#598

THE STATE of OHIO, :
: SS:
COUNTY of CUYAHOGA. :

It? THE COURT OF COMMON PLEAS

MONICA DIXON, et cetera,
plaintiffs,

vs. : Case No. 324550

UNIVERSITY HOSPITALS OF CLEVELAND, et al.,
defendants.

Deposition of DAVID GOLDFARB, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at Gates Mills Medical Building, 125 East Broad Street, Elyria, Ohio, on WEDNESDAY, FEBRUARY 11TH, 1998, commencing at 9:15 a.m. pursuant to agreement of counsel.

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I N D E X

WITNESS: **DAVID GOLDFARB, M.D.**

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

DAVID GOLDFARB, M.D.

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

CROSS-EXAMINATION

BY MR. CULLERS:

Q. State your full name, please.

A. David Benjamin Goldfarb.

Q. Dr. Goldfarb, I'm going to ask you some questions about your involvement in the care of a patient named Monica Dixon.

A. Okay.

Q. I am going to focus your attention on the relevant dates there which would be March of 1995.

As you sit here today do you recall anything about this particular patient?

A. No, I don't have any recollection because it was so long ago. My participation was pretty limited, mostly what I will try to impart is based on how I take care of patients now, and then things I can generate from the chart that are well described and recorded. Direct recollection,

absolutely none.

Q. You reviewed the chart?

A. Urn-hum.

Q. I need you to answer yes.

A. Yes, I have.

Q. When did you review the chart?

A. When I first got the letter.

MR. NORCHI: From when I first sent it to him.

A. When I got it, subsequently several times. I'm pretty acclimated to what transpired.

Q. Would that have all been within the last month or so, your review of the chart?

A. My serious review the last month. When I first got it that was probably six weeks ago, so everything else in the last month, yes.

Q. Did you review any deposition transcripts?

A. No, I have not.

Q. Have you had any discussion with any of the other involved parties in the case?

A. The only person I spoke to has been Kevin.

Q. Based on your review of the chart, when was your first involvement, the date and time, can you tell me by looking at it?

A. No. I think the first time I really spent

some time reviewing the chart was when a formal date to meet with Kevin was arranged, that was changed, it was going to be last week, it became last week, two weeks was the first time.

Q. I appreciate that.

My question is when did you first become involved with the patient in your care and treatment?

A. Directly involved, I was the chief resident who took over and according to this chart and according to the standards at University Hospitals we transfer between 7:15 and 7:45 in the morning. I think what happened is at 7:48 I walked into the room, that is right after we finished changing over shifts.

Q. If you remember, refer to the delivery notes, I have a note at 7:48 says Dr. Goldfarb at bedside, is that probably when you came on?

A. Yes, we probably finished around 7:35 to 7:45 going over all the patients on the floor, transferring from one team to the next team. I was on the next team, the chief of the next daytime team.

First thing I did is went to the patient's room, assessed directly rather than rely

on someone's verbal transfer. It's done orally.
Q. Can you tell from looking at the nursing notes following the 7:48 entry that your name appears up through the point of the delivery?
A. Urn-hum.
Q. I need you to say yes.
A. Yes, that is my job, I was there.
MR. NORCHI: Just answer his question.
Q. It's likely that between 7:48 and the time of delivery that you were consistently there in the operating room?
A. I don't know if I was there the whole time. I was there certain times. I'm managing multiple patients, obviously that wasn't the only patient. I was there, with the record I can assume.
Q. It wouldn't be uncommon for you to be in and out of the room from 7:48 up until the time of delivery?
A. I don't know.
Q. You said you --
A. I was there helping the second year resident. As chief resident I'm responsible for many things, I'm there whenever 1 feel it's necessary.

Q. You could have been in and out of the room between 7:48 and the time of delivery?
A. I was in and out, it was obviously reported that way, but I don't remember.
Q. You were the chief, right?
A. Um-hum.
Q. Can you explain, is that the fourth year resident?
A. All fourth year residents are considered to be chief when they are on service.
Q. Can you tell me how your role differed from the second year resident, Dr. Krietsky?
A. The only difference in roles is I'm supervisory. I cover not only labor and delivery, I'm responsible for multiple patients.

Dr. Krietsky is assigned to labor and delivery, focuses on one particular area. I'm there to supervise her, educate her, help her with anything to teach her.
Q. She focuses on the delivery aspect of treating this particular patient?
A. We're both working with patients, she is more directly -- she is more -- less responsibility. She is focused on just labor and delivery, I'm there to help supervise or train her, make sure

things run smoothly.

Q. When you say she is focused on the labor and delivery, for multiple patients or this particular patient?

A. Multiple patients.

Q. Your role is broader --

A. Yes.

Q. -- than just labor and delivery?

A. Yes.

MR. NORCHI: You have to wait until he finishes his question.

Q. Your role is more than just labor and delivery for multiple patients?

A. Yes.

Q. When you are there interacting with Dr. Krietsky with a particular patient,. you are in the position of a supervisory role?

A. Urn-hum.

Q. I need you to say yes.

A. Yes.

Q. Do you know Dr. Cynthia Austin?

A. Yes.

Q. Do you recall that she was involved in this particular patient's care?

A. No, I don't have any recollection.

Q. You can see she was involved by review of the notes, can't you?
A. Yes.
Q. Is there any way you can tell me by reviewing the notes, either progress notes or the nursing notes, exactly when Dr. Austin was in the room with the patient?
A. The only thing 1 can rely on is the nursing notes. I could not tell exactly. The only time 8:53 Dr. Austin present for delivery, that is the only thing I can rely on concerning Dr. Austin's involvement in the room.
Q. If you look up earlier I think at 8:35 Dr. Austin aware of something, it says that?
A. Yes, Dr. Austin made aware at 8:35.
Q. That doesn't necessarily mean she was in the room at 8:35?
A. No, she could have come in any time until the nurse reports, I have no way of recollecting when she was there.
Q. Tell me about in March of '95, around that time frame how you would normally interface with the attending?
A. It's pretty well described. The attending is there to be called for any questions, any dilemmas,

any time we have a delivery she is responsible to be there for each and all deliveries, each and all procedures done.

Q. What procedures, what are you referring to?

A. Surgery, D&C, any kind of delivery, a vacuum, if you do a forceps, if you have a patient you need to an amniocentesis, any type of procedure the attending is required to be there.

Q. Would that include a scalp gas?

A. No.

Q. Then when she is there, what is your -- how do you interface with her when you are present in the room with her?

A. We call her, we say we are going to do whatever we are going to do, please come to the room. She comes to the room, how involved she gets depends how comfortable she is with the situation. She might get involved, she might sit and watch if things are going well.

Q. It certainly wasn't uncommon in that time frame for a second year resident under the supervision of a chief resident to perform a delivery?

A. Absolutely not.

Q. It appears that is what happened here, isn't

it?

A. That is how it should be.

Q. That is what happened here?

A. Yes, that is how it happened here.

Q. When an operative delivery is being contemplated --

A. Yes.

Q. -- I take it that you are involved in the process of thinking that through with the second year resident?

A. Absolutely.

Q. Can you explain the thought process that you go through with the resident in making a determination as to whether an operative delivery will be done?

A. In this particular case or any case?

Q. If you can tell me in this particular case.

A. It's basically every patient is different. You use your skills, I can't obviously explain to you obstetrics in one day or two days. The skills and books, make a decision when we think an operative delivery would benefit the baby, that our decision is to deliver the baby. I can't tell you all the times. Everything is relative to the situation you are in, based on that exact

circumstance.

Q. Do you recall from your review of the chart that Dr. Krietsky indicated in her operative note that the pre-operative diagnosis, among other things, was macrosomia?

MR. NORCHI: Why don't you turn to it, Doctor, to make sure.

A. In the dictation, that is what you are referring to?

Q. The typed operative note.

A. Based on Dr. Krietsky's dictation she said that the pre-operative diagnosis was intrauterine pregnancy, 40-2/7 weeks, is in fetal distress and macrosomia.

