IN THE STATE OF OHIO

COUNTY OF CUYAHOGA

CIVIL DIVISION

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HOPE JASMINE *
DIVER, etc., *
et al., *
Plaintiffs * No. 305538
vs. *
ANTHONY GINGO, *
JR., M.D., *
et al., *
Defendants *

* * * * * * *

DEPOSITION OF

PATRICIA D. FEDORKA, R.N.C., Ph.D.

JUNE 1, 1999

DEPOSITION

OF

PATRICIA D. FEDORKA, R.N.C., Ph.D., was taken on behalf of the Defendants herein, pursuant to the Rules of Civil Procedure, taken before me, the undersigned, Jacqueline L. Reichert, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at Patricia Fedorka's office, 106 Heldon Drive, Moon Township, Pennsylvania, on Tuesday, June 1, 1999, at 10:05 a.m.

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I N D E X

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P R O C E E D I N G S

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PATRICIA D. FEDORKA, R.N.C., Ph.D.,
HAVING FIRST BEEN DULY SWORN,
TESTIFIED AS FOLLOWS:

- -

DIRECT EXAMINATION

BY ATTORNEY SWITZER:

Q. State your full name.

A. Patricia Fedorka, F-E-D-O-R-K-A.

Q. Ms. Fedorka, have you ever had your deposition taken before?

A. Yes, I have.

Q. How many times?

A. Probably about 10 to 12.

Q. In your capacity for a witness in a medical malpractice case?

A. That's correct.

Q. Now, obviously we're doing this by telephone so you need to make sure you hear my questions or Steve Walters' questions before you answer and make sure you tell us if

you don't hear the question. Okay?
A. Yes, I will.
Q. Do you have a file with you?
A. Yes, I do.
Q. Do you have any notes in that file?
A. Outside of the December 1st, 1998 report that I wrote, I probably have about two pages of notes.
Q. Do you have copies of those notes?
A. Really it's only one page. No, but I can rewrite it because it's very short or have a copy made.
Q. Okay. Would you have the Court Reporter mark that as an exhibit, make it Exhibit A.
A. All right.
Q. And maybe somebody can copy those notes and attach it to the transcript?
A. That's fine.

Q. Okay.

(Exhibit Number A marked for identification).

A. I also have my updated CV here.

BY ATTORNEY SWITZER:

Q. Would you attach a copy of that to the transcript also, we'll make that Exhibit B?

A. Yes.

(Exhibit Number B marked for identification).

BY ATTORNEY SWITZER:

Q. Now, when were you retained by Mr. Becker?

A. Let me look. Sometime in the fall of 1998.

Q. Had you ever reviewed any prior cases for Mr. Becker or his law firm?

A. No, that was the first case I believe that I had from them.

Q. And why were you retained?

A. To review the nursing care that was given to the patient.
Q. Do you know Doreen Allison?
A. No, I don't.
Q. Did you know she was a nurse that had previously reviewed this case for Mr. Becker?
A. No.
Q. Do you know why she's no longer an expert in this case?
A. I have no idea.
Q. Did you ever see her report?
A. No, I have not.
Q. Did you receive a letter from Mr. Becker?
A. I was contacted by telephone.
Q. By the way, your December 1, 1998 letter to Mr. Becker with your opinions, is that the only report or letter you've written?
A. That's correct.
Q. Setting forth your

opinions?
A. Yes.
Q. In your letter of December 1, 1998 you list materials that you reviewed on page one.
A. Yes.
Q. Have you reviewed any other materials?
A. No, I have not.
Q. Have you conducted any research for your work in this case?
A. Not specifically. I did go back through some of my information on taking vitals, ACOG standards. So I do have that information. Fetal ---.
Q. Is that part of your file here?
A. Yes.
Q. Are those voluminous documents?
A. No, there's maybe about 20 pages, 25 pages.
Q. Can we mark that as Exhibit C and have copies attached

to the transcript?

A. All right.

(Exhibit Number C marked for identification).

BY ATTORNEY SWITZER:

Q. Tell me what ACOG standards you looked at?

A. From 1989 ACOG Standards for Obstetric and Gynecological Services, Seventh Edition. And then 1992 guidelines for Perinatal Care, Third Edition. Those are the two ACOG publications.

Q. I see. Did the 1992 guidelines supersede the 1989 edition?

A. Well, they are actually two different publications. One is the standards, the other one is the guidelines and up to a year or so ago, they had two separate publications. The standards for example, are the seventh edition from 1989, the guidelines are the

third edition so again, they are two completely separate publications.

Q. If I understand what you looked at, the guidelines for perinatal care were actually a joint publication between ACOG and the American Academy of Pediatrics?

A. That's correct.

Q. And then the standards you were talking about, those were put out by ACOG?

A. That's correct.

Q. Did you review any technical bulletins by ACOG?

A. Not for this case, no.

Q. How about any nursing techs?

A. Yes, I have the Fetal Heart Rate Monitoring, Principles and Practices from 1993 that AWHONN put out and I do have some copies of certain sections, it's a fairly big book and there's certain sections that I photocopied for this case.

Q. Okay, who's the publisher

of that book?
A. AWHONN.
Q. And why don't you give the initials for that so it's clear for the transcript?
A. Okay. It's A-W-H-O-N-N and that's the Association of Women's Health on Obstetric and Neonatal Nurses.
Q. What's the name of that textbook?
A. Fetal Heart Monitoring, Principles and Practices, 1993.
Q. And you had some excerpts from that textbook?
A. That's correct.
Q. And can we mark that as Exhibit D? Unless that's concluded in Exhibit C?
(Exhibit Number D marked for identification).
A. Well, we can make each one separately if you want, that might be a little clearer. We have the

Perinatal Care, the standards and then we could do the Fetal Heart Rate Monitoring and then I also have a few pages from a high-risk pregnancy book addressing third trimester bleeding.

