IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

- - - - -

JACOB A. FIKTUS, a minor by and thru his next of friend and natural mother, KELLY FIKTUS, et al.,

Plaintiffs,

vs Case No. 430662

UNIVERSITY HOSPITALS of CLEVELAND, et al.,

Defendants.

- - - - -

DEPOSITION OF RICARDO LORET de MOLA, M.D.

FRIDAY, AUGUST 2, 2002

- - - - -

Deposition of RICARDO LORET de MOLA, M.D., a Defendant herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of MacDonald's Womens Hospital, Cleveland, Ohio, commencing at 4:00 o'clock p.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind
LAWRENCE F. PESKIN, ESQ.
Skylight Office Tower Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant University Hospitals

Davis & Young
JAN ROLLER, ESQ.
1700 Midland Building
Cleveland, Ohio 44115
216-348-1700

On behalf of the Defendants University OB/GYN Specialties and Dr. Kiwi

Sutter, O'Connell, Mannion & Farchione
TODD A. GRAY, ESQ.
3600 Erieview Tower
Cleveland, Ohio 44114
216-928-4520

- - - - -

RICARDO LORET de MOLA, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF RICARDO LORET de MOLA, M.D.

BY MR. PESKIN:

Q. Could you state your full name for the record.

A. Julio Ricardo Loret de Mola Gutierrez. Just for purposes of professional name, because most patients cannot pronounce the whole thing, so J. Ricardo Loret de Mola.

Q. Is it all right if I refer to you as Dr. de Mola?

A. If we wanted to be puristic, it would be Loret de Mola.

Q. Dr. Loret deMola.

A. Or you could just go by Ricardo. Most people find it easier.

Q. I may just say doctor.

A. Why not.

Q. Doctor, I assume you have been deposed before or have you not?

A. No.

Q. This is your first deposition?
A. Uh-huh.
Q. You have to answer out loud.
A. Actually, I have been deposed once on behalf of the hospital, once before.
Q. When you say on behalf of the hospital, were you a defendant in that lawsuit?
A. No.
Q. Were you an expert witness in that lawsuit?
A. I guess you could say that. I don't know what the legal term is.
Q. Were you involved at all in the care and treatment of the plaintiff in that lawsuit?
A. Yes, but I wasn't named on the suit. I was involved in her care, but I wasn't named on the suit.
Q. Okay. That makes sense.
Well, since you haven't been through this too many times, I will go over a couple of basic ground rules.
It's my job to ask you a question that you can understand. If for some reason my question is unclear, please ask me to restate it or rephrase it, okay?

A. Uh-huh.

Q. You have to try to remember to verbalize your responses because the court reporter will have a hard time with uh-ugh or uh-huh or gestures, okay?

A. Yes.

Q. If you do answer my questions, we are all going to assume you understood them. Is that fair?

A. That's fair.

Q. And the only other really important thing that makes this different than a normal conversation is the fact that there is somebody trying to take down everything we both say. So it's important for both of us to not step on the others questions or responses. So do your best to let me finish a question, even though you think you may know what it is before you answer it, and I will also try to do my best not to ask another question before you answer one. Is that fair?

A. Fair.

Q. When you were talking about the other case you were deposed in, do you recall the name of the parties, the name of the plaintiff?

A. I'm sure the hospital could figure that out. I don't remember.

Q. And you are quite certain you were not named as a defendant in that lawsuit?

A. I'm very certain.

- - - - -

(Thereupon, LORET DE MOLA Deposition Exhibit 1 was marked for purposes of identification.)

- - - - -

Q. Where were you born, by the way?

A. I was born in Monterey, Mexico.

Q. I am going to try to speed this up by relying on your curriculum vitae which you provided that's been marked as Loret de Mola Exhibit 1. That's a copy of your CV?

A. Yes.

Q. When we were off the record, I think you mentioned it was about a year old?

A. Yes. About. I don't review them every month or so. About every year, year and a half, whenever I have something in particular that I need to revise, I do, so about once a year I just add publications or any other things.

Q. The information that's contained in your CV with regard to your appointments, administrative, academic, your education, your post doctoral training, honors and awards, et cetera, you reviewed all of that to make sure it's accurate?

A. No, I did not review. I just printed it from the computer.

Q. Take a quick look at it to be sure. I'm not going to ask you questions, provided you tell me that everything on there is accurate.

A. It seems okay just from going over it. I mean, things sometimes do change or sometimes there is information that my secretary adds which is incorrect.

Q. Would that generally be in the publication area with conferences that you presented, things like that?

A. Pretty much. Sometimes grants are pending and sometimes they are awarded and sometimes they are not awarded; things of that nature that change.

I would say that at least all the educational background, my current position, my licensures should be okay.

Q. I didn't get a chance to look through that CV in detail, but does it include information regarding your board certification?

A. Yes.

Q. In what areas are you board certified?

A. I'm board certified in obstetrics and gynecology and reproductive endocrinology and infertility.

Some of the trainees that I have had over the years, there is more that I haven't included. I think there may be -- I think this is actually probably reasonably accurate as of a year ago.

Q. I assume you were board certified first in obstetrics and gynecology?

A. That is correct.

Q. And is the date when you obtained your board certification contained on your curriculum vitae?

A. Yes, it is. The year. I don't think the specific date.

Q. The year is fine. Did you pass your written exam on the first attempt?

A. Yes.

Q. And the oral exam, did you pass that on the first attempt, as well?

A. Yes.

Q. And is the date of your board certification of reproductive endocrinology and infertility contained on your CV?

A. 1997 Diplomate for general obstetrics and gynecology. And Diplomate for reproductive endocrinology and infertility, 1999.

Q. Those dates are accurate?

A. Yes.

Q. And did you pass your board certification in reproductive endocrinology on your first attempt, as well?

A. Yes.

Q. Have you been a -- before I get to that, let me ask you. I did not know that you had a CV quite this long and I want to take a little bit of time, because you are going to be more familiar with what is contained in here by way of publications than I am. I am wondering if any of the publications that you have authored or co-authored are relevant to the issues in this lawsuit?

A. Could you be more specific?

Q. Well, have you published anything on Bandl's rings, for example?
A. No.
Q. And you have not been involved in any publications or anything dealing with a Bandl's ring?
A. No.
Q. What about induction of labor? As you flip through that, what I would like you to do -- I'll hand you a pen -- if you could circle or check, put a check next to any publications that are relevant to induction of labor.
A. No, they have been related to obstetrics but not specifically to induction of labor.
Q. What about uterine hyperstimulation, any publications related to that issue?
A. No.
Q. What about interpretation of fetal monitor strips?
A. No.
Q. Let me think of some other things to ask you about. Are you currently a defendant in any other lawsuits other than this one?
A. No.

Q. Have you ever been a defendant in a lawsuit that you are aware of?
A. Not that I can recall.
(Discussion off the record.)
A. Going to your question, I never received any letters to any lawsuits. If I have never received any, does that count?
MR. GRAY: You know of no other suits?
THE WITNESS: No. But there is always the decision of the mail and I don't know what to say. None that I'm aware of.
MR. GRAY: You answered his question.
Q. I am not asking about letters you may have gotten about thinking about filing a lawsuit.
A. Not even that.
Q. What I am asking, complaints filed where your name is on them. And this is the only one that you are aware of?
A. Yes.
Q. What have you reviewed in preparation for your deposition today?
A. What's here in front of me, which is a copy of the chart.

Q. Is that a copy of the entire chart or portions of the chart?
A. This is what was given to me by Mr. Farchione, so this is what is just in front of me.
Q. Let me take a quick look and see what you have got.
MR. GRAY: Before you do that, let me see this.
You don't recall seeing any letters or anything of that nature in here, when you reviewed it, from our office?
THE WITNESS: I don't remember. I put everything --
MR. GRAY: I think it's the exact same copy of what I have here.
THE WITNESS: See, whatever correspondence, I just put it altogether so I don't lose it. This is what this is about and this is about. And it's confusing because sometimes attorneys change law firms, so I get letters from different law firms.
MR. PESKIN: I know about that too. I've made a few changes.
(Discussion off the record.)

Q. This is the form in which you received these records, basically from your attorneys?

A. I'm just looking at more forms, more letters here. This is not relevant to this. I think what I have here is also -- yes.

Q. The question was, did you put this together? Was it delivered to you in this form?

A. It was delivered to me as you see it.

Q. Including the tabs --

A. Yes.

Q. -- with the names on it? Aside from that medical record, what else have you reviewed in preparation for your deposition?

A. Nothing.

Q. Did you look at any of the transcripts of the depositions of anybody else who was deposed in this case?

A. Yes. I received this deposition from Mary McHugh and I read it, but this was about maybe three months ago, two months ago, something like that.

Q. Did you review any other deposition transcripts?

A. No. This is the only deposition

transcript that I have seen.

Q. Other than your attorneys, whatever law firm they may be affiliated with at the time, have you talked with anybody else about this case?

