pH."

Q. Have you done that before, scalp pH's?

A. Yes.

Q. Do you have to do that or can a nurse do that?

A, I do it or a resident does it.

Q. A resident can do that?

A. Yes.

Q. Is that helpful to show you whether the child has become acidotic?

A. Yes.

Q. It wasn't done in this case?

A. No.

Q. When you do them, the scalp pH, does that

generally give you reliable evidence as to whether os not the child has been acidotic or is becoming acidotic?

A. Tt confirms your impression from the heart rate tracing what's going on at the time.

Q. Here is a mother who has not progressed in her labor, right, up until 1:30 in the afternoon of July the 10th? She's still at zero station, I think, isn't that right?

A. She is at zero station.

Q. She's been given medications for either pain or discomfort or for whatever- reason, right?

A. Correct.

Q. She has been given Pitocin?

A. Yes.

Q. Do you recall the dosage of the Pitocin, where it started and where it went to?

A. I don't recall.

Q. You are still prepared to give your opinion that there was no problem with the Pitocin even though you don't, know how much Pitocin was given to this lady, right?

MR. GOLDWASSER: Well, he knows if he looks in the record.

Q. Well, wait. Hold it.

A. Can you repeat your question?
Q. Do you know how much Pitocin was given to Mrs. Berlinger initially and what the last dosage was?
A. No.
Q. Does it make any difference to yon as to whether os not the dosage was increased or decreased on Mrs. Berlinger? Does that affect the standard of care in your judgment or not in this case?
A. I'm not sure what you mean.
Q. Okay. Let us assume that the initial dosage of Pitocin was increased with Mrs. Berlinger.

Does it make any difference to you insofar as the standard of care was met or not, as to how much it was increased or not?
A. There are certain, if you give it too fast, you may have a bad outcome, so I think you need to watch the dose that you are giving.
Q. Do you have any rule or any guidelines in that respect?
A. We do.
Q. What is it?
A. For augmenting Pitocin, we increase, we usually start at about two milliunits per minute and increase every 35 to 20 minutes.

Q. To what.?
A. By one or two units of Pitocin.
Q. To the maximum of what dosage?
A. It depends.
Q. How much have you given?
A. How much have I given?
Q. Yes.
A. Under this circumstance for patients who are progressing during the labor and they need supplemental oxytocin, rarely more than 16 milliunits.
Q. And we know that she has been, Mrs. Berlinger has been on Pitocin from 11:45 to approximately 3:30, right?
A. That's correct.
Q. That has not assisted the progress of labor, true
A. That's correct. It did assist, progress of complete dilatation.
Q. ut. insofar as the rest of the labor, did the Pitocin assist in any way?
A. It d d not. Did not result in descent.
Q. Did ot result?
A. Correct.
Q. Then we also know that, from at least what your

review of the monitor strips are, that the child has gone through late decelerations, true?

A. Had some earlier.

Q. We know that that's in there and there was an experience of bradycardia with the child during labor?

A. I don't recall that.

Q. Were there any other abnormal findings in the, from 12:30 till 3:30 in the afternoon of July 30th that I have not included?

A. There were decelerations that occurred while she was pushing.

Q. Then we also know that she was not pushing very well medically, am I correct on that point?

A. That's what the nursing notes state.

Q. Okay. And based upon that, is it your opinion that you still would not have done a scalp pH or would you have now done a scalp pH?

A. When?

Q. At 3:30?

A. I would have delivered the patient,.

Q. You would not have obtained a scalp pH between 12:30 and 3:30 in the afternoon?

A. That's correct.

Q. The other side of Exhibit Number 2 says, "Review

deposition. Who is this guy? ER physician."
That's your handwriting?
A. Correct.
Q. "Boarded in peds, newborn, perinatal medicine and --"
A. "ER medicine, not neonatology."
Q. "Director nursing, Georgetown.'" Okay.
The next note, sir, what does that say?
A. "Critique."
Q. Under number one you have what?
A. "Unengaged vertex." Those are in reference to Abramson's deposition which I reviewed.
Q. Was he correct on that?
A. That it was an unengaged vertex?
Q. Yes.
A. When she presented in labor, it was not engaged.
Q. Was he right?
A. It was not engaged.
Q. Number two critique says what?
A. "Fetal distress. Decreased variability before ruptured membranes on the monitor."
Q. Is he right?
A. I don't believe so.
Q. Continue with your comment number two?
A. "Fetal distress later."

