

THE STATE of OHIO,
COUNTY of CUYAHOGA.

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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.

PAGE

Cross-examination by Mr. Cullers

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(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

1 DAVID GOLDFARB, M.D.

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

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8 CROSS-EXAMINATION

9 BY MR. CULLERS:

10 Q. State your full name, please.

11 A. David Benjamin Goldfarb.

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

15 A. Okay.

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

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

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

1 absolutely none.

2 Q. You reviewed the chart?

3 A. Urn-hum.

4 Q. I need you to answer yes.

5 A. Yes, I have.

6 Q. When did you review the chart?

7 A. When I first got the letter.

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

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

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

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

17 Q. Did you review any deposition transcripts?

18 A. No, I have not.

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

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

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

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

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

5 Q. I appreciate that.

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

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

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

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

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

1 on someone's verbal transfer. It's done orally.

2 Q. Can you tell from looking at the nursing
3 notes following the 7:48 entry that your name
4 appears up through the point of the delivery?

5 A. Urn-hum.

6 Q. I need you to say yes.

7 A. Yes, that is my job, I was there.

8 MR. NORCHI: Just answer his
9 question.

10 Q. It's likely that between 7:48 and the time of
11 delivery that you were consistently there in the
12 operating room?

13 A. I don't know if I was there the whole time.
14 I was there certain times. I'm managing multiple
15 patients, obviously that wasn't the only patient.
16 I was there, with the record I can assume.

17 Q. It wouldn't be uncommon for you to be in and
18 out of the room from 7:48 up until the time of
19 delivery?

20 A. I don't know.

21 Q. You said you --

22 A. I was there helping the second year
23 resident. As chief resident I'm responsible for
24 many things, I'm there whenever I feel it's
25 necessary.

1 Q. You could have been in and out of the room
2 between 7:48 and the time of delivery?

3 A. I was in and out, it was obviously reported
4 that way, but I don't remember.

5 Q. You were the chief, right?

6 A. Um-hum.

7 Q. Can you explain, is that the fourth year
8 resident?

9 A. All fourth year residents are considered to
10 be chief when they are on service.

11 Q. Can you tell me how your role differed from
12 the second year resident, Dr. Krietsky?

13 A. The only difference in roles is I'm
14 supervisory. I cover not only labor and delivery,
15 I'm responsible for multiple patients.

16 Dr. Krietsky is assigned to labor
17 and delivery, focuses on one particular area. I'm
18 there to supervise her, educate her, help her with
19 anything to teach her.

20 Q. She focuses on the delivery aspect of
21 treating this particular patient?

22 A. We're both working with patients, she is more
23 directly -- she is more -- less responsibility.
24 She is focused on just labor and delivery, I'm
25 there to help supervise or train her, make sure

1 things run smoothly.

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

5 A. Multiple patients.

6 Q. Your role is broader --

7 A. Yes.

8 Q. -- than just labor and delivery?

9 A. Yes.

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

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

14 A. Yes.

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

18 A. Urn-hum.

19 Q. I need you to say yes.

20 A. Yes.

21 Q. Do you know Dr. Cynthia Austin?

22 A. Yes.

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

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

1 Q. You can see she was involved by review of the
2 notes, can't you?

3 A. Yes.

4 Q. Is there any way you can tell me by reviewing
5 the notes, either progress notes or the nursing
6 notes, exactly when Dr. Austin was in the room with
7 the patient?

8 A. The only thing I can rely on is the nursing
9 notes. I could not tell exactly. The only time
10 8:53 Dr. Austin present for delivery, that is the
11 only thing I can rely on concerning Dr. Austin's
12 involvement in the room.

13 Q. If you look up earlier I think at 8:35
14 Dr. Austin aware of something, it says that?

15 A. Yes, Dr. Austin made aware at 8:35.

16 Q. That doesn't necessarily mean she was in the
17 room at 8:35?

18 A. No, she could have come in any time until the
19 nurse reports, I have no way of recollecting when
20 she was there.

21 Q. Tell me about in March of '95, around that
22 time frame how you would normally interface with
23 the attending?

24 A. It's pretty well described. The attending is
25 there to be called for any questions, any dilemmas,

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

4 Q. What procedures, what are you referring to?

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

9 Q. Would that include a scalp gas?

10 A. No.

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

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

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

24 A. Absolutely not.

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

1 it?

2 A. That is how it should be.

3 Q. That is what happened here?

4 A. Yes, that is how it happened here.

5 Q. When an operative delivery is being
6 contemplated --

7 A. Yes.

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

11 A. Absolutely.

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

16 A. In this particular case or any case?

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

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

1 circumstance.

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

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

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

10 Q. The typed operative note.

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

15 Q. Part of the diagnosis was macrosomia?

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

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

21 A. Yes, according to Dr. Krietsky.

22 Q. What?

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

25 Q. Also according to this operative note,

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

3 A. Yes.

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

8 A. Yes.

9 O Explain why you don't believe the baby as
10 macrosomic.

11 A My definition of macrosomia is a baby over
12 4500 grams. Based on the size of this baby, based
13 on the 4500 grams, I feel the baby was large, I
14 don't feel this would be macrosomic. I think that
15 was a choice of words that was used in her
16 dictation.