A. Not that I would recall.

Q. And no conversations with Dr. Kiwi about this case?

A. No. I have not seen Dr. Kiwi in a long time.

Q. Any conversations with Dr. McHugh or Dr. Wang?

A. No. They have been out of the city for a long time and I haven't seen them since then.

Q. And what about any of the obstetrical nurses involved?

A. I don't recall the names of the people. I would say that I do not recall having talked specifically about this case with anyone else.

Q. Are you currently employed by University OB/GYN Specialties, Inc.?

A. I am not.

Q. Who are you employed by at present?

A. MacDonald's Physicians, Inc.
Q. And how long have you been employed at MacDonald's Physicians, Inc.?
A. Since October of 2000.
Q. And how was it that -- did you move from University OB/GYN Specialties, Inc. to MacDonald?
A. No. I left Cleveland in 1999 to join the faculty at University of Texas Health Center of San Antonio and I was recruited back to Cleveland as head of the division of reproductive endocrinology and infertility and it is managed by MacDonald Physicians, that makes the checks. It's one of those weird arrangements between hospitals and physicians.
Q. You were out of town for a period of time and came back?
A. Yes. And yes, I am sane.
Q. University OB/GYN Specialties, Inc., does it still exist, as far as you know?
A. Not that I'm aware of, but I don't know if -- I really don't know. I assume that the name may persist, but as I understand it, there are no physicians working in it anymore.
Q. As far as you know, all of the

shareholders and physician employees have moved on to other things?

A. They created a new corporation and went to The Cleveland Clinic. They are still in practice, but I think that particular corporation is no longer in existence.

Q. At least it doesn't have the name University anymore, I would assume.

Were you a shareholder of University OB/GYN Specialties, Inc.?

A. No.

Q. You were an employee?

A. Yes.

Q. Who were the other physician employees of the corporation in November of 1997, if you can recall?

A. There were probably around 20 people. Do you want me to sort of mentally review them?

Q. If there is that many, that's more than I need to hear about, because I won't remember past the first three or four anyway, but did the practice include subspecialists as well as general OB/GYNs?

A. Yes.

Q. Did you at that time in 1997 have a

general obstetrical practice?

A. A very limited obstetrical practice with private patients, but I had responsibility to cover the staff service for the hospital as part of my duties as faculty.

Q. What do you mean when you say covering the staff service?

A. The OB/GYN clinic at the hospital has a clinic for patients who have Medicaid, Medicare, and no insurance.

Q. So all of the physician employees of your practice at that time provided coverage for the house officers?

A. Correct.

Q. Who cared for the clinic patients?

A. Correct. And at the time, my primary role in the department was as a reproductive endocrinology and infertility specialist, but I did see and I did have a limited obstetrical practice with private patients.

Q. With respect to that limited obstetrical practice involving private patients, did you share call with other members of University OB/GYN Specialties, Inc. in November of 1997?

A. Yes.
Q. Is that a smaller subset than the 20?
A. It's the same physicians.
Q. So all 20, roughly 20 -- I won't hold you to that number -- but that number of physicians that were part of that practice all shared call for private patients?
A. Yes.
Q. Generally, how did that schedule work? How often would you be on call for the group?
A. Roughly, two to three times a month.
Q. Were weekends treated differently than week days?
A. Not really. If you were the physician on call, you were the person who they would primarily call with problems if the primary physician was not available.
Q. Well, what I meant by that is, would people in the group take call for an entire week, one doctor from Friday night to Saturday morning through till Monday morning?
A. No. It would be at the most a 24 hour period.
Q. So you cut the week up each

individual day and didn't treat the weekends any differently than any other day; is that a fair statement?

A. Yes.

Q. And was that call schedule put out on a monthly basis, basically?

A. Yes.

Q. And generally you would be responsible three days a week?

A. No. A month.

Q. And would that be for a 24 hour period?

A. Yes.

Q. If you had patient, when you were on call for the group for a 24 hour period, would you also be seeing patients in the office?

A. Sometimes, yes, and it depended on whether I was also on call for the infertility group at the same time. So I would be on the first floor of the hospital seeing patients and then labor and delivery would be on the second floor, so I was underneath labor and delivery for a few hours in the morning. Our call used to start at 9:00 in the morning and most patients were seen before 9:00 or between 7:00,

8:00, 9:00 o'clock, maybe a few other patients left behind.

What I usually did, I would go upstairs to the second floor and there would be a discussion, a presentation of all the patients who were currently in labor, be present for that, discuss, see any patient that needed to be seen, and go back and finish the patients, which rarely went beyond 10:00 in the morning. That would be on a weekend.

On a weekday there was someone assigned to labor and delivery if you had office hours. You didn't need to be there physically all the time, necessarily.

Q. You mean you didn't need to be physically on labor and delivery?

A. Correct.

Q. Is that because your offices were one floor below?

A. That's right.

Q. So when you were on call for a 24 hour period back in 1997 for the group, would you remain in the hospital, either in the offices or on labor and delivery for that 24 hour period?

A. Yes.
Q. You didn't take call from home?
A. No.
Q. When did the shift change? When did you change over from one doctor to another in the group in terms of your call schedule? Was it 9:00 a.m.?
A. For a weekend. For a weekday, it used to change around 5:00. And I say around, because it wasn't really precisely at 5:00 o'clock. If you were still caught up with patients in the office, whoever was there in the morning would wait for you to finish and vice versa. So roughly around 5:00 o'clock we would have a turnover.

Sometimes physicians who had deliveries during the night and were very tired and may have stayed there for a patient who was laboring longer than 5:00 o'clock to finish the delivery, if they felt very tired, they would come and say, listen, I can't, I'm too tired, I want to go home at 7:00 or 8:00 or 9:00 or 10:00 or midnight, and then we would basically take responsibility of that patient at that time. We always made an effort for each individual

physician to deliver their own individual patients.

Q. At 5:00 p.m. is what you are talking about would be the turnaround?

A. Usually, yes.

Q. And then you would remain physically present in the hospital for 24 hours, generally speaking?

A. Until the next morning on a weekday.

Q. What about on a weekend?

A. On a weekend it would start at 9:00 in the morning and end at 9:00 in the morning the next day.

Q. In general, what role did the residents at University Hospitals play in the management of labor for patients in your group in 1997?

A. In general, they would be responsible for assisting us with the care of the patient. They would be basically our extra arms, our extra eyes, our extra ears as we were in labor and delivery.

Labor and delivery is a very hectic place sometimes and there are a lot of patients being delivered at the same time. We as

physicians are responsible for the floor and to prioritize where to go, where we are needed the most, and the residents assist us with the care of the other private patients in the meantime.

Q. University Hospitals is a teaching hospital; correct?

A. Yes.

Q. Because it's a teaching hospital, did you and your colleagues allow residents to manage the care of private patients even when you might be available on the floor?

Do you understand my question?

A. It's very difficult to say that, because the reality is that it's a dynamic process. Sometimes I walk in the door, see the patient, do something, examine her, walk out. I may be called to another room and there is something that needs to be done with that patient and the resident will come and inform me what happened and I would go back and check.

We are ultimately responsible for that patient and for our private patients. We always made an effort to be there as much as possible, and really all the decisions that were made with regard to that patient, the major

decisions for that patient were never done without our knowledge or authorization.

If you need to order a CBC so you could get the blood count done, the nurses couldn't wait for us to come and do that, they would get an okay from the residents and get the blood samples from the patient and things like that.

Q. And in general, what role did the labor and delivery nurses play in the management of laboring patients for your group?

A. They would be there all the time at the patient's bedside, would be monitoring -- I don't remember if we had the electric monitoring at the time connected to a centralized area, but they would be vigilant of the tracing of the baby, informed us of any problems that would arise, any problems with the patient that would arise. They had protocols to follow for management of medications, so once an order was given for a medication to be started, they had a protocol to follow that and informed us if they needed to go out of that particular protocol or whether we needed to stop the protocol for a reason.

Q. If labor and delivery nurses -- and for purposes of my questions, I'm talking about 1997, not today -- observed a problem with a fetal monitor strip, for example, prolonged bradycardia, would you expect them to notify you or the residents?

A. They would notify the physician that is readily available first, and if it happens to be me, it would be me. If it happens to be one of my residents, it would be one of my residents. The idea would be to get the person, if they believe there is a problem, the first person available to show up and assess the problem and then decide what to do from there.

Q. And that may be you or it may be a resident?

A. Yes.

Q. And it may be a first-year resident or a chief resident?

A. Correct.

Q. I want to talk to you a little about a Bandl's ring that's part of this case. Can you tell me what a Bandl's ring is?

A. It's a contraction ring of the uterus. Do you want me to be technical?

Q. No, that's good enough for now. I will ask you more questions about that.

What is your understanding of the causes of a Bandl's ring?

A. Bandl's ring can happen from prolonged labor. It could happen when the membranes rupture. It could happen in a variety of circumstances in labor with or without the use of pitocin, in general.