Q. Is he correct on that?
A. I don't believe so.
Q. Then?
A. "Not recognized by residents, RN's."
Q. Is he right?
A. I don't believe so.
Q. Your third critique is what?
A. "Arrest of labor and descent."
Q. Is he right, on that?
A. She did have an arrest of labor and descent.
Q. At what time was that, do you know?
A. Her labor arrested at 1:00, from then on; but you would not recognize that until after, later.
Q. Then what's the next critique?
A. "Should have done pH by 11:40."
Q. You disagree with that?
A. I do.
Q. Then the next, item number five?
A. "He noticed variability decreased on those panels."
Q. "87 to 90. 131 to 132. 143 to 44. There was a suspicion.

Do you agree with that analysis he made?

A. No. I noticed those were his observations,
Q. Rut was he right? Was these variability on

Panels 87 to 90?

A. I'd have to review the panels.

Q. You want to do that?

A. Yes. Variability is decreased on 97. Can I look at that?

87 to 90. I disagree.

Q. For Panels 87 to 90?

A. Yes.

Q. How about 131 and 132?

MR. GOLDWASSER: That's in the very beginning. This is when she's in the evening before.

A. It's difficult to say. That's an external monitor.

Q. Then you have marked down here, "0400 to 0645"?

A. 4:00 a.m. to 6:45.

Q. What does he say there?

A. He says it was suspicious.

Q. What was suspicious?

A. I don't know. The heart rate tracing.

Q. Was there anything suspicious during that period of time that you found in that record?

MR. MURPHY: What's the time frame?

A. 0400 to 0645.

MR. GOLDWASSER: That's again the

external tracing?

A. The external tracing.

I disagree.

Q. What does thjs note here mean on the hack of Exhibit 2?

A. "40 to 43 compromise."

Q. What does that mean?

A. Those were his observations. He felt that it represented compromise.

Q. What do you think about that?

A. 1'11 have to look at those sections.

No.

Q. You do not agree?

A. That's correct,.

Q. Did you read Dr. Schwartz's deposition?

A. No.

MR. ILER: If I could get a copy of this before I leave --

MR. GOLDWASSER: I'll be happy to get that for you.

Q. Is oxytocin or Pitocin contraindicated in a case where a baby is going through some distress?

MR. GOLDWASSER: Objection. You may answer. Distress noted before the utilization, before the Pitocin is used, is that,

correct, Don? To make sure I understand it.

MR. ILER: Yes.

MR. GOLDWASSER: Objection. You may answer.

A. I'm sorry.

Q. Is Pitocin contraindicated where a child has been undergoing fetal distress, has been experiencing fetal distress?

As a general rule.

Why should you not use Pitocin with a child who is undergoing -- has undergone fetal distress?

Who is undergoing?

Has undergone it?

It depends on the situation. If it's undergone it and it discontinued, you can.

Let me strike the question.

It may worsen.

If a child is going through late decelerations, is Pitocin contraindicated in that case?

MR. GOLDWASSER: Objection. You may answer.

If the patient is having late decelerations, would it not be a good idea to give Pitocin?

Is it contraindicated?

If the late decelerations persist and you cannot

Q. Has it gone through any decelerations at all before 11:45 on July the 10th?

A. There may have been one or two intermittent somewhere in the previous hours.

A. Eventually, yes.
Q. When in this case should it have been stopped?
A. When do I think?
Q. Yes.
A. After a couple of hours of no progress with good pushing.
Q. That would bring you to about, oh, the Pitocin was started at 11:30, Gary?
MR. GOLDWASSER: 11:45.
Q. Say 12:45, 1:45 you probably would have stopped the Pitocin, right?
A. No, that's not what I said.
Q. What did you say?
A. I said when she had been on Pitocin and pushing well with no descent and given a good trial of that, then I would do a cesarean.
Q. But we know from the record that she was pushing but pushing without success, isn't. that right.?
A. She was not pushing well at 1:30.
Q. At 1:30. Well, doesn't. that mean to you that you would have stopped the Pitocin at 1:30?
A. No.
Q. Can you tell me how long the child, Rebekah, had been at zero station from prior to her delivery backwards? Do you know how long that baby had

been at zero station?

