

THE STATE of OHIO
COUNTY of CUYAHOGA.

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IN THE COURT OF COMMON PLEAS

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ZACHARY HAMMON, et al.,
 plaintiffs,

vs.

: Case No. 209957

MARYMOUNT HOSPITAL,
et al.,
 defendants.

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Deposition of ROBERT KIWI, M.D. a
witness 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 MacDonald House Hospital, 2085 Adelbert
Road, Cleveland, Ohio on Tuesday, the 23rd day of
March, 1993, commencing at 11:30 a.m. pursuant to
agreement of counsel.

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THE 113 SAINT CLAIR BUILDING - SUITE 505

CLEVELAND, OHIO 44114-1273

(216) 771-8018

1-800-837-DEPO

1 APPEARANCES:

2
3 ON BEHALF OF THE PLAINTIFFS:

4 Christopher M. Mellino, Esq.
5 Charles Kampinski Co., L.P.A.
6 1530 Standard Building
7 Cleveland, Ohio 44113
8 (216) 781-4110.
9 _ _ _ _ _

10 ON BEHALF OF THE DEFENDANT AMIN EL-MALEWANY, M.D.:

11 Joan Ford, Esq.
12 Jacobson, Maynard, Tuschman & Kalur
13 1001 Lakeside Avenue
14 Cleveland, Ohio 44114
15 (216) 736-8600.
16 _ _ _ _ _

17 ON BEHALF OF THE DEFENDANT MARYMOUNT HOSPITAL:

18 David L. Little, Jr., Esq.
19 Hahn, Loeser & Parks
20 200 Public Square
21 Cleveland, Ohio 44114-2301
22 (216) 621-0150.
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I N D E X

WITNESS: ROBERT KIWI, M.D.

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<u>KIWI DEPOSITION EXHIBITS</u>	<u>MARKED</u>
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1 - Handwritten note by Dr. Kiwi	8
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(FOR KEYWORD AND OBJECTION INDEX SEE APPENDIX)

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1 ROBERT KIWI, M.D.

2 of lawful age, a witness 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:

7 - - - - -

8 CROSS-EXAMINATION

9 BY MR. MELLINO:

10 Q. State your full name for the record, please.

11 A. Robert Kiwi, K-i-w-i.

12 Q. Where do you live, Dr. Kiwi?

13 A. In Shaker Heights.

14 Q. Address?

15 A. 2974 Morley Road, M-o-r-l-e-y, Shaker
16 Heights, 44122.

17 Q. I'm going to ask you a number of questions.
18 If at any time you don't understand one of my
19 questions ask me to rephrase. I will be happy to
20 do so, okay?

21 A. Sure.

22 Q. When you answer you have to answer verbally
23 so she can take your response.

24 A. I understand.

25 Q. I'm going through your CV right now. I

1 obviously haven't had a chance to read it. Briefly
2 run me through your educational background.

3 A. I graduated from the University of Capetown
4 in 1968. Spent some time in an internship. A year
5 in the South African military. Did a residency in
6 OB/GYN in Capetown at the University of Capetown.
7 1975 I went to England, spent three and a half
8 years working at various institutions in England in
9 different positions.

10 Came to this country in 1978. Did
11 a Fellowship in perinatal medicine '78
12 through '80. Moved on to Mount Sinai Medical
13 Center 1980 until 1990. Came back here to
14 University Hospitals.

15 Q. The University of Capetown, was that a
16 medical school?

17 A. Yes.

18 Q. Is that where you also did your undergraduate
19 training?

20 A. The system is different. It's a six year
21 curriculum. You don't do an undergraduate as
22 such. You do formal six year medical school
23 program.

24 Q. It's a combined program?

25 A. Right.

1 Q. The degree you received was an MB?

2 A. CHB. It's a Bachelor of Medicine, Bachelor
3 of Surgery is basically what that stands for.

4 Q. Then you did an internship you said from '69
5 to '70.

6 A. Yes, that is correct.

7 Q. Where was that at?

8 A. University of Capetown Groote Schuur Hospital
9 which is the main teaching hospital associated with
10 the University of Capetown Medical School.