Q. Did you do any independent reading about Bandl's rings in connection with your preparation for this deposition?

A. No.

Q. Do you recall doing any research or reading about Bandl's rings after the delivery of Jacob Fiktus?

A. I don't remember.

Q. Do you know if Bandl's rings are more or less common in preterm deliveries?

A. I'm not aware of any literature on that.

Q. I think you already answered this. Can a Bandl's ring be caused by prolonged or protracted labor?

A. Yes.

Q. Can hyperstimulation of the uterus lead to a Bandl's ring?
A. I don't know, because it's associated with pitocin use, but you can get hyperstimulation of the uterus with or without pitocin, so it's hard to answer that question.
Q. And it's your understanding that pitocin can cause a Bandl's ring?
A. It's associated with it.
Q. Prior to the delivery of Jacob Fiktus, had you ever encountered a Bandl's ring?
A. No.
Q. How many deliveries roughly had you done prior to that?
A. Thousands.
Q. Had you only read about them?
A. Yes.
Q. Do you know if Bandl's rings are more or less common now or in 1997 than they were, say, 20 or 30 years ago?
A. They would be less common today than they were back then.
Q. Why is it that Bandl's rings are less common today than they were 20 or 30 years ago?
A. Because most Bandl's rings in those

days were associated with prolonged labor. By that, I mean many days of labor. This was not something that would be encountered normally in a 24 hour period. Since right now most patients are not in active labor for more than 24 hours, we don't see it very much.

Q. I wanted to ask you some questions about hyperstimulation. Is hyperstimulation something that causes you, as an obstetrician, greater concern in a preterm delivery?

A. You are talking about this particular case or are you taking --

Q. Generally.

A. Sometimes the uterus contracts very often, which is what you are talking, what we refer to as hyperstimulation. We like to see periods of two to three minutes between contractions. When the contractions happen more often than that, we call it hyperstimulation.

It's very difficult to determine the exact amount of pitocin that you use on patients because people have different reactions to it. So we titer the pitocin, we increase, decrease it, and sort of manage it in order to get an adequate pitocin response in the uterus. So

it's a dynamic process always being evaluated and changed throughout the course of labor because it changes throughout labor.

Q. I'm not sure that we are on the same page in terms of my question. My question really to you was assuming that you are faced with a situation of a hyperstimulated uterus, is that something, as an obstetrician, that causes you greater concern in a premature delivery as opposed to a full-term delivery?

A. No.

Q. Are premature babies more likely to sustain some sort of insult or injury as a consequence of hyperstimulated uterus in an full-term baby?

A. I'm not aware of any information to that effect.

Q. You are not aware of any literature that might suggest that premature babies are more vulnerable to bad outcomes?

A. I suspect there is some literature on that, but I'm not familiar with that or I haven't reviewed it recently, but I take your word for it.

Q. I don't want you to take my word for

anything, necessarily.

I want to talk to you about Kelly Fiktus now. We will move away and talk about this particular case.

Had you seen Kelly Fiktus prior to her admission to University Hospitals in 1997?

A. No.

Q. You have the record and I want you to feel free to refer to it any time you want to it. When was your first actual face-to-face contact with Kelly Fiktus?

A. I probably had my first contact with her around 8:00 to 9:00 o'clock because I'm seeing my signature next to the resident's note. Here, patient seen for first time. So 1940.

Q. 1940 on November 24, 1997?

A. Yes.

Q. And that is your signature on that note right underneath Dr. McHugh's?

A. Yes.

Q. And I guess then it's your handwriting that says patient seen for first time and agreed with above?

A. Yes.

Q. When you wrote that note, agreed with

above, what was it that you were agreeing with? What is it? What was written on the note at 11-24-97 --

A. Yes.

Q. -- in terms of an assessment and plan?

A. Yes.

Q. Do you recall as you sit here today whether when you saw Kelly Fiktus for the first time that you reviewed all the prior entries from either Dr. McHugh or Dr. Wang?

A. I don't recall specifically as to this particular case. I would say that in general most likely I would have discussed this case before Dr. Kiwi left, so I was aware that the patient was in the hospital and that I probably reviewed the record at that time.

Q. When you say at that time, do you mean, would that have been around 5:00 o'clock p.m.?

A. Probably around 1940 more likely.

Q. That's when you think Dr. Kiwi left the hospital?

A. That would be my thought, but I can't tell you for sure, because sometimes

conversations happen in the hallway and they are not necessarily formal conversations that we write a note about.

Q. Well, this would have been a weekday by my calculation. It would have been a Monday evening. And I think you already testified that generally speaking the shift change, if I can use that word, for your group was around 5:00 p.m.

MR. GRAY: I'll object, but he also went on to say that they would stay later and accommodate one another.

MR. PESKIN: I understand.

Q. Do you know from reviewing these records or from any other source exactly when it was that you started call that evening and Dr. Kiwi stopped?

A. No.

Q. Is it fair to say it's only your assumption that you would have had a conversation with Dr. Kiwi about Kelly Fiktus at around 1940?

A. Yes.

Q. Is it fair to say that that conversation about Kelly Fiktus and Dr. Kiwi's

assessment of her situation might have occurred some hours earlier than that?

A. Probably not. I would say that probably it would have been around, again, somewhere between 5:00 and 7:00, but I do not recall specifically at what time. Because, again, frequently we stay in the hospital many hours longer than the 5:00 o'clock and we don't check out with the other physician necessarily at that time. My first contact with her was at 1940 hours.

Q. Okay. Can you tell from the record when Dr. Kiwi's last face-to-face contact with Kelly Fiktus was?

A. I cannot.

Q. I notice that you wrote -- we had been talking about your note at 1940 where you wrote, patient seen for first time and agreed with above. Was it your practice to review and countersign resident's notes on patients?

A. Not if I wasn't supervising them at the time. I would only do that if I saw the patient and the notes were written at the same time.

Frequently, what would happen is that

I would walk into the room with the resident to review something. I would say something to the resident with regard to that encounter. The resident will write it while I go to another room to assess another problem, and then come back, read it, and then agree and sign it.

Q. Okay. Just while we are on the same subject, I guess, the note right below your first countersigned note at 11:24 -- 2130, excuse me -- is that your handwriting?

A. Yes.

Q. So you wrote that entire entry?

A. No. There was a signature next to it. I didn't write the entry, one of my resident's did.

Q. That's what I was asking you about. Patient uncomfortable with contractions, fetal heart rate 120. I can't read it. 120's. That's not your handwriting; correct?

A. No.

Q. You again reviewed this note and signed it?

A. Correct.

Q. So based on my understanding of what your practice was in terms of supervision of

residents, is it likely the resident completed this assessment and discussed it with you and you countersigned the note?

A. Not necessarily.

Q. You might have been there with the resident at the time?

A. They may have written verbatim what I said. Again, the residents are helping us in the process, so if -- I don't recall specifically what the labor and delivery floor looked like that day, whether there were 12 patients or 15 patients, 20 patients at the same time.

I would have walked in the door, I would tell -- I would walk with one of my residents, make a comment, write it down, this is what we are going to do, and the residents would write it and bring it to me and I sign. Other times it would be me making the entry. On some occasions they would come in and say this is what is going on, I wrote a note about it and would come and confirm and sign. It's a dynamic process.

Q. Okay.

A. But what was written in, what I

signed, I reviewed and we discussed.

Q. When you say you reviewed and discussed, you would have reviewed what the resident wrote, what the resident's assessment was?

A. The assessment, but also with the patient.

Q. That's what I was going to ask you. When you countersigned a note that a resident may have written, was it your practice to also have face-to-face contact with the patient in connection with the review of that note?

A. Not necessarily.

Q. Okay.

A. If it's a routine event, you know the patient is progressing normally, she is dilating normally, no, I wouldn't go back and review with the patient. I wouldn't have to subject the patient to multiple pelvic examination. But if there is an issue or a problem, I would normally confirm the information with the patient in the room.

Q. Let's look again at that 2130 note, so I'm clear. The handwriting in the body of the note is Dr. McHugh's?

A. I don't know whose signature that is.
Q. Is your signature at the very bottom of that page?
A. Yes.
Q. And in this case, can you tell from reading this note?
A. I think this is Weiner actually, who is the chief resident.
Q. Can you tell when you reviewed this note whether or not you countersigned this note after having actually seen Kelly Fiktus and verifying what Dr. Wang's assessment was in terms of her status?
A. I can't state that specifically from this note.
Q. What about the following note which is a 2150? This one I think is pretty clear that it was written and signed first by Dr. McHugh. At the very end of that note it says will discuss plan with Dr. Loret deMola; correct?
A. Yes.
Q. Is it fair to say based on the context of that note that you weren't physically present at that time, at the time this

assessment was done at 2150?

A. Not necessarily. She could have discussed this with me. I could have returned to the room and then agreed with her and co-signed.