A. 11:00 a.m.

Q. So that would be how many hours?

A. What time was she delivered?

Do you know what time she was delivered?

MR. MURPHY: 4:14, I think it was.

A. Five hours and 14 minutes.

Q. Is that your judgment? She had been at zero station since that point in time?

A. That's what I read from the records.

Q. There was meconium staining that was evident at the delivery of the child?

A. That's correct.

Q. But what caused that?

A. I don't know.

Q. Pardon me?

A. I don't know.

Q. Is it, is meconium staining occurring when a child is under stress?

A. It can occur under those circumstances.

Q. Is it usually associated, that is, is meconium usually associated with a baby that. has been under stress while .in the mot-her's womb?

A. It depends on the situation; but generally speaking, you can assume there is some stress

sometime.

Q. What meconium is is fecal matter, is that right?

A. That's right.

Q. In other words, the child is placed under stress while in the mother's womb for whatever season, say lack of oxygen, you know, cutting off of blood supply, or medication and the baby defecates in the mother's womb, is that right?

A. That's correct.

Q. Would you agree that since the fluid was clear when Dr. Schwartz ruptured the membranes at 8:00 a.m. on July the 10th of '84, that the meconium was the result of stress placed on Rehekah Berlinger, the baby, from a point after 8:00 until the time of delivery at 4:12?

MR. MURPHY: Objection.

A. I don't know. The reason I say that is that when he ruptured membranes at 8:00, there was very little amniotic fluid and so it's theoretically possible that there would he meconium up high in the fundus that would not be noted when the membranes were ruptured.

Q. That's guessing, though, isn't it?

A. Sure. It's guessing when you say that it occurred later.

Q. You think it's guessing to say that it occurred later as the result of stress?
A. I say it could have occurred either time.
Q. Okay. Dr. Schwartz did not find any meconium at 8:00, did he?
A. None was noted. They did --
Q. Let's assume there was meconium that was evidenced there. Then should Dr. Schwartz have done the cesarean immediately at 8:00 a.m.?
A. No.
Q. Do you know how many times the child was suctioned after delivery for meconium?
A. No.

MR. ILER: Well, without hearing any more of of your direct testimony, because I won't, know what it is until Mr. Goldwasser videotapes you Thursday, then I will end my deposition at this point.

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

MR. ILER: Can we ask for a waiver of signature to the deposition?

MR. GOLDWASSER: Well, it's my practice not to waive signature.

LEROY DIERKER, M.D.

CERTIFICATE

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

I, Pamela S. Greenfield, 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 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__.

_____

Pamela Greenfield, Notary Public, State of Ohio
650 Engineers Building, Cleveland, Ohio 44314
My commission expires June 29, 1988

FEB 14 1986

Cleveland Metropolitan General Hospital

Highland View Hospital

3395 SCRANTON ROAD • CLEVELAND, OHIO 44109 • 216-398-6000

HENRY E. MANNING
PRESIDENT

JAMES KRETZSCHMAR
SENIOR VICE-PRESIDENT
OPERATIONS

February 7, 1986

Gary H. Goldwasser
c/o Reminger and Reminger
Attorney's at Law
The Leader Bldg.
Cleveland, Ohio 44114

RE: BERLINGER, REGEKAH vs. MT. SINAI MEDICAL CENTER
U#: 69-73-39

Dear Mr. Goldwasser:

I have again reviewed the records of the intrapartum events of Heidi Cerlinger on July 10, 1984. The technique of recording the fetal heart rate which is used at Mt. Sinai was one which I was not familiar with. It is apparent that the fetal heart rate was monitored and noted following the epidural anesthesia which was given at approximately 11:15. Mild late decelerations were noted at 12:30 when the patient was 7 centimeters dilated. The patient was treated appropriately by turning her on her side and giving her oxygen. This indicates that the monitor was being closely observed and when abnormal tracings were noted they were treated appropriately. The intrapartum record shows a gradual rise in the fetal heart rate ranging from 150 to 180 and then back down to the 140 range over the next few hours. It was noted at least every 15 minutes and there was no apparent concern on the part of the clinicians managing the patient.