11 Q. What is a registrar?

12 A. Essentially the same as a resident. The
13 setup is a little bit different. In effect the
14 same process.

15 **a.** What did you do from '78 to '79?

16 A. I was here at University Hospitals. I
17 arrived here in April of '78. Started working here
18 in April 1978. Then started a Fellowship in July
19 of '78 at Case Western, UH.

20 Q. That was a one year fellowship?

21 A. No, two year.

22 Q. You started in '78 or '79?

23 A. July '78 to '79 to '80.

24 MISS FORD: There is a typo
25 on your CV, Doctor.

1 A. Is that what it is?

2 Q. Yes, see.

3 A. I am sorry.

4 Q. That should be April of '78?

5 A. Yes.

6 Q. Is that your file in front of you?

7 A. Yes.

8 Q. Can I take a look at it? This is everything
9 you reviewed in the case?

10 A. This is everything I have been sent to
11 review, yes,

12 Q. I want to get on the record everything you
13 reviewed as I go through this. On top were the
14 fetal monitor strips, correct?

15 A, Yes.

16 Q. Next is some correspondence from Steve
17 Albert?

18 A. Correct.

19 Q. Looks like more --

20 A. I think there is some duplication of the
21 strips.

22 Q. Next is reports of Dr. Dierker and
23 Dr. Edelberg?

24 A. Correct.

25 Q. Deposition of Dr. El-Malewany, Dr. Redline,

1 Christine O'Brien; the baby's records from
2 Marymount Hospital, the mother's records from
3 Marymount Hospital; deposition of Rita
4 Berardinelli, Elizabeth Gooden, Joan Hatcher,
5 Stewart Edelberg?

6 A. That is correct.

7 Q. Did you make any notes while you were
8 reviewing this material?

9 A. Yes, I did.

10 - - - - -

11 (Dr. Kiwi Deposition Exhibit 1
12 marked for identification.)

13 - - - - -

14 Q. Would you identify for the record what I have
15 marked as Deposition Exhibit 1?

16 A. These are notes I made at the time I was
17 reviewing the records of the plaintiff, Rita
18 Berardinelli.

19 Q. That consist of three --

20 A. Pages.

21 Q. Plus the little note stapled on the front?

22 A. Right.

23 MISS FORD: Doctor, may I
24 see that, please? Thank you.

25 Q. Have you been retained as an expert in

1 medical malpractice cases before?

2 A. Yes.

3 Q. On how many occasions?

4 A. I have reviewed a number of cases in the
5 past. Have got to deposition in fact only one time
6 before.

7 Q. Over what period of time are we talking
8 about?

9 A. Probably the last 10 years.

10 Q. Only one of those cases has resulted in your
11 deposition being taken?

12 A. Right .

13 Q. You have no idea what the number of cases you
14 have reviewed are?

15 A. I don't remember reviewing many cases, Maybe
16 one or two a year. Over the time, maybe 10 to 15
17 in total.

18 Q. How many times have you acted as an expert on
19 behalf of the plaintiff?

20 A. No times.

21 Q. Have you ever acted as an expert for Steve
22 Albert before?

23 A. Yes, I have.

24 Q. How many times?

25 A. I don't remember exactly. A few times, two

1 to three, three to four times.

2 Q. Do you remember the names of those cases?

3 A. Not offhand, no.

4 Q. Do you have records that would reflect that?

5 A. I'm sure I do.

6 Q. How about his firm, Hahn, Loeser?

7 A. Excuse me?

8 Q. Have you been an expert for any member of his
9 firm before?

10 A. I think only for Steve Albert.

11 Q. How about for anyone in the firm of Jacobson,
12 Maynard?

13 MISS FORD: Objection.

14 You can answer.

15 A. I have reviewed some records in the past.
16 Have not acted as an expert providing testimony or
17 anything of that nature.

18 Q. Were you asked to review records to be an
19 expert in the case?

20 A. Just to review the records to determine what
21 was -- I think one instance was an out of the city
22 case. I was asked to review the records. I looked
23 at the records, made a report. If I remember
24 correctly never heard anything further about it so
25 I have no idea wherever anything developed as a

1 consequence.