Q. Part of the diagnosis was macrosomia?

A. Yes. I don't necessarily believe the baby was macrosomic. It was definitely a large baby, I agree to that.

Q. My question was: Macrosomia was part of the pre-operative diagnosis, wasn't it?

A. Yes, according to Dr. Krietsky.

Q. What?

A. According to this particular -- I didn't make that pre-operative diagnosis.

Q. Also according to this operative note,

macrosomia is included as part of the postoperative diagnosis; is that true?

A. Yes.

Q Earlier when I was asking you about macrosomia being part of the pre-operative diagnosis you said something you don't believe the baby was macrosomic; do you recall that?

A. Yes.

Q Explain why you don't believe the baby as macrosomic.

A My definition of macrosomia is a baby over 4500 grams. Based on the size of this baby, based on the 4500 grams, I feel the baby was large, I don't feel this would be macrosomic. I think that was a choice of words that was used in her dictation.

Q How much did this baby weigh?

A I'm not completely sure, recollection I think 4100; is that right? I'm relying on -- I'm sure it's reported in the nursing notes, hold on. Here it is, baby weighed 4137 grams.

Q. According to your definition of macrosomia --

A. That would not qualify as macrosomia.

Q. Obviously how much the baby weighs isn't something you find out until after the baby is

born?

A. Yes, it's awful hard to make a diagnosis of macrosomia before the baby is delivered. There are a lot of errors made in what you think the baby may weigh.

Q. In estimating the fetal weight, you said that there are a lot of errors that can be made; is that right?

A Urn-hum.

Q You have to say yes.

A. Yes.

Q. Macrosomia is difficult to diagnose ahead of time, there is a certain margin of error, right?

A. Yes.

Q. There wouldn't be any way that you could diagnose that the fetus weighs 4,167 grams as opposed to 4,500 grams before delivery?

A. No test is going to give you guaranteed information.

Q. No way you could do that accurately?

A. No.

Q. There are certain tests that can be done to try to determine estimated fetal weight, aren't there?

A. Yes.

Q. One of those would be a sonographic estimated fetal weight?
A. Yes.
Q. That wasn't done in this case, was it?
A. Not from the chart, it does not look like it.
Q. Is a sonographic estimated fetal weight test accurate in diagnosing macrosomia?
A. Not very accurate, an almost 15 to 20 percent error.
Q. Do you think that prior to labor and delivery it's important to estimate the fetal weight?
A. Not usually, unless you are suspicious for a very large baby. I don't think it has a significant value. You are going to let them labor, see how they do.
Q. How large of a baby do you need to anticipate before it becomes important to estimate a fetal weight?
A. The way I practice 4500 grams, 10 pounds or more I get an ultrasound in practice.

In this case I don't know how it applies, I wasn't -- I don't know what her antepartum care was.

Q. How do you know if the baby is going to be

more than 4,500 grams?
A. Experience feeling the baby, using my skills to know what that baby is.
Q. What are those tests?
A. The only test I use is the Leopold maneuver. You manipulate the baby during the pregnancy to see how big it feels. Based on that, the thousands and thousands of times you do that, see the delivery, see how you feel relates, you develop your own system for estimating what you think the baby may weigh.
Q. Based on your review of the chart, it isn't documented whether an estimated fetal weight was done at all in this case; is that true?
A. Yes, that's true. I didn't see any documentation.
Q. Prior to labor and delivery, were you aware that this was a gestational diabetic pregnancy?
A. No, I was not aware.
Q. When you came on at 7:48 I take it that you are updated on the patient's progress?
A. I know what transpired that morning obviously, it's a short period of time of transfer of patient, 1 don't know if I was related that she was gestational diabetic. I assume I probably

was. No way of being sure of that.
Q. That is what I want to know: Is that likely something that would have been related to you when you came on?
A. I don't know.
Q. Would it have been something that would have been important for you to know when you came on at 7:48?
A. Based on the situation I walked into, I don't know whether I think it was important how we managed the patient's labor, no. I was going to go in and assess the patient myself. When I walked in to see the patient, that is when I take over control. Knowing she was a diabetic wasn't going to change something in a hard labor, delivery within an hour of me entering the room.
Q. Are gestational diabetic pregnancies more likely to yield a large baby?
A. If they are poorly controlled gestational diabetic more likely. Well controlled, studies show they are not at increase for a macrosomic baby.
Q. In your review of the chart was she well controlled?
A. I can't ascertain that.

Q. When you came on 7:48 I take it that is not something you inquired into?
A. I don't know.
Q. Would that be likely that is something you inquired about?
A. If she was GDM she probably would have been on insulin, she wasn't. I can only assume based on the information here it wasn't very relevant at that point in time.
Q. Is a large baby more likely to have a shoulder dystocia than a small baby?
A. Yes.
Q. Obviously a macrosomic baby would be more likely to have shoulder dystocia than a nonmacrosomic baby?
A. Yes.
Q. In making the decision to do an operative vaginal delivery is it important to consider whether the baby is macrosomic?
A. Yes.
Q. Why is that?
A. Because in your own mind you have to believe this baby can fit through the vagina before you apply any kind of operative management.
Q. Going through the thought process that you

went through with the second year resident about whether an operative vaginal delivery would be attempted, I take it you took into consideration whether the baby was macrosomic?

A. I didn't know the baby was macrosomic. I never know how big. I felt the baby, whether I thought the baby can fit you through the vagina, the birth canal.

Q. As part of that process did you consider whether the fact that it was a gestational diabetic pregnancy made any difference?

A. I don't know.

Q. Is it something that you likely would have considered?

A. At that point probably not. Only point I apply any kind of operative delivery at all I consider can I get the baby out easily and safely.

Q. Is the reason that a large baby is more likely to have a shoulder dystocia than a small baby because there is an increased likelihood of fetopelvic disproportion?

A. Yes.

Q. When you are making a decision about whether or not an operative vaginal delivery is going to be attempted is it important or not to determine

whether the fetopelvic disproportion is present?

A Yes, it's important.

Q. Why?

A Like I said before, before you apply any operative delivery you want to make sure you feel based on your clinical assessment there is adequate room, the mother has a big enough pelvis to allow the baby to pass, the baby is small enough to pass. Two factors, size of the baby and size of the mother. Those have to be in your estimate, consistent with each other to allow a vaginal delivery.

Q Is it likely that when you are making the decision with Dr. Krietsky about whether to perform an operative vaginal delivery you considered whether or not fetopelvic disproportion existed?

A Yes, but looking at the situation, I think the chance of that was almost none. The baby was fully engaged, plus 2 to plus 3 station without any operative delivery. That means the head is past the symphysis, sitting in the lower canal of the vagina. We delivered her very easily with minimal assistance after she was almost crowning. In this situation I don't think there was any concern of fetopelvic disproportion.

Q. Do you specifically recall you delivered very easily?
A. I don't recall. I can only relate to time frame, what I read.
Q. Your determination that it was relatively easy to deliver the baby is based on the time frame in which the delivery occurred?
A. Based on the time frame and how things transpired, based on my entering sequence of time, because it was such a smooth delivery based on the assessment of the chart, not direct recollection.
Q. What sequence of time are you referring to?
A. I'm referring to the point that she -- according to the nurse's record, the baby delivered by three pulls with contraction; baby's head delivered head out with three pulls, nuchal cord reduced, baby completely out one minute later which is more than a very reasonable period of time, less than a minute from the head to the rest of the body.
Q. Is the first reference to the three pulls at 8:53?
A. The first reference to the three pulls, all I can see is Dr. Austin was here at 8:53. First the patient is pushing, you pull with contractions to

help guide the head out.
Q. The first pull with a vacuum is at 8:53?
A. According to the chart, yes.
Q. Based on what you were saying earlier about the time frame, that allows you to conclude this was a relatively easy delivery starting at 8:53?
A. No, I didn't say a relatively easy delivery. I don't know that any delivery is easy. It took three pulls, three contractions, that is a very reasonable amount of time considering operative delivery.
Q. Do you think it was an easy delivery?
A. I don't know. I think it was a reasonable delivery. Are you asking about the patient? I don't know if the patient --
Q. No.
A. 1 think it was a very smooth delivery. I don't think the word easy -- I think it went without complication.
Q. The reason I was using the word easy is when you first started telling me you said easy.
A. Yes, that was a very smooth delivery based on the records.
Q. I don't want to get hung up on semantics.
A. That is exactly true.

