IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

CASE NO. 324550

MONICA DIXON, et al.,

Plaintiffs,

versus

UNIVERSITY HOSPITALS OF CLEVELAND, et al.,

Defendants.

DEPOSITION OF

JOANNE KRIVETSKY, M.D.

- - - - - - -

Deposition of JOANNE KRIVETSKY, M.D., a Witness herein, called by the Plaintiffs for cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Carey D. Sporup, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Stark County Women's Clinic, 5000 Higbee Avenue, NW, North Canton, Ohio, on December 17, 1997, at 5:35 p.m.

- - - - - -

ORIGINAL

APPEARANCES:

On behalf of the Plaintiffs:

ROMNEY B. CULLERS, ATTORNEY AT LAW
HERMANN, CAHN & SCHNEIDER
SUITE 500
1301 EAST NINTH STREET
CLEVELAND, OHIO 44114

On behalf of the Defendants:

KEVIN M. NORCHI, ATTORNEY AT LAW
DAVIS & YOUNG
1700 MIDLAND BUILDING
CLEVELAND, OHIO 44115

- - - - - - -

WHEREUPON,

JOANNE KRIVETSKY, M.D.,

who, after being first duly sworn, testified as follows:

CROSS EXAMINATION

BY MR. CULLERS:

Q. Could you state your name, please.
A. Joanne Krivetsky.
Q. And your residence and professional addresses, please.
A. My residence is 5700 Beverly Avenue Northeast, North Canton, Ohio 44721.
Q. Your present occupation?
A. Physician.
Q. Do you have a specialty practicea
A. Obstetrics and gynecology.
Q. What's the name of your practice?
A. Stark County Women's Clinic.
Q. How long have you practiced here?
A. Since July 28th of this year.
Q. July 28, '97?
A. Uh-huh.
Q. I need you to say yes.

A. Yes. Sorry.
Q That's all right. Had you just finished your residency program?
A. I finished my residency June 30th.
Q. Of '97?
A. Of '97.
Q. And I take it your residency was at University Hospitals of Cleveland?
A. Yes.
Q. You were in the program for five years; is that how it works?
A. Four years.
Q. Four years. Where did you go to medical school?
A. Case Western Reserve University.
Q. What year did you graduate?
A. 199 -- no, 1993.
Q. '93. And then you started your residency right then --
A. Yeah.
Q. -- within a couple of months of your graduation?
A. Graduation of medical school was in May of '93, and then I started residency at the end of June of '93.
Q. And this was residency training for obstetrits?
A. For obstetrics and gynecology.

Q. Can you tell me generally how the residency training worked. In other words, did you do rounds with physicians or, you know --

MR. NORCHI: You mean all four years? They -- just maybe narrow it.

MR. CULLERS: Sure.

MR. NORCHI: They do different things in four years; they have different concentrations. So if you want to go to the year in question, it might be a little easier.

BY MR. CULLERS:

Q. Tell me how it's divided up. I mean, I know that you probably do rotations during part of it. And can you explain how that worked, say, for the first year?

A. For the first year of your internship year it's done in obstetrics and gynecology. We rotated through different areas, including the obstetrics and labor and delivery, gynecology, ultrasound, the surgical intensive care unit, the neonatal intensive care unit and medicine.

Q. So then your second year, how was it different, if it is?

A. The second year was mostly concentrated on obstetrics and gynecology.

Q. All right. And so as of March 14, 1995, obviously you're in your second year of your residency? I'm not very good at math. That's why I'm asking you.

A. I was in my second year of residency.

Q. All right. What I want to do is ask you about -- just information that you may or may not have learned during your residency, so I'm going to ask you a bunch of these questions. They may sound repetitive, but that's what I'm trying to do. And what I'm trying to find out is your knowledge prior to 3-14-95, because that's the date of the delivery of Michael Dixon.

A. Okay.

Q. All right. Prior to March 14, 1995 how many deliveries had you been involved in?

a. I cannot give you a number off the top of my head.

Q. Can you give me an estimate as to whether it was more than 10? less than 10? I have no idea.

A. At that point it was more than a hundred.

Q Okay. That's what I'm trying --

A. But I can't give you an exact number. That would have to come from the residency office.

Q. That's okay. I just needed a general idea.
A. Okay.
Q. Can you give me an idea as to how many instrumental vaginal deliveries you'd been involved in prior to March 14, '95?
A. I can't give you an exact number.
Q. That's okay. Can you give me an idea? Again, I'm just trying to figure out if it's a couple? hundreds? I don't have any knowledge of that.
A. Probably -- my guess would be 25 to 50 maybe.
Q. Prior to March 14, 1995 can you tell me how many C-sections you had been involve **in?**
A. Probably at least 50. I think that if you want accurate numbers on this, we have to go back and pull them out of the residency files.
Q. Is that something that we could do?
A. That's information that's available, because these are total guesses on my part.
Q I'm not necessarily concerned with the exact numbers. I'm just trying to get a general idea as to what your experience was. In other words, it looks like you were involved in many deliveries as opposed to a couple.
A Uh-huh.
Q I didn't know. What are those files called, the

residency files you referred to?
A. Oh, they're just our individual files as residents of our experience.
Q. So you would have your own file there --
A. Uh-huh.
Q -- that would have your name on it?
A Uh-huh.
Q. I need you to say yes. I'm sorry
A. Yes.
Q Can you give me some idea as to how many deliveries you had been involved in prior to March 14, 1995 that involved the complication of shoulder dystocia?
A. Again, guessing maybe half a dozen.
Q Can you tell me if before March 14, 1995 you had ever been involved in a delivery that was an instrumental vaginal delivery which also involved the complication of shoulder dystocia?
A I don't recall that.
Q. You don't recall ever having been involved in one?
A. No, I don't recall if that occurred or not.
Q. Okay. That's what I asked.
MR. NORCHI: That's what she answered. She got it.

MR. CULLERS: Okay.

BY MR. CULLERS:

a. Do you recall whether you were ever involved in any deliveries prior to March 14, 1995 that involved the complication of shoulder dystocia but were a C-section -- but were C-section deliveries?

A. I don't recall.

Q. When you say you don't recall, are you saying that you don't recall how many or are you saying that you don't recall having been involved in such a delivery?

A. I don't recall if there was a case like that or not.

Q. Okay. Prior to March 14, 1995 had you ever been involved in a delivery that had an accompanying brachial plexus injury?

A. Not that I'm aware of.

Q. All right. Aside from this case involving Monica Dixon, have you ever been named as a defendant in a malpractice case?

A. Yes.

Q. Can you tell me how many cases?

A. One case.

Q. Did that arise out of a situation that occurred

during your residency?
A. Yes.
Q. Was your deposition given in th t case?
A. Yes.
Q. What was the name of your patie t in that case?
A. I don't remember.
Q. You don't remember. Do you rem mber when it was -- is it pending now?
A. No.
Q Was it dismissed?
A. Yes.
Q. Do you remember --
A. I was dismissed I should say.
Q. You were dismissed from it?
A. I was dismissed from the case.
Q. What was this case about? Don't go into the details of it. Just generally?
MR. NORCHI: Objection. Go ahead and give a brief -- do you remember it?
THE WITNESS: It was a case that involved -- it was a fetal compromise that involved a C-section which led to a bad outcome, and I cannot remember the details. It was a private physician's patient.
BY MR. CULLERS:

Q. Do you remember who the lawyer was who represented the patient in the case?
A. Who represented the patient?
Q. Yes.
A. No.
Q. Who was your attorney in the ca *e?*
A. Mr. Tucker, Bob Tucker.
Q. Is he from Canton?
A. No, he's from Cleveland. I don't know which firm he's with.
Q. All right. And you were named individually in that case?

MR. NORCHI: Do you know if your name was on the pleadings or not?

THE WITNESS: It was named like with the hospital and myself and then the other physicians involved.

BY MR. CULLERS:

Q. Okay. What I want to do now is focus on certain aspects of care that was provided to Monica Dixon --
A. Uh-huh.
Q. -- and in particular I would like to focus your attention on her prenatal care nd what you knew about her status as of 3-13-95. It's my

understanding that your first involvement in her care occurred on 3-13-95. Is that accurate?

MR. NORCHI: Let's look.

THE WITNESS: March 14, 1995.

BY MR. CULLERS:

Q. Okay. The reason I asked about 3-13 is because I know that you prepared a clinical resume indicating that certain things had occurred upon her admission, and the clinical resume indicates her admission date being 3-13-95. That's why I asked about that particular date.

A. I was the discharging physician so I would have dictated the entire resume for her entire hospital course.

Q. So that doesn't necessarily mean that you were involved at any point before 3-14?

A. No.

Q. And in fact, as you said, that was your first involvement. What did you refer to? Was that a physician progress note?

MR. NORCHI: What are you talking about?

BY MR. CULLERS:

Q. Where you can tell that your first involvement was on 3-14?

A. Yeah, it was a progress note from 8:00 in the morning.

Q. Okay. Then what I want to do is shift the focus of my questioning then on your knowledge of Monica Dixon's status as of 3-14-95 at 8:00 when you first became involved in her care, which is -- which would be prior to the interim part of -- phase of her care. Do you agree to that?

MR. NORCHI: Do you understand the question?

THE WITNESS: Can you rephrase the question?

MR. CULLERS: Yes.