2 Q. Do you know if that was for the purpose of
3 you being an expert in the case or the attorney
4 wanted to get an opinion from you?

5 A. I think they wanted an opinion.

6 Q. Do you remember the name of the attorney that
7 contacted you?

8 A. No. It was someone from out of Cleveland.

9 Q. Did any of the cases you acted as an expert
10 on involve shoulder dystocia?

11 A. No.

12 Q. Have you been sued?

13 A. Yes.

14 Q. How many times?

15 A. One time. That suit was dropped.

16 Q. What was the name of the patient that sued
17 you?

18 A. I'm sure I don't want to remember it because
19 I don't like the thought of it.

20 Q. Do you remember when it was?

21 A. The incident happened in '86, I believe. The
22 suit was brought two years later, subsequently
23 dropped. After numerous events I guess during the
24 course of that time it was subsequently dropped.
25 Didn't proceed beyond a certain point, let's put it

1 that way.

2 Q. You can't remember the name of the patient?

3 A. It will come to me. If not, I can find it,

4 Q. What were the allegations against you in this
5 case?

6 A. Wrongful death.

7 Q. It arose out of a labor and delivery?

8 A. No, it arose out a patient having had a
9 seizure and having a cardiopulmonary arrest, was
10 not resuscitated, not resuscitatable, The patient
11 was my patient. I wasn't involved in the actual
12 incident. I wasn't even in the hospital. Because
13 she was my patient I was sued as a primary
14 physician.

15 Q. Was she pregnant?

16 A. Yes.

17 Q. Was she in labor?

18 A. No.

19 Q. I don't know if I asked you this or not; who
20 represented you in this case?

21 A. The attorneys from Jacobson, Maynard.

22 Q. So you are insured by PIE I take it?

23 MISS FORD: Objection.

24 You can answer.

25 A. That is correct.

1 Q. That suit was in Cleveland?

2 A, Yes,

3 Q. What authorities do you consider
4 authoritative, what sources do you consider
5 authoritative regarding the issues involved in this
6 case?

7 A, There have been a number of people who have
8 written articles, who have presented information,
9 that would make them certainly appear to be
10 authoritative,

11 In essence I don't consider any one
12 particular individual an authority on shoulder
13 dystocia as this is a condition that has been
14 around for a very long period of time. It is
15 something we all dealt with over many years.
16 Nevertheless, there have been a few articles
17 written by individuals; Bendetti, Gabbe. Books
18 that I have reviewed in the past including
19 Creaseman and Williams that review and discuss the
20 subject of shoulder dystocia.

21 Q. Do you know Dr. El-Malewany?

22 A. Yes,

23 Q. How do you know him?

24 A. I became acquainted with him a number of
25 years ago. We have been friends. We talk to each

1 other from time to time. He refers me patients
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1 because there was a reference somewhere that he
2 had -- I read a reference to Dierker. I requested
3 this report. That was the only additional personal
4 request that I made.

5 Q. Did that change your opinion or alter your
6 opinion in any way?

7 A. No.

8 Q. The conclusion of your report talks about the
9 shoulder dystocia, correct?

10 A. That is correct.

11 Q. The shoulder dystocia was a hypoxic event?
12 Maybe that is inartfully asked.

13 Did the baby have hypoxia as a
14 result of the shoulder dystocia?

15 A. I'm sure that during the course of the
16 process of delivery, because of the prolongation of
17 the event, I'm sure there was some hypoxia
18 associated with it, yes.

19 Q. If I read the last sentence of your report
20 correctly, you say that the shoulder dystocia ruled
21 in hypoxia?

22 A. I based that on the fact that I didn't find
23 any evidence in reviewing the tracings or labor
24 pattern prior to that time this baby had any
25 evidence of hypoxia prior to delivery, so my

1 suspicion is, given the severe nature of the
2 outcome, this to a large extent must have occurred
3 during the delivery.

4 Q. When you say "this," you are talking about
5 the brain damage to the infant?

6 A. The neurological brain damage, yes.

7 Q. You are saying that occurred as a result of
8 hypoxia that occurred during the delivery process?

9 A. My feeling is that is probably what
10 happened. Partly because I don't have any good
11 evidence of anything else having happened prior to
12 that time to indicate that the baby was in any
13 serious jeopardy prior to the delivery.