17 Q How much did this baby weigh?

18 A I'm not completely sure, recollection I think
19 4100; is that right? I'm relying on -- I'm sure
20 it's reported in the nursing notes, hold on. Here
21 it is, baby weighed 4137 grams.

22 Q. According to your definition of macrosomia --

23 A. That would not qualify as macrosomia.

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

1 born?

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

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

9 A Urn-hum.

10 Q You have to say yes.

11 A. Yes.

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

4 A. Yes.

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

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

20 Q. No way you could do that accurately?

21 A. No.

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

25 A. Yes.

1 Q. One of those would be a sonographic estimated
2 fetal weight?

3 A. Yes.

4 Q. That wasn't done in this case, was it?

5 A. Not from the chart, it does not look like
6 it.

7 Q. Is a sonographic estimated fetal weight test
8 accurate in diagnosing macrosomia?

9 A. Not very accurate, an almost 15 to 20 percent
10 error.

11 Q. Do you think that prior to labor and delivery
12 it's important to estimate the fetal weight?

13 A. Not usually, unless you are suspicious for a
14 very large baby. I don't think it has a
15 significant value. You are going to let them
16 labor, see how they do.

17 Q. How large of a baby do you need to anticipate
18 before it becomes important to estimate a fetal
19 weight?

20 A. The way I practice 4500 grams, 10 pounds or
21 more I get an ultrasound in practice.

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

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

1 more than 4,500 grams?

2 A. Experience feeling the baby, using my skills
3 to know what that baby is.

4 Q. What are those tests?

5 A. The only test I use is the Leopold maneuver.
6 You manipulate the baby during the pregnancy to see
7 how big it feels. Based on that, the thousands and
8 thousands of times you do that, see the delivery,
9 see how you feel relates, you develop your own
10 system for estimating what you think the baby may
11 weigh.

12 Q. Based on your review of the chart, it isn't
13 documented whether an estimated fetal weight was
14 done at all in this case; is that true?

15 A. Yes, that's true. I didn't see any
16 documentation.

17 Q. Prior to labor and delivery, were you aware
18 that this was a gestational diabetic pregnancy?

19 A. No, I was not aware.

20 Q. When you came on at 7:48 I take it that you
21 are updated on the patient's progress?

22 A. I know what transpired that morning
23 obviously, it's a short period of time of transfer
24 of patient, I don't know if I was related that she
25 was gestational diabetic. I assume I probably

1 was. No way of being sure of that.

2 Q. That is what I want to know: Is that likely
3 something that would have been related to you when
4 you came on?

5 A. I don't know.

6 Q. Would it have been something that would have
7 been important for you to know when you came on
8 at 7:48?

9 A. Based on the situation I walked into, I don't
10 know whether I think it was important how we
11 managed the patient's labor, no. I was going to go
12 in and assess the patient myself. When I walked in
13 to see the patient, that is when I take over
14 control. Knowing she was a diabetic wasn't going
15 to change something in a hard labor, delivery
16 within an hour of me entering the room.

17 Q. Are gestational diabetic pregnancies more
18 likely to yield a large baby?

19 A. If they are poorly controlled gestational
20 diabetic more likely. Well controlled, studies
21 show they are not at increase for a macrosomic
22 baby.

23 Q. In your review of the chart was she well
24 controlled?

25 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

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

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

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

12 A. I don't know.

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

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

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

22 A. Yes.

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

1 whether the fetopelvic disproportion is present?

2 A Yes, it's important.

3 Q. Why?

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

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

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

1 Q. Do you specifically recall you delivered very
2 easily?

3 A. I don't recall. I can only relate to time
4 frame, what I read.

5 Q. Your determination that it was relatively
6 easy to deliver the baby is based on the time frame
7 in which the delivery occurred?

8 A. Based on the time frame and how things
9 transpired, based on my entering sequence of time,
10 because it was such a smooth delivery based on the
11 assessment of the chart, not direct recollection.

12 Q. What sequence of time are you referring to?

13 A. I'm referring to the point that she --
14 according to the nurse's record, the baby delivered
15 by three pulls with contraction; baby's head
16 delivered head out with three pulls, nuchal cord
17 reduced, baby completely out one minute later which
18 is more than a very reasonable period of time, less
19 than a minute from the head to the rest of the
20 body.

21 Q. Is the first reference to the three pulls
22 at 8:53?

23 A. The first reference to the three pulls, all 1
24 can see is Dr. Austin was here at 8:53. First the
25 patient is pushing, you pull with contractions to

1 help guide the head out.