BY MR. CULLERS:

Q. On 3-14-95 at 0800 she was not in labor?

A. On 3-14-95 at 0800?

Q. Yeah.

A. That is incorrect. She was in labor.

Q. She was in labor. Okay. All right. As of 3-14-95 at 0800, were you aware that Ms. Dixon was a gestational diabetic?

A. I don't recall, you know, what I -- I cannot tell you. I don't recall verbatim what I was aware of at that time. All I can tell you is what is in the clinical records.

Q. All right. Again, the reason I ask that question is -- referring back to the clinical resume, the discharge summary that you prepared, there is some information regarding the result of the patient's glucose tolerance tests, and I was wondering if you knew this information here prior to your first involvement in her care?

A. I can tell you that in morning rounds what generally would happen would be that the patient's general condition would be reported, but I cannot tell you, you know, verbatim what I knew at that time.

Q. All right. Are you now aware that the patient was a gestational diabetic as of 3-14-95 at 0800?

A. I don't know what you're trying to ask me. I've answered that the most complete way I can. I cannot tell you with 100 percent certainty I knew that. What I can tell you is in morning rounds, that is the kind of information that would generally be conveyed.

Q. I understand that. And the question that I asked was a little different, and that was: Having now reviewed the record -- and if you would like, you can look at the clinical

resume -- are you aware that she was, in fact, a gestational diabetic as of 3-14-95 at 0800?

A. Reviewing the record, yes, now I can tell you on 3-14-95 at 0800 she was a gestational diabetic.

Q. Now, the information that you indicated that you sometimes would obtain on rounds, is that something that likely would have included this information about the fact that she was a gestational diabetic?

A. Yes, it would likely be conveyed.

Q. Okay. And based on that, is it likely that that's information that you would have known on 3-14-95 at 0800?

A. Yes.

Q. Okay. As of 3-14-95 at 0800 were you aware of a likelihood of macrosomia?

MR. NORCHI: What do you mean -- well, let me just object to the term "likelihood," but --

MR. CULLERS: Okay.

MR. NORCHI: Just because it -- for my client's sake, I want to make her understand that it refers to probabilities versus possibilities, and that has legal connotations as opposed to things you may consider when

you're -- when you're involved in the management of this patient's care. That's the basis of the objection.

MR. CULLERS: Let me rephrase the question, because I'm not trying to pin any percentage of probabilities on any part of my question.

BY MR. CULLERS:

Q. I'm just wondering if you were aware that macrosomia was suspected as of 3-14-95 at 0800?

A. Yes.

Q. Okay. Is that -- that's likely that -- something that you would have known when you became involved in her care?

A. That is something that may have been discussed in morning rounds.

Q. All right. And that, in fact, turned out to be the case, didn't it?

A. I don't know the answer to that.

Q. Okay.

A. I mean, as to whether or not it was discussed in morning rounds.

Q. Okay. From your review of the records, do you now believe that macrosomia was, in fact, present? In other words, was this a large, for

gestational age, baby?
A. Are you asking me if it's macrosomic based on what the weight of the baby was at delivery?
Q. Yes.
A. That depends on whose definition you use for macrosomia.
Q. I would like to use your definition.
A. The definition for macrosomia can be anything over 4,000 grams or anything over 4,500 grams, depending on what literature you read.
Q. And this baby was 4,100-something grams?
A. Uh-huh. So it may or may not qualify for macrosomia.
Q. Do you have an opinion as to which of those standards is appropriate for the determination of macrosomia?

MR. NORCHI: I'm going to object because she -- and I'm objecting because you're referring to two different schools of thought and theory here; so I mean, if you ask her what she adheres to to determine what's macrosomic for her, that's fine.

MR. CULLERS: All right.

BY MR. CULLERS:
Q. Do you have an opinion as to what macrosomic is,

whether it's 4,000 grams or 4,500 grams? Do you have an opinion?

A. No. I think that it can depend on different things.

Q. Okay. What different things?

A. I think it can depend on the maternal habitus; and I think 4,500 grams might be fine for one person, whereas 4,000 grams might not be okay for another person.

Q. Is there anything in particular about this woman's habitus that would cause you to differentiate or go either way?

A. I don't know what her height and weight are.

Q. All right. You weren't aware of her size prior to --

A. I do not --

Q. -- your involvement?

A. I do not know what that is. I cannot recall that, and I don't see that stated in the medical record.

Q. Okay. I take it from your previous answer that if she was a large person, meaning obese, then the definition of macrosomia could possibly be 4,000 grams as opposed to 4,500 grams?

MR. NORCHI: Objection.

THE WITNESS: No, that s not what I mean.

BY MR. CULLERS:

Q Can you explain to me --

A. What I mean is I don't hold myself to one definition or another. I keep that range in mind --

Q Okay.

A -- and I use that in individual clinical situations.

Q Okay.

A. I don't reference that as to a large woman. I keep that range in mind that's been set by studies that have been done in the past.

Q. The reason I ask that question is because you said that the woman's habitus could cause you to feel that in one case perhaps 4,000 grams could constitute macrosomia, whereas in another it might not. I was trying to figure out what you meant by habitus. I didn't know if you meant weight or --

A. I was referring more to her pelvis.

Q. In any event, as of your first involvement in her care, do you think it was likely that you would have been aware that there was a

Q. I need you to say yes, please.
A. Yes.
Q. This is part of the clinical resume that you prepared, correct?
A. Yes.
Q. Is it likely that as of 3-14-95 at 0800 when you became involved in Monica Dixon's care, that you were aware that one of her obstetrical risks included evidence of macrosomia?
A. There was a suspicion that she may have macrosomia. There was no documentation to prove that she had macrosomia.
Q. And that's something that you likely would have been aware of as of your first involvement **an**

her care?
A. What is likely that I would have been aware of?
Q. That there was a suspicion of macrosomia, as you just described?
A. Yes.
Q. Okay. As of 3-14-95, were you aware that her pelvis had not been tested by previous deliveries?
A. I was aware that this was her first pregnancy.
Q. Okay. Good. Was a sonographic estimated fetal weight ever done with this patient?
A. I don't know the answer to that.
Q. You don't know?
A. I don't know the answer.
Q. There's something I forgot to ask you earlier when I was asking you questions about certain information that you may have had prior to 3-14-95, and that is: Did you review any information in preparation for this evening's proceeding?
A. I reviewed the medical records.
Q. Did you review anything else?
A. No, just the medical records.
Q. Okay. I would like you to refer again to the discharge summary to -- right toward the lower

third of the page where you're talking about vaginal examination showed patient to be 4 to 5 centimeters dilated, 100 percent effaced, 0 to plus 1 station?

A. Yes.

Q. Do you see that?

A. Yes.

Q. What I need to know is if this s reads here, implies fetal pelvic

A. No.

Q. It does not?

A. It does not.

Q. Okay. I would like to refer you to your first progress note if I could that we've been talking about: 3-14-95, 0800.

First of all, could you read the part under your objective findings starting with "VS."

A. Vital signs: 37.6, 122, 94/56; vaginal exam 8 to 9; 100 percent; caput plus 2; head 0 to plus 1.

Q. Can I stop you there. What does "8 to 9" mean?

A. 8 to 9 centimeters dilated.

Q. What does "100 percent" mean?

A. 100 percent effaced.

Q. What does "effaced" mean?
A. Shortening and thinning of the cervix.
Q. Okay. Next "caput"?
A. Caput.
Q. Caput. What does that mean, caput plus 2?
A. That means molding of the tissues of the head, and plus 2 is the station at which those are felt at.
Q Okay. And then next is "0"?
A 0 to plus 1 station.
Q Okay. And I'm assuming that that means that the head was --
A. The bones of the head were felt at 0 to plus 1 station.
Q. When you were determining station at this point at 0800, I mean, did you do that yourself or did someone else do that and you recorded this?
A I would assume that I did that exam.
Q Do you recall that?
A. No, I do not recall that.
Q Okay. By the way, do you recall this particular patient as you sit here?
A No.
Q Do you recall anything about her?
A No.

Okay. I would like you to refer to -- on the far left side where it indicates "scalp gas" and there is -- there are numerals recorded there. Do you see that?

A. Uh-huh.

Q. It says "scalp gas 7.22"?

A. Yes.

Q. That's a marginal scalp gas, isn't it?

A. A scalp gas of 7.20 to 7.25 warrants a repeat within 20 to 30 minutes.

Q. Okay. Well, the reason I said marginal is because I thought that's what you had indicated in your note.

A. It's a borderline value that would indicate a repeat gas is needed in 20 to 30 minutes.

Q. All right. I guess my question was just 7.22 is a marginal scalp gas?

A. Yes.

Q. Okay. And then you've indicated that a marginal scalp gas is defined as having a value of between 7.20 and 7.25 which warrants a repeat in 15 to 20 minutes?

A. 20 to 30 minutes.

Q. 20 to 30 minutes. And that was what I was going to get at. I wanted to find out what the range

was for a marginal scalp gas, because I noticed that -- if you back up, there are a couple of notes preceding yours, and I as ume at 0700 hours -- this is Laszlo Sogor's (phonetic) note?

A. Uh-huh.

Q. Do you see that?

A. No, that's not Laszlo Sogor's note.

Q. Do you know whose note that is a

A. This one?

Q. Yes.

A. Are you looking at 700 hours?

Q. Yeah, 700 hours.

A. I believe that's Dr. Segal's signature.

Q. Oh, Dr. Segal. What's -- S-e-g a-l. What's Dr. Segal's first name?

A. Jeffery.

Q. Dr. Segal, he indicates there t..at there"s a pH value of 7.23. Do you see that?

A. Yes.

Q. And he says there was a previously reassuring pH, which I assume he was referring to the one above which was 7.27. Would you agree with that?