If you notice, for example, if there is anything I need to add -- and you can see the following page, there is her note from the procedure. I felt that clarification was needed, so I signed her note because I agreed with it, but added information next to it because there was more information that I felt was needed to be included.

Q. What you are talking about is the note immediately following the note at 2150, which is a note at 2200 hours, I assume, and 11:24; right?

A. Right. The note where it says preoperative diagnosis.

Q. No, I'm looking at --

A. It's the next page. If you look at the next page, you will see that there is a note from Dr. McHugh co-signed by me and then I had another entry right below it.

Q. I got you, okay.

A. So sometimes if there is something, I could have come back and looked at the patient, and if I agreed with everything that was discussed, I wouldn't necessarily write another note.

Q. You jumped ahead of me a couple notes. I want to go back to the 2150 note. Immediately after that is a note at 2200 hours, I believe.

A. Yes.

Q. Is that in your handwriting?

A. Yes.

Q. So you wrote that entire note?

A. Yes.

Q. And is it fair to say that you wrote that note based on your own examination of Kelly Fiktus at that time?

A. Yes.

Q. And the entire note is in your handwriting?

A. It is in my handwriting.

Q. The following entry at 2210, is that entirely in your handwriting?

A. Yes.

Q. And that again is based on your

assessment?

A. Yes.

Q. And then we already talked a little bit about what is on the next page, which has a preoperative diagnosis, and then you added more information; correct?

A. Yes.

Q. Do you know why it was that Kelly Fiktus was admitted?

A. Because she had prodromal labor. She was having irregular contractions and she was uncomfortable and there was a question of whether she ruptured her membranes, and I believe that was later confirmed.

Q. I believe the record reflects -- and if you disagree with anything I say to you that I believe to be a fact, let me know -- at around 0500, after her admission, Kelly Fiktus ruptured her membranes.

A. That may be the case. It wasn't completely confirmed, I guess, until 9:45 when she actually had an examination. What it says here is that she wet her pad and had nitrocine paper. But sometimes when you see that, it's not necessarily that someone ruptured her

membranes. Sometimes vaginal fluid could give you a false positive. It's possible she ruptured membranes at 5:00 in the morning, but I have to say it was confirmed at 9:45, so I have to say that's when she ruptured her membranes when she was actually examined for it.

Q. Did you see the nursing note at 0500?

A. Yes.

Q. What you are looking at.

Patient awakened and upon arising felt fluid running down --

A. Yes.

Q. So you would say that you wouldn't rely on the nursing note for the time of the rupture of membranes?

A. No. I just have to go with facts. The fact is that the exam that made the determination of ruptured membranes was done at 9:45. It could have been at 5:00, but at that time the patient did not get a pelvic examination, and if she did, it's not documented, so I don't know. I wasn't there at the time.

Q. Do you have any idea what was the cause of the premature rupture of membranes?

A. I have no idea.
Q. When a patient's membranes rupture, is it generally a loss of amniotic fluid?
A. Yes.
Q. And does the loss of amniotic fluid from ruptured membranes make the fetus more susceptible to cord compressions?
A. Perhaps, yes.
Q. At the time that Kelly Fiktus' membranes ruptured, would Dr. Kiwi have been on call?
A. I don't know.
Q. Well, assuming that your call schedule is as you described it, you took over for Dr. Kiwi; correct?
A. He may have not been on call the night before. He could have been just there for office hours during the day and went home. I don't know what he did before. I haven't seen the call schedule from that time. In fact, I wasn't even scheduled to be on call that day, there was someone else.
Q. You were covering for someone?
A. Well, someone asked to change call with me that day because they had a personal

event going on. So I wasn't even -- I don't think I was scheduled for that particular day. I covered for someone else and here I am.

Q. Do you know who it was who made the decision to order an induction of pitocin?

A. I presume it was Dr. Kiwi, but again, when I arrived to labor and delivery, everything was already done and decided. I had no participation in this patient's care before that note from 1940 hours.

Q. You were at some point -- so I'm clear, you were unable to say when it was that you assumed responsibility for Kelly Fiktus' care other than that first note, the time of that first note?

A. That is correct.

(Record read.)

A. It would have to be between 5:00 o'clock and that note.

Q. At no time before 5:00 o'clock p.m. is your testimony? --

A. No time before.

Q. -- you had any responsibility for Kelly Fiktus' care?

A. No.

Q. It would have been a number --
A. Her personal physician was in the hospital. I had no reason to take her care.
Q. That would have been Dr. Kiwi?
A. Yes.
Q. You have had an opportunity now to review the records that are in front of you. Do you concur with the decision that was made to begin an induction with pitocin for Kelly Fiktus?
A. I have to say that I only had to do with after the fact. I don't know if I can render an opinion of what other people did.
MR. GRAY: Are you asking him based on what he sees here?
Q. Based on everything you know about why it was that Kelly Fiktus was admitted and your understanding from the records of what occurred following her admission prior to your assuming responsibility for her care, do you concur with the decision that was made to begin the pitocin?
A. To deliver this baby.
Q. To begin a pitocin induction?
A. To get her delivered, that's the idea

of doing pitocin. To induce labor so this patient gets delivered, yes.

- - - - -

(Thereupon, LORET DE MOLA Deposition Exhibit 2 was marked for purposes of identification.)

- - - - -

Q. I have handed you what's been marked as Loret de Mola 2. This is a document that was produced in this litigation that's titled University Hospitals of Cleveland maternity-gynecology nursing policy number one dealing with the care of women during oxytocin augmentation.

Oxytocin is pitocin; correct?

A. Yes.

Q. And it's been represented to us that this policy was in effect in November of 1997. Are you familiar with this policy?

A. I have seen it before, but I haven't read it in some time.

Q. I want to ask you some questions about it. Are you generally familiar with the policy?

A. With the policy in general or this

particular policy?

Q. This particular policy.

A. I'm familiar with it. I have seen it before, but I haven't reviewed it in detail in some time.

Q. We have talked and you have already mentioned a bit about the responsibility of labor and delivery nurses and the management of patients that are laboring in your practice; that they have in some instances standing orders or protocols to follow for the administration of certain medications. Would this be one of those situations?

A. Yes.

Q. Nurses at University Hospitals in 1997 had some guidelines or protocol to follow with regard to administration of pitocin; correct?

A. Yes.

Q. And that policy directed the nurses to take certain actions in response to a laboring patient's response to pitocin. Is that a fair statement?

A. Yes, that's a fair statement.

Q. Now, I assume you have in the records

the labor flowsheet for this case, which is something the nurses maintain?

A. Labor flowsheets, is that it?

Q. University MacDonald Women's Hospital labor flowsheet. It has number 3's on it.

A. Yes, I have it here.

Q. If you start looking at the page that has 1400 as the first hour entry for November 24th --

A. I have 11-24.

Q. Do you see 1400 there again?

A. Yes.

Q. There are entries on the preceding page for that, duplicate in terms of the time entries, the entries on the page that I directed your attention to; correct?

A. I don't know. I haven't reviewed this.

Q. Do you see an entry for 1500 on that page you are looking at?

A. Yes.

Q. If you turn the page -- before you flip the page, verify for me that's for November 24th; correct?

A. No, the 23rd.

Q. That may explain it. We want to look at the next page, which is the 24th. That one starts at 1400 and has entries recorded every half hour, although sometimes the time is not written at the top. Do you agree with me?

A. It may be. Again, I don't know this for a matter of fact, but it wouldn't surprise me that it's empty because it's common practice around here to do it every half hour. So they may have forgotten to enter the time.

Q. There are still things entered in the column below it even though the time isn't noted?

A. Correct. Because they would normally -- again, you would need to ask one of our nurses to confirm this -- but I believe that they are entered every half hour in this particular flowsheet and they simply enter the first hour and you assume that the next one, the next entry is a half hour later.

Q. The pitocin induction is implemented by the physician by giving an order to do the induction; is that correct?

A. Could you repeat that?

(Record read.)

A. We write an order for pitocin per protocol and then the nurses execute it.
Q. Is that what was done in this case?
A. I don't know. I didn't write that order.
Q. Do you know if -- have you seen that order in the chart when you reviewed the records?
A. No.
Q. And the way it works is that --
MR. GRAY: Let's be clear. I think you said did you see that order in the chart when you reviewed the records. I think he is saying he hasn't reviewed that portion of the record.
THE WITNESS: If I have, I don't recall.
MR. GRAY: You are not saying it's not in there.
Q. I don't want to suggest it's not there. Let's assume that it's there.
A. Okay. And let's state that I wasn't the one who wrote it.
Q. Right. I know that.
So generally speaking, there would be

an order that would say pitocin per protocol or something to that effect, and the nurses then would follow the policy that we have been looking at, which is Exhibit 2; correct?

A. In general, yes. There would be exceptions to that and those would be noted in the chart.

Q. Absent some exception, the policy provides that the nurse starts the pitocin at one milliunit per minute or two cc's per hour. That would be on number 4 of the policy?