(Exhibit Number E marked for identification).

BY ATTORNEY SWITZER:

Q. What's the name of that book?

A. That is Knuppel, K-N-U-P-P-E-L, and Drukker, D-R-U-K-K-E-R, 1993, High-Risk Pregnancy, A Team Approach, second edition published by Saunders.

Q. Is that Joan Drukker?

A. Yes.

Q. Is she from Pittsburgh?

A. She was at Magee Hospital a few years ago, I don't know where she is now.

Q. Why don't we mark that as Exhibit, I don't know what we're up

to now, E or F?

A. I think we're up to F.

Q. Mark that as Exhibit F then.

(Exhibit Number F marked for identification).

BY ATTORNEY SWITZER:

Q. Any other research you have?

A. No, that's about it.

Q. Why did you review these publications?

A. I always do that to support my opinions because it's many of the opinions are just not my personal opinions or based on my personal experience, it's also based on national standards and that is one of the things that we use for evaluating nursing care.

Q. But you consider the materials that you just identified made to be sources for the standard of nursing care?

A. Yes, in general. Again, ACOG, even though it's a physician group usually the nursing association follows ACOG recommendations.

Q. You consider any other publications to be sources for the obstetrical nursing standard of care in this case other than what you've just discussed?

A. No.

Q. Are you familiar --- well, let me back up a minute. Are you licensed to practice nursing in Ohio?

A. No, I'm not.

Q. Are you familiar with the Ohio statutes governing nursing care?

A. As far as the Nurse Practice Act, yes, I do have a copy of that.

Q. You do. What's the name of that?

A. I don't have it in front

of me right now, it's in with my reference information.

Q. What do you mean reference information?

A. Well, I have a lot of books and pamphlets and it's with that.

Q. That's not for this case, that's in general?

A. Yes, I have a lot of the nurse practice acts from different states.

Q. Have you reviewed any journal articles for this case?

A. No, not specifically.

Q. Any hospital policies you reviewed?

A. No, I don't have those.

Q. And we've already covered the textbooks that you looked at; right?

A. Yes.

Q. Now, I do have a copy of your Curriculum Vitae. The copy I have is dated fall of 1998. You

stay you have an updated one?
A. That's correct.
Q. You're not a medical doctor; correct?
A. That's correct.
Q. Do you teach at the Duquesne University?
A. That's correct.
Q. Correct?
A. Correct.
Q. You teach obstetrical nursing?
A. That's correct.
Q. Do you use any particular textbooks to teach obstetrical nursing?
A. Right now we're using a Saunders book, the first author is Gorrie, G-O-R-R-I-E.
Q. What's the name of that textbook?
A. Maternal and Infant Care, I could get that after we're done here.
Q. Okay. You can just give

that to the Court Reporter?
A. That would be fine.
Q. Is that the only obstetrical textbook you're using right now?
A. That's the one that we're using presently, yes.
Q. Were you teaching obstetrical nursing in October 1994?
A. Yes, I was.
Q. What textbooks were you using at that time?
A. I would have to go back and look, it might have been Olds and London, I think that's a Lippincott, but again, I'd have to check.
Q. How many hours a week do you spend teaching at the nursing school?
A. It's for the full semester for obstetrics I teach 90 hours in a 14-week block.
Q. What does that mean, 90 hours in a 14-week block, what does

that mean?

A. Well, they have class every week. Sometimes depending on the topic, I teach a little bit more. I share it with another instructor, the OB content. So some weeks, I teach, they have class Wednesdays and Fridays, they have actual theory class from 9:00 to 12:00. So some weeks I'm teaching all of that content, some weeks I'm teaching half of it. So it's just easier to say for those 14 weeks, I'm responsible for 90 hours of content that I'm teaching in the classroom.

Q. Do you have any other teaching responsibilities?

A. Yes, I teach in some other courses.

Q. What is that?

A. Trends and issues, sometimes I teach nursing research, I guest lecture in some of the Master's classes.

Q. What are the subject matters?
A. Also community health nursing. The subject matter is history of nursing, legal ramifications in nursing, nursing research about nursing research, I don't know how much in detail you want me to get into that.
Q. What I meant is, I'm sorry, I wasn't clear, do you teach any courses in cancer, caring for other than obstetrical patients?
A. Community health nursing and that's taking care of patients in the home.
Q. Do you engage in the clinical practice of nursing?
A. Yes, I am.
Q. What do you do?
A. I teach or I'm actually supervising the students giving patient care for 14 hours a week during the fall semester when I teach obstetrical nursing and in the

spring when I teach community nursing, I'm in the home health care agencies supervising students giving care to high-risk OB patients and medical/surgical patients.

Q. Are you employed as an obstetrical staff nurse?

A. Yes, I am.

Q. What hospital?

A. Allegheny General Hospital.

Q. And you've been employed there since 1996?

A. That's correct.

Q. How many hours in a two-week period or a week period, whatever it is, do you work for them?

A. I would say it comes to about one to two days a week.

Q. Do you work as a --- are you a head nurse or a charge nurse or what's your title?

A. I'm a staff nurse.

Q. What does that mean?

A. I'm just a normal staff nurse that takes care of patients like every other nurse does. I don't have any head nurse responsibilities.

Q. How many deliveries are you generally involved in on a monthly basis?

A. And again, this is an estimate because we also have our sick antepartal patients up there so sometimes I'm taking care of antepartal. Maybe 10 to 12 deliveries per month.

Q. That's been true since 1996?

A. Yes, again, that's a very rough estimate. Some days you have more, some days you have less. Like I said, some days I'm taking care of antepartal patients so hopefully they don't deliver.