A. I would agree with that.

Q. And he's saying that although 7.27 may be reassuring, 7.23 certainly is not. Is that what that seems to indicate?

A. I don't know if that indicates that.

MR. NORCHI: I will just object to the question, because you're asking her to comment on what somebody else's thought process was.

BY MR. CULLERS:

Q. Did you review that note or is it likely that you would have reviewed that note when you entered the scene on 3-14-95 at 0800 to find out what was going on with the patient?

A. Not necessarily.

Q. You wouldn't have gone back to see what the previous scalp gas -- scalp gasses would have been?

A. It may have been reported in rounds that morning, but I would not necessarily have went back and read the note.

Q. All right. Would you look at your operative note, please. Actually there are two. There's one that you prepared, I believe, and then there's one that you prepared for Dr. Austin. This is the one that I'm referring to.

A. Sure.

Q. Do you have that?
A. Yeah, I have it.
Q. Okay. This is a document that you prepared?
A. Yes. That's my signature.
Q. And this is your writing up here?
A. Yes.
Q. Okay. If you would look, please, at the sequential scalp gasses indication on this, which is in the second line down.
A, Uh-huh.
Q. Do you see those?
A. Yes.
Q. There are five scalp gasses indicated there?
A. Yes.
Q. Would your progress note of 3-14 at 0800, which recorded a scalp gas of 7.22, refer to what would be the fourth scalp gas that's listed on your operative note?
A. Yes.
Q. Okay. Why were the scalp gasses being obtained as of the time that you became involved when the -- when the scalp gas was 7.22?
A. The scalp gas was obtained, when I had done a first scalp gas based on the medical record, because it was being a repeat from one that was

previously done, which was borderline, and because of the fetal tracing.

Q. All right. When you say "because of the fetal tracing," what do you mean?

A. All I have is my notes. I don't have the fetal tracing to review. But there was evidence of some fetal tachycardia and some late decelerations.

Q. Is this evidence of some distress?

A. This may be indicative of distress.

Q. Okay. Did you obtain any reassurance with the scalp pH values which eased your concern that there was fetal distress?

A. The scalp gas essentially told me that there was no further deterioration compared to the one that was done previously which was 7.23.

Q Is **the** reason that the scalp gasses were obtained because prior to delivery it appeared as if the fetus was becoming compromised?

A. The scalp gasses were -- the scalp gas that I obtained was the scalp gas done for the reasons I've already stated. I cannot state why other people did their scalp gasses prior to me.

Q. Would you refer to the next page, the operative report you prepared for Dr. Austin.

A. Yes.
Q. Would you refer to your clinical note and refer to the last sentence of that.
A. Uh-huh.
Q. Could you read that for me, please.
A. "She was able to push and brought the baby down to plus 3 station; however, at that time the fetus appeared to be becoming compromised and an operative vaginal delivery was indicated."
Q. Is part of the reason that the fetal scalp gasses were obtained is because it appeared that the fetus was becoming compromised? That's what I was asking earlier.
A. Based on the clinical notes prior to this, what I can tell you is the fetal scalp gas that I did was obtained because of a prior borderline scalp gas and because the tracing was not reassuring at that given time.
Q. Okay. Why did you write in your clinical note on the operative report that you prepared for Dr. Austin that "the fetus appeared to be becoming compromised"? What was the basis of your writing that?
A. Based on the clinical record, I would say that that was based on the fact that we did have

consecutive borderline scalp gasses, that there was fetal tachycardia, and there were some decelerations.

Q. How was the scalp gas obtained?

A. I don't understand your question.

Q. How do you obtain these readings? Do you stick a hole in the baby's head?

A. The patient is placed in a dorsal lithotomy position. There is the cone inserted into the vagina. The baby's scalp is cleansed. And there is a small blade on the end of the instrument that is used to put a tiny puncture in the tissue of the scalp, through which a small drop of blood is obtained in the capillary tube, which is then taken to a machine and ran through the machine and it gives us the number of the pH.

Q. All right. At any point prior to the time that it was determined that an operative vaginal delivery was appropriate, was there any concern on your part that the fetus was becoming compromised?

A. The actions that the medical record indicate show that there was some concern because the scalp gasses were performed.

Q. Okay. So there was some concern that the fetus was becoming compromised?
A. There -- the medical record indicates that we were observing the patient closely and the fetal tracing closely, and we were doing repetitive scalp gasses because of the values we had obtained previously.
Q. And that was out of concern that the fetus may be becoming compromised?
A. That was out of concern that the tracing was not reassuring.
Q. And if it's not reassuring, what does that mean? What did it mean to you?
A. If it's not reassuring, that means it needs to be investigated further, which is why the scalp gasses were done.
Q. Why does it need to be investigated further? What are you looking for? What are you trying to find out?
A. You're trying to find out if there's any indication if the fetus is having any kind of -- any kind of in utero complications.
Q. Okay. Do you have an opinion as to how many consecutive marginal scalp gasses there have to be before a C-section is appropriate?

MR. NORCHI: Can you -- I'm sorry. Can you repeat it?

MR. CULLERS: Yeah. That's fine.

MR. NORCHI: I think I would object to it only because you're asking her expert opinion questions and she's a fact witness here, because she was a resident at the time answering to other people so --

MR. CULLERS: I'm just asking if she's got an opinion. Let me re-ask the question.

BY MR. CULLERS:

Q. Earlier you indicated that a marginal scalp gas, which is a value between 7.20 and 7.25, warrants a repeat in 20 to 30 minutes. Do you recall that?

A. Yes.

Q. Does the fact that there are consecutive scalp gasses indicate anything further that you need to do aside from taking another scalp gas in 20 to 30 minutes?

MR. NORCHI: You mean regardless of value?

MR. CULLERS: No.

BY MR. CULLERS:

Q. If -- all right. If there is a -- if there are

let's say two consecutive marginal scalp gasses, marginal being between 7.20 and 7.25, is there anything that that then requires you to do that's different than simply repeating the test in 20 to 30 minutes?

A. It depends on the individual case.

Q. Okay. In this -- is there ever a situation where two consecutive borderline scalp gasses can require a C-section?

A. Is there ever a case?

MR. NORCHI: Objection.

BY MR. CULLERS:

Q. Yes.

MR. NORCHI: Objection. Romney, that's -- anything is possible. It's just a difficult question. I don't know if you can answer it or not.

BY MR. CULLERS:

Q. Here's what I'm getting at, okay, so let me just explain my thought process here and maybe that will help us: I'm trying to figure out if the fact that there are consecutive borderline scalp gasses is significant in any way. That's all.

In other words, I understand that if you see one borderline scalp gas, it then

triggers an obligation on your part to repeat it in 20 to 30 minutes. What I need to know is: Is it significant that there are consecutive borderline scalp gasses?

A. This scenario would not be unusual for a patient at this point in her labor process --

Q. Okay. Why is that?

A. -- who is 8 to 9 centimeters dilated and close to delivering vaginally.

Q. Can you explain why?

MR. NORCHI: Do you understand the question? If you do, go ahead.

THE WITNESS: This value would be different if it was with a patient who was earlier in her labor process.

BY MR. CULLERS:

Q. All right.

A. Because if the fetus is beginning to get compromised or beginning to not tolerate labor, then you wouldn't -- they would be further away from a vaginal delivery. If this was with somebody who was 2 centimeters dilated, it's very different than if it's somebody who is 9 centimeters dilated.

Q. Because if they're 9 centimeters dilated,

they're closer to the delivery time?
A. Exactly.
Q. All right. In this situation involving Monica Dixon where she has these scalp pH values of 7.27, 7.23, then another one at 7.23, then at 7.22, then at 7.25, does this situation -- forget it. Strike the question.

In Monica Dixon's case, is there anything about these consecutive scalp gas values that raised any concerns on your part that a C-section would be indicated?
A. No.
Q. No?
A. No.
Q. Okay. And that's because she was 8 to 9 centimeters dilated?
A. And the scalp gasses were maintaining.
Q. All right. Do you have an opinion as to what the standard of care is after two marginal scalp gasses -- after two consecutive marginal scalp gasses are obtained? Does that mere fact indicate anything that needs to be done pursuant to the standard of care?

MR. NORCHI: I'm going to object. It's been asked and answered. I thought we've

already gone through that. Are you going to change your answer from before?

THE WITNESS: No. My answer is the same.

MR. NORCHI: Romney, it was asked and answered already.

MR. CULLERS: I didn't -- I mean, maybe I just -- I'm not trying to be repetitive. I just -- maybe I missed it in some of the confusion.

MR. NORCHI: There's no confusion. She said based upon the patient who is at this particular stage in her labor, given the other things you're finding on the fetal monitor strips and all the other factors that are going on, they did what -- they met the accepted standard of care. Now, I mean -- and then -- that's one issue.

The other thing is she's not an expert, she hasn't been identified as an expert, and she didn't make treatment decisions here.

MR. CULLERS: First, she doesn't have to be identified as an expert for me to ask if she has opinions. I mean, she's obviously trained.

MR. NORCHI: I understand. I'm not going to tell her not to answer. I'm just telling you the problem here.

MR. CULLERS: I understand.

