

1                   IN THE COURT OF COMMON PLEAS  
2                   OF CUYAHOGA COUNTY, OHIO

3                   - - - - -

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

8                   Plaintiffs,

9                   vs                               Case No. 430662

10       UNIVERSITY HOSPITALS  
11       of CLEVELAND, et al.,

12                   Defendants.

13                   - - - - -

14       DEPOSITION OF RICARDO LORET de MOLA, M.D.

15                   FRIDAY, AUGUST 2, 2002

16                   - - - - -

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

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 LAWRENCE F. PESKIN, ESQ.

5 Skylight Office Tower Suite 660

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9

10 On behalf of the Defendant University Hospitals

11 Davis & Young

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17

18 On behalf of the Defendants University OB/GYN

19 Specialties and Dr. Kiwi

20 Sutter, O'Connell, Mannion & Farchione

21 TODD A. GRAY, ESQ.

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

6 EXAMINATION OF RICARDO LORET de MOLA, M.D.

7 BY MR. PESKIN:

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

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

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

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

18 Q. Dr. Loret deMola.

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

21 Q. I may just say doctor.

22 A. Why not.

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

25 A. No.

1 Q. This is your first deposition?

2 A. Uh-huh.

3 Q. You have to answer out loud.

4 A. Actually, I have been deposed once on  
5 behalf of the hospital, once before.

6 Q. When you say on behalf of the  
7 hospital, were you a defendant in that lawsuit?

8 A. No.

9 Q. Were you an expert witness in that  
10 lawsuit?

11 A. I guess you could say that. I don't  
12 know what the legal term is.

13 Q. Were you involved at all in the care  
14 and treatment of the plaintiff in that lawsuit?

15 A. Yes, but I wasn't named on the suit.  
16 I was involved in her care, but I wasn't named  
17 on the suit.

18 Q. Okay. That makes sense.

19 Well, since you haven't been through  
20 this too many times, I will go over a couple of  
21 basic ground rules.

22 It's my job to ask you a question  
23 that you can understand. If for some reason my  
24 question is unclear, please ask me to restate it  
25 or rephrase it, okay?

1           A.     Uh-huh.

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

6           A.     Yes.

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

10          A.     That's fair.

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

22          A.     Fair.

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

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

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

5           A.     I'm very certain.

6                     - - - - -

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

10                    - - - - -

11          Q.     Where were you born, by the way?

12          A.     I was born in Monterey, Mexico.

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

17          A.     Yes.

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

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

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

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

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

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

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

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

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

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

4           A.     Yes.

5           Q.     In what areas are you board  
6     certified?

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

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

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

17           A.     That is correct.

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

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

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

25           A.     Yes.



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

3           A.     Yes.

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

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

10          Q.     Those dates are accurate?

11          A.     Yes.

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

15          A.     Yes.

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

25          A.     Could you be more specific?

1 Q. Well, have you published anything on  
2 Bandl's rings, for example?

3 A. No.

4 Q. And you have not been involved in any  
5 publications or anything dealing with a Bandl's  
6 ring?

7 A. No.

8 Q. What about induction of labor? As  
9 you flip through that, what I would like you to  
10 do -- I'll hand you a pen -- if you could circle  
11 or check, put a check next to any publications  
12 that are relevant to induction of labor.

13 A. No, they have been related to  
14 obstetrics but not specifically to induction of  
15 labor.

16 Q. What about uterine hyperstimulation,  
17 any publications related to that issue?

18 A. No.

19 Q. What about interpretation of fetal  
20 monitor strips?

21 A. No.

22 Q. Let me think of some other things to  
23 ask you about. Are you currently a defendant in  
24 any other lawsuits other than this one?

25 A. No.

1           Q.     Have you ever been a defendant in a  
2     lawsuit that you are aware of?

3           A.     Not that I can recall.

4                     (Discussion off the record.)

5           A.     Going to your question, I never  
6     received any letters to any lawsuits. If I have  
7     never received any, does that count?

8                     MR. GRAY: You know of no other  
9     suits?

10                    THE WITNESS: No. But there is  
11     always the decision of the mail and I don't know  
12     what to say. None that I'm aware of.