A. Yes.

Q. And the nurse is supposed to monitor the patient's response to the pitocin and take action based on the response?

A. Right. But you also must know that sometimes the physician may give the nurse a verbal order and say, no, no, don't start at one, I want you to start at four and they would start at four or start at a different number.

Q. Okay.

A. So if the physician doesn't state otherwise, they would follow with this. If the physician would state differently, the nurses may do the protocol different from here.

This would be sort of a default system, in a sense, that unless the physician states otherwise, this is what they would follow. Sometimes physicians would make different statements to them and this may be verbal reports to them as we walk in and out of the room. You know, why don't you increase this by two units or go down a unit or so on and so forth. Again, this is a dynamic process, constantly being changed.

Q. If an order of that nature were given by a physician to a nurse to deviate from the protocol, you would expect it would be recorded on this flowsheet; correct?

A. Or there would be a verbal order per doctor so-and-so, yes, I would expect that.

Q. In this case, can you tell what the infusion rate was at 1400?

A. If you help me find the place for it.

Q. It's right around the middle of the page. The middle of the first column, there is a block that says time, fetal heart rate and then says pitocin.

A. Yes. I think this is a two at 1400 or maybe a one, I don't know.

Q. It appears to be two --
A. Yes.
Q. -- milliunits. And then at that point, according to the record, Kelly Fiktus was having mild contractions; is that correct?
A. Where did you read that?
Q. That would be under contraction intensity, which is a little further up the column at 1400.
A. Yes. It says mild, so I assume they were not strong.
Q. And the duration of the contraction is recorded right below that?
A. The duration is 40 to 70 seconds.
Q. Okay. And then there is a number of other measures -- obviously the nurses are monitoring whether there is adequate uterine rest, right below the pitocin; correct?
A. Yes.
Q. At 1430, looking at the pitocin entry, going across now, could you see what the level of pitocin was?
A. Four milliunits.
Q. Based on your understanding of the protocol and the entries that the nurse has made

regarding the level of the contractions and whether there is adequate uterine rest, was the increase --

A. I have to say what the protocol says. But one to two milliunits per OB/GYN is a standard order.

Q. Every 30 minutes; correct?

A. Yes.

Q. So to go from two units to four units would be consistent with this protocol?

A. Yes.

Q. 30 minutes later so long as the contractions are less than 60 seconds, 60 seconds or less; right?

A. With a period of rest of 60 seconds between contractions. Is that what you are referring to?

Q. Right. They last 60 seconds and the period of rest of at least 60 seconds between them?

A. Yes.

Q. So the increase in the pitocin at 1430 from two milliunits to four milliunits is consistent with that policy; correct?

A. So it would be contraction frequency,

2 to 5, they would be referring, not to 2 to 5 contractions in one minute. They would be referring to contractions every 10 or 15 minute period of time. Again, you would need to ask one of our nurses.

Q. What I am more focused on is the contraction duration at this point.

A. The same as before.

Q. Okay.

A. No change. And also mild.

Q. Okay.

A. Meaning that there were not, they didn't feel strong to touch.

Q. And then the following entry at 1500, do you see again that the pitocin was increased this time to six milliunits; correct?

A. Correct.

Q. And again, the contraction duration is approximately the same, 40 to 70?

A. Yes.

Q. Exactly the same. They are still indicating that the contractions are mild; correct?

A. Yes.

Q. And this increase is consistent with

the nursing protocol; correct?
A. Yes.
Q. And then look at the entry at 1530.
A. Okay.
Q. Do you see again that the pitocin was increased?
A. Yes.
Q. To eight milliunits; correct?
A. Yes.
Q. And at the beginning of that there is an entry right under the pitocin that says adequate uterine rest where the nurses are supposed to answer yes or no; correct?
A. Where did you see that?
Q. Right underneath where the pitocin is recorded.
A. There is a Y there.
Q. There is a Y there and there are three blocks for that half hour?
A. 1550, 1555 and 1600 hours, is that what you are referring to?
Q. 1530 and then 1555 and then it looks like 1558 is written in after 1600 is crossed out.
A. I don't see that. I think it was the

1600 hour that was erased, which may be the next entry, and it was probably inadvertently entered here.

Q. Okay.

MR. GRAY: 1558; right?

Q. Do you see that there is an N under adequate uterine rest?

A. Yes, I see an N here.

Q. And what, if anything, can you tell was done by the nurses in response to that finding of inadequate uterine rest?

A. I can't tell you unless I can see the tracing.

Q. Well, I meant with respect to the pitocin protocol. I'm not talking about the tracing.

A. If you were to do that, I would presume it would be to check with one of the physicians as to what to do or follow the protocol, either/or.

Q. And what does the protocol say about the nurse's authority to decrease the pitocin infusion rate in response to the patient's reaction to pitocin? Take a look at number 9 on the protocol.

A. Okay. I read it.
Q. Now, having read number 9 and seeing what was recorded here, if the nurse was observing that there was not adequate uterine rest at approximately 1600, and the contraction duration at that time is recorded at 60 to 90 seconds -- do you see that, up a little higher?
A. Yes.
Q. Would you agree that according to this protocol the nurse had the authority on her own to cut the --
A. Cut the medication in half.
Q. -- cut the medication in half? Is it recorded that the pitocin was decreased by 50 percent on the record?
A. I don't see that. The next entry, decreased to five units; is that what you are referring to.
Q. Decrease to five milliunits?
A. Yes.
Q. Five milliunits is not half of eight?
A. Correct.
Q. The next entry is at 1600. Do you see that there is nothing recorded in the boxes for adequate uterine rest?

A. Yes.
Q. Based on your understanding of the way this medical record is kept, is it fair to assume that if the boxes are blank, that the answer to whether there is adequate uterine rest is still no until it changes to yes?
MR. GRAY: Objection.
MS. ROLLER: Objection.
A. No, I don't agree with that.
Q. What was the duration of the contractions at that time at 1600?
A. 60 to 3 minutes.
Q. Based on the protocol for pitocin, what should the nurse do if decreasing the pitocin dose by 50 percent, if after reducing the pitocin dose by 50 percent the patient still is showing signs of uterine hyperstimulation?
A. I don't believe that it says specifically what to do under those circumstances, unless you have read it.
Q. Could you look back at number 8.
MR. GRAY: Maybe we could do this a different way. Instead of him having to confirm everything in the protocol, if there is something you think was deviated from, ask him

his opinion about it. We are going through and confirming things that we know are already there in the record.

MR. PESKIN: I'm not sure about that. I want to verify.

Q. Let's look at number 8. The protocol number 8 says the nurse is supposed to discontinue the pitocin, notify charge nurse and the physician if any of the following signs, symptoms or complications are observed.

And then do you see where it says consistently prolonged uterine contractions lasting 90 second or longer or less than 60 seconds uterine relaxation?

A. Yes.

Q. Could you tell whether that procedure was followed in this case at 1600?

A. I can't tell because it wasn't recorded.

Q. Do you see under assessment and patient outcomes there is another column there where it says positive hyperstimulation with pitocin?

A. Yes. They may have discontinued the pitocin altogether at that period of time.

Q. Do you see any evidence in the record that the pitocin was discontinued at any time between 1600 and 1630?

A. It is left blank.

MS. ROLLER: Objection in that the reference is only made at this point to the labor flowsheet.

A. We are not looking at the rest of the chart. I just don't see that here. That doesn't mean it's not recorded somewhere else. I would assume -- my interpretation of this is that the pitocin was discontinued because there is no entry, if you are asking for my interpretation.

Q. Well, do you see that at 1630 there is an indication that the pitocin is increased to six milliunits?

A. Right. And it's very possible that they may have stopped the pitocin during this period of time altogether and they restarted it later, but it's an elaboration on our part because I don't see anything written.

Q. You don't know, you are not aware of anything in the medical record that would indicate that the pitocin was discontinued by

the nurses at 1600?

A. I can't say that, because it may be recorded on the actual tracing. We would have to go over the tracing. I could say on this patient it's not recorded, but it may be recorded somewhere else.

Q. We have all the tracings here. Let's look at between 1600, right around 1600, 1630. I don't see that there is really any notations about --

MS. ROLLER: Let me make a note on the record. I'm not sure that we have the original tracings with nursing notes on it.

MR. PESKIN: I don't know what is on them. There is nothing on them.

MS. ROLLER: Right.

THE WITNESS: Frequently they do write on them.

MR. PESKIN: I have seen them with notes on it. The ones that we all have, there is no indication, no notations on them. So they probably won't help us in this situation, would you agree, unless you have something I haven't seen. I don't see any notations on any of the tracings.

MS. ROLLER: Just so that you are clear with my point is that there may be tracings that have written notes on them that we have not been able to locate, because these do not have any notes on them and normally that occurs.

A. Plus is there handwritten notes about patients here on the nursing notes on the side? Did we review those and see that there is something written to that effect?