BY MR. CULLERS:

Q. I guess the question I had was a little different than what you described. I just wanted to know if you have an opinion as to whether this -- just the fact that there are two marginal scalp gasses that are obtained, if that fact alone requires any particular action on your part?

A. It requires observation for this particular patient at this stage of labor.

Q. All right. I want to refer you again to your op note, which is the one that was handwritten. We've already talked about the scalp gasses. What I would like to do is start at the line after the scalp gasses are indicated and read that for me.

A. "Patient became complete 100 percent plus 1. Pushed and able to bring baby to plus 3 station. Direct OA."

Q. Okay. Stop there. I want to ask you about the determination of station. First of all, if you

wrote this, is it likely that you would have been the person who determined station?

A. Yes, and it is also likely that somebody else also performed the exam with me.

Q. Okay. Explain that, what you mean

A. Being a second year resident, I am under the direct supervision of my chief resident and the attending physician.

Q. Who was the chief resident?

A. Dr. Goldfarb.

Q. And the attending was Dr. Austin?

A. Yes.

Q. In this situation where you're determining station, when you say it was likely that it would have been -- did you say supervised or did you say confirmed? I'm not sure what you said. E want to get it right.

A. In this situation, because an operative vaginal delivery was performed, it is likely that it was confirmed by the chief resident.

Q. Okay. Do you recall, having now read this, determining station in this situation?

A. I don't recall performing the exam. Is that the question?

Q. Yes. you don't recall performing the exam which

led to the information that the baby was at plus 3?

MR. NORCHI: Just so the record is clear, she doesn't remember the delivery and the patient generally.

MR. CULLERS: Right. I know.

THE WITNESS: All I have that I -- all I have is what I have written in this note.

BY MR. CULLERS:

Q. Okay. That's why I'm asking yo if you remember it, and if you don't, that's -- I understand that. And you don't?

A. No, I don't remember it. I'm sorry.

Q. All right. Let me see if I can do this* As of that time, as of 3-14-95 when you were determining station, how did you do it?

A. With a vaginal exam.

Q. All right. Explain that. Give me the detaids here.

A. A bimanual vaginal exam, which determines how far the head is below the pelvic spines.

Q. You place your finger inside the vagina?

A. Place two fingers inside the vagina.

Q. Do you use your right land, left hand on this?

A. I use my right hand.

Q. On your right hand, these two fingers?
A. Yes.
Q. And when you're determining station, tell me how you do it.
A. You feel the relationship between the fetal -- the presenting part of the fetal head to the ischial spines.
Q. All right. Which -- when you say "the presenting part of the fetal head" --
A. The lowest part of the head.
Q. Which is?
A. Whatever the lowest part of the baby's head is in the canal.
Q. How do you know when you're there.
A. I don't understand the question.
Q. How do you know when you -- I mean, I understand you feel for the ischial spines.
A. Uh-huh.
Q. All right. And then tactilely you have to feel for the presenting part of the baby's head?
A. Yes.
Q. How do you know when you've found it?
A. You have to feel the lowest part of the head in relationship to the spines. It's the first part of the head you feel when you go into the

vagina. It's the lowest part, the first part you touch, and its relationship to the spines.

Q. How do you know that you're touching bone?

A. You can feel the bones of the skull.

Q. And that's what you feel for?

A. Uh-huh.

Q. Okay. After you -- after you -- your note where it says "direct OA," could you pick up and read from that point forward.

A. "Second-degree episiotomy cut."

Q. Stop there. I'm sorry. Can you tell from looking at the record when you made the determination that she was at plus 3? Is there any way to do that?

A. Time?

Q. Yes.

A. No.

Q. Or not necessarily time, but in relation to some other event? For example, if you look at your physician progress note, at 8:30, 3-14 at 8:30 you're talking about she's starting to push. She's at plus 1. 100 percent effaced. Plus 1. And then somehow she gets to plus 3. This is at 8:30. Is there some way you can narrow down when she got to plus 3?

A. Sometime between 8:30 and delivery.
Q. There's no other way?
A. There's no other way.
Q Is there anything that I could look at in the record which would indicate where that is? Because it's not recorded in your progress note. I looked in the nurse's note and I don't see it.
A There's nowhere else it would be.
Q The nurses wouldn't record it, would they?
A Probably not in the middle of the delivery.
Q. That would be something that you would record anyway?
A. And the reason it's not recorded with the time is because we were probably gowned to do a delivery, so it's not recorded in a sequential -- like time sequential event.
Q. Okay. I just wanted to know if there was some way to determine when she was at plus 3?
A. If it's not in the nurse's notes, there's nowhere else it would be.
Q. I'm trying to -- all right. Let's move on to the issue of the second-degree episiotomy. It's my understanding that, based on information that's farther down in the note, that the

second-degree episiotomy also had an accompanying perirectal extension. Do you see that? It's at the bottom.

A. Uh-huh.

Q. What is a perirectal extension?

A. Where the episiotomy goes down to the level of the -- around the level of the rectum, but it doesn't extend into the rectum; so it's not a fourth-degree episiotomy. It hasn't torn through the rectal/vaginal wall, and it hasn't necessarily -- it hasn't -- from this I can't tell, but it hasn't even necessarily gone through the sphincter.

Q. That's what I didn't understand when I read this, because it was my understanding that --

A. It's probably --

MR. NORCHI: Slow down.

THE WITNESS: Go ahead.

BY MR. CULLERS:

Q. It was my understanding that a second-degree episiotomy does not at all involve either the rectal sphincter or rectal tissue, whereas a third-degree episiotomy does, and I didn't understand why it was classified as a eecond-degree episiotomy as epposed to a

third-degree episiotomy?
A. It probably went to that level but didn't classify -- it probably did not go into the sphincter, and I'm surmising this based on -- based on this because that's all I have to --
Q. Right. Well, if it would have been an episiotomy that did, in fact, go into the rectal sphincter, meaning that the rectal sphincter was severed, don't you think you would have put third-degree episiotomy versus second-degree episiotomy?
A. If the sphincter is torn or severed, then it's considered a third-degree episiotomy; so this probably went up to that level but didn't go into the sphincter. It's probably better to say perianal versus perirectal.
Q. So from looking at this, I mean, you can comfortably tell me that it probably didn't invade the rectum or the -- I'm sorry, the rectal sphincter?
A **Yes.**
Q Okay. That's what I wanted to know. Now, what I would like to know is, first of all, if you recall cutting the episiotomy?
A **Bo.**

Q. Do you recall your normal procedure when you performed an episiotomy and how you went about doing it as of 3-14-95?
A. I don't understand the question.
Q. For example, do you have a particular instrument that you use? Do you use a scissor or do you use a scalpel?
A. You use a scissor.
Q. All right. And you don't remember doing this on this particular day?
A. No.
Q. Okay. What I want to know now is if you can tell me when the episiotomy was cut in relation to the application of the Mityvac?
A. There's no way to know that from this note.
Q. From what it appears in reading this note is that it's placed at least before the area where you start talking about the Mityvac?
A. Yeah, but that doesn't mean it wasn't done at the same time, that the Mityvac was applied and the episiotomy was cut.
Q. Okay. The reason that this -- the question was raised is because it looks like you intended to write that in but you didn't, and then you went back and put a caret and wrote it in. Do you

see that?
a. Yes.
Q Do you remember doing that?
A Do I remember adding that in th re?
Q. Yes.
A No, I don't remember writing that in there.
&- Would you please look at the nurse's notes up at 3-14 at 8:53.
A Okay.
Q Do you see the note where it reads, "Dr. Austin present for delivery, push/pull with vacuum"?
A Yes.
Q Does that mean that the vacuum 5 being applied at 8:53?
A, I don't know the answer to that
Q. Okay. Because then obviously the next note three minutes later at 8:56 ind cates --
A. "The episiotomy was cut."
Q. -- "the episiotomy was cut by Dr. Krivetsky." The reason I referred you to this is because I need to know if this in some way can help you identify whether the episiotomy was cut before the vacuum was applied or afterward?
MR. NORCHI: If you don't, that's fine.
THE WITNESS: I don't know. All I have

)ws.

Q. .ght into that?

A. urse's note, it .ed and there was was cut after pushes.

Q. our note, please, your operative note.

A. (The witness complies.) Okay.

Q Can you tell by looking at your note where the episiotomy was?

A No.

Q Okay. Can you tell me why the episiotomy wasn't cut through to the rectum?

A. No.

Q. ht process was in y? your decision? ing to say I cess was, and it

Q. "do that; do the episiotomy"?

A. You have to understand, I am following the auspices of basically the chief resident and the attending physician in the room, so I am doing what I am instructed to do.
Q. I'm going to ask you some questions about that --
A. Okay.
Q. -- in particular, but I take it from your answer that at least the decision to do the episiotomy isn't something that you can recall making?
A. No, it's not.
Q. What I was getting at is I wanted to know what the considerations were that formed part of that decision, and you can't tell me that?
A. Correct.
Q. By the way, up to this point who was it -- who was with you in the room by way of physicians? Was Dr. Goldfarb there and was Dr. Austin there?
A. My note on 3-14-95 at 8:00 in the morning indicates that Dr. Goldfarb was in the room with me, and the nurse's notes from 8:31 indicate Dr. Goldfarb was in the room.
Q. Who's "Hoyt"?
A. Oh, that's the anesthesia attending.
Q. Okay. And then?