13                    MR. GRAY: You answered his question.

14           Q.     I am not asking about letters you may  
15     have gotten about thinking about filing a  
16     lawsuit.

17           A.     Not even that.

18           Q.     What I am asking, complaints filed  
19     where your name is on them. And this is the  
20     only one that you are aware of?

21           A.     Yes.

22           Q.     What have you reviewed in preparation  
23     for your deposition today?

24           A.     What's here in front of me, which is  
25     a copy of the chart.

1           Q.     Is that a copy of the entire chart or  
2 portions of the chart?

3           A.     This is what was given to me by  
4 Mr. Farchione, so this is what is just in front  
5 of me.

6           Q.     Let me take a quick look and see what  
7 you have got.

8                   MR. GRAY: Before you do that, let me  
9 see this.

10                   You don't recall seeing any letters  
11 or anything of that nature in here, when you  
12 reviewed it, from our office?

13                   THE WITNESS: I don't remember. I  
14 put everything --

15                   MR. GRAY: I think it's the exact  
16 same copy of what I have here.

17                   THE WITNESS: See, whatever  
18 correspondence, I just put it altogether so I  
19 don't lose it. This is what this is about and  
20 this is about. And it's confusing because  
21 sometimes attorneys change law firms, so I get  
22 letters from different law firms.

23                   MR. PESKIN: I know about that too.  
24 I've made a few changes.

25                   (Discussion off the record.)

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

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

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

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

10          Q.     Including the tabs --

11          A.     Yes.

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

15          A.     Nothing.

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

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

23          Q.     Did you review any other deposition  
24     transcripts?

25          A.     No. This is the only deposition

1 transcript that I have seen.

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

6 A. Not that I would recall.

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

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

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

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

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

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

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

24 A. I am not.

25 Q. Who are you employed by at present?

1           A.     MacDonald's Physicians, Inc.

2           Q.     And how long have you been employed  
3     at MacDonald's Physicians, Inc.?

4           A.     Since October of 2000.

5           Q.     And how was it that -- did you move  
6     from University OB/GYN Specialties, Inc. to  
7     MacDonald?

8           A.     No. I left Cleveland in 1999 to join  
9     the faculty at University of Texas Health Center  
10    of San Antonio and I was recruited back to  
11    Cleveland as head of the division of  
12    reproductive endocrinology and infertility and  
13    it is managed by MacDonald Physicians, that  
14    makes the checks. It's one of those weird  
15    arrangements between hospitals and physicians.

16          Q.     You were out of town for a period of  
17    time and came back?

18          A.     Yes. And yes, I am sane.

19          Q.     University OB/GYN Specialties, Inc.,  
20    does it still exist, as far as you know?

21          A.     Not that I'm aware of, but I don't  
22    know if -- I really don't know. I assume that  
23    the name may persist, but as I understand it,  
24    there are no physicians working in it anymore.

25          Q.     As far as you know, all of the

1     shareholders and physician employees have moved  
2     on to other things?

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

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

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

11          A.     No.

12          Q.     You were an employee?

13          A.     Yes.

14          Q.     Who were the other physician  
15    employees of the corporation in November of  
16    1997, if you can recall?

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

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

24          A.     Yes.

25          Q.     Did you at that time in 1997 have a



1 general obstetrical practice?

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

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

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

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

14 A. Correct.

15 Q. Who cared for the clinic patients?

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

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

1 A. Yes.

2 Q. Is that a smaller subset than the 20?

3 A. It's the same physicians.

4 Q. So all 20, roughly 20 -- I won't hold  
5 you to that number -- but that number of  
6 physicians that were part of that practice all  
7 shared call for private patients?

8 A. Yes.

9 Q. Generally, how did that schedule  
10 work? How often would you be on call for the  
11 group?

12 A. Roughly, two to three times a month.

13 Q. Were weekends treated differently  
14 than week days?

15 A. Not really. If you were the  
16 physician on call, you were the person who they  
17 would primarily call with problems if the  
18 primary physician was not available.

19 Q. Well, what I meant by that is, would  
20 people in the group take call for an entire  
21 week, one doctor from Friday night to Saturday  
22 morning through till Monday morning?