Q. Looking at the CV I have. I have some questions about your background.

A. All right.
Q. From 1979 to 1985, you were living outside of the United States?
A. Yes. We were back for a few months in '81 before we left the country again.
Q. Were you practicing as a nurse in those years?
A. No, I wasn't.
Q. And then when you came back in 1985, were you practicing clinical practice of nursing?
A. Yes.
Q. Where was that?
A. I think it was probably the winter of 1986, that's when I started working for Duquesne University part time and part time was just doing the clinical component and that was at Magee Hospital, I think at that point, the tertiary care center in Pittsburgh for obstetrical patients and for community, I was at Allegheny County

Health Department supervising students giving care to high-risk mothers through the health department. I also was working part time for Sewickley Valley Hospital in that time period working one day a week, one weekend a month in their labor, delivery, postpartum and newborn nursery areas.

Q. Where were you practicing as a staff nurse in obstetrics in October of 1994?

A. In '94 I was not working specifically for a hospital. I was there as a clinical person supervising students giving patient care.

Q. Okay. Before you started in 1996 for Allegheny Hospital, ---

A. Yes.

Q. --- when was the last time you had been employed as a staff nurse on an obstetrical unit by a hospital?

A. Again, I worked for

Sewickley Valley Hospital I think from, boy, it's been so long. I think I started around 1986 or '87 when we came back and I worked there probably until 1990. And then I was getting my doctorate and teaching at Duquesne and getting my clinical there so I stopped working at the hospital.

Q. So from approximately 1990 until you started again in 1996, you were not working as a staff nurse or a nurse on an obstetrical unit in a hospital; is that correct?

A. Not directly for the hospital but we have to pass our competency test to supervise the students taking care of patients in the OB setting. I mean, we have to take care of those LND patients, postpartum and newborn and antepartal patients and I'm there supervising students giving care so I am working not technically as a staff nurse for the hospital, but I

am responsible for that patient care that I and the students deliver.

Q. That was part of your duties as an instructor; is that correct?

A. That's correct.

Q. You were not acting as a staff nurse in an obstetrical unit similar to the nurses involved in this case; correct?

A. Well, I am taking care of patients. Again, they're assigned to me and the students so I'm not employed by the hospital, but I have to pass all the competency tests that their staff nurses have to pass to take care of patients because I am giving patient care charting and responsible for those patients.

Q. When you say, let's cover the period of 1990 to 1996. You were an instructor?

A. Correct.

Q. And that was at Duquesne University?

A. That's correct.
Q. Who did you report to in your capacity as an instructor? Was that another nurse or was that a physician?
A. At Duquesne University, my supervisor in charge of clinical activities was Judy Depalma (phonetic).
Q. Was she a doctor or a nurse?
A. She's a nurse.
Q. Okay. Do they have residents at this hospital?
A. Yes, they do.
Q. Now, on your publications on your CV, you have a book you've identified on nursing standards?
A. Let me turn to that.
Q. Page three of my copy.
A. Okay.
Q. Has that been published yet?
A. Defining the Standard of Care, The Association of Women's

Health Obstetric and Neonatal Nurses, yes, that's been published.

Q. By Lippincott?

A. That's correct.

Q. Do you have any other publications other than the three you've listed there?

A. Well, I don't know which ones you have, but Defining the Nursing Practice by F.A. Davis, do you have those two? Those are in press right now?

Q. Mine is fall of 1998 so I don't have that.

A. Okay. So there's two that are in press right now and then two journal articles that have come out.

Q. Okay. Would those be identified in your CV?

A. Yes.

Q. Okay. When did you first start reviewing medical malpractice cases?

A. 1994.

Q. And how did you become

involved in that?
A. One of the instructors that I worked with at Duquesne asked me if I would review an obstetrical case for a lawyer that she knew and needed a review done.
Q. I know this is an estimate unless you have an exact number, how many cases have you reviewed since 1994?
A. Probably in the range of about 100.
Q. And is there a general breakdown of those cases? In other words, on behalf of the hospitals versus on behalf of the patients?
A. I would say probably 30 percent Defense, 70 Plaintiff.
Q. Do you advertise your services anywhere?
A. No, I don't.
Q. You said you never reviewed any other cases for Mr. Becker; right?
A. To the best of my

knowledge, yes.

Q. Do you know how he learned about you?

A. Someone who Kathy Mulligan who used to work for a defense firm that I reviewed many cases for, I think gave him my name. It's now in his office I believe.

Q. And what is your fee that you're charging for your deposition today?

A. $175 an hour.

Q. Do have a separate fee for review of records and preparation of reports?

A. Yes, I do, that's $125.

Q. How about for trial testimony?

A. $175 plus expenses, plus travel time.

Q. Have you ever been disqualified as an expert witness in any case involving a hospital?

A. No.

Q. Have you ever been named a

defendant in any malpractice case?
A. No, I have not.
Q. Have you ever had to testify in a malpractice case as a witness?
A. You mean as an expert?
Q. I wasn't clear, I'm sorry. For the patients that you had been caring for?
A. No.
Q. Have you ever been involved in the labor and delivery of a baby that subsequently was diagnosed with some type of brain damage?
A. Not to my knowledge.
Q. Have you ever been involved in the labor and delivery of a patient who presented with the same type of complaints and symptoms that Mrs. Diver presented at the hospital on October 7th?
A. In general with a patient coming in with unexplained bleeding, yes.