2 Q. The first pull with a vacuum is at 8:53?

3 A. According to the chart, yes.

4 Q. Based on what you were saying earlier about
5 the time frame, that allows you to conclude this
6 was a relatively easy delivery starting at 8:53?

7 A. No, I didn't say a relatively easy delivery.
8 I don't know that any delivery is easy. It took
9 three pulls, three contractions, that is a very
10 reasonable amount of time considering operative
11 delivery.

12 Q. Do you think it was an easy delivery?

13 A. I don't know. I think it was a reasonable
14 delivery. Are you asking about the patient? I
15 don't know if the patient --

16 Q. No.

17 A. I think it was a very smooth delivery. I
18 don't think the word easy -- I think it went
19 without complication.

20 Q. The reason I was using the word easy is when
21 you first started telling me you said easy.

22 A. Yes, that was a very smooth delivery based on
23 the records.

24 Q. I don't want to get hung up on semantics.

25 A. That is exactly true.

1 Q. You said easy, now you are saying smooth.
2 I'm trying to get an idea how you characterize the
3 difficulty in delivering the baby, that is all?

4 A. Doesn't appear that was difficult beyond the
5 use of an operative delivery made it a little more
6 challenging. No, I don't think it was a difficult
7 delivery.

8 Q. Is part of the reason that the attending is
9 required to be there during an operative delivery
10 is because an operative delivery can be more
11 challenging than a regular delivery?

12 A. Yes.

13 Q. It's more likely for complications to arise
14 in an operative delivery than a nonoperative
15 delivery?

16 MR. NORCHI: Objection. You
17 can answer. Go ahead.

18 A Yes, that's true.

19 Q It's true that with an operative delivery
20 it's more likely that an injury can occur to the
21 fetus than a nonoperative delivery?

22 MR. NORCHI: Objection. If
23 you know. These are expert questions, you can base
24 them on your experience and expertise if you know.
25 If you have an answer to the question, provide it.

1 I'm just objecting to the nature of the question.

2 A. I think I answered. I think there is more
3 risk of complications with any manipulation of any
4 baby rather than a completely natural delivery.
5 Higher risk of episiotomy, small risk, I don't
6 consider them a long-term risk, increased getting
7 more involved with a delivery.

8 Q. Is there increased likelihood of an injury to
9 the fetus when it's an operative delivery as
10 opposed to a delivery not involving instruments?

11 MR. NORCHI: I object to the
12 term likelihood. Is it probability you're
13 establishing, basic probability in your question,
14 increasing the probability?

15 THE WITNESS: I don't know.

16 MR. NORCHI: I don't want to
17 tell you how to ask questions, I believe an
18 increased risk is the way it's usually
19 characterized.

20 Q. Is there an increased risk of injury to the
21 fetus when an operative delivery is attempted as
22 opposed to a delivery that doesn't involve the use
23 of instruments?

24 A. Yes.

25 Q. You were talking about certain aspects of

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

3 Can you go to the progress of labor
4 chart.

5 A. Where is that?

6 Q. In the labor notes.

7 A. Is this it?

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

11 A. Yes.

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

15 A. According to this chart, yes.

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

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

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

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

1 didn't change.

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

4 A. Do I have an opinion?

5 Q. Yes.

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

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

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

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

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

21 A. Okay.

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

23 A. Okay.

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

1 A. Urn-hum.

2 Q. I need you to respond yes, please.

3 A. Yes.

4 Q. The purpose is obviously to monitor the
5 strength of contractions?

6 A. Yes.

7 Q. Can you look at the following two or three
8 notes, tell me if that information about the
9 strength of contractions indicates to you that the
10 patient was in active labor?

11 A. What was the question again?

12 Q. Can you look at the information that is
13 contained in the nursing notes at three o'clock and
14 four o'clock, tell me if based on that information
15 you feel confident in --

16 A. No, I can't.

17 Q. I need to finish my question.

18 You can't tell from the information
19 contained in the nursing notes between 3:00 a.m.
20 and 4:00 a.m. whether this lady was in the active
21 phase of labor?

22 A. I cannot.

23 Q. What information do you need to be able to
24 figure that out?

25 A. The information I need to know is how strong

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

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

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

12 Q. At that point she is in active labor?

13 A. Absolutely.

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

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

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

22 A. Yes.

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

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

1 that.

2 Q. Can you refer to that, please?

3 A. Yes.

4 Q. Station reported zero to plus 1?

5 A. Dr. Krietsky plus 2 station, you are saying
6 zero to plus 1.

7 Q. Station is zero to plus 1?

8 A. It's hard for me to say, I didn't do the
9 exam.

10 Q. That is what that says?

11 A. What Dr, Krietsky believes. I said before
12 station and dilatation, effacement are very
13 subjective terms.

14 Q. I understand that.

15 A. Based on her assessment of the caput was a
16 plus 2, station was zero to plus 1, I did not
17 record an exam, I don't know.

18 Q. Based on what you reviewed in Dr. Krietsky's
19 note at eight o'clock, she believed the station was
20 somewhere between zero and 1?