Q. I have and have not seen it, but I can't testify. So I'm asking you if you have seen it anywhere?

A. You see, the other thing is there is other big forms that are actually fairly large that are not here and they are hard to read.

MR. GRAY: I think he is asking you if you have seen the evidence of that.

THE WITNESS: I don't see any evidence.

MR. GRAY: If you don't recall, you don't recall. You can't be expected to remember everything in the chart.

A. It may be somewhere in the chart. If this is the evidence I have, I don't see it. I

would assume that a blank means that it was discontinued based on what is written here. That's my interpretation.

Q. At 1530, the patient, or Kelly Fiktus in this case, had been on five milliunits, do you see that? The first entry we have at 1530 is five milliunits?

A. Right.

Q. Then at 1630 we have an entry, pit with an arrow going up, which you would agree with me generally means increased; right?

A. Where would that be?

Q. Right at the 1630 column.

A. Yes, that means to me that whatever happened, it was increased to six units. I don't know what it was before, but it means that it was lower than six.

Q. Would you agree with me, doctor, that it would not, it would be inappropriate if the pitocin had been stopped for a half hour to restart it at six milliunits?

A. Again, it depends on the clinical scenario. We are just looking at an order. We are not looking at the status of the patient, at the baby at the time. In general, I would

say that most of us will tell patients when we discontinue the pitocin to restart it at about half the dose of when you turn it off.

Q. So in this case, if it had been stopped at five milliunits, your general practice would be if you were going to restart it to restart it at two to three milliunits?

A. Roughly.

Q. Not six?

A. Correct. But we don't know what it was during this period of time?

Q. That's correct. We don't know. Take a look at the entry in the physician progress notes by Dr. Wang at about 1740 -- not at about, it says 1740. Do you see that note?

A. Yes.

Q. And as I'm reading, tell me if I read anything wrong. Down at the bottom where he has his plan, labor with dysfunctional contraction pattern but reassuring tracing throughout. DC pitocin times 30 minutes --

A. Let me -- I lost you. You are reading an impression.

Q. End of the impression. DC pitocin times 30 minutes and restart at one milliunit.

A. Yes, I read that.
Q. That is a physician order; correct?
A. Correct.
Q. And that was an order that instructed the nurses at that point, 1740, to DC the pitocin?
A. Correct. For 30 minutes.
Q. I want you to assume for purposes of my questions, since we don't know the answer to that question, that that was the first time that the pitocin was discontinued.
A. I would not agree with that.
Q. Well, I'm asking you to agree with it just for purposes of this question. Assume that.
A. Okay.
Q. Assume that the first time the pitocin was discontinued was at 1740 in response to an order by Dr. Wang.
A. Uh-huh.
Q. If that were true, would it be the case that the nursing staff at University Hospital failed to follow the protocol that we have been discussing with regard to the administration of oxytocin?

MS. ROLLER: At what time?
MR. PESKIN: Between 1600 and 1740.
A. No. But the note was written at 1740. I can't say what happened before then. Obviously, this note from 4:30 was an hour later. What she wrote was an hour later than what you are claiming.
Q. The order from Dr. Wang is at 1740?
A. That's when it's written on the chart.
Q. And that's when she is telling the nursing staff to discontinue the pitocin; correct?
A. Correct.
Q. If you look back at the policy, would you agree that the nurse pursuant to the policy on her own should have discontinued the pitocin if she observed hyperstimulation?
A. Well --
Q. I'm assuming again for purposes of these questions that it had not been discontinued up until that point.
MR. GRAY: Objection.
MS. ROLLER: Objection.
A. I can only go with the facts written

on the chart. I wasn't there at the time.

Q. I understand.

A. I have to assume that at or about 1740 hours the pitocin would be discontinued and the reason why I think that is because there is blanks. So during the 1630 hours that you are describing, I'm assuming that there was no specific note from a physician stating to discontinue the medication and that they were following the protocol.

Q. Would you expect a nurse consistent with this protocol who encounters a patient that is exhibiting signs of uterine hyperstimulation to on her own discontinue the pitocin and then notify a physician?

A. Yes.

Q. Do you see any evidence that that is what occurred in this case?

A. I can't say, because I don't see any notes, but I think it's a fair assumption. The nurses are there to protect our patients, to help them.

Q. I understand that. What I'm asking about, in this case, doctor, do you see anything in the nursing notes or in the physician notes

that indicate in response to the observation by the nurses of uterine hyperstimulation at 1600 that they discontinued the pitocin?

A. Most likely if they follow the protocol, that's what they would have done, yes.

Q. I'm asking you if you know that they followed the protocol and in fact discontinued it?

MS. ROLLER: Objection.

MR. GRAY: Objection.

A. I don't know.

Q. If they did not follow the protocol at 1600 hours and discontinued the pitocin in response to an observation of hyperstimulation, that would be inappropriate; correct?

MS. ROLLER: Objection.

A. You have to look at the entire picture. This is again a dynamic process constantly with patients, physicians, nurses. There may be exceptions to rules, and I don't know what the physicians said at that particular time. Whether there would have been a verbal conversation with a nurse that was not recorded here, I don't know that. All I know is that this is blank and that I presume that if the

patient was hyperstiming that the nurses would have followed this unless they checked with a physician. Because as you can see also from this protocol, it says that the physicians could potentially or would potentially change this particular protocol if medically necessary or indicated.

Q. Well, check back, flip back one page. There is a note from another resident.

A. Which page?

Q. Physician progress notes.

A. Okay.

Q. At 1615, which is close to the time we are talking about.

A. It says pitocin augmentations, placed intrauterine pressure catheter, continue pitocin.

Q. Right.

A. Follow contraction pattern. That's Richard Beigi.

Q. Was he a resident at University Hospitals?

A. I think he was a chief -- I don't remember. This is confusing. Years get confusing. But he was a resident. I do not

recall his year at the time.

Q. This note was written at 1615, which is in that half hour where there is a blank under pitocin. Do you see where he wrote a note that says continued pit?

A. Yes.

Q. So is it fair to assume that the pitocin was not discontinued if doctor --

I can't remember his last name.

A. Beigi.

Q. -- Dr. Beigi wrote continued pitocin at 1650?

A. Again, Dr. Beigi could have come in, written a note, and he would have turned around, left the door, and 30 seconds later see the hyperstim pattern and I would expect the nurses to discontinue the pitocin. At that particular point in time, I would expect if there was a disagreement in the protocol and what the physician wrote, that there would be some type of clarification for it. So I have to assume, again, because it was left blank, that it was left blank, that it wasn't done, but again, it's an assumption.

Q. Okay. I don't want to belabor the

point. You don't know as you sit here today what response the nurses made to the observation of hyperstimulation sometime around 1600?

A. Correct.

Q. And you don't know if the pit was turned off?

A. I don't.

Q. Okay. We do know that there was an order to turn off the pit at 1740 by Dr. Wang; correct?

A. Yes.

Q. And you see that he noted -- she noted, I'm sorry -- that there was a dysfunctional contraction pattern?

A. Right.

Q. Dysfunctional contraction pattern but reassuring tracing throughout; correct?

A. Correct.

Q. Do you know if any attending physician from your group reviewed Dr. Wang's assessment of Kelly Fiktus' contraction pattern and the fetal monitor tracings at that time at 1740?

A. I can't say.

Q. Can you say whether you would have

gone back when you first saw Kelly Fiktus face-to-face approximately two hours later and reviewed those fetal monitor tracings from two hours earlier?

A. I can't say that I did that. I don't remember.

Q. I wasn't suggesting you should. I'm asking if you can remember?

A. I can't remember.

Q. Can you look now at the fetal monitor tracing from around 1740.

A. Okay.

Q. Actually, if you could flip back a little bit from there to 1722. How would you describe the fetal heart rate tracing between 1722 and 1729?

A. Reassuring.

Q. And what about the next page?

A. That's reassuring.

Q. And the following page?

A. Reassuring.

Q. And the next page, which would be 1749, starting at 1749?

A. It looks okay.

Q. So would you agree with -- I assume

you would agree with Dr. Wang's assessment that the monitor tracings were reassuring at that time?

A. Yes.

Q. Doctor, what does a sinusoid pattern look like?

A. I can't draw, can I?

Q. You could.

A. Because it's hard to describe it verbally. It's a visual, like if you know what -- I mean, the description is --

Q. It's not necessary to do that.

Would you disagree with someone's description of the pattern that was observed between 1720 and 1738 as sinusoid?

A. Yes.

MS. ROLLER: You would disagree?

THE WITNESS: That is not a sinusoidal plan.