A. And then at 8:39 it says Dr. Goldfarb was in the room; 8:46 it says Dr. Goldfarb and I are in the room; and then 8:53, Dr. Austin was with us too.
Q. Who is Dr. Anthony who is down in the 9:00 note?
A. Dr. Anthony was an intern at that time.
Q. In other words, a first year resident?
A. First year resident.
Q. And then "Girrard" is a certified nurse midwife?
A. Yes.
Q. Do you know what "H" stands for?
A. Heather.
Q. Okay. I take it from some of the testimony you gave earlier that you're not the person who was making the decision about what was going to be done here?
A. Correct.
Q. All right. Who was the person who was making the decisions, at least up until the point where the episiotomy was cut and the Mityvac applied? Who was doing that?
A. As a second year resident, I would make an assessment, then I would notify my chief resident who would confirm my assessment, and then together with the attending physician develop a plan.

Q. All right. And you don't recal any of that --
A. I don't recall --
Q. -- analysis here?
A. -- the specifics of any of that
Q. All right. I asked you earlier why wasn't the episiotomy cut through to the rectum, you said you didn't know, and that's what triggered all this discussion about who was making the decisions.
A. Uh-huh.
Q. Do you recall having any discus ion, like what you just described with the chief resident and with the attending, about the decision to cut the episiotomy at all?
A. I don't recall having those discussions.
Q. Okay. Do you recall any discus ions to the effect that the episiotomy needed to be cut because there was a suspected shoulder dystocia complication?

MR. NORCHI: I assume ou re trying to jog her memory with these?

MR. CULLERS: Yeah.

THE WITNESS: I don't recall any -- I don't recall this patient. I don't recall any of the delivery.

BY MR. CULLERS:

Q. All right. So I take it that you don't remember anything having to do with shoulder dystocia being a reason why the episiotomy was cut?

A. That's correct.

Q. All right. Let's get back on your operative note where you indicate here, "Mityvac applied and head delivered." I want to ask you about that.

A. "Mityvac applied and head delivered."

Q. All right. Do you know how long the Mityvac was applied before the head was delivered?

A. Are you referring to how many attempts were made with the Mityvac to deliver the head, or are you referring to how many seconds the Mityvac was applying suction to the baby's head at any given particular push/pull event?

Q. If you can give me information with respect to either of those, either would be fine. First of all, how do you do it? When you're using the Mityvac, tell me how you'd use it. You said attempts versus number of seconds that traction is being applied. Explain to me --

MR. NORCHI: I'm thoroughly confused, Romney. You want to understand how you apply --

how the Mityvac is used?

BY MR. CULLERS:

Q. You make the distinction --

A. A suction cup device is applied through the vagina to the baby's head, not over fontanel, and during a contraction it is connected to a device that applies pressure, a suction to the baby's head. It is applied during the time of the contraction; and at that time while the patient is pushing, you apply pressure and are pulling back.

Q. All right. So it would be more --

A. That's why it's called a push/pull, because the patient is pushing and you're pulling.

Q. It would be more informative if you could tell me how many times it was used versus how many seconds it was used, if you could tell me that.

A. According to the nurse's note, it appears that there was a push/pull at 8:53, at 8:56 and at 8:59.

Q. So it sounds like there were three push/pulls?

A. Yes.

Q. Is there any way to know how long those occurred, each of those push/pulls?

A. No.
Q. Okay. Who was operating the Mityvac?
A. Which part of the Mityvac?
Q. All right. How about the part -- all right.
A. Sorry.
Q. That's all right. No, that's all right. What I'm concerned with is the person who's applying the traction. All right.
A. Okay.
Q. And I assume that there's some part of the Mityvac device which is the -- whoever the surgeon is, is able to apply to the head and somehow can gauge the traction that's being applied; is that accurate?
A. Uh-huh.
Q. Is that true?
A. Yes.
Q. Who was doing that?
A. That -- according to these notes, it would have been myself and Dr. Goldfarb.
Q. All right. Do you recall anything at all about the traction that was applied to this baby's head?
A. No, I don't recall anything.
Q. You don't?

A. No.
Q. All right. Do you recall what your normal procedure in using the Mityvac to apply traction was back in March of 1995?
A. What specifically are you asking?
Q I'm asking, you know, what you typically did when you used it? I know that you put it up through the mother's vagina and somehow it attaches to the baby's head, and then do you turn it on? Is there a switch on it that you can operate?
A. No, it's connected to the device --
Q. Okay.
A -- that generally the nurse has in her hand that pumps up the pressure on the vacuum when you tell her to do that during a contraction, and then she has the release for that also.
Q. You have to tell her to do that?
A Yes.
Q And then it comes on and then it adheres to the baby's head?
A. Yes.
Q And then when the traction is applied, that's actually the force of your hands pulling on the device?

A. In combination with the mother pushing.
Q. Okay. Back in March of '95 when you would use this, is there some way you can describe for me how you applied the traction when you would use the Mityvac in a given situation?
A. I don't recall this delivery.
Q. Okay. I'm talking about generally back in March. Since you don't -- strike that. Since you don't recall this particular delivery, I'm asking you if you recall what your, you know, general custom was or your general practice was when you used the Mityvac back then?
A. I don't understand the question, because we've already talked about how a Mityvac is applied, and there's nothing else -- there's nothing else to describe to you.
Q. All right. What do you do? I mean, you have ahold of it somehow.

MR. NORCHI: What does the second year resident do at that time when it's being applied?

MR. CULLERS: Yeah.

MR. NORCHI: It looks like Dr. Austin is applying it. I don't know if she was assisting with the vacuum. I don't know.

THE WITNESS: No, she probably would not have applied it. I mean, the general practice is you apply the vacuum to the baby's head when the position is confirmed.

BY MR. CULLERS:

Q. Right.

A. And then at the time of the contraction, it is -- the pressure is increased to apply the suction, and then as the patient is pushing it's guided with your hand -- with your two hands, holding and pulling with the suction.

Q. All right. And you actually pull on it?

A. Yes.

Q. Do you recall how much force you applied when you were using the Mityvac in this particular situation?

A. No.

Q. All right. Is there any way you can tell me typically back during this time period, March of '95, how much force you would have used when you used the Mityvac when you applied traction?

A. I couldn't give you a number.

MR. NORCHI: Is there a way to generally describe the type of traction that's applied? Is it a gentle traction?

THE WITNESS: It's a gentle traction; gentle, steady traction.

BY MR. CULLERS:

Q. How do you know if it's gentle, just by your experience and just by the way it feels or --

A. Yes.

Q. Is that it? Is that how you do it?

A. I mean, there's nothing that has -- you know, that's measuring how much pressure you're pulling on -- I mean, there's not a gauge that's measuring out how much pressure you're applying, if that's what you're asking.

Q. But you can just feel it?

A. It's a feel.

Q. All right. Being in the position that you were as a second year resident in this instance where traction was being applied with the Mityvac and, you know, there are other people around, you know, where are they and what are they doing?

A. I can't tell you specifics to this case. I can tell you how things generally went, if that's what you want to know.

Q. That's what I would like to know.

A. Generally, prior to any operative vaginal delivery being performed, the chief resident --

the second or third year resident on the floor reports to the chief resident. The chief resident assesses the patient and will make the determination as to where to go in that situation.

Once it's been determined to do an operative vaginal delivery, then typically the people that would be gowned for that procedure and gloved for that procedure would be that second or third year resident and the chief resident, and then the attending physician would be in the room.

MR. CULLERS: Off the record.

(Thereupon a discussion was held off the record.)

(Thereupon, a recess was taken, after which the deposition continued as follows:)

BY MR. CULLERS:

Q Where we left off, I was asking you about who would have been around and who would have been doing what at the time that the Mityvac was being applied in this particular situation. You indicated you don't remember much about this specific instance; however, generally back around that time frame, the second and third

year residents would be gowned for the procedure and then the attending would be in the room. Do you remember that -- saying that stuff?

A. The second and third year residents would be gowned with the chief resident, and the attending would be in the room.

Q. The chief resident?

A. Is a fourth year resident.

Q Who was the third year resident in this situation, if there was one?

A. There wasn't one at this time.

Q. Okay. Now, when the Mityvac would have been being applied in this situation, you said it was likely that you were operating it. Where were the other people? Where was the attending and where was the third year resident? -- or the chief resident, I mean.

A. I don't -- I can't tell you where everybody was specifically in this case, and it's not indicated specifically in the medical record. What I can generally tell you is an operative vaginal delivery would be done in combination with the second or third year resident and the chief resident, so it would be a combination of myself and Dr. Goldfarb that would be doing the

vacuum delivery.

Q. Whose hands are where doing what while the vacuum --

A. I don't know whose hands were where in this case, because it doesn't indicate that.

Q. All right. In a typical situation back then when someone would have been operating a Mityvac, where would the other person's hands have been and what would they have been doing? That's what I'm trying to figure out. Helping?

A. Yeah. It would depend on the scenario. One person's hands might be on the vacuum and the other person's hands might be guiding them. One person might be doing the vacuum and the other one is supporting the perineum or cutting the episiotomy. It depends on the individual situation.

Q. That's what I wanted to know. I would like you to go to your progress note at 8:30. The last thing you've written in your plan section of your note, "consider attempted operative vaginal delivery." Do you see that?

