THE STATE of OHIO
: *SS:*
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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I N D E X

WITNESS: ROBERT KIWI, M.D.

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KIWI DEPOSITION EXHIBITS	MARKED
1 - Handwritten note by Dr. Kiwi	8

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(FOR KEYWORD AND OBJECTION INDEX SEE APPENDIX)

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ROBERT KIWI, M.D.

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

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CROSS-EXAMINATION

BY MR. MELLINO:

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

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

Q. Where do you live, Dr. Kiwi?

A. In Shaker Heights.

Q. Address?

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

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

A. Sure.

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

A. I understand.

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

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

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

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

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

A. Yes.

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

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

Q. It's a combined program?

A. Right.

Q. The degree you received was an MB?
A. CHB. It's a Bachelor of Medicine, Bachelor of Surgery is basically what that stands for.
Q. Then you did an internship you said from '69 to '70.
A. Yes, that is correct.
Q. Where was that at?
A. University of Capetown Groote Schuur Hospital which is the main teaching hospital associated with the University of Capetown Medical School.
Q. What is a registrar?
A. Essentially the same as a resident. The setup is a little bit different. In effect the same process.
Q. What did you do from '78 to '79?
A. I was here at University Hospitals. I arrived here in April of '78. Started working here in April 1978. Then started a Fellowship in July of '78 at Case Western, UH.
Q. That was a one year fellowship?
A. No, two year.
Q. You started in '78 or '79?
A. July '78 to '79 to '80.
MISS FORD: There is a typo on your CV, Doctor.

A. Is that what it is?
Q. Yes, see.
A. I am sorry.
Q. That should be April of '78?
A. Yes.
Q. Is that your file in front of you?
A. Yes.
Q. Can I take a look at it? This is everything you reviewed in the case?
A. This is everything I have been sent to review, yes,
Q. I want to get on the record everything you reviewed as I go through this. On top were the fetal monitor strips, correct?
A, Yes.
Q. Next is some correspondence from Steve Albert?
A. Correct.
Q. Looks like more --
A. I think there is some duplication of the strips.
Q. Next is reports of Dr. Dierker and Dr. Edelberg?
A. Correct.
Q. Deposition of Dr. El-Malewany, Dr. Redline,

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

A. That is correct.

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

A. Yes, I did.

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

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

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

Q. That consist of three --

A. Pages.

Q. Plus the little note stapled on the front?

A. Right.

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

Q. Have you been retained as an expert in

medical malpractice cases before?
A. Yes.
Q. On how many occasions?
A. I have reviewed a number of cases in the past. Have got to deposition in fact only one time before.
Q. Over what period of time are we talking about?
A. Probably the last 10 years.
Q. Only one of those cases has resulted in your deposition being taken?
A. Right.
Q. You have no idea what the number of cases you have reviewed are?
A. I don't remember reviewing many cases, Maybe one or two a year. Over the time, maybe 10 to 15 in total.
Q. How many times have you acted as an expert on behalf of the plaintiff?
A. No times.
Q. Have you ever acted as an expert for Steve Albert before?
A. Yes, I have.
Q. How many times?
A. I don't remember exactly. A few times, two

to three, three to four times.
Q. Do you remember the names of those cases?
A. Not offhand, no.
Q. Do you have records that would reflect that?
A. I'm sure I do.
Q. How about his firm, Hahn, Loeser?
A. Excuse me?
Q. Have you been an expert for any member of his firm before?
A. I think only for Steve Albert.
Q. How about for anyone in the firm of Jacobson, Maynard?

MISS FORD: Objection.
You can answer.

A. I have reviewed some records in the past. Have not acted as an expert providing testimony or anything of that nature.
Q. Were you asked to review records to be an expert in the case?
A. Just to review the records to determine what was -- I think one instance was an out of the city case. I was asked to review the records. I looked at the records, made a report. If I remember correctly never heard anything further about it so I have no idea wherever anything developed as a

consequence.
Q. Do you know if that was for the purpose of you being an expert in the case or the attorney wanted to get an opinion from you?
A. I think they wanted an opinion.
Q. Do you remember the name of the attorney that contacted you?
A. No. It was someone from out of Cleveland.
Q. Did any of the cases you acted as an expert on involve shoulder dystocia?
A. No.
Q. Have you been sued?
A. Yes.
Q. How many times?
A. One time. That suit was dropped.
Q. What was the name of the patient that sued you?
A. I'm sure I don't want to remember it because I don't like the thought of it.
Q. Do you remember when it was?
A. The incident happened in '86, I believe. The suit was brought two years later, subsequently dropped. After numerous events I guess during the course of that time it was subsequently dropped. Didn't proceed beyond a certain point, let's put it