Q. What do you believe was the cause of the hyperstimulation that was noted by the nursing staff at 1600?

A. I'm sorry?

Q. What do you believe was the cause of the hyperstimulation that the nursing staff

observed at around 1600?
A. It could be many things.
Q. Is it likely that it was related to the pitocin induction?
A. It's one of the possibilities, yes.
Q. Is it likely, though?
A. It's possible.
Q. Possible, okay. I apologize for jumping around a little bit.
A. As long as you give us time to go back.
Q. We are going to go on. I would like to go to the note at 1940. I guess this was your first face-to-face contact with Kelly Fiktus, to the best of your recollection?
A. My note, 1940, got it.
Q. This is the note we talked about earlier, where you agreed with Dr. McHugh's assessment, and to the best of your recollection, this may have been the first time you actually were face-to-face with Kelly Fiktus; correct?
A. Correct.
Q. I want you to look at the monitor strips too. Was there an episode of bradycardia

sometime around 1940? Look at the strips starting at 19 or so.

A. 19 hours?

Q. 1919.

A. 1919, an episode of bradycardia.

Q. I want you to start looking at that point.

A. Okay.

Q. Do you see an episode of bradycardia reflected on these strips?

A. I see a decrease in fetal heart activity, but it is also very frequent when you are using the monitors that you get lack of adequate connection, especially when the patient is having a contraction or when the patient is moving, and sometimes it looks jagged or it looks, you get periods of skipping. I could say that there is a change in baseline to the 90's for a few minutes; one, two, three, four minutes, perhaps. The other is too erratic for me to make a statement.

Q. So you would not necessarily view that section of the monitor tracing as an indication of bradycardia?

A. Again, it's sometimes difficult,

because we are looking at a piece of paper, we are not looking at a patient during labor, and sometimes when we cannot get this good, when we can't get a good, clear tracing, we put an ultrasound machine to confirm, or we use an external device to listen to the heartbeat directly.

So I don't know if it was done at the time, but frequently when we see prolonged bradycardia, we like to confirm it with a second method, because we are relying on the electronics of the machine and the connection with the baby's head to be able to make that determination, and we frequently go back and verify that that's in fact what we are getting. Frequently we find that it's an error in part of the tracing and it's not real.

Q. Did you --

A. So I can't say by looking at this. I see a change in baseline to the 100's, and, again, bradycardia would be under 100.

Q. Look back at that labor flowsheet at 1930. It's the nurses flowsheet.

A. Yes.

Q. Do you see that there is an entry

where the nurses indicated there was an episode of bradycardia at --

A. 19 --

Q. -- 30?

A. Yes, there is an entry that states so.

Q. If you look now at the strips at 2100.

A. Okay.

Q. Starting at 2102 or so.

A. Correct.

Q. Is there an episode of bradycardia beginning at that point?

A. It's hard to tell, because you also have at 2104 a heart rate in the 150's, so it could have been, it could have been a change in baseline or it could have been just a misconnection between that period.

Q. Look on the next page.

A. That is a change in baseline, but with good beat-to-beat variability.

Q. Would you consider that a bradycardia?

A. Change in baseline.

Q. Do you know if the pitocin was on or

off at this time?

A. What's the hour?

Q. 9:02 to 9:13.

A. Pit off, it says, at 2100 hours. So it was off.

Q. Do you know what the cause of this change in baseline or bradycardia was between 9:02 and 9:13?

MR. GRAY: I'll object to the form of the question. He said it was just a change in baseline.

Q. Change in baseline, using your terminology, do you know what the cause of that was?

A. I don't. Babies can go into periods of time where they rest, they sleep, their baseline changes. Again, it's a little person there and they have a mind of their own.

Q. 2130, back to the progress notes.

A. Yes.

Q. Again, I can't remember whose handwriting this is. Is this one of Dr. Wang's or Dr. McHugh's?

A. I'm looking at the nurse's notes.

Q. The progress notes, I'm sorry.

A. Okay. I think that's Dr. Wang.
Q. Okay. And this is again something you would have reviewed?
A. Yes.
Q. Would you have reviewed the monitor tracings at that time?
A. I probably did. Since there was a question about the monitor, I'm certain that I would have.
Q. By this time, at this point at 2130, how dilated was Kelly Fiktus?
A. Four to five centimeters and completely effaced, so she entered at that particular point in time -- I'm looking at the previous -- could you find the previous vaginal exam? We have a vaginal exam at 1650.
MS. ROLLER: 1740.
THE WITNESS: 1740.
MS. ROLLER: VE.
A. VE not done. And then objective, blah, blah, blah, so there was no vaginal from 1650 when she was in latent phase of labor, not in active labor yet and became active labor at that particular point in time.
Q. Which particular point in time?

A. The 2130 hours.

So she entered labor at that point in time.

Q. She had been on pitocin for several hours and off pitocin for several hours prior to that?

A. Correct.

Q. She had come into the hospital contracting?

A. Correct, with an irregular contraction pattern. And what you want to do with pitocin is make it a regular pattern.

Q. At this point, after this much time, and given the fact that her membranes had ruptured --

A. That morning.

Q. -- that morning, was it reasonable to assume that a vaginal delivery was going to take place with this mother?

A. Could you repeat that?

Q. Was it reasonable to assume that she was going to deliver vaginally at 2130?

A. It's reasonable to assume that she progressed in labor and that we were hoping we would have a vaginal delivery, sure.

Q. You wouldn't consider this a failure to progress --
A. No.
Q. -- at this point?
A. No.
Q. 2130, okay.
A. So she is responding within a normal pattern. Her membranes ruptured around 9:00 in the morning or at least that was documented at the time, and she was in an active labor pattern within 12 hours.
Q. Did you agree at the time that the tracings around 2130 were reassuring?
A. At 2130 hours, yes.
Q. What about beyond 2130?
A. Past 2130?
Q. Look at 2134 through 2150. Do you consider those to be reassuring tracings?
A. Yes. There was an acceleration in the heart rate of the baby with good -- with variability.
Q. And look on the next page.
A. Say that again.
Q. 2143, would you consider that page to be reassuring?

A. There was a bradycardia here or a change, most likely a bradycardia here from 2144 to 2147, a mild bradycardia.

Q. So my question is, would you consider this to be a reassuring pattern at this point between 2143 -- 2142 and 2150?

A. When we read patterns, we look at the context of the pattern. We don't read one minute, because it changes. So at this point in time, I'm still reassured that this baby is doing well.

Q. And also at the next page between 2151 and 2159?

A. That would be reassuring, as well.

Q. At the end of your, the end of the note, from 2130, it says reassuring tracing -- if I'm reading this correctly -- epidural, amnioinfusion, monitor carefully. Do you see that?

A. Yes.

Q. Do you know -- it appears, and correct me if I am wrong, that the amnioinfusion never took place in this case; correct?

A. I can't say. I haven't reviewed those records. I was under the impression that

was to be initiated, but I would have to go back and reread.

Q. Do you know one way or the other whether there was an amnioinfusion?

A. I don't remember. It would be written somewhere in here if a -- there could have been. There was already an intrauterine pressure catheter in place, which is what you need to do the amnioinfusion, so I would have to look carefully at the notes, but it would be very easy to start one.

Q. My question is, do we know whether it was done or not?

A. I don't remember.

Q. There has been testimony from other witnesses in this case that it was not done. Do you have any reason to disagree?

A. No, I don't.

Q. Do you have any opinion as to whether it would have made a difference in the outcome in this case if there would have been an amnioinfusion done?

A. No.

Q. You don't have an opinion or it would not have made any difference?

A. I don't think it would have made a difference.

Q. Okay. The next note is at 2150, and, again, this looks like -- this is Dr. McHugh's handwriting; correct?

A. Yes.

Q. And Dr. McHugh was a first-year resident at that time or a junior resident at that time?

A. Again, when you are in a training program, dates get blurry. I will take your word that she was a first year at the time. I don't remember.

Q. Now, from reading this note, it looks as if she noted that there has been a decrease in fetal heart tones 90 to 100 beats per minute for six minutes and then a return to 130's baseline; correct?

A. That's what she wrote on the chart.

Q. And then at the end of it in terms of her plan, she said will discuss plan with Dr. Loret deMola. And we have already talked about this. You countersigned that note?

A. Right.

Q. And that indicates to you that you

did, in fact, discuss the plan with her, and then ten minutes later you wrote your own note; correct?

A. Correct.

Q. At this point, you wrote that the patient had several episodes of bradycardia associated with contractions. What did you mean by several episodes?

A. I probably meant that there were several. I see the one that we discussed earlier and another one earlier here.

Q. When you say --

A. Several, two or more.

Q. Which one earlier do you mean?

A. There was a deceleration at 2140 hours.

Q. Okay.

A. And to me it simply means two or more by several.

Q. There had been two or more bradycardias at 2200 hours; correct?

A. Correct.

Q. And then could you read the rest of that note to me? Or read your entire note, actually.

A. Patient is status post epidural. Patient has had several episodes of bradycardia associated with contractions. Nonstress test showed accelerations and the patient's heartbeat responded to scalp stimulation.

What that means is that some of these accelerations here may have been related to the scratching of the head, and a healthy baby will react by increasing the heart rate. It's like tickling the baby and they react.

With good variability. I cannot interpret the tracing, and by that I mean, the contractions. I was unclear about what was happening to the uterus. I was reassured that the baby was doing well, but I couldn't interpret the contraction part of the tracing.