14 Q. So based on that your opinion is that the
15 neurological deficit is the result of the hypoxia
16 occurring during the attempt to deliver the
17 shoulders?

18 A. Well, it's obvious not only the hypoxia that
19 occurred during delivery, the hypoxia that occurred
20 subsequent to delivery. The resuscitation and
21 efforts to properly oxygenate that fetus, the
22 events were started during the course of delivery,
23 continued until resuscitation, all through
24 resuscitation.

25 Q. If I understood what you were saying a minute

1 ago, there is no evidence that the infection was
2 causing any problem?

3 A. We didn't discuss infection. I didn't say
4 that. The fact is that we don't know up until the
5 time of delivery what if any factor the infection
6 might have been. We know the mother had a fever.
7 We can expect there may have been some
8 chorioamnionitis. That is not involved with the
9 ability to resuscitate an infant or hypoxia.

10 Q. To what do you attribute the inability to
11 resuscitate?

12 A. Clearly there was a difficult shoulder
13 dystocia, difficult delivery. The time frame was
14 stated to be six minutes which may in many
15 instances be a reasonable amount of time for a baby
16 to be resuscitated. In this instance it does
17 appear that it was. We don't know if this baby was
18 illier than it appeared on the surface given the
19 fact it had shown some evidence, after birth, there
20 was possible infection present.

21 There may be a combination of
22 events that wasn't evident that may play an
23 additive role. I can't say absolutely most of the
24 problems didn't occur at the time of delivery.

25 Q. What took six minutes? You referred to a six

1 minute time period there.

2 A. If my recollection of the process is correct,
3 from the time of application of forceps until the
4 time of delivery I think it was six minutes, that
5 second stage of labor.

6 Q. You are talking about from the time the head
7 was delivered until the rest of the infant was
8 delivered?

9 A. Yes.

10 Q. You said that was a reasonable period of time
11 to resuscitate?

12 A. What I said was that it's not an unreasonable
13 time to expect a baby to be resuscitated. That is
14 different from what you were saying.

15 Q. Is that a long time to take to deliver the
16 body of the baby after the head is delivered?

17 A. In the usual course of obstetrical
18 deliveries, yes.

19 Q. How about with shoulder dystocia?

20 A. It's going to be so totally variable,
21 depending on the particular set of circumstances,
22 that in some instances that would be a long period
23 of time. Others it might not be expected that
24 would take quite as long. I would say in general
25 if it's taking up to six minutes to deliver a

1 patient, to deliver shoulders, that is a fairly
2 long period of time.

3 Q. How do you define hypoxia?

4 A. Hypoxia is going to be defined as a
5 biochemical event. The baby is clearly not
6 breathing then. On testing the oxygenation, PO_2 of
7 the infant, whoever is being tested, it is going to
8 be low. With other evidence of changes present as
9 well, relating to pH and bicarbonate, pCO_2 , other
10 levels that would support that contention.
11 Essentially hypoxia refers to a low oxygen state.

12 Q. Do you think the baby was getting any oxygen
13 during the time when they were attempting to
14 deliver the body?

15 A. I'm not sure. I can't say yes or no for part
16 of the reason it's extremely difficult to be
17 monitoring heart rates. Clearly with a large
18 infant the cord is almost certain to be
19 compressed. The chest is being compressed, the
20 baby cannot breathe. We don't know whether the
21 cord is being compressed during that time.

22 In some instances that baby may be
23 receiving, maybe not completely, to some extent, an
24 adequate blood flow because the cord may not be
25 compressed.

1 In other instances the cord may be
2 so completely compressed there may be absolutely no
3 inflow of blood during that time. It's not an
4 absolute answer. It could be either way.

5 Q. Would that influence how easily
6 resuscitatable the baby was?

7 A. Yes, because during that period of time if
8 the cord was not completely compressed the baby was
9 getting some flow through the cord, it may not be
10 quite as depressed as the infant that is being
11 delivered where you have complete cord compression
12 during that whole period of time that is
13 continuing, yes.