23 A. No. It would be at the most a 24  
24 hour period.

25 Q. So you cut the week up each

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

4 A. Yes.

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

7 A. Yes.

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

10 A. No. A month.

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

13 A. Yes.

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

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

1 8:00, 9:00 o'clock, maybe a few other patients  
2 left behind.

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

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

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

17 A. Correct.

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

20 A. That's right.

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

1           A.     Yes.

2           Q.     You didn't take call from home?

3           A.     No.

4           Q.     When did the shift change?  When did  
5     you change over from one doctor to another in  
6     the group in terms of your call schedule?  Was  
7     it 9:00 a.m.?

8           A.     For a weekend.  For a weekday, it  
9     used to change around 5:00.  And I say around,  
10    because it wasn't really precisely at 5:00  
11    o'clock.  If you were still caught up with  
12    patients in the office, whoever was there in the  
13    morning would wait for you to finish and vice  
14    versa.  So roughly around 5:00 o'clock we would  
15    have a turnover.

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

1 physician to deliver their own individual  
2 patients.

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

5 A. Usually, yes.

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

9 A. Until the next morning on a weekday.

10 Q. What about on a weekend?

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

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

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

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

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

5 Q. University Hospitals is a teaching  
6 hospital; correct?

7 A. Yes.

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

12 Do you understand my question?

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

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

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

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

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

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



1           Q.     If labor and delivery nurses -- and  
2     for purposes of my questions, I'm talking about  
3     1997, not today -- observed a problem with a  
4     fetal monitor strip, for example, prolonged  
5     bradycardia, would you expect them to notify you  
6     or the residents?

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

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

17          A.     Yes.

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

20          A.     Correct.

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

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

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

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

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

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

13          A.     No.

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

17          A.     I don't remember.

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

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

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

25          A.     Yes.

1 Q. Can hyperstimulation of the uterus  
2 lead to a Bandl's ring?

3 A. I don't know, because it's associated  
4 with pitocin use, but you can get  
5 hyperstimulation of the uterus with or without  
6 pitocin, so it's hard to answer that question.

7 Q. And it's your understanding that  
8 pitocin can cause a Bandl's ring?

9 A. It's associated with it.

10 Q. Prior to the delivery of Jacob  
11 Fiktus, had you ever encountered a Bandl's ring?

12 A. No.

13 Q. How many deliveries roughly had you  
14 done prior to that?

15 A. Thousands.

16 Q. Had you only read about them?

17 A. Yes.

18 Q. Do you know if Bandl's rings are more  
19 or less common now or in 1997 than they were,  
20 say, 20 or 30 years ago?

21 A. They would be less common today than  
22 they were back then.

23 Q. Why is it that Bandl's rings are less  
24 common today than they were 20 or 30 years ago?

25 A. Because most Bandl's rings in those

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

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

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

13 Q. Generally.

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

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

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

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

11 A. No.

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

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

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

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

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

1 anything, necessarily.

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

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

7 A. No.

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

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

16 Q. 1940 on November 24, 1997?

17 A. Yes.

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

20 A. Yes.

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

24 A. Yes.

25 Q. When you wrote that note, agreed with

1     above, what was it that you were agreeing with?

2     What is it?   What was written on the note at

3     11-24-97 --

4           A.     Yes.

5           Q.     -- in terms of an assessment and

6     plan?

7           A.     Yes.

8           Q.     Do you recall as you sit here today

9     whether when you saw Kelly Fiktus for the first

10    time that you reviewed all the prior entries

11    from either Dr. McHugh or Dr. Wang?

12          A.     I don't recall specifically as to

13    this particular case.   I would say that in

14    general most likely I would have discussed this

15    case before Dr. Kiwi left, so I was aware that

16    the patient was in the hospital and that I

17    probably reviewed the record at that time.

18          Q.     When you say at that time, do you

19    mean, would that have been around 5:00 o'clock

20    p.m.?

21          A.     Probably around 1940 more likely.

22          Q.     That's when you think Dr. Kiwi left

23    the hospital?

24          A.     That would be my thought, but I can't

25    tell you for sure, because sometimes

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

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

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

13           MR. PESKIN: I understand.

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

18           A.     No.

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

23           A.     Yes.

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



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

3           A.     Probably not. I would say that  
4     probably it would have been around, again,  
5     somewhere between 5:00 and 7:00, but I do not  
6     recall specifically at what time. Because,  
7     again, frequently we stay in the hospital many  
8     hours longer than the 5:00 o'clock and we don't  
9     check out with the other physician necessarily  
10    at that time. My first contact with her was at  
11    1940 hours.