Q. Were you involved as a primary staff nurse?
A. Yes.
Q. What was the outcome of the baby in that case, or cases if there's more than one?
A. The baby, the one case I'm thinking of, the APGAR scores were somewhere on the low range, I think they were like five and seven and the baby was transferred to the NICU, as far as the outcome, I can't speak to that.
Q. Now, your report of December 1, 1998, do you have a copy of that with you?
A. Yes, I do.
Q. At the top it refers to yourself as a legal nurse consultant.
A. Yes.
Q. What is that?
A. That's just a general term for nurses that work in the legal arena.

Q. So this is not in your capacity as an instructor at the university, this is your own separate business?
A. That's correct.
Q. Okay. And at the bottom of page one of your report, it refers to perinatal nursing issues and nursing standards?
A. Yes.
Q. What does that mean?
A. Well, perinatal is that whole range of pregnancy through delivery and postpartum, nursing standards, again, are, there is a variety of sources for nursing standards ranging from the State Nurse Practice Acts, professional organizations, national organizations, hospital polices and standards, JCHO standards, all those form a basis for nursing standards.
Q. Let me refer to your report then before I get into specifics because you did give a

detailed report here. Do you have any other opinions with respect to the nursing standard of care issues in this case other than what you discuss in your report?

A. Well, I did want to address the fact that in my report I didn't actually talk about the NST that was done on October 7th. My copy isn't very clear as far as the background lines and I do need to get a clearer copy of that, but I feel that nurse really should have prolonged the test. The beginning part of it does not appear to be reactive and then where it ends, it's hard to tell if the infant was having accelerations or decelerations and shoulders on the decels which are technically not considered accelerations for a reactive test. And I think that test should have been run longer to establish again, whether they were excels or just shoulders on the

decelerations.

Q. Who long does the test run?

A. I'm sorry?

Q. How long was the test run?

A. I think about 45 minutes, I could look for sure. But it doesn't matter how long it was run, the thing is it needs to be run until you can determine that you have a reactive strip and I'm not sure that they had one at that point. And the strip started at 9:00 and ended yeah, just about 9:45 it looks like maybe even a little bit longer. Could we take a break for a minute, please?

OFF RECORD DISCUSSION

BY ATTORNEY SWITZER:

Q. Are you saying that this non-stress test on the morning of October 7, 1994 was not reactive?

A. I can't tell from where the strip ended. It started to pick up towards the end, but again, as I

said, I'm not sure if those are accelerations or shoulders on decelerations. So I think it would have been a good idea to run that strip a little bit longer so one could be sure of what exactly was going on because the first few minutes were definitely not reactive and then again, as I said, the variability seemed to pick up and you see an increase in the variability, but it's just difficult to tell what you're actually seeing there in those last five minutes or so, so I would have run the test longer.

Q. Did Doctor Gingo review this strip?

A. I think they called it in, I don't know, I'd have to look through the record. It says a copy was sent to Doctor Gingo but I don't know exactly when he reviewed it.

Q. But do you know whether he reviewed the strip or not, the

non-stress test?
A. No, I'm not sure.
Q. If he did review it, you don't know what he found, do you?
A. No.
Q. Okay. Any other opinions other than those set forth in your report and the one we just discussed?
A. Yes. After reviewing the depositions again, I was a little confused as to this code pink status and it looked as if the code pink did not always include a physician, but they have the option of calling the physician or a pediatrician if they felt that there was a chance that there was going to be a high-risk infant or some problems. The nurse said that that was her responsibility to call the code pink. So I'm not sure whose responsibility it was to say we also need to have the pediatrician here for this delivery since there's a

possibility of having some problems. So again, depending on whose responsibility it is under the hospitals guidelines and protocols, someone should have made sure the pediatrician was actually there for the delivery since this was a high-risk delivery with the bleeding. That's my other comment.

Q. Okay. You don't know whose responsibility that is today; right?

A. That's correct.

Q. Any other opinions other than in your report that's discussed?

A. No.

Q. Okay. Let's go to your report then.

A. All right.

Q. By the way, was this patient in labor on October 7, 1994?

A. Technically probably not. She did have some irregular contractions but she didn't appear

to be having much cervical change so technically you would say not.

Q. Let's go to number one then on page two.

A. All right. Do you want me to read it or ---?

Q. You can read it, I think we have all copies of it in front of us.

A. Okay.

Q. Are you talking about the fetal monitoring strip after she was admitted on the 7th?

A. That's correct.

Q. Would you explain what you mean by that paragraph?

A. All right. Again, according to standards when you're monitoring someone, you really have to, in your description, either in your flow sheets or your narrative chart addressing baseline fetal heart rate, whether accelerations are present or not, what decelerations are there and

long-term variability. And they did not do that according to standards and so it wasn't done consistently and also it wasn't done correctly.

Q. Okay. So let me talk about, before we get to the correctly, you're saying that they didn't document what they were seeing on the strip?

A. Not in the detail that they should have been doing it, correct.

Q. The detail that you would have liked to have seen, be the baseline fetal heart rate, any accelerations, any decelerations?

A. That's according to AWHONN standards, yes.

Q. Now, what do you mean by it was not done correctly?

A. Well, the nurse in her deposition said she wasn't as concerned. I mean, she was concerned because of the decreased variability but she said that the

infant was still having accelerations and no decelerations. And that's not correct. According to the fetal monitoring strip, this infant was not having any accelerations, anything that you see are really shoulders on decelerations and by definition, those are not accelerations. But if you read them as accelerations, it gives you a false sense of security which you shouldn't be having and also, she said that the infant wasn't having any decelerations and it's clear on the fetal heart rate tracing that indeed this infant was having decelerations. On top of that with a poor variability, there was nothing reassuring about this strip at all so she said she was concerned about the tachycardia, but she should have been much more concerned with this non-reassuring strip than she was.