Q. You said easy, now you are saying smooth. I'm trying to get an idea how you characterize the difficulty in delivering the baby, that is all?
A. Doesn't appear that was difficult beyond the use of an operative delivery made it a little more challenging. No, I don't think it was a difficult delivery.
Q. Is part of the reason that the attending is required to be there during an operative delivery is because an operative delivery can be more challenging than a regular delivery?
A. Yes.
Q. It's more likely for complications to arise in an operative delivery than a nonoperative delivery?
MR. NORCHI: Objection. You can answer. Go ahead.
A Yes, that's true.
Q It's true that with an operative delivery it's more likely that an injury can occur to the fetus than a nonoperative delivery?
MR. NORCHI: Objection. If you know. These are expert questions, you can base them on your experience and expertise if you know. If you have an answer to the question, provide it.

I'm just objecting to the nature of the question.
A. I think I answered. I think there is more risk of complications with any manipulation of any baby rather than a completely natural delivery. Higher risk of episiotomy, small risk, 1 don't consider them a long-term risk, increased getting more involved with a delivery.
Q. Is there increased likelihood of an injury to the fetus when it's an operative delivery as opposed to a delivery not involving instruments?
MR. NORCHI: I object to the term likelihood. Is it probability you're establishing, basic probability in your question, increasing the probability?
THE WITNESS: I don't know.
MR. NORCHI: I don't want to tell you how to ask questions, I believe an increased risk is the way it's usually characterized.
Q. Is there an increased risk of injury to the fetus when an operative delivery is attempted as opposed to a delivery that doesn't involve the use of instruments?
A. Yes.
Q. You were talking about certain aspects of

progress of labor earlier, I want to go on, talk to you more about it.

Can you go to the progress of labor chart.

A. Where is that?

Q. In the labor notes.

A. Is this it?

Q. Yes. Obviously the progress of labor chart charts the degree of the dilatation as well as the station at certain times; is that right?

A. Yes.

Q. You would agree with me wouldn't you between two o'clock a.m. and seven o'clock a.m. on March 14th station remains static?

A. According to this chart, yes.

Q. Do you have any reason to believe the station as recorded on this chart is inaccurate?

A. I have no reason to believe that. Station is a very judgmental decision. I didn't check her any of those times. I'm relying on a nurse's recollection.

Q. If you assume that station is accurately recorded at two o'clock at zero, seven o'clock at zero, you would agree it didn't change?

A. Yes, if I assume these are right, definitely

didn't change.

Q. Do you have an opinion as to whether the patient was in active labor by two o'clock a.m.?

A. Do I have an opinion?

Q. Yes.

A. I don't think she was in active labor before two o'clock.

Q. Do you have an opinion as to when active labor began?

A. It's hard for me to say because I wasn't there, I wasn't doing the exams, I didn't feel the station or dilatation.

I think when we ruptured -- she was artificially ruptured at 2:00 a.m., that is usually done to try to get somebody to speed up, get into active labor, I think somewhere between two and six o'clock she entered active labor. That with the gap there is no way for me of knowing.

Q. Why don't you refer to the nurses' notes if you would.

A. Okay.

Q. Can you look at three o'clock a.m.?

A. Okay.

Q. See where the placing of internal monitoring is indicated?

A. Urn-hum.
Q. I need you to respond yes, please.
A. Yes.
Q. The purpose is obviously to monitor the strength of contractions?
A. Yes.
Q. Can you look at the following two or three notes, tell me if that information about the strength of contractions indicates to you that the patient was in active labor?
A. What was the question again?
Q. Can you look at the information that is contained in the nursing notes at three o'clock and four o'clock, tell me if based on that information you feel confident in --
A. No, I can't.
Q. I need to finish my question.
You can't tell from the information contained in the nursing notes between 3:00 a.m. and 4:00 a.m. whether this lady was in the active phase of labor?
A. I cannot.
Q. What information do you need to be able to figure that out?
A. The information I need to know is how strong

her contractions were, based on the IUPC, which I do not have. Without that, I can't tell you if she was having adequate contractions, there is no way of knowing.

Q. Is there any way you can tell by looking at the progress of labor chart?

A. There is no way I can tell looking at this exactly when active labor started. I can tell, I know she was in active labor when she started around -- I don't know what the dot is between, between 6:00 and 5:00, 5:30 really took off.

Q. At that point she is in active labor?

A. Absolutely.

Q. According to Dr. Krietsky's operative note the station at the point of intervention was plus 3; do you recall that?

A. Direct recollection, no. I did read that in her dictation, yes. I believe that is probably very reliable.

Q. It's likely that station was at plus 3 at the time of intervention?

A. Yes.

Q. Do you recall reading Dr. Krietsky's note at eight o'clock regarding station?

A. No, I don't recall right now. I can read

that.
Q. Can you refer to that, please?
A. Yes.
Q. Station reported zero to plus 1?
A. Dr. Krietsky plus 2 station, you are saying zero to plus 1.
Q. Station is zero to plus 1?
A. It's hard for me to say, I didn't do the exam.
Q. That is what that says?
A. What Dr, Krietsky believes. I said before station and dilatation, effacement are very subjective terms.
Q. I understand that.
A. Based on her assessment of the caput was a plus 2, station was zero to plus 1, I did not record an exam, I don't know.
Q. Based on what you reviewed in Dr. Krietsky's note at eight o'clock, she believed the station was somewhere between zero and 1?
A. Yes, she did believe that.
Q. Zero to plus 1; is that right?
A. Yes.
Q. We know by looking at the progress of labor chart someone reports station at seven o'clock a.m.

to be at zero; is that correct?
A. Says zero to 1 plus based on Dr. Radke's note at seven o'clock.
Q. That is not 7:00, 7:21?
A. Sorry.
Q. If you go back to the note at seven o'clock by --
A. Yes.
Q. Says plus 1, doesn't it?
A. Yes, it does.
Q. If you look at the nurses' note at seven o'clock Dr. Segal is reported to have been in the room, reported station at zero; is that true?
A. That's true,
Q. So we know that at least Dr. Segal indicated in two places in the record, one at seven o'clock and one at --
A. At 7:00.
Q. Two places at 7:00 indicates his determination of station, one says zero, one says plus 1?
A. That's right.
Q. Based on what we observed in Dr. Krietsky's note, her determination of station at eight o'clock, is it fair to say station has not

progressed during that one hour period?
A. Well, unless -- I don't know if it was fair to say that if Dr. Segal was zero, she was plus 1, then it had changed. There is a big discrepancy here. You have two exact time frames with two different stations. There is no way of knowing which one is accurate, knowing if Dr. Krietsky is accurate because it's so subjective.
Q. Do you feel confident in saying that in fact station did change one centimeter between 7:00 and eight o'clock?
A. I don't feel confident saying either way.
Q. Can you say station changed a centimeter between 7:00 and 8:00?
A. No, I don't think I can say that.
Q. If you go back to the progress of labor chart, if you would, where it says intrapartum problems, says in the space abnormal labor; do you see that?
A. Yes.
Q. Directly next to that says protracted?
A. Yes.
Q. Isn't the definition of protracted descent contained on the chart?
A. 1 don't think you can make the diagnosis like

that because I feel that personally an evaluation of station is objective. More important and more reliable was dilatation, how she dilated very quickly. I can't tell you if it was protracted, I don't have a whole lot of faith of a reproducible exam with effacement.