21 A. Yes, she did believe that.

22 Q. Zero to plus 1; is that right?

23 A. Yes.

24 Q. We know by looking at the progress of labor
25 chart someone reports station at seven o'clock a.m.

1 to be at zero; is that correct?

2 A. Says zero to 1 plus based on Dr. Radke's note
3 at seven o'clock.

4 Q. That is not 7:00, 7:21?

5 A. Sorry.

6 Q. If you go back to the note at seven o'clock
7 by --

8 A. Yes.

9 Q. Says plus 1, doesn't it?

10 A. Yes, it does.

11 Q. If you look at the nurses' note at
12 seven o'clock Dr. Segal is reported to have been in
13 the room, reported station at zero; is that true?

14 A. That's true,

15 Q. So we know that at least Dr. Segal indicated
16 in two places in the record, one at seven o'clock
17 and one at --

18 A. At 7:00.

19 Q. Two places at 7:00 indicates his
20 determination of station, one says zero, one says
21 plus 1?

22 A. That's right.

23 Q. Based on what we observed in Dr. Krietsky's
24 note, her determination of station at
25 eight o'clock, is it fair to say station has not

1 progressed during that one hour period?

2 A. Well, unless -- I don't know if it was fair
3 to say that if Dr. Segal was zero, she was plus 1,
4 then it had changed. There is a big discrepancy
5 here. You have two exact time frames with two
6 different stations. There is no way of knowing
7 which one is accurate, knowing if Dr.

8 Krietsky is accurate because it's so subjective.

9 Q. Do you feel confident in saying that in fact
10 station did change one centimeter between 7:00 and
11 eight o'clock?

22 A. I don't feel confident saying either way.

13 Q. Can you say station changed a centimeter
14 between 7:00 and 8:00?

15 A. No, I don't think I can say that.

16 Q. If you go back to the progress of labor
17 chart, if you would, where it says intrapartum
18 problems, says in the space abnormal labor; do you
19 see that?

20 A. Yes.

21 Q. Directly next to that says protracted?

22 A. Yes.

23 Q. Isn't the definition of protracted descent
24 contained on the chart?

25 A. I don't think you can make the diagnosis like

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

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

12 MR. NORCHI: Do you
13 understand the question?

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

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

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

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

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

3 A. Yes.

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

6 A. Yes.

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

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

15 Q. What was the purpose of that?

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

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

21 A. No.

22 Q. You don't have that opinion?

23 A. I don't have that opinion.

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

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

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

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

7 Q. The top left corner of the screening room
8 flow sheet indicates that -- first of all dated
9 3-13-95?

10 A. Yes.

11 Q. The patient is in at 12:44?

12 A. Yes.

13 Q. That would be a little after noon?

14 A. Noon.

15 Q. She is out at 2041, right?

16 A. Yes, true.

17 Q. About eight o'clock or so?

18 A. 8:41.

19 Q. If you look down to the middle where it says
20 notes, it indicates that there was a vaginal exam
21 and the patient was reported to be 3 to
22 4 centimeters dilated; is that correct?

23 A. Yes.

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

1 dilated 3 to 4 centimeters?

2 A. Yes.

3 Q. Effacement 75 percent?

4 A. Yes.

5 Q. Station at first indicated at floating

6 station, that is marked out?

7 A. Yes, that's true.

8 Q. Minus 2, minus 3?

9 A. Yes.

10 Q. High station?

11 A. Yes.

12 Q. At that point the baby's head is not engaged?

13 A. Yes.

14 Q. Fundal height 41 to 42 centimeters?

15 A. Yes.

16 Q. Is a fundal height of 41 to 42 centimeters

17 indicative of a large baby?

18 A. No.

19 Q. It is not?

20 A. No.

21 Q. Can you look up here, in the center of the

22 notes where some of the exam findings are noted,

23 says irregular uterine contraction; do you see

24 that?

25 A. Yes.

1 Q. What does that mean, why is that significant?

2 A. Simply a report that the patient was having
3 irregular uterine contractions.

4 Q. Why is that something that is significant?

5 A. I don't know if it's significant, you report
6 what is is going on. She is having irregular
7 contractions.

8 Q. You don't attach any specific significance?

9 A. No, irregular uterine contracts are totally
10 normal during pregnancy.

11 Q. If a patient presents, is 3 to 4 centimeters
12 dilated, the fetus is at a high station, minus 2,
13 minus 3, effacement 75 percent, does that suggest
14 fetopelvic disproportion?

15 A. No.

16 Q. Does it indicate anything of significance?

17 A. Doesn't indicate anything of significance
18 other than the situation she was 3 to 4 centimeters
19 dilated, not having regular contractions.

20 Q. Do you expect an a lipara who is 3 to 4
21 centimeters dilated is having irregular
22 contractions, to have the fetal head engaged?

23 A. Every pregnancy is different. There is no
24 way of making any general estimate when it comes to
25 pregnancy, engagement is relative to each

1 individual.