Q. How would you describe the

variability on the strip?
A. Minimal to absent.
Q. And how did that equate to the fact this was an external monitor?
A. Well, you can evaluate long-term variability with an external monitor. The only thing they say that technically you can't do is get beat to beat variability. But you certainly can get long-term variability.
Q. Where are the decelerations that you find on the strip, panel numbers?
A. Well, I have my strip starting off at panel 55972. So let's go to panel 55974, you can see it's a fairly flat line, but there's a definite decel because her baseline is pretty stable at 180. And then you can see when you get over passed the 126 at the bottom, she has a slight deceleration there below the baseline of 180. And to

the left of that, it's a little bit of a shoulder and again, I don't know if that's what the nurse was reading as an acceleration, but that's not, that's a deceleration. When you go to the next page, which is 55976, again, you have pretty much a flat line, anything that gives you any movement on that line at all is below the baseline which by definition is a decel but it looks like she has, here she has her one contraction on this page, at the very end 55977 and it really looks like she has a late deceleration there but in any case, it is a definite decel at the end of the page. Also, I'd like to point out that I don't know if they didn't adjust the baseline or what was going on, but for the monitors itself, the baseline is over the 20 mark so they should have either recalibrated that by pushing a button on the machine to bring it

down since that's arbitrary or it could be an indication of some uterine irritability which goes along with an abruption so they should have been alert to that. When you go to the next page, again, if you look at the uterine irritability there and she has those squiggles again, about 20, it looks like some irritability and then another contraction, the fetal heart rate just has those teeny tiny variable decelerations. Again, no excels at all.

Q. What panel number is that?

A. I'm sorry, let me see, that was 55978. And also, if you look at that contraction at the end of the page, it stays up there. Again, if we're assuming that the baseline is about close to 30 which is abnormal, again, they should have adjusted it, but that contraction, it leaves the baseline and is up there for 10, 20, 30, 40, 60, 70,

80, 90, 100, 120 I mean, it's staying up there for quite a while and that also can be an indication of hyperstimulation. And then when you turn the page over and we're on panel 55980, then it's marked that Dr. Gingo is there and using the ultrasound so there's no tracing for a while.

And then they pick up on 55982 and it says pressure cuff applied by Doctor Gingo, the IV was started in the left hand and also a sterile vaginal exam by Doctor Gingo, cervix closed. And up here again, the baseline is a little bit, tiny bit above 180 and you're having that deceleration pattern again with some shoulders on it. It almost looks a little bit sinusoidal. When you turn it over, the next page 55984, again, you just have that tachycardic undulating line which is certainly non-reassuring and the same with the next page which is

55986. It says Doctor Gingo to do a C-section explained this to patient permit signed. The next page you have 55988. It looks like that's where they, it says IV 1,000 hung, I'm not sure what that word is, added. And then the next page and we're on panel 55990, again, that undulating baseline with a decel towards the end of the page and it looks like the first line is cut off on my strip, I can't read it but underneath it says abdominal prep done, Doctor Andres (phonetic) here to discuss anesthesia options and then small to moderate amount of red vaginal bleeding on pad. And then the next page, again, you have more decelerations and that undulating baseline and then on 55994, more of the same, more of those decelerations and then they take her to surgery roughly around 13:22 and that's the end of the fetal monitoring.

Q. Do you know whether Doctor Gingo had reviewed this strip at any time before this patient was taken to surgery?

A. No, I don't.

Q. Do you know what his interpretation of the strip was?

A. Well, he said that it was tachycardic and he was concerned about that whenever it didn't come down and that's why he decided to do a C-section. That's from his deposition.

Q. Let's go to the next page of your report, number two where you have a paragraph or criticism?

A. Okay.

Q. That's basically similar to what we just discussed; is that correct?

A. Yes, it really is.

Q. Okay.

A. Except to say that really, the American Nurses Association speaks to a nurse needing to be

competent when they work in an area of specialization and AWHONN, our professional organization certainly speaks to that too. And if you really are not competent at reading fetal monitoring strips, you shouldn't be doing it.

Q. What makes you think this nurse was not competent at reading fetal monitoring strips?

A. Well, she's saying there's accelerations and there aren't any, she's saying there is no decelerations when there are. She's saying that the tachycardia can be concerning but I mean, is there a realization there, I don't see it that number one, tachycardia has a few causes but one of the most common after infection and there was no indication that this woman was infected or had an increased temperature is hypoxia of the infant. And you have a woman who's been complaining of bleeding since

11:00 in the morning. She's been bleeding the whole time you've been observing her and nobody is putting this picture together that maybe this baby is hypoxic. I think it's interesting they had just done a non-stress test on this woman a few hours earlier the same day and that baby's heart rate was around 150. Now, she comes back into the hospital a few hours later and this baby's baseline has gone from 150 to 180 and the woman is bleeding and I don't think it takes a whole lot to realize that, you know, it's probably a good guess that this baby is experiencing some distress based on the mother's bleeding and to be conservative in treating this mom.

Q. Are you saying that this nurse caring for this patient was not concerned?

A. I said conservative. I think she was concerned, but unfortunately, she didn't intervene

in an appropriate manner.
Q. What would you have expected her to have done?
A. Well, basic interventions are number one, put oxygen on the mother, make sure an IV line is in and she says in her own deposition that under their own standards, she could have started the IV at any time, change her position and assess her very carefully. Just about any book you could read would say if you have unexplained bleeding, and that's in some of the information I'll be sending you, that you need to assess patients very closely and they took this woman's vital signs twice, once on admission at 12:00 noon and then later at 13:20. They waited over an hour to reassess her vital signs. That is not close assessment of a bleeding patient from an unidentified source. So she didn't intervene to help the infant even though she says in her

deposition she was concerned about the tachycardia and did approach the doctor at least twice saying that the infant was still tachycardic and she wasn't really assessing the mother as carefully and closely as she should have been.