Q. We will talk about dilatation in a second. All I'm asking you is whether or not what it says on this form, protracted labor is less than one centimeter per hour, is something that purports to describe abnormal progress on this chart?

MR. NORCHI: Do you understand the question?

A. Yes. I don't know that she has a protracted active phase.

Q. Would you agree there were points during her active labor where descent did not increase at least a centimeter per hour?

A. I would agree that based on -- I would only agree to the point I think that is based on the recording of others there was not change of descent but that is the opinions of others, very subjective. I don't put a whole lot of faith in that.

Q. Does this part of the chart have an area over

here where you can check it, for example where there is abnormal progress?

A. Yes.

Q. If someone believed that descent was protracted they would check that over here?

A. Yes.

Q. Did this mean that if someone were to review the chart, or review the progress of the patient overall, conclude that descent had not progressed at least a centimeter per hour, they would check this?

A. This was very seldom, I don't think they were completely filled out all the time to tell you the truth.

Q. What was the purpose of that?

A. That was the purpose, it wasn't used here.

Q. Based on what you said, it's my understanding from your testimony you do not have the opinion that there was a protracted descent with this labor?

A. No.

Q. You don't have that opinion?

A. 1 don't have that opinion.

Q. Do you have an opinion as to whether dilatation was protracted with this labor?

A. I do not think dilatation was protracted with this labor.

Q. I would like to refer you to part of the record, it's a screening room flow sheet that is dated 3-13-95; do you have that?

A. I don't know. 3-13-95, yes, I have that.

Q. The top left corner of the screening room flow sheet indicates that -- first of all dated 3-13-95?

A. Yes.

Q. The patient is in at 12:44?

A. Yes.

Q. That would be a little after noon?

A. Noon.

Q. She is out at 2041, right?

A. Yes, true.

Q. About eight o'clock or so?

A. 8:41.

Q. If you look down to the middle where it says notes, it indicates that there was a vaginal exam and the patient was reported to be 3 to 4 centimeters dilated; is that correct?

A. Yes.

Q. If you go down to the lower third of the page it indicates that same information, vaginal exam,

dilated 3 to 4 centimeters?
A. Yes.
Q. Effacement 75 percent?
A. Yes.
Q. Station at first indicated at floating station, that is marked out?
A. Yes, that's true.
Q. Minus 2, minus 3?
A. Yes.
Q. High station?
A. Yes.
Q. At that point the baby's head is not engaged?
A. Yes.
Q. Fundal height 41 to 42 centimeters?
A. Yes.
Q. Is a fundal height of 41 to 42 centimeters indicative of a large baby?
A. No.
Q. It is not?
A. No.
Q. Can you look up here, in the center of the notes where some of the exam findings are noted, says irregular uterine contraction; do you see that?
A. Yes.

Q. What does that mean, why is that significant?
A. Simply a report that the patient was having irregular uterine contractions.
Q. Why is that something that is significant?
A. I don't know if it's significant, you report what is is going on. She is having irregular contractions.
Q. You don't attach any specific significance?
A. No, irregular uterine contracts are totally normal during pregnancy.
Q. If a patient presents, is 3 to 4 centimeters dilated, the fetus is at a high station, minus 2, minus 3, effacement 75 percent, does that suggest fetopelvic disproportion?
A. No.
Q. Does it indicate anything of significance?
A. Doesn't indicate anything of significance other than the situation she was 3 to 4 centimeters dilated, not having regular contractions.
Q. Do you expect an a lipara who is 3 to 4 centimeters dilated is having irregular contractions, to have the fetal head engaged?
A. Every pregnancy is different. There is no way of making any general estimate when it comes to pregnancy, engagement is relative to each

individual.

Q. First of all, would you then look at the nursing notes at midnight when she comes back 3-13, midnight nursing notes?

A. I have no idea --

MR. NORCHI: I'll show you.

Q. At that point she is 4 to 5 centimeters?

A. Yes.

Q. It says here that the patient is admitted in early active labor; is that correct?

A. Yes.

Q. You disagree she was in early active labor?

A. I don't know if I disagree or not. I feel it's a subjective decision. I think early.

That's a nurse's opinion she was in early active labor. That is not my opinion. I don't think she was in active labor until later on.

Q. Which is what you said earlier, right?

A. Yes.

Q. Can you tell based on your review of the note at midnight how her condition has changed from the point where she leaves the screening room just a couple hours earlier?

A. Repeat the question.

Q. You can see from looking at the screening

room flow sheet she had left the hospital a couple of hours before?
A. That's true.
Q. The information is written in here at midnight, true?
A. She left at 8:41 then comes back at midnight, 11:40.
Q. Left at 8:41, comes back at 11:40?
A. Three hours later.
Q. Can you tell by looking the data when she left at 8:41 to the data when she comes back at midnight, tell me what has changed in her general situation?
A. I can't tell a big difference, what changed. According to Dr. Segal there is no contraction pattern, I can't tell you how often she is contracting or anything else.
Q. As far as you can tell from looking at these particular notes, no appreciable change?
A. She is 4 to 5 centimeters, rather than 3 to 4, that's an appreciable change.
Q. If at that time, midnight, if she is a high station, she is 3 to 4?
A. We don't know she is a high station.
MR. NORCHI: Let him

finish. It's easier when you prepare an answer.
Q. Go down to 2:07 a.m., Doctor, vaginal exam reported at 4 to 5 centimeters, zero station?
A. Yes.
Q. Is zero station a high station?
A. No.
Q. If an a lipara is 4 to 5 centimeters dilated, high station, had some contractions, does that imply fetopelvic disproportion?
A. No.
Q. Is it consistent with fetopelvic disproportion?
A. I don't know. I don't think the question is what is consistent.
Q. Is the fact that the baby's head is at a zero station, in conjunction with the fact she is 4 to 5 centimeters dilated, having contractions, consistent with fetopelvic disproportion?
A. I don't think so, no.
Q. I would like you to look back at the progress of labor chart.
A. Okay.
Q. When we were talking about when you felt the patient was in active labor, you mentioned something about her dilatation taking off or

increasing, some words to that affect; do you recall that?

A Yes.

Q After she is completely dilated do you know how quickly the fetal presenting part descends?

A After complete dilatation?

Q. Yes.

A Second stage of labor?

Q Correct.

A Can be two hours without an epidural, three hours with an epidural cut off for when it becomes concerning.

Q With respect to this patient, do you know how rapidly the fetal presenting part descended after complete dilatation?

A I can only base my time frame on the chart, she was reported to be completely dilated at --

Q. 8:35?

A She delivered before 9:00 or nine o'clock, that is less than half an hour of second stage of labor which is wonderful.

Q Can you make that determination that the descent moved normally just by virtue of the fact it occurred within a half an hour -- let me start over, strike that.

The second stage of labor is about 23, 26 minutes, something like that. You said that was wonderful, meaning fast?

A. That is relatively smooth --

MR. NORCHI: Smooth what?

THE WITNESS: That is smooth labor.

MR. NORCHI: I want you to finish your sentence.

A. Under an hour is less than average,

Q. There is intervention with vacuum, isn't there?

A. At plus 3 station.

Q. That made it faster?

A. Maybe a small amount faster, yes.

Q. What I was getting at earlier is when you were looking at the progress of labor chart, I wanted to know if you know how rapidly the fetal presenting part descended, you said she was plus 3 when the vacuum was applied?

A. Yes.

Q. We know that happened at 8:53, right?

A. Yes.

Q. If descent moves from plus 1 at 8:35 to plus 3 at 8:53, is that rapid descent?

A. I don't know what the description of rapid descent is. It's a very judgmental term. It's a reasonable descent, very reasonable.

Q. I want you to characterize it for me. I don't want you to get hung up on my semantics, rapid.

A. It's a reasonable second stage of labor, that is the best way I can put it.

Q. Was descent from 8:35 when we know she is at plus 1 to a station of plus 3 at 8:53, something you would characterize as moving quickly?

MR. NORCHI: Can I go off the record for a second?

MR. CULLERS: Sure.