A. Yes.

Q. Do you recall writing that?

A. No.

Q. Do you recall what your thought process was when you wrote that down?
A. No.
Q. According -- well, according to this record here, you made this note at 8:30; is that correct?
A. Yes.
Q. And if you look at the nurse's notes where the Mityvac is indicated as first being used is at 8:53. Do you see that?
A. Uh-huh.
Q. I need you to say yes.
A. Yes.
Q. That's 23 minutes later, right?
A. Yes.
Q. During that period of time, do you recall anything about what was going on with this patient?
A. No.
Q. At any point up to the point where the Mityvac was being applied for the first time according to the nurse's notes, do you recall anyone involved in this patient's care suggesting that a C-section may be needed?
A. I don't recall that.

Q. If you would go back to your operative note again. Where you were reading from earlier was the part where it says "Mityvac applied and head delivered."

A. Yes.

Q. Do you remember anything about the head being delivered?

A. No.

Q. So you can't tell me when the baby's head came out whose hands were on the baby's head?

A. No, I don't recall that.

Q. Is there any wag. you can look at the record and determine anything specific about the baby's head being delivered other than the fact that it was delivered?

A. I don't know what you're asking. I'm sorry.

Q. In other words -- well, I'm just asking if there's anything in particular that yair remember or that you can look at the record to find which would give any specific information about the delivery of the baby's head?

MR. NORCHI: You mean like where people were positioned and had --

MR. CULLERS: Anything at all?

MR. NORCHI: How about times of

delivery?

BY MR. CULLERS:

Q. If you refer to the nurse's note, you can see that at 9:00, according to the nurse's note, the baby's head is out.

A. I saw that on the nurse's note.

Q. Okay.

MR. NORCHI: Is there a question?

MR. CULLERS: Oh.

THE WITNESS: I'm sorry.

BY MR. CULLERS:

Q. My question was: Obviously you've indicated that you can't remember as you sit here today the delivery of the head in this particular instance, and I asked you if there is something in the record that would give you any specific information about the delivery of the head?

A. No.

Q. Okay. We do know that it was delivered at 9:00, right?

A. 9:01.

Q. The head, the head out was at 9:00?

A. Okay. The delivery time is listed as 9:01.

Q. Would you look at the nurse's notes, please.

A. Okay.

Q. See where it says "9:00, head out"?
A. Uh-huh.
Q. And then down at 9:01 it says "delivery of male infant"?
A. Yes.
Q. Do you see that?
A. Yes.
Q. It appears as if some time, whether a minute or less, elapsed between the delivery of the head and then the delivery of the remainder of the --
A. Yes.
Q. After the baby's head was delivered, do you remember anything at all being discussed about the baby being stuck, about shoulder dystocia being present, about having trouble with the shoulder, anything at all like that?
A. No.
Q. Let's go back to your note. Will you keep your finger on that.
A. I've got it.
Q. Then go back to your note, your operative note. After you've indicated "and head delivered," could you read on, please.
A. "Due to macrosomia, shoulder dystocia was anticipated and no suctioning done."

Q. Okay. Stop there. Can you tell me when shoulder dystocia was anticipated?
A. No.
Q. Is it likely based upon your review of information that you prepared for the discharge summary and other records that we've reviewed, that shoulder dystocia was anticipated before the operative delivery was attempted?
MR. NORCHI: You mean before application of the Mityvac?
MR. CULLERS: Yes.
THE WITNESS: Any time you have a woman with a large baby and the gestational diabetes it's a concern and you anticipate that there could be a shoulder dystocia, so that if there is, the practitioners are ready to deal with that situation.
BY MR. CULLERS:
Q. Okay. So is it fair to say that it was likely that shoulder dystocia was something that was anticipated before she went into her second stage of labor?
MR. NORCHI: By whom?
MR. CULLERS: By anyone involved in her care.

THE WITNESS: I can't say what other people anticipated, and I can't even say what I anticipated, because I don't recall the --

BY MR. CULLERS:

Q. I understand that.

A. -- the whole delivery.

Q. Okay. Let me ask it to you this way: Based upon your review of the information that you personally were responsible for placing in the chart and the other records here, is it likely that you would have anticipated shoulder dystocia prior to the commencement of the second stage of labor?

A. It is possible that it was cons'dered The patient had risk factors to con ider that she may have a shoulder dystocia.

Q. Yeah. That's what I wanted to know. And I'm just trying to figure out if -- is that something that was anticipated, say, at 8:30 on 3-14 or before? And I just picked that because you wrote a note at that time where you said "operative vaginal delivery may be considered."

A. Uh-huh.

Q. So as of that time, is it likely that shoulder

dystocia was something that was anticipated?

MR. NORCHI: Objection. Can you answer that question, that last question? If you can, answer it. Do you want it repeated by the court reporter?

THE WITNESS: I want it rephrased.

BY MR. CULLERS:

Q. Let me rephrase the question. Let me start with in your note you've indicated "shoulder dystocia was anticipated." Do you agree with that?

A. The note indicates that.

Q. All right. What I want to know is based upon your review of the information related to this patient's history and treatment up to the point where you became involved, is it likely that shoulder dystocia was something that was anticipated before 8:30 on 3-14-95, which is when you wrote a note?

A. It is possible that it was thought that the patient may have some factors that need to be considered for a possible shoulder dystocia.

Q. Okay. Can you tell me whether or not it was likely that it was considered? I'm using different words. You said "possible."

A. No, I can't tell you that.

Q. You can't?
A. Uh-uh.
Q. All right. Now -- all right. Never mind. Let me give -- let me ask this one more time in a different way.
MR. NORCHI: Objection Go ahead.
BY MR. CULLERS:
Q. I'm not trying to ask you if, in fact, you know, as of 8:30 on 3-14-95 that shoulder dystocia was likely. What I was asking was if it was likely that shoulder dystocia was anticipated as of that time?
A. I don't know the answer to that --
Q. Okay.
A. -- because it's not indicated in the record.
Q. All right. You indicated earlier that when shoulder dystocia is anticipated based upon a patient's history or based on a variety of information that you have about the patient, that certain precautions or certain measures need to be taken to prepare for that possibility. Do you recall that?
A. I don't know if I stated that certain precautions need to be taken.
Q. Well, I'm not trying to pin you down with those

words, but you did say something about --

MR. NORCHI: Just ask a question. Just ask her.

BY MR. CULLERS:

Q. Okay. Is -- all right. In a situation where shoulder dystocia is anticipated, is there anything that is done by the medical personnel involved in the patient's care to prepare for that possibility?

A. Any time you are partaking in a vaginal delivery you should anticipate there's a possibility of a shoulder dystocia, because a shoulder dystocia is an unpredictable occurrence regardless of any risk factor, any fetal size, any maternal pelvis; so you should always be prepared that you may have one and be prepared to do maneuvers you would need to do to deliver the fetus if one should occur.

Q. Is there anything in particular about the possibility of shoulder dystocia that would cause you to do something different than you would do to prepare for any operative vaginal delivery?

A. No, not necessarily.

Q. Based upon testimony that you've provided

earlier, I take it you don't recall any discussions that were had among the medical personnel involved in Ms. Dixon's care about the fact of whether shoulder dystocia was anticipated?

A. That's correct.

Q. Reading on in your note, it says -- you say "attempted to deliver anterior shoulder and there was evidence of a shoulder dystocia." Do you see that?

A. Yes.

Q. What I want to know is: What was done in attempt to deliver the anterior shoulder; if you recall?

A. I do not recall the specifics.

Q. As of that time, 3-14-95, had you ever been involved in a situation where attempts needed to be made to deliver a shoulder in a situation involving shoulder dystocia?

A. As stated at the beginning of our interview, yes.

Q. Maybe half a dozen of those you said you were involved in?

A. That was an estimated number.

Q. Okay. Do you remember if in connection with any

of those, you were involved at all in attempting to deliver a shoulder that wouldn't come out?

A. I don't understand the question.

Q. Okay. It says here "attempted to deliver anterior shoulder." What does that mean, the shoulder is stuck, won't come out? I don't know what it means.

A. Once the head is delivered, the shoulders are the next part of the baby to be delivered.

Q. Okay.

A. And it is the anterior shoulder that is delivered first, so attempt was made to deliver the anterior shoulder. If the anterior shoulder does not deliver, that's considered a shoulder dystocia.

Q. Do you ever recall that situation occurring in one of these dozen or so cases that you've described earlier?

A. I don't remember specifics about those cases.

Q. All right. Do you remember ever attempting to deliver the anterior shoulder and it not coming out in any instance?

A. I recall having cases like that. I can't recall specifics.

Q. You don't recall?

MR. NORCHI: What --

THE WITNESS: I don't know you're asking for.

BY MR. CULLERS:

Q. What I'm asking for is: Have you ever had a situation where you -- that you attempted to deliver the baby's anterior shoulder and you realized that there was evidence of a shoulder dystocia because the shoulder wouldn't deliver? I'm just asking if you specifically remember that ever happening?

A. Yes.

Q. Okay. Do you recall what you did when that happened?

A. No, because I don't recall the specific cases.

Q. Okay. And you can't recall in any instance what you did in the face of that situation?

A. No.

Q. Okay.

MR. NORCHI: Do you understand the question?

THE WITNESS: Yeah, but I can't give him specifics. I think he's looking for what did you do specifically with these other cases --

MR. NORCHI: Okay.

THE WITNESS: -- and I can't give you details of the other cases.

BY MR. CULLERS:

Q. I guess I would be interested to know -- I appreciate that because you don't remember the details of those and I understa d that.