Q. Was this patient on a blood pressure monitor?

A. I see that she took her blood pressure, but I do not see any dynamap readouts or anything about a blood pressure, so I don't know.

Q. This patient did receive an IV, didn't she?

A. Yes, after she was in the hospital for a period of time. She was admitted ---.

Q. There was an increase in the IV fluid, wasn't there?

A. What was that question?

Q. Wasn't there an increase in the IV fluids?

A. All the nurses notes say is that, let me find it, I'm still

looking. She was admitted at 12:00, the IV was started at 12:40, it says IV LR started left hand 18 inch angiocalf, pressure cuff applied to IV per Doctor Gingo. So whether they bolus her there, that could be, and he does reflect that in his notes but I don't see anything specific in the nurses notes, that's all it says.

Q. What condition was the mother in the during the fetal monitoring?

A. Well, they said they rolled her to her left side after a vaginal exam, but there is no note about her position at any other time that I can see in the nurses notes or the flow sheet.

Q. So you don't know what position she was in, do you?

A. No, since they didn't chart it, I don't.

Q. All right.

A. She should have been on

her left side or switched to her right side to see if they could change the profusion to the infant. Hopefully she wasn't flat on her back.

Q. You don't know that, do you?

A. No, I don't.

Q. Now, you also mention in paragraph three of your report, the chain of command?

A. Yes.

Q. What would you have expected the nurse to do with respect to Doctor Gingo?

A. Well, most hospitals and specifically I don't have their chain of command policy, but in general, you go to your charge or your staff nurse whenever you have a concern that is not being addressed by the physician.

Q. Well, what makes you think that Doctor Gingo was not addressing the situation?

A. All I can say is if you have a patient who's been bleeding, who has tachycardia, the infant does and has a non-reassuring fetal heart rate strip, my expectation would be working in hospitals is these patients get immediate attention and immediate surgery. And to wait around for long periods of time with no intervention and just watching this infant get a less reassuring fetal heart rate strip, the nurse said she was concerned and she went to the doctor twice. There's a point that you go to your head nurse and say I am concerned this patient is not being processed normally the way we normally handle unexplained bleeding and I'm very concerned about this. And that's what a patient advocate does, a nurse who's working in that role and we all should be patient advocates.

Q. And what would you have expected the head nurse to do and

had this nurse done that?
A. Probably also look at the strip, evaluate the case, hopefully she was competent enough to realize that yes, this woman has been bleeding, we have a non-assuring fetal heart rate strip, we need to, again, the nurse could have done the interventions herself and approached Doctor Gingo and said, we're real concerned, you know, what are your plans and we need to do something about this patient. Get her delivered as quickly as we can.
Q. Wasn't Doctor Gingo's plan to deliver the baby?
A. At some point in time, but everyone says it was not treated as an emergency. Unexplained bleeding in the third trimester unless you know the cause and you're doing something to control it is considered an emergency situation. I have never seen a patient lay around from over an hour before an

infant's delivered unless you know exactly what's going on and you're monitoring the patient very closely. And no one was concerned about getting this baby delivered quickly and nobody was really concerned about monitoring the mother's vitals or monitoring the infant. I think one of the biggest lapses they had was taking this woman back to the delivery room and only checking the fetal heart rate once. That is also not according to ACOG standards which clearly say that a woman on external monitoring should be monitored in the OR until the abdominal prep was done so somewhere during this time that she was laying back in the OR, the fetal heart rate went from 180 which was tachycardic, down to zero. Maybe if they had been monitoring her the way they should have, they would have picked up that the baby was getting even in more distress and could have

intervened promptly and done the emergency C-section for the better outcome of the infant.

Q. Well, let me back up here. For a C-section patient, the monitoring is stopped once the abdominal prep is begun; is that correct?

A. That's correct.

Q. All right. Now, the last time that the heart rate was checked was after the spinal was given and at that time, it was I believe 178 or so; is that correct?

A. That's correct.

Q. And you're not going to do any monitoring while the doctor is doing his surgery; correct?

A. That's correct.

Q. So you don't know when the heart rate went down to the zero, do you?

A. No one knows, no. The thing is if you're doing an emergency C-section it really

doesn't matter because you're getting that baby out as quickly as you can. If you have a non-reassuring strip going into a C-section, you make a choice, you either do it as quickly as you can and get the infant out or you monitor the infant while she's laying on the table for these long periods of time until you do the abdominal prep. The fact that everybody was moving very slowly lead this baby to be not monitored for a long period of time and the baby ultimately got into trouble.

Q. Well, you can't give any opinion as to whether this baby got in trouble, can you?

A. No.

Q. You're not qualified to do that, are you?

A. Well, I mean, no one can but obviously from the time the nurse checked that infant at 178 to when it was born over a half an hour

later, the baby had no heartbeat so we can assume that somewhere in between that time, that the infant crashed.

Q. You can't assume that. Are you qualified to give such an opinion in this state, do you know?

A. It's not a medical opinion to say that a baby's heart rate went from the 178 and when it was born it was zero.

Q. When was the 178 recorded?

A. There's no time. She just said that she normally does it once the patient is on the table.

Q. After the spinal is given; correct?

A. Sometimes she just says on the table, so I'm not sure what she was referring to. Sometimes she says normally after the spinal, sometimes she says once the patient is positioned on the table. That's from her deposition.

Q. Okay. Going back to your

report, you say failure to position Mrs. Diver correctly for surgery, that's number eight.