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

5 A. I have no idea --

6 MR. NORCHI: I'll show you.

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

8 A. Yes.

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

11 A. Yes.

12 Q. You disagree she was in early active labor?

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

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

18 Q. Which is what you said earlier, right?

19 A. Yes.

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

24 A. Repeat the question.

25 Q. You can see from looking at the screening

1 room flow sheet she had left the hospital a couple
2 of hours before?

3 A. That's true.

4 Q. The information is written in here at
5 midnight, true?

6 A. She left at 8:41 then comes back at midnight,
7 11:40.

8 Q. Left at 8:41, comes back at 11:40?

9 A. Three hours later.

10 Q. Can you tell by looking the data when she
11 left at 8:41 to the data when she comes back at
12 midnight, tell me what has changed in her general
13 situation?

14 A. I can't tell a big difference, what changed.
15 According to Dr. Segal there is no contraction
16 pattern, I can't tell you how often she is
17 contracting or anything else.

18 Q. As far as you can tell from looking at these
19 particular notes, no appreciable change?

20 A. She is 4 to 5 centimeters, rather than 3
21 to 4, that's an appreciable change.

22 Q. If at that time, midnight, if she is a high
23 station, she is 3 to 4?

24 A. We don't know she is a high station.

25 MR. NORCHI: Let him

1 finish. It's easier when you prepare an answer.

2 Q. Go down to 2:07 a.m., Doctor, vaginal exam
3 reported at 4 to 5 centimeters, zero station?

4 A. Yes.

5 Q. Is zero station a high station?

6 A. No.

7 Q. If an a lipara is 4 to 5 centimeters dilated,
8 high station, had some contractions, does that
9 imply fetopelvic disproportion?

10 A. No.

11 Q. Is it consistent with fetopelvic
12 disproportion?

13 A. I don't know. I don't think the question is
14 what is consistent.

15 Q. Is the fact that the baby's head is at a zero
16 station, in conjunction with the fact she is 4 to
17 5 centimeters dilated, having contractions,
18 consistent with fetopelvic disproportion?

19 A. I don't think so, no.

20 Q. I would like you to look back at the progress
21 of labor chart.

22 A. Okay.

23 Q. When we were talking about when you felt the
24 patient was in active labor, you mentioned
25 something about her dilatation taking off or

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

3 A Yes

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

6 A After complete dilatation?

7 Q. Yes.

8 A Second stage of labor?

9 Q Correct.

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

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

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

18 Q. 8:35?

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

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

1 The second stage of labor is about
2 23, 26 minutes, something like that. You said that
3 was wonderful, meaning fast?

4 A. That is relatively smooth --

5 MR. NORCHI: Smooth what?

6 THE WITNESS: That is smooth
7 labor.

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

10 A. Under an hour is less than average,

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

13 A. At plus 3 station.

14 Q. That made it faster?

15 A. Maybe a small amount faster, yes.

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

21 A. Yes.

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

23 A. Yes.

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

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

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

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

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

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

14 MR. CULLERS: Sure.

15 -----

16 (Discussion had off the record.)

17 -----

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

20 A. Yes.

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

24 A. Yes.

25 Q. Is that degree of descent during the second

1 stage something you would characterize as moving
2 quickly?

3 A. It's hard for me to say. Dr. Krietsky
4 believes she's plus 1, she could have been plus 2,
5 changed before that. You are relying on very
6 subjective conditions that I can't make -- I think
7 that's a reasonable descent. Whether she changed
8 1 or 2 in a half an hour doesn't make a
9 difference.

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

15 A. Exactly.

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

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

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

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

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

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

16 A. Between what times?

17 Q. Between full dilatation and delivery, the
18 descent?

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

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

1 vacuum assist could then occur?

2 A. Yes.

3 Q. We know that descent occurred over the period
4 of about 23, 24 minutes?

5 A. If we assume everybody's station is factual
6 and it's not, it's subjective.

7 Q. Let's assume station isn't even a factor
8 here.

9 A. Okay.

10 Q. When she is completely dilated the baby's
11 presenting part is somewhere?

12 A. Yes.

13 Q. It goes down to somewhere else, at which
14 point the vacuum is applied?

15 A. Yes.

16 Q. The baby's head moving from the point where
17 it was at when it was fully dilated down to the
18 point the vacuum was applied now took 23 minutes or
19 26 minutes?

20 A. Yes.

21 Q. Is that descent something you can
22 characterize as fast, slow?

23 A. The word fast, I don't use the word fast.
24 It's a very reasonable period of time. Not
25 concerning at all to me.

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

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

6 Q. You can't do that?

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

8 Q. That is what I want to know.

9 A. Sorry.

10 Q. That's all right.

11 I want to ask you some questions
12 about scalp gases.

13 Off the record.

14 -----

15 (Discussion had off the record.)