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

15          A.     I cannot.

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

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

25                   Frequently, what would happen is that

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

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

11 A. Yes.

12 Q. So you wrote that entire entry?

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

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

20 A. No.

21 Q. You again reviewed this note and  
22 signed it?

23 A. Correct.

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

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

4 A. Not necessarily.

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

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

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

24 Q. Okay.

25 A. But what was written in, what I

1 signed, I reviewed and we discussed.

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

6 A. The assessment, but also with the  
7 patient.

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

13 A. Not necessarily.

14 Q. Okay.

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

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

1           A.     I don't know whose signature that is.

2           Q.     Is your signature at the very bottom  
3 of that page?

4           A.     Yes.

5           Q.     And in this case, can you tell from  
6 reading this note?

7           A.     I think this is Weiner actually, who  
8 is the chief resident.

9           Q.     Can you tell when you reviewed this  
10 note whether or not you countersigned this note  
11 after having actually seen Kelly Fiktus and  
12 verifying what Dr. Wang's assessment was in  
13 terms of her status?

14          A.     I can't state that specifically from  
15 this note.

16          Q.     What about the following note which  
17 is a 2150? This one I think is pretty clear  
18 that it was written and signed first by  
19 Dr. McHugh. At the very end of that note it  
20 says will discuss plan with Dr. Loret deMola;  
21 correct?

22          A.     Yes.

23          Q.     Is it fair to say based on the  
24 context of that note that you weren't physically  
25 present at that time, at the time this

1     assessment was done at 2150?

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

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

14          Q.     What you are talking about is the  
15    note immediately following the note at 2150,  
16    which is a note at 2200 hours, I assume, and  
17    11:24; right?

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

20          Q.     No, I'm looking at --

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

25          Q.     I got you, okay.

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

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

10          A.     Yes.

11          Q.     Is that in your handwriting?

12          A.     Yes.

13          Q.     So you wrote that entire note?

14          A.     Yes.

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

18          A.     Yes.

19          Q.     And the entire note is in your  
20     handwriting?

21          A.     It is in my handwriting.

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

24          A.     Yes.

25          Q.     And that again is based on your

1      assessment?

2            A.      Yes.

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

7            A.      Yes.

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

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

15          Q.      I believe the record reflects -- and  
16      if you disagree with anything I say to you that  
17      I believe to be a fact, let me know -- at around  
18      0500, after her admission, Kelly Fiktus ruptured  
19      her membranes.

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



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

7 Q. Did you see the nursing note at 0500?

8 A. Yes.

9 Q. What you are looking at.

10 Patient awakened and upon arising  
11 felt fluid running down --

12 A. Yes.

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

16 A. No. I just have to go with facts.  
17 The fact is that the exam that made the  
18 determination of ruptured membranes was done at  
19 9:45. It could have been at 5:00, but at that  
20 time the patient did not get a pelvic  
21 examination, and if she did, it's not  
22 documented, so I don't know. I wasn't there at  
23 the time.

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

1 A. I have no idea.

2 Q. When a patient's membranes rupture,  
3 is it generally a loss of amniotic fluid?

4 A. Yes.

5 Q. And does the loss of amniotic fluid  
6 from ruptured membranes make the fetus more  
7 susceptible to cord compressions?

8 A. Perhaps, yes.

9 Q. At the time that Kelly Fiktus'  
10 membranes ruptured, would Dr. Kiwi have been on  
11 call?

12 A. I don't know.

13 Q. Well, assuming that your call  
14 schedule is as you described it, you took over  
15 for Dr. Kiwi; correct?

16 A. He may have not been on call the  
17 night before. He could have been just there for  
18 office hours during the day and went home. I  
19 don't know what he did before. I haven't seen  
20 the call schedule from that time. In fact, I  
21 wasn't even scheduled to be on call that day,  
22 there was someone else.

23 Q. You were covering for someone?

24 A. Well, someone asked to change call  
25 with me that day because they had a personal

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

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

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

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

16 A. That is correct.

17 (Record read.)