A. Uh-huh.

Q. I guess what I would like to know is what you recall about having done in the past at any time when faced with this situation of, you know, the anterior shoulder not delivering because of shoulder dystocia?

A. Are you asking me what do you normally do if a shoulder dystocia occurs?

Q. Yeah, but I can't ask it to you that way because I'm not talking about now; I mean in the past.

MR. NORCHI: As of March of 1995.

THE WITNESS: See, I can't separate that out.

BY MR. CULLERS:

Q. You can't?

A. I can't tell you -- it's hard to go back and tell you what I knew as of March 14th of '95 and what I know now and how that was different.

Q. All right. Is there some way you can tell me what you do now when you're faced by that?

MR. NORCHI: Objection. I understand the difficulty. She's not an expert and that's -- and she's not here to talk about standards of care, but if you want to --

THE WITNESS: I'm stuc here. I'm sorry.

MR. NORCHI: Are you asking what is the -- how do you manage shoulder dystocia -- presentation of a shoulder dystocia? Is that -- I think that's what you're asking.

MR. CULLERS: I'm not asking for her opinion in that regard.

BY MR. CULLERS:

Q. What I'm asking is: What do you do now when you're faced with this situation, just so I can gain an understanding of how this is dealt with.

MR. NORCHI: How do you manage a present shoulder dystocia that presents during a vaginal delivery, I think is the question, right?

MR. CULLERS: Yes.

THE WITNESS: Answer it?

MR. NORCHI: Go ahead.

THE WITNESS: Number one, you have to identify the fact that you have a shoulder dystocia.

BY MR. CULLERS:

Q. And that is done by your realiz tion that the shoulder will not deliver?

A. It's done by realizing the ante ior shoulder wouldn't deliver.

Q. How do you ascertain that?

A. As you're going through the movements of delivering the baby and once the head is out and you're going to deliver the shoulder, the shoulder just doesn't -- it doesn't deliver. I mean, you can tell; it just doesn't deliver beyond the pubic bone, because it's lodged behind the pubic bone.

Q. Do you then ever apply any trac ion --

A. To --

Q. -- to see if the shoulder will then come forth?

A. You can apply light traction, b_t not -- I mean, you don't -- I mean, that's -- here we go again with this whole traction thing. You don't pull. If it's lodged, you do something to try to dislodge it.

Q. You apply gentle traction?
A. Uh-huh.
Q. Then what do you do?
A. Then you have to say "I have a shoulder dystocia" so somebody looks at the clock, and then you begin the movements to try to dislodge the shoulder, which can include various things; one can include suprapubic pressure.
Q. Which is what?
A. Downward pressure right on the pubic bone, right above the pubic bone, to try to push the shoulder out from behind the pubic bone.
Q. Fist -- using a fist?
A. You don't do it because you're delivering the baby; somebody else does.
Q. Somebody else has to do it?
A. Yeah.
Q. Your hands are on the baby's head supporting the baby's head?
A. Uh-huh.
Q. Somebody else does the suprapubic pressure?
A. Yes.
Q. Below the naval, above the pubic bone?
A. Yeah.
Q. All right.

A. Then another maneuver you can use is the McRoberts maneuver, which is the hips flexed all the way back.
Q. How many people does it take to do the McRoberts maneuver?
A. Usually at least one on each leg.
Q. That's recommended, isn't it, that one person be assigned to each leg?
A. Yeah.
Q. All right. Why do you laugh?
A. It's hard to do if you have a large patient.
Q. Yes. One person is assigned to each leg, and what do they do?
A. They flex the hip.
Q. Push the legs up?
A. All the way to the chest.
Q. All right, You're not -- you can't be ne of those people?
A. -- --
Q. You're holding the baby's head?
A. -- you can't be one of those people --
Q. Xight?
A. -- if you're the delivering person.
You can do a Woods screw maneuver to try to rotate the shoulders out from underneath

the pubic bone.
Q. Do you do that before attempting the McRoberts?
A. It doesn't matter what order you do this in.
Q. It doesn't matter?
A. No.
Q. Have you ever done that maneuver at the same time that the McRoberts maneuver was being done?
A. As of March 14th, '95?
Q. Yeah.
A. As of that date?
Q. Yes.
A. I don't know.
Q. All right. As of today?
A. As of today, yes.
Q. All right. Have you ever -- explain rotating the shoulders. When do you -- how do you do it?
A. You have to get your hands around the shoulders and you can rotate in either direction, either forward or backward, to try to dislodge the shoulder from underneath the pubic bone. You can try to deliver your posterior shoulder.
Q. How do you do that?
A. Try to get the arm -- the posterior arm out and delivered.

Q. Do you reach up and see if you can get ahold of the baby's arm and pull?
A. Yes.
Q. It makes the shoulders become oblique?
A. It makes the shoulders rotate. You can cut a fourth-degree episiotomy. You can do a Zavanelli maneuver.
Q. What is that?
a. Place the baby back up into the pelvis.
Q Have you ever done that?
A No.
Q. Have you ever seen it done?
A. No.
Q. It's where the -- you actually ush the baby's head back up through the birth anal?
A. Uh-huh.
Q. Okay. Is it ever appropriate i a delivery, I'm not talking about a delivery involving shoulder dystocia but just in a delivery, appropriate to rotate the baby's head?
MR. NORCHI: Objection.
BY MR. CULLERS:
Q. Is it appropriate to rotate the baby's head?
A, I don't understand what you mean.
Q. All right. In your note here, after it says

"there was evidence of a shoulder dystocia," you indicate "suprapubic pressure and McRoberts position initiated." Do you see that?

A. Yes.

Q. As you sit here today, do you recall either the suprapubic pressure being applied or the McRoberts position being initiated?

A. No.

Q. Okay. Would you turn to the nurse's notes up to 9:00 here.

A. (The witness complies.)

Q. Do you see in there where it says "suprapubic pressure by Dr. Anthony" --

A. Yes.

Q -- "and H. Girrard"?

A. Yes.

Q. Having reviewed that, does that cause you to recall anything about the suprapubic pressure being applied in this instance?

A. No.

Q. Earlier when I asked you what "H" stood for, you said "Heather," so you obviously remember this person, Heather Girrard?

A. Yes.

Q. As you sit here today do you remember

Dr. Anthony?
A. Yes.
Q. It doesn't say anything in this note of 9:00 about the McRoberts position being initiated. Is that something that normally is recorded in nursing notes; if you know?
A. I don't know the answer to that.
Q. In a situation where the McRoberts position would be initiated back, you know, in March '95, you being the second year resident, what would your role in that be; if you can answer that?
A. With this particular patient?
Q. Yes.
A. I would not have been doing that because I would have been gowned doing the delivery.
Q. So you would have been one of the -- you would have been responsible for holding the baby's head or --
A. I don't know the answer to the questions. I can tell you that on the delivery record, Dr. Goldfarb and myself are listed as the delivering physicians, so we would not have been the two that were holding the legs to do the McRoberts maneuver.

Q. While that was going on, what would your role have been in the delivery, not necessarily in the McRoberts maneuver but in the delivery?
A. To somehow be involved in delivering the baby, but I can't tell you specifically what my role was because it's not indicated in this record.
Q. All right. In this situation where we know some of the people who are present, this Girrard, this Dr. Anthony, you were there, Dr. Goldfarb, who would have been responsible for flexing the mother's legs in connection with the McRoberts maneuver? Can you tell me that?
A. Who would have actually been doing the flexion of the legs?
Q. Yeah. Can you tell me that?
A. I can't tell you that by the record.
Q. All right. Can you tell me by your recollection of what the procedures were around that time?
A. It would have been one of the other parties in the room, which would either have been Dr. Anthony, Heather Girrard or the nurses.
Q. Do you know how many nurses were around?
A. No.
Q. Who's the person who makes the decision about when the McRoberts maneuver will be employed,

the attending?
A. It's not -- it's not something that one person makes a decision about.
Q. Tell me how it --
A. Because the staff is trained -- both resident, midwife and nursing staff -- that if a shoulder dystocia is present, those things automatically occur.
Q. They spontaneously will do that?
A. Yeah. I mean, it's not anybody is standing there giving orders.
Q. If somebody says there's evidence of shoulder dystocia, then they will automatically initiate the McRoberts maneuver?
A. And everybody in the room automatically knows what to do, and they begin these maneuvers.
Q. In your note it indicates suprapubic pressure was applied and the McRoberts maneuver was initiated. Is there any order in which those were done? Can you tell by looking at the record?
A I can't tell by looking at the record.
Q. Back then do you know if it was customary to do them in any particular order, or were they done together back then? How -- what would have been

the most likely occurrence?
A. When something like this happens, there's a lot of things going on simultaneously.
Q. Is it possible that, you know, based on your memory of the way things were done back on 3-14-95, that the McRoberts maneuver and the suprapubic pressure both were being done at the same time?
A. Did you say is that likely?
Q. Yeah.
A. Yes, it's likely.
Q. Do you ever -- strike that. Do you remember during your residency ever being involved in a delivery where the McRoberts maneuver and suprapubic pressure both were applied simultaneously?
A. Yes.
Q. Do you recall if in those instances, if there are more than one, whether an episiotomy also was done?
A. I don't recall.
Q. Is there any way you can tell by looking at the nurse's notes and knowing who t ese **people** were who were involved in this delivery who would have been the one applying the suprapubic