14 Q. You know Dr. Wiznitzer?

15 A. I know him by name. I don't think I have
16 ever met him.

17 Q. He takes care of infants at this hospital?

18 A. That is correct, I believe.

19 Q. He could take care of babies that you deliver
20 if they had some sort of neurological complication?

21 A. It's possible. I have not had any personal
22 relationship with him regarding patients.

23 Q. If you delivered a baby at this hospital that
24 had neurological complications, I take it him or
25 somebody on his service would treat that baby?

1 A. I suspect you are probably correct. Although
2 there are other physicians within that group of
3 pediatric neurologists who might also become
4 involved, sure.

5 Q. It would be from that department here?

6 A. Considering the fact I would be delivering
7 the baby in this hospital I would think that would
8 be the correct assumption.

9 Q. Is the incidence of shoulder dystocia higher
10 when instruments are used for delivery?

11 A. There certainly is a suggestion based on some
12 of the studies that instances where instruments
13 have been used, because those instruments have been
14 applied in patients who had a prolonged second
15 stage of labor, in those circumstances you might
16 find increased incidence of shoulder dystocia.
17 Just use of instruments alone is not associated
18 with an increase in shoulder dystocia in the
19 absence of any other factors.

20 Q. Did she progress at all, talking about
21 Mrs. Berardinelli, during the second stage of
22 labor?

23 A. What do you mean by progress?

24 Q. I mean the baby coming down the birth canal,
25 between the time she was complete, started pushing,

1 until the time the forceps were applied?

2 A. Based on the review of the information that
3 was available I would say she did. According to
4 Dr. El-Malewany's notes and review of his
5 deposition, the station of the fetus at the time of
6 intervention was plus two, which would indicate she
7 had progressed during that time or there was
8 evidence of progression.

9 Q. Is that based on the record or his
10 deposition?

11 A. I'm not sure I can recall clearly enough
12 whether he made that clear in his note or whether
13 that came from the deposition. I would have to
14 check that.

15 Q. Would you do that for me, check the record,
16 see if she progressed at all during that time
17 interval.

18 A. Well, at 1:00 p.m. she was fully dilated,
19 zero station. At 1:05 the head was at plus one.
20 She was pushing. Given that information I would
21 assume she was progressing during the second stage
22 of labor.

23 Q. Did she progress beyond that do you see in
24 the record?

25 A. In the operative record she was pushing, she

1 brought the head to plus one to plus two station.
2 It would appear that in here at the time of
3 delivery the patient was plus two station. It
4 would appear she continued to progress.

5 Q. Was there molding of the fetal head?

6 A. I can't say based on the report whether there
7 was or wasn't. I would expect there would be
8 molding. Every baby's head is molded as it comes
9 down the birth canal. I can't say specifically
10 because there is no reference in the reports. In
11 Dr. El-Malewany's reports I should say.

12 Q. Does that affect the determination at what
13 level the fetal head is at?

14 A. Certainly molding would indicate that the
15 presenting part could be lower in the birth canal
16 than the rest of the fetal head because of molding.

17 Q. Is it acceptable to use forceps on an infant
18 that is at plus two, when their head is molded?

19 MISS FORD: Note my
20 objection, This doctor is here as an expert for
21 the hospital, if I recall, not against
22 Dr. El-Malewany.

23 Q. Do you have an opinion on that?

24 A. Please restate the question.

25 Q. Do you have an opinion if it's acceptable to

1 deliver with forceps when there is molding and the
2 presenting part is at plus two?

3 A. As I mentioned, every baby that comes through
4 the birth canal will have molding. I think it's
5 very reasonable to expect to find molding and to be
6 able to do a forceps delivery at a plus two station
7 in an appropriate set of circumstances. In a
8 roundabout way, yes, I do believe there is a way
9 that we can safely accomplish delivery in those
10 kinds of circumstances.

11 Q. Would that be a low forceps or mid forceps
12 under those circumstances?

13 A. Let me ask you a question first before I
14 answer that. Are you using the definition of
15 station as a zero, one, two, three or using the
16 A.C.O.G. defined station of naught to five? That
17 makes a difference.