My impression from reviewing these data is that the patient was indeed monitored throughout and although the fetal heart rate tracing cannot be located, they were treating suspicious tracings appropriately and observing her closely. This relieves much of my concern about the absence of written clinical notes following the notation at 12:30.

If I can be of any further assistance in this case, please do not hesitate to contact my office.

Sincerely yours,

LeRoy J. Dierker, Jr., M.D.
Associate Professor
Director, Maternal-Fetal Medicine
Case Western Reserve University
Department of Ob/Gyn

LJD/deb

Cleveland Metropolitan General Hospital

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HENRY E. MANNING
PRESIDENT

JAMES KRETZSCHMAR
SENIOR VICE-PRESIDENT
OPERATIONS

MAR 3 1986

February 25, 1986

Gary H. Goldwasser
c/o Reminger and Reminger
The Leader Bldg.
Cleveland, Ohio *44114*

RE: REBEKAH BERLINGER VS MT. SINAI MEDICAL CENTER

Dear Mr. Goldwasser:

I reviewed the electronic fetal monitoring strips which you forwarded to ne. On reivew of the monitoring tracing, it is evident that there were some mild late decelerations, as well as occasional variable decelerations and early decelerations. Throughout the tracing, the fetal heart rate variability was normal with accelerations of the heart rate apparently associated with fetal movement. The deceleration: were not present with all contractions, and, as mentioned, were always associated with normal variability, a feature indicating that the fetus appeared to be non-acidotic.

Sincerely yours,

LeRoy J. Dierker, Jr., M.D.
Associate Professor
Director, Maternal-Fetal Medicine
Department of Ob/Gyn

LJD/deb

2M 7/13/87 Review

Reminger & Reminger – Goldwasser

Berlinger, Heidi VS Mt. Sinai Med Center –

7/9/84 39 5/7 wk 25Y0 PO

11:15 PM Contrax since early evening 1cm, 50%, -2

11:45P FHR stable

7/10/84 1 35 A 1.5cm, 75%, -1 FHR stable

MS 0230 2 35 2cm, 75% FHR stable c Accel M.S.

4 35 A Contr irreg

50 c 25 phen 0700 3-4, 90% -1 FHR variability reduced

Dem 0830 0800 AROM - little AF, Show, scalp electrode – Early uniform Decel after D:

Cord PATTERN 1000 4-5, 100%, -1 FHR 155 ↓ variability (medicated)

1100 5-6, 100, 0 Epidural, (1140) Pitocin

1250 7cm, 100, 0 mild late decels, O_2, (L) side

~~3~~ 15 Complete, 0/-1 since 1300

Monitor – Normal variability – Early ~~[illegible]~~ decels ..

after IV Demerol.

off monitor 1105 for epidural – okay before

1350 150-160 c minimal int variability

1400-1410 – 4 late decels 10BPM (160-150)

1420 Resolved Baseline 160 – mild intermittent

1 late

1500-1520 normal variability, accel

Pushing – Cord pattern, normal variability

1640 variables, good variability base 150

I would not have gotten scalp pH –

Review Deposition - Who is this guy? ER physician?
Boarded in Peds, Newborn + Perinatal Medicine + ER Med - Not Neonatology
Director Nursery Georgetown 1970-77 → OBGyn ?!!

Critique - 1) Unengaged vertex
2) Fetal distress - ↓ variability before AROM, monitor - Fetal distress later, Not recognized by residents/RN
3) Arrest labor / descent.
4) Should have done pH by 11:40
5) ↓ Variability [illegible] 87-90
131,-132
143-44 [illegible]

0400-0645 [illegible]
[illegible] 29,30 - ? late decels 40-43 ? [illegible] ↓ late

40-43 compromise

By 0900 ↓ variability, "nonprogressive labor"

7/16/87 (3hr)

PLAINTIFF'S EXHIBIT 2 7-25-87 PG
PENGAD-Bayonne, N.J.