pressure?
A. No, I don't know that by reading these notes
Q. At 9:00 it says "suprapubic pressure by Dr. Anthony." Is there any way you can tell from that if he's the one that actually did that?
A. Well, it says "by Dr. Anthony and Heather Girrard," so I don't know which one of them or if both of them were applying suprapubic pressure.
Q. Would they both have been applying suprapubic pressure?
A. I don't know. I don't know if they alternated doing it or --
Q. Have you ever seen two people doing that at the same time on a patient?
A. I don't understand the question.
Q. Well, I understand --
A. I mean, it's -- you can't tell by this note who was applying the suprapubic pressure or if one was applying it and then the other one was applying it. There's no way that that note indicates that.
Q. Okay. Is there ever a situation where two people would be applying suprapubic pressure at

the same time? Would that be unusual?
A. I wouldn't say it would be unusual. I don't know if it's possible.
Q. That's what -- I mean, I understand what you're saying about you can't tell which one of these people was doing the suprapubic pressure. All I want to know is if it would be --
A. It would be unlikely that they both would have been doing it at the same time, but I can't tell you which one was doing it at which point.
Q. That's fair. Did you become aware during the course of treatment of either Monica Dixon or Michael Dixon that Michael Dixon had an Erb's palsy?
A. Was I aware that he had an Erb's palsy?
Q. Yes.
MR. NORCHI: During th s -- during what time? I'm sorry.
MR. CULLERS: Just dur'ng any -- any time during the course of eithe. his treatment or --
MR. NORCHI: She didn't treat him.
MR. CULLERS: -- the mother's treatment.
THE WITNESS: I didn't treat the baby.

Once the baby is delivered, the baby goes to the pediatrician.

BY MR. CULLERS:

Q. So did you ever learn at any point around the time of the delivery or during the next few days that he had an Erb's palsy?

A. I don't recall that.

Q. Is that something that you likely would have learned?

A. Possibly.

Q. In other words, is it part -- would it have been part of your practice to follow for any reason an infant's progress that had been born in which you were involved in the delivery?

A. It wouldn't be unusual to follow the infant's progress during the course of the mother being hospitalized in the hospital.

Q. Do you have any knowledge at all today about Michael Dixon's present condition?

MR. NORCHI: Other than what I told her you mean? I don't even have that.

BY MR. CULLERS:

Q. Do you have any understanding of what transpired with him after 3-14-95?

A. No, I don't.

Q. Were you aware that he had an injury to his brachial plexus?

MR. NORCHI: When?

BY MR. CULLERS:

Q. Just at any time did you become aware that he had an injury to his brachial plexus?

A. When I received the medical record to review.

Q. All right. Do you have any opinion as to how the brachial plexus was injured?

MR. NORCHI: Objection. You can answer.

THE WITNESS: No, I don't.

BY MR. CULLERS:

Q Have you ever -- I mean, have you thought about why it happened?

MR. NORCHI: How what happened?

MR. CULLERS: How the Erb's palsy resulted.

MR. NORCHI: She hasn't seen any -- go ahead Objection. If you have have you thought a is the question.

THE WITNESS: I don't understand the question.

BY MR. CULLERS

Q. Okay. What I'm trying to figure out is, first

on that a
to the infant;
as to how it
ow it occurred?
A. ecause I feel the
opriate way; and
, it states that
know, anticipated
l that the
ppropriately and
--
Q.
A. eliver a viable
Q. about whether or
e or not
I'm really
have an opinion
hysical
n other words,
esulted in the
to object only
because she
hasn't seen the

documentation that establishes that he has Erb's palsy. It's in a different medical specialty. I think we're getting far fielded from what a second year resident would know.

MR. CULLERS: If she doesn't have an opinion, she can tell me she doesn't have an opinion.

THE WITNESS: I don't have an opinion. I'm lost.

MR. NORCHI: You have to understand his question. If you have no opinion, that's fine.

BY MR. CULLERS:

Q. You said you're lost. Is it my question? What is it?

A. I don't have an answer. I gave you the best answer I could, which was I fee that the shoulder dystocia was handled appropriately.

Q. I mean, do you know today that he had an injury to his brachial plexus?

A. All I know is what was indicate in the medical records that I was given to rev ew.

Q. Was that in there?

MR. NORCHI: I don't know.

THE WITNESS: I don't know. I don't know specifically, because I -- I don't know

where the baby is at this point in its progress.

BY MR. CULLERS:

Q. All I wanted to know is if you were aware of whether or not he had the brachial plexus injury? If you're not, then all these other questions don't really matter.

A. Do we have any of those records

MR. NORCHI: I might. I don't know if you do. And they only go up to a certain date and they're limited, so --

THE WITNESS: I guess knew he had the brachial plexus injury because assumed that's what this all -- this whole pro ess involved.

BY MR. CULLERS:

Q. All right. Did you ever have any discussions with anybody who would have been involved in his care about the fact that he had a brachial plexus injury?

A. No.

Q. Did you ever have any discussions later after 3-14-95 with any people who were involved in either the care of Monica Dixon or Michael Dixon about the delivery and what had occurred during the delivery?

A. Not that I recall.
Q. Have you had any discussions with any of the involved medical personnel since the lawsuit was filed?
A. Not that I recall.
Q. After you received whatever information you did about the lawsuit being filed, did you contact any of the involved physicians or nurses or other medical professionals?
A. No, I did not.
Q. I mean --
A. I consulted the legal department. That was it.
Q. You didn't call any of these other involved people and say, "I got sued here. What's going on?"
A. (The witness shakes head.)
Q. "Did you get sued?"
A. I knew who got sued. It was listed on the lawsuit.
Q. I'm not trying -- I don't want to be indelicate or anything, but I find it --
MR. NORCHI: Wait. Before you go that path, usually what happens with doctors is that they are advised by their counsel, by legal departments and hospitals, don't talk to anybody

about the case because a lawyer will ask you at your deposition what did you talk about, and then they travel down roads of speculation and conjecture, which are just foggy and cloudy; so that's what happens in a situation like this,

BY MR. CULLERS:

Q. If that's the case --

A. I mean, that's the case. I don t find that unusual, what I'm telling.

Q. No. The reason -- having now heard that, it makes sense; but before that, it seemed a little strange to me to think that you get sued and not call and say something about it or have a discussion about it. That's all. But it's because you were told not to.

MR. NORCHI: The realties of the world.

THE WITNESS: Yes.

BY MR. CULLERS:

Q. And that's what he described as your situation.

A. Yes.

MR. CULLERS: All right. Let me look over my notes.

(Thereupon, a discussion was held off the record.)

MR. CULLERS: Let's go back on.

BY MR. CULLERS:

Q. I realize that you don't recall any specifics it sounds like about the care involved here with either Monica Dixon or Michael Dixon, but I need to ask you anyway if at any time during your involvement in Monica Dixon's care, do you remember hearing anybody say that it may be necessary to perform a C-section?

A. I don't recall ever hearing that.

MR. CULLERS: All right. I don't have anything further.

MR. NORCHI: I mean, you don't recall one way or the other?

THE WITNESS: I don't recall hearing any discussion related to that.

MR. CULLERS: Okay.

MR. NORCHI: I just wanted to make sure it comes out right, as opposed to they never talked about it or I recall that they didn't talk about it, as opposed to I have no recollection of any discussions at this time,

BY MR. CULLERS:

Q. In other words, the distinction that's being made here is that --

MR. NORCHI: Semantics.

BY MR. CULLERS:

Q. You're not saying --

A. I'm not saying it didn't take place. I'm saying I don't recall that happening.

Q. And if it did, you don't remember it obviously?

A. Correct.

MR. CULLERS: All right.

MR. NORCHI: Okay. Dr. Krivetsky will receive the transcript, read the transcript. I would like to waive the usual seven days, but we'll get it back at a reasonable time.

(Thereupon, a discussion was held off the record.)

THE WITNESS: 5,000 Higbee Avenue North --

MR. NORCHI: You don't even know it.

THE WITNESS: -- Northwest, it's 44718 -- Canton, Ohio 44718.

- - - - - - -

Deposition concluded at 7:50 p.m.

- - - - - - -

C E R T I F I C A T E

STATE OF OHIO

STARK COUNTY

I, Carey D. Sporup, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named Witness, JOANNE KRIVETSKY, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony given was by me reduced to Stenotypy and afterwards transcribed, and that the foregoing is a true and correct transcription to the best of my knowledge and ability of the testimony so given by her as aforesaid.

I do further cer Ify that this deposition was taken at the tim and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Canton, Ohio, on this 26th day of December, 1997.

Carey Sporup

Carey D. Sporup, RPR & Notary Public
My commission expires July 7, 2002

C E R T I F I C A T E

I, JOANNE KRIVETSKY, M.D., do hereby certify that I have read the foregoing deposition in the case of MONICA DIXON, Plaintiff, versus UNIVERSITY HOSPITALS OF CLEVELAND, et al., Defendants, and said deposition constitutes a true and correct transcript of my testimony give at the specified time.

_____
JOANNE KRIVETSKY, M.D.

Subscribed and sworn to before me this _____ day of _____, 1997.

_____
Notary Public
My commission expires _____

- - - - -

CHANGES REQUESTED TO THE DEPOSITION OF
JOANNE KRIVETSKY, M.D.
TAKEN ON DECEMBER 17, 1997

Page	Line	From	To	Reason