18 Q. What was Dr. El-Malewany using in this case?

19 A. I suspected he was using zero, one, two,
20 three. Three being the head virtually on the
21 perineum. If he's using that definition, if you
22 are referring to the same process of defining where
23 the station is, then that would be a low forceps.

24 Q. If he were using the A.C.O.G. definition of
25 **zero** to five, that would be a mid **forceps**?

1 A. Yes, it would be.

2 Q. Did you see any late deceleration on the
3 heart monitor strip?

4 A. I reviewed the tracings. I would say that if
5 there were late decelerations, they were present in
6 a very irregular fashion. There was no consistent
7 late deceleration I was aware of. My overall
8 assessment is that I did not see late decelerations
9 that would by definition be consistent with late
10 decelerations.

11 Q. I take it from your answer you saw some?

12 A. Areas where one might look at it and be not
13 sure whether that was or was not a late
14 deceleration because of its change in the heart
15 rate in association with contractions. If that
16 were there, might be an isolated event. I did not
17 see any consistent pattern of late deceleration.

18 Q. Can you show me where these are that you are
19 talking about?

20 A. Here at 11:50, this is page 99. One could
21 make a case for an occasional, what might appear as
22 a late deceleration.

23 Q. When you say occasional, how many are there?

24 A. Just one episode. That is what I meant by
25 that. There is one episode in that tracing.

1 Q. That is at?

2 A. 11:50.

3 At 12:10 to 12:20 there may be one
4 or two that might be interpreted as possibly being
5 a late deceleration.

6 Q. What are the strip numbers on those?

7 A. 108 and 107. After that I don't see any real
8 changes until we start getting down to just before
9 delivery, during the second stage with the patient
10 pushing where she has variable decelerations.

11 Q. What was the baseline heart rate from
12 twelve o'clock to the time the tracings end?

13 A. Twelve o'clock?

14 Q. Yes.

15 A. Probably 170 to 180.

16 Q. Are there other decelerations besides the
17 possible lates you identified?

18 A. There is an occasional variable deceleration
19 but no changes until we get to page 120, about
20 one o'clock when we start seeing the variable
21 deceleration.

22 Q. I am sorry, until what time?

23 A. One o'clock, 1300 hours.

24 Q. Could you identify for me where the variable
25 decelerations are?

1 A. On page 120 there is a variable
2 deceleration. Then again at 1300 hours further
3 variable deceleration. 1310 further episodes of
4 variable decelerations.

5 Q. Why don't you stick to the strip number.

6 A. I'm sorry.

7 Q. That is okay.

8 A. 123, 124. There is also one variable
9 in 121. The variables continue 126, 127, 128 at
10 which time the tracing is stopped.

11 Q. Do you see any deceleration for the time
12 period 12:20 to one o'clock?

13 A. We have already mentioned some of the
14 variable decelerations. During the rest of the
15 tracing it's hard to know exactly what is going on
16 all the time.

17 The patient was getting Pitocin,
18 was having fairly frequent contractions. There may
19 have been some decelerations going on here between
20 1:09 and 1:12. Whether they are late or variable
21 it's hard to tell because the contractions are
22 fairly frequent. When I reviewed this tracing I
23 did not think they were late decelerations.

24 Q. That was strip number 109 and 112?

25 A. Yes.

1 Q. Those each have a variable deceleration on
2 them?

3 A, It's hard to tell exactly because of the
4 contraction pattern. They don't look like late
5 decelerations, no.

6 Q. So you didn't see any late deceleration
7 between 12:20 and one o'clock?

8 A, I said that in this pattern, 109 to 112,
9 which is that time period you referred to.

10 Q. Other than that pattern?

11 A. Yes.

12 Q. Were there other variables besides --

13 A. No, those are the only ones I referred to
14 that I see.

15 Q. In that same time period?

16 A. Yes.

17 Q. Those are the only decelerations are in
18 the 109, 112 strip?

19 A. We already referred to some of the variables
20 in other parts of the strips.

21 Q. Those were after one o'clock though?

22 A. Yes, you're correct.

23 Q. By the way, do you know Dr. Edelberg or
24 Dr. Dirker?

25 A. Yes, I know them,

1 Q. How do you know Dr. Edelberg?

2 A. I met him when he was at Metro as a Fellow in
3 perinatal medicine. I met Dr. Dierker with his
4 association with Metro and our association. I have
5 known him for many years.