16 -----

17 MR. CULLERS: Back on.

18 BY MR. CULLERS:

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

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

25 Q. Quickly is not a word you use?

1 A. In medical terms no, too subjective.

2 Q. I want to talk about scalp gases.

3 You came on at 7:48, right?

4 A. Yes.

5 Q. Can you refer to the last progress note
6 before you came on which I believe is 7:21,
7 Dr. Radke?

8 A. Yes, 7:20, he tends to write in
9 hieroglyphics.

10 Q. When you came on at 7:48 it's likely like you
11 would have gone and reviewed this note of
12 Dr. Radke?

13 A. It's likely, yes.

14 Q. It is likely you would have reviewed the
15 previous note of Dr. Segal?

16 A. Yes.

17 Q. Seven o'clock a.m.?

18 A. Likely I would have reviewed.

19 Q. That you would have been aware at 8:48 there
20 were two borderline pH values?

21 A. Two equivocal pH values.

22 Q. You use the word equivocal?

23 A. Yes.

24 Q. Can you explain what you mean by equivocal?

25 A. A scalp gas of 7.20 and 7.25 repeated in 20

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

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

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

8 Q. It can be inaccurate?

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

11 Q. Can be inaccurate?

12 A. Yes.

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

15 A. Yes.

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

18 A. I didn't assign it.

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

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

25 Q. It stays at 7.20 and 7.25 on four consecutive

1 readings, is that reassuring?

2 A. Yes.

3 Q. It's reassuring?

4 A. It's reassuring the baby is not acidemic.

5 Q. When the scalp gases are being obtained with
6 this patient --

7 A. Yes.

8 Q. -- as far as you can tell, is there concern
9 about the tracings?

10 A. Yes.

11 Q. That is while they are doing it, right?

12 A. Yes.

13 Q. They see something sinister in the tracings,
14 they are looking for more accurate information to
15 see if the baby is getting adequate oxygenation?

16 MR. NORCHI: I object to the
17 word "sinister."

18 Q. They see tracings that do not look
19 reassuring?

20 A. Yes.

21 Q. Therefore they obtain the gases, sort of a
22 back up to see if --

23 A. Not really a back up. Direct measurement of
24 fetal acidemia.

25 Q. I'm getting hung up on my words.

1 A. That's all right.

2 Q. They are taking the pH because they are not
3 comfortable with what they are seeing on the
4 tracings?

5 A. Not comfortable is a subjective
6 interpretation of the tracings, they are going to
7 get a direct test.

8 a. If the pH values are reassuring, why do they
9 keep doing it?

10 A. Because they are equivocal, meaning you have
11 to follow them much more carefully. They weren't
12 wonderful, aren't bad, they are in between.

13 Q. I asked you if the four consecutive equivocal
14 pH values were reassuring, you said yes?

15 A. In that context. They haven't dropped. In
16 fact, the last pH was 7.25, that's considered to be
17 good, we wouldn't repeat that for an hour.

18 Q. If it is reassuring you wouldn't repeat them?

19 A. I apologize, the word reassuring, they were
20 reassuring for 20 or 30 minutes is what they are
21 reassuring for.

22 Q. That as a process over time, the consecutive
23 equivocal pH values are not reassuring?

24 MR. NORCHI: Wait. Try that
25 again. I don't think that is what the testimony

1 has been.

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

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

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

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

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

16 MR. CULLERS: I see what you
17 are saying.

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

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

23 MR. NORCHI: He answered.
24 Go ahead.

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

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

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

5 A. I thought I just answered it.

6 MR. NORCHI: Answer it
7 again.

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

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

13 A. Yes.

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

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

18 Q. Can you --

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

21 Q. Can you tell me by looking at the way
22 information is recorded in the nurses' notes from
23 midnight up to the point of Dr. Radke's note at
24 7:20 what the beat to beat variability pattern
25 looks like over time?

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

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

6 A. With any kind of confidence, no.

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

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

15 MR. CULLERS: Other people.

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

21 THE WITNESS: I wasn't
22 there.

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

25 MR. CULLERS: I hear what you

1 are saying.

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

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

12 Q. Without looking at the tracings?

13 A. Looking at the tracings, having been there.

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

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

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

22 A. You are asking me if it looks --

23 Q. -- it's a guess?

24 A, It's a guess.

25 MR. NORCHI: You have to let

1 him finish.

2 MR. CULLERS: Read that
3 back.

4 -----

5 (Question read.)

6 -----

7 Q. Let me try it again.

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

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

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

18 A. Yes.

19 Q. That would be careless on your part?

20 A. Yes.

21 Q. Is there any way that --

22 MR. CULLERS: Off the
23 record.

24 -----

25 (Discussion had off the record.)

1

2

Q. That you can compare the pattern of beat to

3

beat variability at the time period between 8:30

4

and 8:53 and the pattern of beat to beat

5

variability that occurred up to 7:21?

6

A. There is no way.

7

Q. I would like you to refer to the operative

8

note, the typed one that Dr. Krietsky dictated. If

9

you refer to the last paragraph where it is

10

entitled operative note; are you there?