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

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

22 A. No time before.

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

25 A. No.

1 Q. It would have been a number --

2 A. Her personal physician was in the  
3 hospital. I had no reason to take her care.

4 Q. That would have been Dr. Kiwi?

5 A. Yes.

6 Q. You have had an opportunity now to  
7 review the records that are in front of you. Do  
8 you concur with the decision that was made to  
9 begin an induction with pitocin for Kelly  
10 Fiktus?

11 A. I have to say that I only had to do  
12 with after the fact. I don't know if I can  
13 render an opinion of what other people did.

14 MR. GRAY: Are you asking him based  
15 on what he sees here?

16 Q. Based on everything you know about  
17 why it was that Kelly Fiktus was admitted and  
18 your understanding from the records of what  
19 occurred following her admission prior to your  
20 assuming responsibility for her care, do you  
21 concur with the decision that was made to begin  
22 the pitocin?

23 A. To deliver this baby.

24 Q. To begin a pitocin induction?

25 A. To get her delivered, that's the idea

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

3 - - - - -

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

7 - - - - -

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

15 Oxytocin is pitocin; correct?

16 A. Yes.

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

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

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

25 A. With the policy in general or this

1 particular policy?

2 Q. This particular policy.

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

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

14 A. Yes.

15 Q. Nurses at University Hospitals in  
16 1997 had some guidelines or protocol to follow  
17 with regard to administration of pitocin;  
18 correct?

19 A. Yes.

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

24 A. Yes, that's a fair statement.

25 Q. Now, I assume you have in the records

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

3 A. Labor flowsheets, is that it?

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

6 A. Yes, I have it here.

7 Q. If you start looking at the page that  
8 has 1400 as the first hour entry for November  
9 24th --

10 A. I have 11-24.

11 Q. Do you see 1400 there again?

12 A. Yes.

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

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

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

21 A. Yes.

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

25 A. No, the 23rd.

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

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

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

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

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

24          A.     Could you repeat that?  
25                   (Record read.)



1           A.     We write an order for pitocin per  
2     protocol and then the nurses execute it.

3           Q.     Is that what was done in this case?

4           A.     I don't know. I didn't write that  
5     order.

6           Q.     Do you know if -- have you seen that  
7     order in the chart when you reviewed the  
8     records?

9           A.     No.

10          Q.     And the way it works is that --

11                 MR. GRAY: Let's be clear. I think  
12     you said did you see that order in the chart  
13     when you reviewed the records. I think he is  
14     saying he hasn't reviewed that portion of the  
15     record.

16                 THE WITNESS: If I have, I don't  
17     recall.

18                 MR. GRAY: You are not saying it's  
19     not in there.

20          Q.     I don't want to suggest it's not  
21     there. Let's assume that it's there.

22          A.     Okay. And let's state that I wasn't  
23     the one who wrote it.

24          Q.     Right. I know that.

25                 So generally speaking, there would be

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

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

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

12 A. Yes.

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

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

21 Q. Okay.

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

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

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

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

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

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

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

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

1 Q. It appears to be two --

2 A. Yes.

3 Q. -- milliunits. And then at that  
4 point, according to the record, Kelly Fiktus was  
5 having mild contractions; is that correct?

6 A. Where did you read that?

7 Q. That would be under contraction  
8 intensity, which is a little further up the  
9 column at 1400.

10 A. Yes. It says mild, so I assume they  
11 were not strong.

12 Q. And the duration of the contraction  
13 is recorded right below that?

14 A. The duration is 40 to 70 seconds.

15 Q. Okay. And then there is a number of  
16 other measures -- obviously the nurses are  
17 monitoring whether there is adequate uterine  
18 rest, right below the pitocin; correct?

19 A. Yes.

20 Q. At 1430, looking at the pitocin  
21 entry, going across now, could you see what the  
22 level of pitocin was?

23 A. Four milliunits.

24 Q. Based on your understanding of the  
25 protocol and the entries that the nurse has made

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

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

7           Q.     Every 30 minutes; correct?

8           A.     Yes.

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

11          A.     Yes.

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

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

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

21          A.     Yes.

22          Q.     So the increase in the pitocin at  
23    1430 from two milliunits to four milliunits is  
24    consistent with that policy; correct?