(Discussion had off the record.)

Q. We know that at 8:30 Dr. Krietsky recorded station at plus 1?

A. Yes.

Q. Then we know that Dr. Krietsky was of the opinion when the vacuum was applied the fetal presenting part was at plus 3?

A. Yes.

Q. Is that degree of descent during the second

stage something you would characterize as moving quickly?

A. It's hard for me to say. Dr. Krietsky believes she's plus 1, she could have been plus 2, changed before that. You are relying on very subjective conditions that I can't make -- I think that's a reasonable descent. Whether she changed 1 or 2 in a half an hour doesn't make a difference.

Q. I'm trying to get an idea whether this was -- this seemed like something that was happening quickly, slowly, I know you said reasonable, that doesn't tell me anything. Reasonable could be two hours based on the standard of care.

A. Exactly.

Q. So what I'm asking you about is how to characterize how fast it occurred or quickly it occurred, I'm trying to figure out if it's something --

A. She pushed for under an hour, 30 minutes, I don't know if that is fast or slow.

MR. NORCHI: Use the terms you want to use, medical terms. Hold on, let me tell you, he's allowed to ask these questions, they are fair questions. Answer the best you can, the

deposition transcript will probably be read by an expert, somebody who is an OB/GYN, Board certified, will review your testimony, you have to communicate the best way you can using the terms you are comfortable with. If you can answer fine, if you can't answer that is fine, Mr. Cullers will work with that, If you don't feel comfortable using his terms, use your terms.

A. No. I don't feel comfortable using fast, it's not a medical term.

Q. Is there some way you can explain it to me which will characterize the speed or the quickness, the shortness of time in some way so I can get an idea what your feeling is about whether it was slow progress or not?

A. Between what times?

Q. Between full dilatation and delivery, the descent?

A. It was not slow progress, very reasonable, under an hour. If the standard is two hours, it's an hour, it's a reasonable period of labor. Some labor is an hour.

Q. I'm more specifically referring to the descent, We know that the baby's fetal presenting part descended to a point it could be -- where a

vacuum assist could then occur?
A. Yes.
Q. We know that descent occurred over the period of about 23, 24 minutes?
A. If we assume everybody's station is factual and it's not, it's subjective.
Q. Let's assume station isn't even a factor here.
A. Okay.
Q. When she is completely dilated the baby's presenting part is somewhere?
A. Yes.
Q. It *goes* down to somewhere else, at which point the vacuum is applied?
A. Yes.
Q. The baby's head moving from the point where it was at when it was fully dilated down to the point the vacuum was applied now took 23 minutes or 26 minutes?
A. Yes.
Q. Is that descent something you can characterize as fast, slow?
A. The word fast, I don't use the word fast. It's a very reasonable period of time. Not concerning at all to me.

Q. You can't tell me whether that is moving quickly or not?

MR. NORCHI: I'll object, asked and answered. If you can answer to the best of your ability, state that.

Q. You can't do that?

A. I can't say it's quick, no.

Q. That is what I want to know.

A. Sorry.

Q. That's all right.

I want to ask you some questions about scalp gases.

Off the record.

(Discussion had off the record.)

MR. CULLERS: Back on.

BY MR. CULLERS:

Q. Earlier we were having a discussion in which I was trying to ask you to characterize descent in terms of whether it was quick or fast or slow, we had some difficulty, that is because --

A. I don't use those words, those are not medical words.

Q. Quickly is not a word you use?

A. In medical terms no, too subjective.
Q. I want to talk about scalp gases.
You came on at 7:48, right?
A. Yes.
Q. Can you refer to the last progress note before you came on which I believe is 7:21, Dr. Radke?
A. Yes, 7:20, he tends to write in hieroglyphics.
Q. When you came on at 7:48 it's likely like you would have gone and reviewed this note of Dr. Radke?
A. It's likely, yes.
Q. It is likely you would have reviewed the previous note of Dr. Segal?
A. Yes.
Q. Seven o'clock a.m.?
A. Likely I would have reviewed.
Q. That you would have been aware at 8:48 there were two borderline pH values?
A. Two equivocal pH values.
Q. You use the word equivocal?
A. Yes.
Q. Can you explain what you mean by equivocal?
A. A scalp gas of 7.20 and 7.25 repeated in 20

to 30 minutes, staying the same, which is okay, not going below 7.20 which is acedemia for a baby.

Q. The purpose of obtaining the scalp gases is to determine that the fetus is receiving adequate oxygenation?

A. Direct purpose is to directly measure the fetal pH, which reflects oxygenation.

Q. It can be inaccurate?

A. Fetal scalp gas in the most accurate way to evaluate the baby.

Q. Can be inaccurate?

A. Yes.

Q. We know fetal scalp gas below 7.20, that requires expedited delivery, doesn't it?

A. Yes.

Q. When you say equivocal, you assign it as equivocal --

A. I didn't assign it.

Q. I used the word borderline, you are using equivocal, I never heard the word equivocal used, I'm trying to get a feel for what you mean.

A. Equivocal means you can't make any direct interpretation, you need a report of 7.20, the same or above.

Q. It stays at 7.20 and 7.25 on four consecutive

readings, is that reassuring?
A. Yes.
Q. It's reassuring?
A. It's reassuring the baby is not acidemic.
Q. When the scalp gases are being obtained with this patient --
A. Yes.
Q. -- as far as you can tell, is there concern about the tracings?
A. Yes.
Q. That is while they are doing it, right?
A. Yes.
Q. They see something sinister in the tracings, they are looking for more accurate information to see if the baby is getting adequate oxygenation?
MR. NORCHI: I object to the word "sinister."
Q. They see tracings that do not look reassuring?
A. Yes.
Q. Therefore they obtain the gases, sort of a back up to see if --
A. Not really a back up. Direct measurement of fetal acidemia.
Q. I'm getting hung up on my words.

A. That's all right.
Q. They are taking the pH because they are not comfortable with what they are seeing on the tracings?
A. Not comfortable is a subjective interpretation of the tracings, they are going to get a direct test.
Q. If the pH values are reassuring, why do they keep doing it?
A. Because they are equivocal, meaning you have to follow them much more carefully. They weren't wonderful, aren't bad, they are in between.
Q. I asked you if the four consecutive equivocal pH values were reassuring, you said yes?
A. In that context. They haven't dropped. In fact, the last pH was 7.25, that's considered to be good, we wouldn't repeat that for an hour.
Q. If it is reassuring you wouldn't repeat them?
A. I apologize, the word reassuring, they were reassuring for 20 or 30 minutes is what they are reassuring for.
Q. That as a process over time, the consecutive equivocal pH values are not reassuring?
MR. NORCHI: Wait. Try that again. I don't think that is what the testimony

has been.

Q. My understanding of what you said was its reassuring for 20 minutes?

A. 20 or 30 minutes, you have 20, 30 minutes, you reevaluate.

Q. If you look at four of them that are consecutively equivocal, that isn't reassuring as a pattern?

MR. NORCHI: Objection. I think you are missing it is an independent test and length of time, reliable, if you will, on a pattern of what you see over a period of time. The pattern, the maintenance of pH at a certain level.

Let him ask the question *so* we're on the same page.

MR. CULLERS: I see what you are saying.

Q. Let me tell you what I'm trying to ask you.

What I'm trying to ask you is the fact they are consecutive equivocal pH values does that tell you anything? That is what I'm trying to ask, the fact they are consecutive?

MR. NORCHI: He answered. Go ahead.

A. The fact they don't drop below 7.20, they are

done very well, done at set intervals, those don't go downward toward acidemia, the baby is stable.

Q. Now the question is: Are the consecutive values, are four consecutive values reassuring?

A. I thought I just answered it.

MR. **NORCHI:** Answer it again.