A. Okay.

Q. It's your understanding there was no wedge placed under her hips?

A. That's what's marked on the OR sheet, yes, and that's something that she also addresses in her deposition.

Q. And whose responsibility is it to place the wedge under the patient's hip during a C-section surgery?

A. The circulating nurse.

Q. Okay. What's the purpose of that?

A. To displace the uterus off the major blood vessels so the woman does not become hypotensive and decrease the oxygen flow to the infant.

Q. I'm still looking at your report. I think a lot of things we

covered, so let me just take a minute here.

A. Okay.

Q. Oh, number four on page three?

A. Yes.

Q. Did Doctor Gingo order the nurse to perform a vaginal exam?

A. Yes.

Q. And you're saying that the nurse should not have complied with that order?

A. That's correct.

Q. How did this nurse perform that exam, do you know?

A. She did a sterile vaginal exam.

Q. How did she do it? Did she do it any differently than in a normal situation?

A. I don't know, she said she did a gentle one but I don't know anybody who does rough ones, so I'm not quite sure what she was alluding to. I think we all do gentle exams.

Q. Did Doctor Gingo do a vaginal exam?
A. Yes, he did after the ultrasound was done.
Q. You have no problem with that, do you?
A. Once the ultrasound is done and you're sure that there's not a placenta previa that you're going to dislodge, that's perfectly acceptable. But it is never acceptable to do a vaginal exam on a bleeding patient when you don't know what the cause does. Much less when Doctor Gingo was not available because he was finishing a C-section and the patient did not even have IV access in case she started hemorrhaging if the nurse had accidentally dislodged a placenta previa. That is unsafe nursing, you never, ever do that because you can cause profound hemorrhaging in a patient.
Q. Do you have any knowledge

as to the reason why Doctor Gingo asked the nurse to do this exam?

A. I assume that he wanted to know if she was dilated or not, but no, I don't know for sure.

Q. Unless I misread your report, I think we've covered all your opinions; is that correct?

A. That's correct.

Q. Let me just take a look at my notes if I would for one minute.

A. All right.

Q. Unless you have something to add on your opinions on the standard of care on those other nurses, I have no other questions at this time.

A. No, I have nothing more to add.

ATTORNEY SWITZER:

Steve?

ATTORNEY WALTERS:

Yes, just a few.

CROSS EXAMINATION

BY ATTORNEY WALTERS:

Q. This is Steve Walters, I represent Doctor Gingo.
A. Hello.
Q. Hi. With regard to your report, am I correct that it is not the intention of your report to express opinions as to whether or not the physician fell below the standard of care?
A. That's correct.
Q. And nor has that been the intent of your testimony here?
A. That's correct.
Q. Do you understand the limitations in the State of Ohio on nurses with regard to opining on the compliance or noncompliance with the standard of care by physicians?
A. Yes.
Q. You mentioned some interventions that could have been done. What are the interventions you're referring to?
A. Applying oxygen by a type face mask 8 to 12 liters, again,

position change and IV bolus.
Q. And at what point in time were those indicated?
A. I think as soon as the woman came to the hospital with the unexplained bleeding and the non-reassuring fetal heart rate strip, that that could have been done or should have been done.
Q. You mentioned in this last few minutes about an order to a nurse to do a vaginal exam and you have indicated in your report that you do not believe that the nurse should have complied with that; is that correct?
A. That's correct.
Q. Do you know or do you have any opinion as to whether or not there is a difference between a vaginal exam done to determine the amount of dilatation versus a deep digital vaginal exam done to determine the position of the placenta?

A. No. All I know is that you should do no vaginal exams in the face of unexplained bleeding.

Q. Not even what I'll call a shallow vaginal exam to determine dilatation?

A. Absolutely, and I can show you in the basic undergraduate textbook that I use for my first-time students, that it specifically says you never do a vaginal exam in the face of unexplained bleeding.

Q. Do you know what a double setup is?

A. Yes.

Q. Are you of a view that any vaginal exam, whether it be digital or shallow requires a double setup, is that what you're saying?

A. Well, I mean, in the days before we had ultrasounds, that's what you did. You were ready to deliver immediately in a double setup in case you did dislodge the

placenta in a previa and the woman started hemorrhaging. Nowadays again, you can do an ultrasound and at least rule out placenta previa and then you feel more comfortable doing a vaginal exam because you're not going to dislodge the placenta because you already know it's not there and that's certainly leads you to the, well, to the feeling that you're probably dealing with an abruption. So you can do vaginal exams as long as you're sure that it's not a placenta previa and again, you can do that with the use of an ultrasound nowadays.

Q. Now, a placenta previa is a position of the placenta that either wholly or partially covers the cervical loss; is that correct?

A. That's correct.

Q. Do you see any indication in the records that you have reviewed that this woman had a placenta previa?

A. No.
Q. So in terms of the vaginal exam that we've been talking about, the problem that in your mind should prohibit doing a vaginal exam as it turned out did not exist; correct?
A. That's correct.
Q. And Nurse Fedorka, I don't have your report. What did you review other than the records, the depositions?
A. I can go through it. I have Anthony Gingo's prenatal records, pages 1 through 46, Southwest General Hospital, labor and delivery records, pages 1 through 49, Southwest General Hospital, fetal monitoring strips from the labor. Southwest General newborn records of Baby Hope, non-stress test from 9/16/94, 9/22/94 and 9/30/94, 10/7/94 and the depositions of Kathleen Joniak, J-O-N-I-A-K, Karen McGirr, M-C-G-I-R-R, Jane Barth, Linda

Modock, M-O-D-O-C-K, Anthony Gingo, M.D., Kelly Diver and Betty Deberry, D-E-B-E-R-R-Y.