6 Q. Are you friends with him?

7 A. We are acquaintances.

8 Q. I take it you belong to the same professional
9 societies?

10 A. Correct.

11 Q. Do you ever see each other socially?

12 A. No.

13 Q. When is it you were acquainted with
14 Dr. Edelberg?

15 A. He was a perinatal Fellow at Metro General.
16 I'm afraid I don't remember the time. I knew he
17 was there. I met him a couple of times.

18 Q. If there were persistent late decelerations
19 on the strip, would that change your opinions in
20 this case?

21 MISS FORD: Objection.

22 A. Change my opinion in what regard?

23 Q. In how the labor and delivery should have
24 been managed?

25 A. If there were persistent late

1 decelerations -- it is a hypothetical situation
2 because I don't think there were -- it would have
3 increased my resolve to deliver this patient. I
4 might have been prepared to deliver her somewhat
5 sooner than was the case.

6 Q. Would, in your opinion, forceps still have
7 been the appropriate way to deliver?

8 MISS FORD: Objection.

9 A. If the fetus is in the station that it was,
10 if the position of the fetal head was appropriate,
11 in this instance an occipital anterior, it was
12 possible based on the station to do a forceps
13 delivery. It would certainly be the most rapid way
14 to resolve the situation and deliver the patient.
15 In a long sort of roundabout way, yes, I think I
16 would have certainly considered it.

17 Q. The maternal weight gain, does that give you
18 some idea of macrosomia?

19 A. By itself, no.

20 Q. I take it you don't take any factor by itself
21 in making the diagnosis of macrosomia, do you?

22 A. Not one single factor, no.

23 Q. Would maternal weight gain be a factor?

24 A. It might be. It would depend obviously on
25 the weight at which we started out from. What is

1 associated with the weight gain. Some women will
2 gain a lot of weight. It would be associated with
3 a large fetus. Others might gain a lot of weight
4 associated with edema, not necessarily a large
5 fetus. I don't think it's possible to make an
6 evaluation on one factor alone.

7 Q. What would you consider a large amount of
8 wait to gain during pregnancy?

9 A. I consider normal 25 to 30, 35 to 40 pounds.
10 Anything over that would be excessive weight gain.

11 Q. Did you happen to notice the amount of weight
12 the mother gained in this case?

13 A. I don't recall, no.

14 Q. Are you saying that if there is an excessive
15 weight gain, without any -- I don't want to put
16 words in your mouth. If there is an excessive
17 weight gain without any clinical reason such as
18 edema, that would lead you to suspect macrosomia?

19 A. It might. It wouldn't lead me to suspect
20 macrosomia in and of itself. It would lead me to
21 evaluate whether or not the patient is diabetic,
22 whether or not that would be a factor in maybe
23 changing the size of the fetus.

24 So I look at the whole picture. I
25 don't look at one aspect of it. Clearly an

1 individual who gains an enormous amount of weight
2 may also have a large fetus. Clearly that has to
3 be investigated and evaluated as well.

4 Q. That is something you have to think about
5 when you are the obstetrician?

6 A. Sure.

7 Q. From the nurse's standpoint, if there were
8 persistent late decelerations on the strip, what
9 would have been their responsibility to the
10 patient?

11 A. The nurse notes an abnormal fetal heart
12 tracing, late deceleration or any other, she needs
13 to notify the physician who is in charge of the
14 patient. Basically take some measure to try and
15 resolve the situation as best she can. She may
16 find that if the patient is lying flat on her back,
17 turning her on her side might be appropriate. If
18 the patient is receiving Pitocin she may need to
19 switch off or reduce the Pitocin rate. She may
20 elect to use oxygen, depending on what the
21 circumstances are, how rapidly the situation
22 resolves.

23 Her responsibility is to make an
24 evaluation of what is happening at that time, try
25 and deal with the situation in the most appropriate

1 fashion.