A. I think four consecutive values, that are not changing, is reassuring the baby is not acidemic, yes.

Q. As of the time that Dr. Radke records one of the equivocal pH's I think he recorded 7.23?

A. Yes.

Q. Can you look at his note, if you can read what he says about beat to beat variability?

A. Slightly -- I think it means slightly increased beat to beat variability.

Q. Can you --

A. I'm not sure that is what he wrote. I'm guessing an arrow above is increased.

Q. Can you tell me by looking at the way information is recorded in the nurses' notes from midnight up to the point of Dr. Radke's note at 7:20 what the beat to beat variability pattern looks like over time?

A. Without the tracings I can't tell you anything.

Q. Is there any way to tell me anything about the long-term beat to beat variability without looking at the tracings?

A. With any kind of confidence, no.

Q. Would it be imprudent for you to try to tell me information about the beat to beat variability over the course of time from midnight say to 7:20 without having the tracings?

MR. NORCHI: I object to the word imprudent. I understand what you mean. The other thing is the record does contain at certain points interpretations by certain individuals --

MR. CULLERS: Other people.

MR. NORCHI: -- what is on the strips, so there is some information in the chart that tells what beat to beat variability is. There are other doctors in charge of this patient up until 7:00.

THE WITNESS: I wasn't there.

MR. NORCHI: 7:00 a.m., 7:30 Dr. Goldfarb came on.

MR. CULLER§: I hear what you

are saying.

Q. Is there any way you feel comfortable looking at that information about what the nurses and what other doctors have said about beat to beat variability over time and making some conclusion about whether the beat to beat variability is reassuring?

A, I feel really uncomfortable making that decision. I don't have the tracings, nor was I there, I can't tell you anymore than they told you in their own words about beat to beat variability.

Q. Without looking at the tracings?

A. Looking at the tracings, having been there.

Q. Would it be just a guess on your part?

MR. NORCHI: Would what be a guess? What it was beforehand, before he was there?

Q. No. If I were to ask you to tell me what your conclusion is about whether or not the beat to beat variability over the course of time looks reassuring --

A. You are asking me if it looks --

Q. -- it's a guess?

A, It's a guess.

MR. NORCHI: You have to let

him finish.

MR. CULLERS: Read that back.

(Question read.)

Q. Let me try it again.

If I were to ask you to look at the information contained in the chart about what other individuals have recorded regarding the beat to beat variability over time, would you be able to tell me whether or not the pattern of beat to beat variability over time is reassuring?

A. I would not be able to tell you either way.

Q. Is that because it would require you to be guessing about the accuracy of other people's recording of what was seen on the tracings?

A. Yes.

Q. That would be careless on your part?

A. Yes.

Q. Is there any way that --

MR. CULLERS: Off the record.

(Discussion had off the record.)

Q. That you can compare the pattern of beat to beat variability at the time period between 8:30 and 8:53 and the pattern of beat to beat variability that occurred up to 7:21?

A. There is no way.

Q. I would like you to refer to the operative note, the typed one that Dr. Krietsky dictated. If you refer to the last paragraph where it is entitled operative note; are you there?

A. Yes.

Q. It says, I was called to the room and the patient was having late decelerations on the tracings along with fetal bradycardia, who is "I"?

A. Dr. Krietsky, I assume,

Q. Do you know that?

A. She dictated it. It is her unless she uses "I" unusually. Yes, it was her.

Q. Do you recall that fetal bradycardia in fact occurred with this patient?

A. I do not recall.

Q. Can you look at the nurses' notes, the delivery notes 8:46 a.m., do you see there where it says fetal heart rate persists with variable decelerations to the 90's?

A. Yes.
Q. That doesn't constitute bradycardia, does it?
A. No, it does not.
Q. If you look up from that point back in time, there aren't any decelerations recorded which fall within the definition of bradycardia?
MR. NORCHI: Hold on. You mean changes in fetal heart rate, that's different than decelerations that may be seen on a monitor strip.
Q. Let me ask the question a different way.
Is there any information you see from 7:48 when you came on up until 8:46 that is indicative of fetal bradycardia?
A. I don't know. There is no tracings to tell me.
MR. NORCHI: Listen to the question.
Q. Is there anything in the chart?
A. No, nothing in the chart.
Q. Are you familiar with the term terminal bradycardia?
A. Yes.
Q. What is that?
A. Terminal bradycardia to me means the baby's

heart rate drops and remains dropped until delivery.

Q. When does that occur?

A. When does what occur?

Q. When do you expect to see terminal bradycardia during the delivery?

A. Hopefully never.

Q. If you see it, when do you see it?

A. By definition you see it at the end of delivery, it's terminal bradycardia.

Q. Let's *go* back to Dr. Krietsky's note. I'm sorry, the discharge summary prepared by Dr. Krietsky, can you refer to the last part.

Says we had patient begin to push, however the patient developed bradycardia so at that time operative vaginal delivery was performed; do you see that?

A. Yes.

Q. Do you recall that the fact that the fetus developed bradycardia was the reason as to why operative vaginal delivery was performed?

A. I do not recall that.

Q. Based on what you reviewed here in the discharge summary, does that seem to be the case?

A. There is a controversy between the discharge

summary and nurses' notes so I don't know what the case was.

Q. You told me you can't really tell whether the fetal bradycardia existed based on the nurses' notes?

A. Exactly.

a. Based on what she said --

MR. NORCHI: I'm going to object to the conclusion you drew from the testimony, Romney, only because he said he can't tell what occurred, the nursing notes indicate there wasn't fetal bradycardia, true fetal bradycardia, are we on the same page?

MR. CULLERS: I'm not sure 1 follow you. I hear what you are telling me, I'm not sure if that is consistent with what he said earlier.

MR. NORCHI: What he said earlier was that nursing notes do not show fetal bradycardia.

MR. CULLERS: He told me he can't tell by looking at the nursing notes whether fetal bradycardia existed. I understand the reason is it's not indicated in there.

THE WITNESS: That's the same

thing. I can't tell if the bradycardia is there, bradycardia in the nursing notes, so I can't.

MR. NORCHI: Absent evidence that there was fetal bradycardia.

THE WITNESS: There is no evidence there was bradycardia in the recording in the nurses' notes.

MR. NORCHI: I don't know if it is a minor quibble.

MR. CULLERS: I understand.

MR. NORCHI: What Dr. Krietsky means is fetal bradycardia, the note the fetal heart beat is 130 to 90, maybe that is a trend she identified, we don't as we sit here know what she was thinking.

MR. CULLERS: I'm asking if he knows what was going on here?

THE WITNESS: I don't,

MR. NORCHI: That is kind of broad. I want to clarify that for the record we -- although we're talking about the same thing --

MR. CULLERS: What I'm trying to figure, I'll say to you, Kevin, for the record, is whether or not he remembers the development of fetal bradycardia as being the reason for the

operative delivery taking place. Sounds like he doesn't remember.

THE WITNESS: I don't remember.

MR. CULLERS: I'm asking him to read this based on his review of the discharge summary and some of the chart portions we went over, does that indicate to him that fetal bradycardia was in fact part of the reason as to why the operative vaginal delivery was done?

MR. NORCHI: That's fine.

Q. Let me ask you this question, let me ask you to tell me: By reviewing the discharge summary and the chart, are you able to tell me with any certainty as to whether the development of fetal bradycardia by the fetus was a factor in the decision to do the operative vaginal delivery?

A. I can't tell you with any certainty, no.

Q. There is certainly no way you can tell me it's a critical issue in the decision to deliver?

A. What was a critical issue?

Q. Bradycardia?

A. No, I can't tell you it was a critical issue.

Q. Why was the patient not permitted to continue in labor at 8:53?

A. Obviously based on the chart there was a concern, we had done four or five scalp gases to identify the acidemia, they were fine, the plus 3 station she was having variable decels, she was according to the nurses' notes not having a -- not wonderful tracings, not a perfect labor at that point in time, no point in waiting if you can do an easy operative delivery at a plus 3 to deliver the baby, get him in the hands of the pediatrician instead of waiting.

Q. Let me think about what you said.

Let me ask you some follow-up questions. When I asked you why the patient wasn't permitted to continue in labor you said several things, I want to try to clarify some of it for my own understanding.