Q. Did you review any of the expert reports that had been submitted in this case?

A. No, I have not. Those have not been sent to me.

Q. All right. You mentioned that you were contacted by a Kathy Mulligan from the office of Mr. Becker?

A. I think so or one of the other legal nurse consultants they have in their office. There's a Susan too. I would have to go back to my records to see who initially contacted me.

Q. And you don't have those in front of you?

A. No, I could get them though.

Q. Were you sent a letter?

A. No, it was a telephone contact.

Q. Okay. And you made note of that apparently somewhere?
A. Yes, I usually keep track of my contacts in my folder.
Q. And you keep that separate from what has been marked as Exhibit A in this case?
A. Yes.
Q. And where is that notation of who contacted you?
A. It's up in my files. I have a notebook that I keep all my contacts with law firms.
Q. All right. And is that just like a listing on such and such a date?
A. Yeah, so and so called or I received this information, sent this report.
Q. Did Kathy Mulligan provide you with any information about this case when she contacted you?
A. I'm sure she told me generally what the case was about.
Q. Did she tell you that

Doctor Gingo was being defended by the law firm that she had left to come to Mr. Becker's office?

A. No, not to my recollection.

Q. You didn't discuss that at all?

A. No, no.

Q. Did she tell you whether she had worked on the case or had any contact with the case in her prior office?

A. No.

Q. And when was it that you were contacted?

A. Again, the best estimate I can give unless I go look at that file would be in the fall of '98.

Q. Okay. But do you know now that my office is the office at which Kathy Mulligan worked prior to going to Mr. Becker's office?

A. I do now. No, I did not realize that she had been at --- no.

Q. And you did not know that

the defense of Dr. Gingo was in my office while Kathy Mulligan was still working at our office?

A. No, we didn't discuss any of that. And again, I could check my records. Susan might have been the one that contacted me about this case rather than Kathy. I just know that Kathy had changed offices and given someone my name.

Q. With regard to standards and guidelines, what standards, if any, do you believe applied to nurses in a labor and delivery setting and let me qualify that question, I'm talking about any so-called standards that are committed to writing.

A. Well, AWHONN has many standards and guidelines. They usually set the policies for obstetrical nurses and labor and delivery as to monitoring how often it should be done, how often vitals should be done but again, that's

usually a reflection of ACOG. I mean, we agree on monitoring practices and evaluations. So they come from both sources. Again, the Nurse Practice Act in the individual states certainly sets the legal parameters, American Nurses Association is the professional organization for all nurses regardless of what your speciality is. And they talk to general concepts such as being a patient advocate, being competent in your field, the nurses responsibility to stay educationally updated, ethics so again, standards of clinical practice, but again, they're more general type standards. Hospital polices and procedures certainly can be more stringent than national standards but shouldn't be less so. JCHO again has some standards and guidelines about assessments of patients in general.

Q. Do the standards, if they

are standards, of AWHONN indicate that they are intended to apply to obstetricians as opposed to nurses?

A. No. AWHONN specifically is a nursing organization.

Q. All right. And you're saying that there may be instances in which the guidelines of AWHONN mirror or are similar to guidelines of ACOG?

A. Yes.

Q. Is that what you're saying?

A. Right. I mean, they are usually identical.

Q. Okay.

ATTORNEY WALTERS:

That's all I have.

ATTORNEY SWITZER:

Just another question.

REDIRECT EXAMINATION

BY ATTORNEY SWITZER:

Q. On the last page of your report, ---?

A. Yes.
Q. Mrs. Fedorka, do you see that?
A. Yes, you're on ---.
Q. In your report.
A. In conclusion, okay.
Q. You stay the substandard nursing care is a contributing factor in the outcome of this trial?
A. Yes.
Q. What is the basis for that statement?
A. I'm sorry?
Q. What is the basis for that statement?
A. That if the nurses had given appropriate care themselves and gotten appropriate care for the patient by using their chain of command, if they had realized what was going on, that hopefully the child would have been delivered earlier and in better shape.
Q. You have no way of knowing whether had they instituted the

chain of command if this child would have been delivered any earlier; correct?

A. No. I mean, we'll never know that but it's still their duty this make every effort to have that happen.

Q. In fact, the child could have been delivered later; isn't that correct?

A. Well, anything is possible but I would say that is certainly not probable in light of the non-reassuring fetal heart rate tracing.

ATTORNEY SWITZER:

Okay. Thank you very much. I don't have any other questions. Steve?

ATTORNEY WALTERS:

Yes, I just have one final question.

RECROSS EXAMINATION

BY ATTORNEY WALTERS:

Q. Nurse Fedorka, just as you

understand that you are limited in your opining on compliance with standards to the standards that apply to nurses, do you also understand that in Ohio, you are not permitted to render an opinion on causation? In other words, whether or not the ultimate outcome in a given situation results from some act or omission that you see.

A. Yes.

Q. Okay.

ATTORNEY SWITZER:

Okay. If you would give the Court Reporter those exhibits and she'll make copies of them and attach to the transcript. And Jackie, would you go ahead and send me a copy of the transcript.

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DEPOSITION CONCLUDED AT 11:20 A.M.

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COMMONWEALTH OF PENNSYLVANIA:

: SS

COUNTY OF ERIE

C E R T I F I C A T E

I, Jacqueline L. Reichert, Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify:

That the witness was hereby first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was taken in Stenotype by me and reduced to typewriting, and constitutes a true and correct record of the testimony given by the witness.

I further certify that the reading and signing of said deposition were (not) waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative, employee or attorney of any of the parties, nor a relative or employee of counsel, and that I am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and stamp this 25th day of June, 1999.

NOTARIAL SEAL
JACQUELINE L. REICHERT, Notary Public
Millcreek Twp., Erie County, PA
My Commission Expires Aug. 20, 2001