2 Q. I take it that your opinion is that none of
3 that action is warranted based on an occasional, as
4 you termed it, late deceleration?

5 A. That is is correct.

6 Q. There is nothing on this strip rising to the
7 level of requiring that action by the nurse?

8 A. After reviewing these tracings I would say
9 that is correct. I did not think there was any
10 severity that would warrant unusual action to take
11 place.

12 Q. Should she have notified Dr. El-Malewany of
13 the late deceleration?

14 A. If there was only one late deceleration, no.
15 I don't think that a nurse can interpret a tracing
16 based on one episode. There needs to be some
17 pattern she needs to be able to review, or anyone
18 else for that matter, to make a determination what
19 is happening.

20 Unless, excuse me for going on,
21 unless it happens to be a prolonged episode where
22 something is going on resulting in bradycardia.
23 That would be the exception.

24 Q. What are variable decelerations evidence of?

25 A. Generally cord compression.

1 Q. If there is head compression, those would
2 show up on the monitor strip as early
3 decelerations?

4 A. They might. If there are going to be
5 decelerations they tend to be early decelerations.

6 Q. You are saying there might not be
7 decelerations at all?

8 A. Correct.

9 Q. Do persistent variable decelerations require
10 any action by the nurse?

11 A. Basically the same kind of action I outlined
12 before, Most importantly in this case changing the
13 patient's position to determine if the change in
14 position will relieve the variable decelerations.

15 Q. Were there persistent variable decelerations?

16 A. Only right at the end at the time of delivery
17 in the late second stage. Just prior to delivery.

18 Q. What time did they start?

19 A. 1310.

20 Q. 10 after 1:00?

21 A. Correct.

22 Q. Did the nurses do any of the things you
23 outlined?

24 A. Well, at that time the patient was pushing,
25 it is not surprising at all to expect to find those

1 at the time of pushing. It wouldn't be reasonable
2 to expect to change positions and do all those
3 things if those are occurring at that period of
4 time. No, I don't think they would be expected to
5 stop doing what they were doing to do manipulation
6 because it's not an unusual expectation at that
7 point in time.

8 Q. If those were late decelerations, as opposed
9 to variable decelerations, that would not be
10 expected though during the second stage of labor?

11 A. It might not be unusual to see them, but if
12 they were late decelerations, one would react to
13 them slightly differently because there wouldn't be
14 an association one would expect to see, yes.

15 Q. The treatment should be what you said before
16 for late decelerations?

17 A. At that point in the stage of labor the
18 treatment may be delivery rather than attempts at
19 trying to correct the situation.

20 Q. Delivery how?

21 A. In the most appropriate fashion. Which might
22 be forceps, might be vacuum extraction, might be
23 Cesarean section. It would depend entirely on the
24 set of circumstances at that time.

25 Q. Does the fact she had three therapeutic

1 abortions have anything to do with the care she got
2 in this case or outcome of this case?

3 A. I don't think this has any relevance to the
4 outcome or care.

5 MR. MELLINO: I don't have
6 any other questions for you, Doctor-

7 MISS FORD: As I mentioned
8 off the record Mr. Kalur is in trial. Mr. Seibel
9 is in St. Louis. Mr. Little graciously agreed to
10 reproduce the doctor if Mr. Kalur deems it
11 necessary. We reserve our right to recall the
12 doctor.

13 MR. LITTLE: Doctor, you
14 have the right to review this deposition before you
15 sign it to be sure it's been taken down accurately
16 or you can waive that right. It's totally up to
17 you if you believe she has taken everything down
18 you said accurately.

19 THE WITNESS: I would like to
20 review it.

21 - - - - -

22 (Deposition concluded; signature not waived.)

23 - - - - -

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ERRATA SHEET

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LINE

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

ROBERT KIWI, 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, ROBERT KIWI, M.D. by me
6 first duly sworn to testify the truth in the cause
7 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 29th day of March, 1993.

21 
22 -----

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

25 Commission expiration: January 14, 1998.

Look-See Concordance Report

841 UNIQUE WORDS
386 NOISE WORDS
5,812 TOTAL WORDS

SINGLE FILE CONCORDANCE

CASE SENSITIVE

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