One thing I think you said was the baby appeared to be fine?

A. I don't recollect, I remember saying the scalp gases showed there was no significant sign of acidemia up to that point.

Q. What does that indicate to you?

A. That the baby didn't have acidemia, I can say there was no sign of significant acidemia.

Q. The no significant sign of acidemia, what

does that tell you about the status of the fetus?
A. That there is no sign -- fetal scalp gases and acidemia is telling you about the baby's heart, lungs. Status is a bad word.
Q. What did you say acidemia?
A. The pH.
MR. NORCHI: He asked you acidemia.
A. Yes.
Q. You said the pH value shows what?
A, No significant sign of acidemia.
Q. If the scalp gases show no sign of significant acidemia, why is that significant to you when you are trying to determine whether or not an operative delivery will be performed?
A. Because if the gases are below 7.20, as you said before, it's imperative to deliver the baby as soon as possible.
Q. But they weren't 7.20 or below?
A. They were not.
Q. If they are above 7.20 how's that significant in your determination?
A. I see what you are getting at. It wasn't -- it wasn't pushing me to be very aggressive. As I said before, the way I practice OB, if the person

has a concerning tracing, she is plus 3 station, we can easily speed up the delivery by 10 or 15 minutes, I do that. I think it's in the best interest of the mother and the baby.

Q. At the time that the decision was made to intervene and do the operative delivery --

A. Yes.

Q. -- was the fetal tracing not reassuring?

A. No, I don't know. Reassuring? I think it was concerning.

Q. It was concerning?

A. Yes.

Q. You didn't consider the scalp gases to provide information that would cause you to feel like you need to be aggressive in the delivery?

A. That's true. I don't consider what we did to be very aggressive. I think very simple plus 3 delivery, it's operative, obviously we got involved, I don't consider it to be aggressive at all. Simply make the patient's labor a little quicker, that is why we did it.

Q. Quicker?

MR. NORCHI: There is that word again.

A. It sped up the second stage of labor, made it

short. It was very easy to do a simple procedure at plus 3 station. I don't consider that to be very aggressive.

Q. Prior to that point what was the speed of the second stage of labor, the vacuum assisted delivery sped it up, what was the speed of it before that point?

A. I don't know.

Q. We talked about that.

A. It was a seasonable second stage.

Q. You now said the use of vacuum sped it up?

A. It did speed it up even more.

Q. What was the speed of it before that, was it moving slow, needed to be sped up?

A. No, if it's equivocal scalp gases I'm not going to do another scalp gas at plus 3 station. Why do an invasive procedure that doesn't deliver the baby when we can do a procedure and deliver the baby.

Q. Is there a reason you would not have expected the baby to deliver on its own?

A. It would have delivered on its own.

Q. Any season why you wouldn't have expected the delivery to occur within a half an hour?

A. I don't know how long it would take. There

is no reason to think it would be more than half an hour, yes.

Q. Did you have any reason to believe if you didn't intervene there would be a problem if the labor was allowed to continue?

A. I simply felt that doing another scalp gas was -- I would rather have done an easy operative delivery than put the baby through the entire scalp gas, entire interpretation of blood on the baby's scalp gas.

Q. If you allowed the baby to continue, you would have had to do another scalp gas?

A. Yes, I would have done another scalp gas.

Q. Because the time --

A. An equivocal range, you follow the trend, I'm not going to have big gaps of time the baby would be decompensating, we wouldn't know,

Q. So, let me think about this for a minute.

A. I'm trying to be clear, it's hard.

Q. You are all right. From what you are saying it sounds like in your mind the decision to do the operative delivery was more beneficial than waiting and doing another scalp gas?

A. I don't know it was more beneficial. I think it makes more sense to me clinically.

Q. Clinically makes more sense to you to proceed with an operative delivery than to wait and do another scalp gas?
A. In this situation in a person that is crowning, yes.
Q. What is crowning?
A. Plus 3 station.
Q. When you are making that choice of either intervening with the vacuum when the patient is crowning or to wait and do another scalp gas, do you take into consideration whether or not you expect the baby to be large?
A. I don't think at that point, no, I don't at plus 3 station, I don't think I take that into account. The baby's head already entered the pelvis, it's hard to say what goes through your head, it's innate, everything is thought, at that point I don't think I was worried about size of the baby.
Q. You weren't?
A. No.
Q. You don't think that you considered the size of the baby at the time that the intervention with a vacuum was done?
A. It was considered, it's a factor. The baby

was large, you don't make a decision whether or not you are going to do something on one particular instance. You have to formulate a scenario, she was plus 3 station, she brought the baby's head down well, she would have delivered on her own if we wait, it was the scenario of putting her through more testing of the baby for acidemia when we could deliver the baby in two or three minutes, which we did.

Q. Could you go to the nurses' notes, the labor notes at the time of delivery, 8:53.

A. Yes.

Q. I note that at nine o'clock it says head out, nuchal times one reduced, see that?

A. Yes.

Q. Says difficulty with shoulder; do you see that?

A. Yes.

Q. Do you recall anything about having difficulty with the baby's shoulder in this case?

A. I don't recall.

Q. In the next note it says delivery of male infant with shoulder dystocia; do you see that?

A. Yes.

Q. Does that mean this baby's shoulder was

stuck?

A. I don't think this baby's shoulder was stuck. The head came out in under a minute, the shoulder came out in under a minute. I don't consider -- shoulder dystocia is a very broad word. If anything we could use a very mild or none at all based on time frame. I don't recollect directly.

Q. What is mild or none at all?

A. The only thing we did, the baby was felt to be large, we simply did suprapublic pressure, put the bed down, put her in McRoberts, the baby came out.

Q. When you said mild, what were you talking about, what noun were you describing with the adjective mild, the degree of stuckness so to speak?

A. I don't think it was stuck.

Q. Something happened where his head came out, the rest of him didn't come out?

A. That always happens with deliveries.

Q. Somebody said shoulder dystocia?

A. Yes, somebody said that.

Q. When I was asking you about whether or not he was stuck you said no, you said mild, what was

mild?

A. I don't think -- we're getting caught in semantics.

I don't think the baby as stuck at all. Any time you do a delivery the head comes out, the shoulders are the biggest part, you do manipulation to deliver the baby. Babies don't come flying out usually. The nurse chose the words shoulder dystocia, I don't think it was shoulder dystocia. A normal delivery of a larger baby. To me shoulder dystocia -- the sequence of events does not imply shoulder dystocia.

Q. Even though it says difficulty with shoulder?

A. Does not mean shoulder dystocia, that means difficulty with shoulder.

Q. The fact the nurse wrote shoulder dystocia, that doesn't imply shoulder dystocia?

A. If you assume, if you accept what she said which I necessarily don't, it would have to be mild if anything because it was such a --

Q. It would be -- what would be mild?

A. The shoulder dystocia. I don't think there was one. If you want to accept this, then be that as it may, we have to deal with what is recorded, I don't think there is shoulder dystocia. I think

it was difficulty delivering a shoulder, which happens quite often.

Q Do you have any information about this infant's condition after birth?

A. No.

Q Are you aware that he had -- he was noted to have some difficulty with his left arm, do you know anything about that?

A Somewhere I read, I don't know where, there was an Erb's palsy. I don't know where I read that, later on.

Q. Do you know what Erb's palsy is?

A. Yes, I do.

Q. What is it?

A. It's weakness in the arm that usually resolves.

Q. What causes it to happen?

A. I don't know. I'm not expert on Erb's palsy.

Q. Do you know anything about how it can happen?

MR. NORCHI: Object to the line of questioning because he just told you he's not expert.

A. I don't know much about Erb's palsy.

MR. NORCHI: We've already established that. Then the question what he thinks

about Erb's palsy, it has no evidentiary basis, the concern is the delivery and quality of care of the child subsequently.

MR. CULLERS: I think it does.

MR. NORCHI: I'm not telling him not to answer.