11

A. Yes.

12

Q. It says, I was called to the room and the

13

patient was having late decelerations on the

14

tracings along with fetal bradycardia, who is "I"?

15

A. Dr. Krietsky, I assume,

16

Q. Do you know that?

17

A. She dictated it. It is her unless she uses

18

"I" unusually. Yes, it was her.

19

Q. Do you recall that fetal bradycardia in fact

20

occurred with this patient?

21

A. I do not recall.

22

Q. Can you look at the nurses' notes, the

23

delivery notes 8:46 a.m., do you see there where it

24

says fetal heart rate persists with variable

25

decelerations to the 90's?

1 A. Yes.

2 Q. That doesn't constitute bradycardia, does it?

3 A. No, it does not.

4 Q. If you look up from that point back in time,
5 there aren't any decelerations recorded which fall
6 within the definition of bradycardia?

7 MR. NORCHI: Hold on. You
8 mean changes in fetal heart rate, that's different
9 than decelerations that may be seen on a monitor
10 strip.

11 Q. Let me ask the question a different way.

12 Is there any information you see
13 from 7:48 when you came on up until 8:46 that is
14 indicative of fetal bradycardia?

15 A. I don't know. There is no tracings to tell
16 me.

17 MR. NORCHI: Listen to the
18 question.

19 Q. Is there anything in the chart?

20 A. No, nothing in the chart.

21 Q. Are you familiar with the term terminal
22 bradycardia?

23 A. Yes.

24 Q. What is that?

25 A. Terminal bradycardia to me means the baby's

1 heart rate drops and remains dropped until
2 delivery.

3 Q. When does that occur?

4 A. When does what occur?

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

7 A. Hopefully never.

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

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

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

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

18 A. Yes.

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

22 A. I do not recall that.

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

25 A. There is a controversy between the discharge

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

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

6 A. Exactly.

7 a. Based on what she said --

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

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

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

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

25 THE WITNESS: That's the same

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

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

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

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

10 MR. CULLERS: I understand.

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

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

18 THE WITNESS: I don't,

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

22 MR. CULLERS: What I'm trying
23 to figure, I'll say to you, Kevin, for the record,
24 is whether or not he remembers the development of
25 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?

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

11 Q. Let me think about what you said.

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

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

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

22 Q. What does that indicate to you?

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

25 Q. The no significant sign of acidemia, what

1 does that tell you about the status of the fetus?

2 A. That there is no sign -- fetal scalp gases
3 and acidemia is telling you about the baby's heart,
4 lungs. Status is a bad word.

5 Q. What did you say acidemia?

6 A. The pH.

7 MR. NORCHI: He asked you
8 acidemia.

9 A. Yes.

10 Q. You said the pH value shows what?

11 A, No significant sign of acidemia.

12 Q. If the scalp gases show no sign of
13 significant acidemia, why is that significant to
14 you when you are trying to determine whether or not
15 an operative delivery will be performed?

16 A. Because if the gases are below 7.20, as you
17 said before, it's imperative to deliver the baby as
18 soon as possible.

19 Q. But they weren't 7.20 or below?

20 A. They were not.

21 Q. If they are above 7.20 how's that significant
22 in your determination?

23 A. I see what you are getting at. It wasn't --
24 it wasn't pushing me to be very aggressive. **As** I
25 said before, the way I practice OB, if the person

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

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

7 A. Yes.

8 Q. -- was the fetal tracing not reassuring?

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

11 Q. It was concerning?

12 A. Yes.

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

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

22 Q. Quicker?

23 MR. NORCHI: There is that
24 word again.

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

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

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

8 A. I don't know.

9 Q. We talked about that.

10 A. It was a seasonable second stage.

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

12 A. It did speed it up even more.

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

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

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

22 A. It would have delivered on its own.

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

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

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

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

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

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

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

14 Q. Because the time --

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

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

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

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

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

1 Q. Clinically makes more sense to you to proceed
2 with an operative delivery than to wait and do
3 another scalp gas?

4 A. In this situation in a person that is
5 crowning, yes.

6 Q. What is crowning?

7 A. Plus 3 station.

8 Q. When you are making that choice of either
9 intervening with the vacuum when the patient is
10 crowning or to wait and do another scalp gas, do
11 you take into consideration whether or not you
12 expect the baby to be large?

13 A. I don't think at that point, no, I don't at
14 plus 3 station, I don't think I take that into
15 account. The baby's head already entered the
16 pelvis, it's hard to say what goes through your
17 head, it's innate, everything is thought, at that
18 point I don't think I was worried about size of the
19 baby.

20 Q. You weren't?

21 A. No.

22 Q. You don't think that you considered the size
23 of the baby at the time that the intervention with
24 a vacuum was done?