that way.
Q. You can't remember the name of the patient?
A. It will come to me. If not, I can find it,
Q. What were the allegations against you in this case?
A. Wrongful death.
Q. It arose out of a labor and delivery?
A. No, it arose out a patient having had a seizure and having a cardiopulmonary arrest, was not resuscitated, not resuscitatable, The patient was my patient. I wasn't involved in the actual incident. I wasn't even in the hospital. Because she was my patient I was sued as a primary physician.
Q. Was she pregnant?
A. Yes.
Q. Was she in labor?
A. No.
Q. I don't know if I asked you this or not; who represented you in this case?
A. The attorneys from Jacobson, Maynard.
Q. So you are insured by PIE I take it?
MISS FORD: Objection.
You can answer.
A. That is correct.

Q. That suit was in Cleveland?
A, Yes,
Q. What authorities do you consider authoritative, what sources do you consider authoritative regarding the issues involved in this case?
A, There have been a number of people who have written articles, who have presented information, that would make them certainly appear to be authoritative,

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

Q. Do you know Dr. El-Malewany?
A. Yes,
Q. How do you know him?
A. I became acquainted with him a number of years ago. We have been friends. We talk to each

other from time to time. He refers me patients

because there was a reference somewhere that he had -- I read a reference to Dierker. I requested this report. That was the only additional personal request that I made.

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

A. No.

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

A. That is correct.

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

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

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

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

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

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

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

A. The neurological brain damage, yes.

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

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

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

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

Q. If I understood what you were saying a minute

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

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

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

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

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

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

minute time period there.
A. If my recollection of the process is correct, from the time of application of forceps until the time of delivery I think it was six minutes, that second stage of labor.
Q. You are talking about from the time the head was delivered until the rest of the infant was delivered?
A. Yes.
Q. You said that was a reasonable period of time to resuscitate?
A. What I said was that it's not an unreasonable time to expect a baby to be resuscitated. That is different from what you were saying.
Q. Is that a long time to take to deliver the body of the baby after the head is delivered?
A. In the usual course of obstetrical deliveries, yes.
Q. How about with shoulder dystocia?
A. It's going to be so totally variable, depending on the particular set of circumstances, that in some instances that would be a long period of time. Others it might not be expected that would take quite as long. I would say in general if it's taking up to six minutes to deliver a

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

Q. How do you define hypoxia?

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

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

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

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

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

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

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

Q. You know Dr. Wiznitzer?

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

Q. He takes care of infants at this hospital?

A. That is correct, I believe.

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

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

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

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

Q. It would be from that department here?

A. Considering the fact 1 would be delivering the baby in this hospital I would think that would be the correct assumption.

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

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

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

A. What do you mean by progress?

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

until the time the forceps were applied?
A. Based on the review of the information that was available I would say she did. According to Dr. El-Malewany's notes and review of his deposition, the station of the fetus at the time of intervention was plus two, which would indicate she had progressed during that time or there was evidence of progression.
Q. Is that based on the record or his deposition?
A. I'm not sure I can recall clearly enough whether he made that clear in his note or whether that came from the deposition. I would have to check that.
Q. Would you do that for me, check the record, see if she progressed at all during that time interval.
A. Well, at 1:00 p.m. she was fully dilated, zero station. At 1:05 the head was at plus one. She was pushing. Given that information I would assume she was progressing during the second stage of labor.
Q. Did she progress beyond that do you see in the record?
A. In the operative record she was pushing, she

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

Q. Was there molding of the fetal head?

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

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

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

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

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

Q. Do you have an opinion on that?

A. Please restate the question.

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

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

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

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

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

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

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

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

A. Yes, it would be.
Q. Did you see any late deceleration on the heart monitor strip?
A. I reviewed the tracings. I would say that if there were late decelerations, they were present in a very irregular fashion. There was no consistent late deceleration I was aware of. My overall assessment is that I did not see late decelerations that would by definition be consistent with late decelerations.
Q. I take it from your answer you saw some?
A. Areas where one might look at it and be not sure whether that was or was not a late deceleration because of its change in the heart rate in association with contractions. If that were there, might be an isolated event. I did not see any consistent pattern of late deceleration.
Q. Can you show me where these are that you are talking about?
A. Here at 11:50, this is page **99**. One could make a case for an occasional, what might appear as a late deceleration.
Q. When you say occasional, how many are there?
A. Just one episode. That is what I meant by that. There is one episode in that tracing.