25          A.     So it would be contraction frequency,

1 2 to 5, they would be referring, not to 2 to 5  
2 contractions in one minute. They would be  
3 referring to contractions every 10 or 15 minute  
4 period of time. Again, you would need to ask  
5 one of our nurses.

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

8 A. The same as before.

9 Q. Okay.

10 A. No change. And also mild.

11 Q. Okay.

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

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

17 A. Correct.

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

20 A. Yes.

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

24 A. Yes.

25 Q. And this increase is consistent with

1 the nursing protocol; correct?

2 A. Yes.

3 Q. And then look at the entry at 1530.

4 A. Okay.

5 Q. Do you see again that the pitocin was

6 increased?

7 A. Yes.

8 Q. To eight milliunits; correct?

9 A. Yes.

10 Q. And at the beginning of that there is

11 an entry right under the pitocin that says

12 adequate uterine rest where the nurses are

13 supposed to answer yes or no; correct?

14 A. Where did you see that?

15 Q. Right underneath where the pitocin is

16 recorded.

17 A. There is a Y there.

18 Q. There is a Y there and there are

19 three blocks for that half hour?

20 A. 1550, 1555 and 1600 hours, is that

21 what you are referring to?

22 Q. 1530 and then 1555 and then it looks

23 like 1558 is written in after 1600 is crossed

24 out.

25 A. I don't see that. I think it was the

1 1600 hour that was erased, which may be the next  
2 entry, and it was probably inadvertently entered  
3 here.

4 Q. Okay.

5 MR. GRAY: 1558; right?

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

8 A. Yes, I see an N here.

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

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

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

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

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



1           A.     Okay. I read it.

2           Q.     Now, having read number 9 and seeing  
3     what was recorded here, if the nurse was  
4     observing that there was not adequate uterine  
5     rest at approximately 1600, and the contraction  
6     duration at that time is recorded at 60 to 90  
7     seconds -- do you see that, up a little higher?

8           A.     Yes.

9           Q.     Would you agree that according to  
10    this protocol the nurse had the authority on her  
11    own to cut the --

12          A.     Cut the medication in half.

13          Q.     -- cut the medication in half? Is  
14    it recorded that the pitocin was decreased by 50  
15    percent on the record?

16          A.     I don't see that. The next entry,  
17    decreased to five units; is that what you are  
18    referring to.

19          Q.     Decrease to five milliunits?

20          A.     Yes.

21          Q.     Five milliunits is not half of eight?

22          A.     Correct.

23          Q.     The next entry is at 1600. Do you  
24    see that there is nothing recorded in the boxes  
25    for adequate uterine rest?

1 A. Yes.

2 Q. Based on your understanding of the  
3 way this medical record is kept, is it fair to  
4 assume that if the boxes are blank, that the  
5 answer to whether there is adequate uterine rest  
6 is still no until it changes to yes?

7 MR. GRAY: Objection.

8 MS. ROLLER: Objection.

9 A. No, I don't agree with that.

10 Q. What was the duration of the  
11 contractions at that time at 1600?

12 A. 60 to 3 minutes.

13 Q. Based on the protocol for pitocin,  
14 what should the nurse do if decreasing the  
15 pitocin dose by 50 percent, if after reducing  
16 the pitocin dose by 50 percent the patient still  
17 is showing signs of uterine hyperstimulation?

18 A. I don't believe that it says  
19 specifically what to do under those  
20 circumstances, unless you have read it.

21 Q. Could you look back at number 8.

22 MR. GRAY: Maybe we could do this a  
23 different way. Instead of him having to confirm  
24 everything in the protocol, if there is  
25 something you think was deviated from, ask him

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

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

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

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

15 A. Yes.

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

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

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

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

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

4 A. It is left blank.

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

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

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

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

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

1 the nurses at 1600?