MR. CULLERS: I want to put on the record we know that Erb's palsy can come from trauma at birth, as a complication of shoulder dystocia. If he doesn't, that's fine8

THE WITNESS: I don't know there is shoulder dystocia here.

MR. NORCHI: Let him ask a question, Doctor, then you can respond to it if you can.

Q. Is it true that Erb's palsy can result from a brachial plexus injury that occurs at birth as a result of shoulder dystocia?

A. Yes, that's true.

Q. You don't believe it happened in this case?

A. No.

Q. The reason you don't believe it happened in this case is because you don't believe there was shoulder dystocia?

A. That's true.
Q. What is your professional address?
A. What do you mean professional?
Q. Office address?
A. Right now that's a good question. I'm doing locum tenens here in Elyria, I work at Northcoast OB/GYN.
Q. What is locum --
A. Locum tenens, which I was at a prior practice in Columbus, I decided that I was going to move out west, I did a temporary job, six months waiting for my wife to finish her Fellowship.
Q. What was the practice in Columbus?
A. Central Ohio Medical Group.
Q. Central Ohio?
A. Medical Group.
Q. How long did you practice with them?
A. Three years.
Q. I take it you started with them right when you finished your residency training?
A. Yes, I did.
Q. Your residency training was all done at University Hospitals?
A. University Hospitals.
Q. How long were you with these guys in

Columbus, three years?
A. Yes, three years.
Q. Up here?
A. For six months.
Q. Then where are you going?
A. We haven't decided yet.
Q. You are moving out of state?
A. We don't know. I have some job offers. Every day I get more offers, what I'm doing depends on my wife. She is finishing her Fellowship, whereever she gets a job we will go.
Q. You don't know the address of this place?
A, That's pretty sad, no, I don't.
Q. I want to have it on the record.
A. Northcoast OB/GYN, 125 East Broad Street, Suite 201, Elyria, Ohio 44035. I've only been here a few weeks,
Q. As of March, 1995 can you tell me the number of operative vaginal deliveries you were involved in?
A. I have no idea.
Q. Hundreds?
A. No, not hundreds.
Q. Dozens?
A. Dozens.

Q. Can you tell me the number of vacuum assisted deliveries?
A. In the last --
Q. As of March, 1995?
A. Since then on?
Q. No, as of the time you were involved in this patient.
A. How much up to there?
Q. Yes.
A, I would say between 50 and 100.
Q. How many operative vaginal deliveries had you been involved in that involved shoulder dystocia?
A. I really don't know. I would say over 20.
Q. Were you ever involved in operative vaginal deliveries as of March of '95 which involved shoulder dystocia and accompanying brachial plexus injury?
MR. NORCHI: Up until March of 1995?
A. No, I was not.
Q. I'm not excluding March. I'm not saying up until the last day of February.
A. No, not involved with shoulder dystocia that involved brachial plexus injury.
Q. Were you involved in any operative deliveries

that involved an Erb's palsy later that developed?
A. I don't know.
Q. Have you ever been named as a defendant in a lawsuit other than this one?
A. No.
MR. NORCHI: Objection. Go head, you can answer.
A. No.
Q. Have you ever given your deposition before?
A. No.
Q. Today was the first one?
A. Yes.
MR. CULLERS: Let me look over my notes, we will be done.

(Discussion had off the record.)

MR. CULLERS: I don't want to ask anything else.
MR. NORCHI: I would like the doctor to read the transcript of his deposition. We won't waive signature.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

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

_____

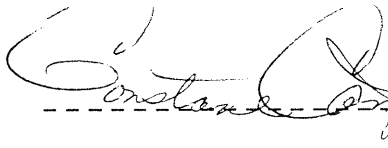
DAVID GOLDFARB, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 19th day of February, 1998.



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

Look-See Concordance Report

- - -

UNIQUE WORDS: **1,036**
TOTAL OCCURRENCES: **3,898**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **12,623**

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

PHRASE WORD LIST(S):

- - -

NOISE WORD LIST(S): **NOISE.NOI**

- - -

COVER PAGES = 4

- - -

INCLUDES ONLY TEXT OF:
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

- - -

DATES **ON**

- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE FORMS **ON**

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **3**

- - -

LIST OF THRESHOLD WORDS:

- - -

baby [75]
delivery [84]
labor [56]

* * DATES * *

3-13-95 [3]
35:5, 6, 9
February [1]
76:22
March [3]
10:21; 76:15, 21
March, 1995 [2]
75:18; 76:4
March 14th [1]
26:14
March of 1995 [1]
76:18

* * 1 * *

1 [15]
30:4, 6, 7, 76, 20, 22; 31:2, 9, 21; 32:3; 42:24; 43:10, 19; 44:4, 8
10 [2]
16:20; 65:2
100 [1]
76:10
11:40 [2]
39:7, 8
125 [1]
75:15
12:44 [1]
35:1f
130 [1]
61:13
14th [1]
26:14
15 [2]
16:9; 65:3
1995 *[3]*
75:18; 76:4, 19

* * 2 * *

2 [7]
21:19; 30:5, 16; 36:8; 37:12; 44:4, 8
20 [7]
16:9; 48:25; 51:20; 52:3, 4; 76:13
201 [1]
75:16
2041 [1]
35:15
23 131
42:2; 46:4, 18
24 [1]
46:4
26 [2]
42:2; 46:19
2:00 [1]
27:14
2:07 [1]
40:2

* * 3 * *

3 [26]
21:19; 29:16, 20; 35:21; 36:1, 8; 37:11, 13, 18, 20; 39:20, 23; 42:13, 19, 25; 43:10, 23; 63:3, 8; 65:1, 17; 66:2, 16; 68:7, 14; 69:4
3-13 [1]
38:3
3-13-95 [3]
35:5, 6, 9
30 [5]
44:20; 49:1; 51:20; 52:4
3:00 [1]
28:19

* * 4 * *

4 [12]
35:22; 36:1; 37:11, 18, 20; 38:7; 39:20, 21, 23; 40:3, 7, 16
4,167 [1]
15:16
4,500 [2]
15:17; 17:1
40-2/7 [1]
13:13
41 [2]
36:14, 16
4100 [1]
14:19
4137 [1]
14:21
42 [2]
36:14, 16
44035 [1]
75:16
4500 [3]
14:12, 13; 16:20
4:00 [1]
28:20

* * 5 * *

5 [5]
38:7; 39:20; 40:3, 7, 17
50 [1]
76:10
5:00 [1]
29:11
5:30 [1]
29:11

* * 6 * *

6:00 [1]
29:11

* * 7 * *

7.20 [9]
48:25; 49:2, 13, 23, 25; 52:25; 64:16, 19, 21
7.23 [1]
53:12
7.25 [3]
48:25; 49:25; 51:16
75 [2]
36:3; 37:13
7:00 [7]
31:4, 18, 19; 32:10, 14; 54:20, 23
7:15 [1]
6:12
7:20 [3]
48:8; 53:24; 54:9
7:21 [3]
31:4; 48:6; 57:5
7:30 [1]
54:23
7:35 [1]
6:19
7:45 *[2]*
6:12, 19
7:48 [12]
6:13, 17; 7:3, 10, 18; 8:2; 17:20; 18:8; 19:1; 48:3, 10; 58:13

* * 8 * *

8:00 [1]
32:14
8:30 [2]
43:18; 57:3
8:35 [6]
10:13, 15, 17; 41:18; 42:24; 43:9
8:41 [4]
35:18; 39:6, 8, 17
8:46 [2]
57:23; 58:13
8:48 [1]
48:19
8:53 [11]
10:10; 22:22, 24; 23:2, 6; 42:22, 25; 43:10; 57:4; 62:25; 69:11

* * 9 * *

90 [1]
61:13
90's [1]
57:25
95 [2]
10:21; 76:15

* * C * *

* * D * *

* * E * *

* * F * *

* * G * *

* * M * *

* * N * *

* * Q * *

* * R * *

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* * U * *

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