Q. That is at?
A. 11:50.
At 12:10 to 12:20 there may be one or two that might be interpreted as possibly being a late deceleration.
Q. What are the strip numbers on those?
A. 108 and 107. After that I don't see any real changes until we start getting down to just before delivery, during the second stage with the patient pushing where she has variable decelerations.
Q. What was the baseline heart rate from twelve o'clock to the time the tracings end?
A. Twelve o'clock?
Q. Yes.
A. Probably 170 to 180.
Q. Are there other decelerations besides the possible lates you identified?
A. There is an occasional variable deceleration but no changes until we get to page 120, about one o'clock when we start seeing the variable deceleration.
Q. I am sorry, until what time?
A. One o'clock, 1300 hours.
Q. Could you identify for me where the variable decelerations are?

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

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

A. I'm sorry.

Q. That is okay.

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

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

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

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

Q. That was strip number 109 and 112?

A. Yes.

Q. Those each have a variable deceleration on them?
A, It's hard to tell exactly because of the contraction pattern. They don't look like late decelerations, no.
Q. So you didn't see any late deceleration between 12:20 and one o'clock?
A, I said that in this pattern, 109 to 112, which is that time period you referred to.
Q. Other than that pattern?
A. Yes.
Q. Were there other variables besides --
A. No, those are the only ones I referred to that I see.
Q. In that same time period?
A. Yes.
Q. Those are the only decelerations are in the 109, 112 strip?
A. We already referred to some of the variables in other parts of the strips.
Q. Those were after one o'clock though?
A. Yes, you're correct.
Q. By the way, do you know Dr. Edelberg or Dr. Dirker?
A. Yes, I know them,

Q. How do you know Dr. Edelberg?
A. I met him when he was at Metro as a Fellow in perinatal medicine. I met Dr. Dierker with his association with Metro and our association. I have known him for many years.
Q. Are you friends with him?
A. We are acquaintencess.
Q. I take it you belong to the same professional societies?
A. Correct.
Q. Do you ever see each other socially?
A. No.
Q. When is it you were acquainted with Dr. Edelberg?
A. He was a perinatal Fellow at Metro General. I'm afraid I don't remember the time. I knew he was there. I met him a couple of times.
Q. If there were persistent late decelerations on the strip, would that change your opinions in this case?
MISS FORD: Objection.
A. Change my opinion in what regard?
Q. In how the labor and delivery should have been managed?
A. If there were persistent late

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

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

MISS FORD: Objection.

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

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

A. By itself, no.

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

A. Not one single factor, no.

Q. Would maternal weight gain be a factor?

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

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

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

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

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

A. I don't recall, no.

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

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

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

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

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

A. Sure.

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

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

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

fashion.

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

A. That is is correct.

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

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

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

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

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

Q. What are variable decelerations evidence of?

A. Generally cord compression.

Q. If there is head compression, those would show up on the monitor strip as early decelerations?
A. They might. If there are going to be decelerations they tend to be early decelerations.
Q. You are saying there might not be decelerations at all?
A. Correct.
Q. Do persistent variable decelerations require any action by the nurse?
A. Basically the same kind of action I outlined before, Most importantly in this case changing the patient's position to determine if the change in position will relieve the variable decelerations.
Q. Were there persistent variable decelerations?
A. Only right at the end at the time of delivery in the late second stage. Just prior to delivery.
Q. What time did they start?
A. 1310.
Q. 10 after 1:00?
A. Correct.
Q. Did the nurses do any of the things you outlined?
A. Well, at that time the patient was pushing, it is not surprising at all to expect to find those

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

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

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

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

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

Q. Delivery how?

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

Q. Roes the fact she had three therapeutic

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

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

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

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

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

THE WITNESS: I would like to review it.

- - - - -

(Deposition concluded; signature not waived.)

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ERRATA SHEET

PAGE LINE

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

ROBERT KIWI, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 29th day of March, 1993.

Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 1998.

Look-See Concordance Report

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841 UNIQUE WORDS
386 NOISE **WORDS**
5,812 TOTAL WORDS

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SINGLE FILE CONCORDANCE

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CASE SENSITIVE

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