Q. Okay. Your plan at that point was to do a scalp pH?

A. Correct. Because I couldn't interpret it. I wasn't sure exactly what was happening. But my note indicates that I felt that this baby from a clinical point of view was doing well.

Q. Okay. And then after scalp pH it says, is that US?

A. Yes. The other thing that was also evident -- and you have to look at the next note, when I examined her -- I felt -- and again, you have to remember that all this happened sort of around the same time and I can't really tell you what happened first. But when I examined the patient myself, I felt that the scalp on the baby was too soft, and I questioned whether perhaps this baby was breach position, and that could have explained some of the abnormalities we were seeing. So I took the ultrasound and verified that the baby was in the right position.

The baby obviously was vertex and the head was, you know, soft enough and there was what we call a cap, and usually you don't get a lot of blood flow here, so I did a scalp pH in an attempt to try to figure out what was happening. I knew something wasn't right. I just didn't know exactly what it was.

Q. 2200 hours, you were concerned by fetal distress?

MR. GRAY: I'll object. I think he is referring to 2210.

Q. I'm asking another question. Were

you concerned at 2200 hours that there may be fetal distress?

A. No. What I was concerned about was that I couldn't interpret the whole picture and I needed more information.

Q. And that was why you wanted to do a scalp pH and ultrasound?

A. Correct.

Q. And then let's back up so we get the sequence. The last sentence in your note at 2200 hours said what?

A. It said that I cannot interpret the tracing. I'm going to do a scalp pH and an ultrasound. If everything is normal, we will proceed with an amnioinfusion. So I guess that answers what the question about the amnioinfusion, like it's answered, and low dose pitocin if normal.

Q. Is it fair to say that that plan did not work out that way?

A. Correct.

Q. You did not, in fact, proceed with the induction and amnioinfusion?

A. Correct.

Q. So there was something that occurred

that concerned you about the scalp pH?

A. Say that again.

Q. Was there something that concerned you about the scalp pH and/or the ultrasound?

A. No. What happened here is I expected the pH of the scalp to be low because of the edema that I spoke about on the head. I expected that to be abnormal, but I needed an indication to do a cesarean section and that was my indication. Something didn't check in this patient, something wasn't right, and I wasn't sure what it was. But now I have my indication for a cesarean section, because I didn't have one before.

Q. The 7.15 scalp pH was what you are saying was your indication for doing a cesarean section?

A. Correct.

Q. And you decided then at 2210 to do a C-section stat; correct?

A. Correct.

Q. That's how it is written. Generally, in a hospital like University Hospitals, is it fair to say that a stat or an urgent cesarean section can be accomplished within 30 minutes?

A. You mean the whole procedure?
Q. Yes.
A. From beginning to end?
Q. To delivery. From the time a decision is made to do an urgent or stat C-section to the time a baby is delivered, can that generally be accomplished within 30 minutes?
A. Yes.
Q. Would you agree that you did accomplish those stat or emergency sections quickly because if you decided to do one, you are concerned about fetal distress for one reason or another?
A. I didn't think this baby was in distress.
Q. I'm not asking about this baby, I'm asking generally.
A. Yes. If your indication is fetal distress, yes.
Q. You did do an ultrasound, as well; correct?
A. Yes.
Q. Do you have any independent recollection as we sit here today about what you

observed on that ultrasound?

A. What I was looking for was the baby's head. My concern was whether this baby was actually a breach position that had been misdiagnosed, because the feeling of the pelvic exam was soft and there is two things that could give you that: A malpresentation of the baby's butt or side, or something coming out and not the head, or two, you have edema of the head.

Q. Okay.

A. So what I needed to know at that point in time, is this baby breach, because now we know what is going on, this baby is simply breach. And my ultrasound showed that, no, it was the baby's head.

Q. What about the baby's head?

A. That the baby was coming head down. That the baby was not in an abnormal presentation. There was nothing from a physical exam point of view that would indicate anything else. Her abdominal examination was otherwise of a normal pregnant uterus.

Q. Would you have, yourself, examined in all likelihood Kelly Fiktus' abdomen at around 2200 hours?

A. Yes, because it's part of the pelvic exam.

Have you ever been in a delivery room?

Q. Yes.

A. You got to see everything?

Q. Yes.

At 2200 hours, or thereabouts, when you did this ultrasound, you were looking at Jacob Fiktus' head and would you have also seen Kelly Fiktus' uterus on the ultrasound?

A. No. You can't see the soft tissues as well. My focus at that time was, was Jacob breach or was the head coming first. That's what I needed to determine.

Q. Would you have been able to see if there was a Bandl's ring on the ultrasound?

A. No.

Q. Are you familiar with any literature that indicates that Bandl's rings are generally palpable externally?

A. I would expect it to be palpable externally.

Q. You didn't palpate a Bandl's ring in this case?

A. Correct, I did not.
Q. Am I correct that the first time you appreciated that there was a Bandl's ring in this case was in the midst of this cesarean section?
A. Correct.
Q. When do you believe that the Bandl's ring formed, if you have any idea?
A. Based on my understanding of Bandl's ring, probably many hours before.
Q. What is it about your understanding of Bandl's rings that indicates to you that it would have formed many hours before?
A. The edema of the baby's head. That's something that didn't happen in one hour or two hours or three hours, it was too large. This is probably something that happened earlier than this tracing that we are looking at.
Did you see pictures of him?
Q. I have not seen pictures. Do you have pictures?
A. No, I don't. I wish I did. But I think the pediatricians did take pictures, because it was very unusual.
MR. PESKIN: I don't know that anyone

has seen pictures.

MS. ROLLER: I have not.

THE WITNESS: I think it would be worthwhile asking, because no one had ever seen that before.

MS. ROLLER: They are not part of the chart, I can tell you that.

MR. PESKIN: No offense, but not a very good drawing.

THE WITNESS: Are you criticizing my drawings? I went to medical school, not art school.

MR. PESKIN: You do a better job than I would have.

Q. Do you understand that Bandl's rings often are precursors to uterine rupture?

A. Yes.

Q. There was no rupture of Kelly Fiktus' uterus?

A. No.

Q. Assuming that you had made a decision earlier to perform a cesarean section, is it fair to say that Jacob Fiktus' head would have spent less time entrapped in that Bandl's ring?

A. Yes.

Q. And that's because you believe that the Bandl's ring had been present for some time, several hours probably?
A. Yes.
Q. You are aware that Jacob Fiktus sustained some neurologic damage?
A. No.
Q. You didn't know that?
A. Well, I believe that that's what is the claim in the case, but I have not reviewed any information as to that effect. It's all been verbally communicated.
Q. You understood that --
A. Yes.
Q. -- that it's alleged.
Have you ever looked at any of the records from University Hospitals prior to his discharge, Jacob Fiktus' discharge?
A. I haven't reviewed it in some time, and my understanding was that neurology and everyone else in pediatrics felt that this baby did very well and went home fairly quickly, all things considered.
Q. Were you aware that there were some abnormalities noted on a CAT scan prior to Jacob

Fiktus' discharge?

A. Based on what I looked at in the chart, yes.

Q. You have seen the discharge summary for the neonate?

A. I have seen it, but I haven't read it in some time.

Q. It refers to bilateral intraventricular hemorrhage noted on a CT scan.

A. Okay.

Q. And a right intraventricular hemorrhage?

A. Yes.

Q. With regard to those findings on the CT scan, would you agree that it's likely that they were caused by Jacob Fiktus' head being entrapped in a Bandl's ring?

A. It's possible. We do not do CT scans on every baby that's born, so we don't know what the background of intraventricular hemorrhage is, we really don't. All I know is, for example, going here and seeing a note from 11-25-97 at 11:30 in the morning, the next morning, and it says no neurological abnormality. This is all the information I

have.

Q. Right.

A. So looking at this record, it appears that the neonatologist and the neurologist at the time felt that the baby was okay and went home. I don't know anything past that.

Q. Well, assuming that Jacob Fiktus is not okay and did sustain some neurologic insult, do you have an opinion if an earlier cesarean section would have avoided that insult?

A. Perhaps. The question is when. And I don't know that anybody could say when this injury happened.

Q. You would agree, though, that if it was known that there was a Bandl's ring present, it would not be advisable to allow Jacob Fiktus' head to be entrapped in it for any period of time?

A. Yes.

MR. PESKIN: I don't have any other questions.

Thank you, doctor.

MS. ROLLER: No questions.

- - - - -

(Thereupon, LORET DE MOLA Deposition

Exhibit 3 was marked for purposes of identification.)

- - - - -

- - - - -

(Deposition concluded at 6:45 p.m.)

- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 98 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

RICARDO LORET de MOLA, M.D.

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named RICARDO LORET de MOLA, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 14th day of August, 2002.

Vivian L. Gordon

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

INDEX

DEPOSITION OF RICARDO LORET de MOLA, M.D.