25 A. It was considered, it's a factor. The baby

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

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

12 A. Yes.

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

15 A. Yes.

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

18 A. Yes.

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

21 A. I don't recall.

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

24 A. Yes.

25 Q. Does that mean this baby's shoulder was

1 stuck?

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

9 Q. What is mild or none at all?

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

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

18 A. I don't think it was stuck.

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

21 A. That always happens with deliveries.

22 Q. Somebody said shoulder dystocia?

23 A. Yes, somebody said that.

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

1 mild?

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

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

13 Q. Even though it says difficulty with shoulder?

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

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

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

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

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

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

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

5 A. No.

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

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

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

13 A Yes, I do.

14 Q What is it?

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

17 Q What causes it to happen?

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

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

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

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

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

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

4 MR. CULLERS: I think it
5 does.

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

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

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

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

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

20 A. Yes, that's true.

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

22 A. No.

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

- 1 A. That's true.
- 2 Q. What is your professional address?
- 3 A. What do you mean professional?
- 4 Q. Office address?
- 5 A. Right now that's a good question. I'm doing
6 locum tenens here in Elyria, I work at Northcoast
7 OB/GYN.
- 8 Q. What is locum --
- 9 A. Locum tenens, which I was at a prior practice
10 in Columbus, I decided that I was going to move out
11 west, I did a temporary job, six months waiting for
12 my wife to finish her Fellowship.
- 13 Q. What was the practice in Columbus?
- 14 A. Central Ohio Medical Group.
- 15 Q. Central Ohio?
- 16 A. Medical Group.
- 17 Q. How long did you practice with them?
- 18 A. Three years.
- 19 Q. I take it you started with them right when
20 you finished your residency training?
- 21 A. Yes, I did.
- 22 Q. Your residency training was all done at
23 University Hospitals?
- 24 A. University Hospitals.
- 25 Q. How long were you with these guys in

1 Columbus, three years?

2 A. Yes, three years.

3 Q. Up here?

4 A. For six months.

5 Q. Then where are you going?

6 A. We haven't decided yet.

7 Q. You are moving out of state?

8 A. We don't know. I have some job offers.

9 Every day I get more offers, what I'm doing depends
10 on my wife. She is finishing her Fellowship,
11 wherever she gets a job we will go.

12 Q. You don't know the address of this place?

13 A, That's pretty sad, no, I don't.

14 Q. I want to have it on the record.

15 A. Northcoast OB/GYN, 125 East Broad Street,
16 Suite 201, Elyria, Ohio 44035. I've only been
17 here a few weeks,

18 Q. As of March, 1995 can you tell me the number
19 of operative vaginal deliveries you were involved
20 in?

21 A. I have no idea.

22 Q. Hundreds?

23 A. No, not hundreds.

24 Q. Dozens?

25 A. Dozens.

1 Q. Can you tell me the number of vacuum assisted
2 deliveries?

3 A. In the last --

4 Q. As of March, 1995?

5 A. Since then on?

6 Q. No, as of the time you were involved in this
7 patient.

8 A. How much up to there?

9 Q. Yes.

10 A, I would say between 50 and 100.

11 Q. How many operative vaginal deliveries had you
12 been involved in that involved shoulder dystocia?

13 A. I really don't know. I would say over 20.

14 Q. Were you ever involved in operative vaginal
15 deliveries as of March of '95 which involved
16 shoulder dystocia and accompanying brachial plexus
17 injury?

18 MR. NORCHI: Up until March
19 of 1995?

20 A. No, I was not.

21 Q. I'm not excluding March. I'm not saying up
22 until the last day of February.

23 A. No, not involved with shoulder dystocia that
24 involved brachial plexus injury.

25 Q. Were you involved in any operative deliveries

1 that involved an Erb's palsy later that developed?

2 A. I don't know.

3 Q. Have you ever been named as a defendant in a
4 lawsuit other than this one?

5 A. No.

6 MR. NORCHI: Objection. Go
7 head, you can answer.

8 A. No.

9 Q. Have you ever given your deposition before?

10 A. No.

11 Q. Today was the first one?

12 A. Yes.

13 MR. CULLERS: Let me look
14 over my notes, we will be done.

15 -----

16 (Discussion had off the record.)

17 -----

18 MR. CULLERS: I don't want to
19 ask anything else.

20 MR. NORCHI: I would **like**
21 the doctor to read the transcript of his
22 deposition. We won't waive signature.

23 -----

24 (Deposition concluded; signature not waived.)

25 -----

ERRATA SHEETNOTATIONPAGE /LINE

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

DAVID GOLDFARB, M.D.

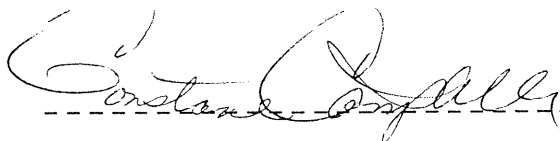
1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

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

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

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

21 
22 -----

23 Constance Campbell, Stenographic Reporter,
24 Notary Public/State of Ohio.
25 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:

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