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

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

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

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

16 MS. ROLLER: Right.

17 THE WITNESS: Frequently they do  
18 write on them.

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

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

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

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

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

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

19 THE WITNESS: I don't see any  
20 evidence.

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

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

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

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

8 A. Right.

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

12 A. Where would that be?

13 Q. Right at the 1630 column.

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

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

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

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

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

8 A. Roughly.

9 Q. Not six?

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

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

16 A. Yes.

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

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

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



1 A. Yes, I read that.

2 Q. That is a physician order; correct?

3 A. Correct.

4 Q. And that was an order that instructed  
5 the nurses at that point, 1740, to DC the  
6 pitocin?

7 A. Correct. For 30 minutes.

8 Q. I want you to assume for purposes of  
9 my questions, since we don't know the answer to  
10 that question, that that was the first time that  
11 the pitocin was discontinued.

12 A. I would not agree with that.

13 Q. Well, I'm asking you to agree with it  
14 just for purposes of this question. Assume  
15 that.

16 A. Okay.

17 Q. Assume that the first time the  
18 pitocin was discontinued was at 1740 in response  
19 to an order by Dr. Wang.

20 A. Uh-huh.

21 Q. If that were true, would it be the  
22 case that the nursing staff at University  
23 Hospital failed to follow the protocol that we  
24 have been discussing with regard to the  
25 administration of oxytocin?

1 MS. ROLLER: At what time?

2 MR. PESKIN: Between 1600 and 1740.

3 A. No. But the note was written at  
4 1740. I can't say what happened before then.  
5 Obviously, this note from 4:30 was an hour  
6 later. What she wrote was an hour later than  
7 what you are claiming.

8 Q. The order from Dr. Wang is at 1740?

9 A. That's when it's written on the  
10 chart.

11 Q. And that's when she is telling the  
12 nursing staff to discontinue the pitocin;  
13 correct?

14 A. Correct.

15 Q. If you look back at the policy, would  
16 you agree that the nurse pursuant to the policy  
17 on her own should have discontinued the pitocin  
18 if she observed hyperstimulation?

19 A. Well --

20 Q. I'm assuming again for purposes of  
21 these questions that it had not been  
22 discontinued up until that point.

23 MR. GRAY: Objection.

24 MS. ROLLER: Objection.

25 A. I can only go with the facts written

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

2 Q. I understand.

3 A. I have to assume that at or about  
4 1740 hours the pitocin would be discontinued and  
5 the reason why I think that is because there is  
6 blanks. So during the 1630 hours that you are  
7 describing, I'm assuming that there was no  
8 specific note from a physician stating to  
9 discontinue the medication and that they were  
10 following the protocol.

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

16 A. Yes.

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

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

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

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

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

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

9                   MS. ROLLER:  Objection.

10                  MR. GRAY:  Objection.

11           A.     I don't know.

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

16                   MS. ROLLER:  Objection.

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

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

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

10 A. Which page?

11 Q. Physician progress notes.

12 A. Okay.

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

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

18 Q. Right.

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

21 Q. Was he a resident at University  
22 Hospitals?

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

1 recall his year at the time.

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

6 A. Yes.

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

9 I can't remember his last name.

10 A. Beigi.

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

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

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

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

4 A. Correct.

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

7 A. I don't.

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

11 A. Yes.

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

15 A. Right.

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

18 A. Correct.

19 Q. Do you know if any attending  
20 physician from your group reviewed Dr. Wang's  
21 assessment of Kelly Fiktus' contraction pattern  
22 and the fetal monitor tracings at that time at  
23 1740?

24 A. I can't say.

25 Q. Can you say whether you would have

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

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

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

9           A.     I can't remember.

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

12          A.     Okay.

13          Q.     Actually, if you could flip back a  
14     little bit from there to 1722. How would you  
15     describe the fetal heart rate tracing between  
16     1722 and 1729?

17          A.     Reassuring.

18          Q.     And what about the next page?

19          A.     That's reassuring.

20          Q.     And the following page?

21          A.     Reassuring.

22          Q.     And the next page, which would be  
23     1749, starting at 1749?

24          A.     It looks okay.

25          Q.     So would you agree with -- I assume



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

4 A. Yes.

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

7 A. I can't draw, can I?

8 Q. You could.

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

12 Q. It's not necessary to do that.

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

16 A. Yes.

17 MS. ROLLER: You would disagree?

18 THE WITNESS: That is not a  
19 sinusoidal plan.

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

23 A. I'm sorry?

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

1 observed at around 1600?

2 A. It could be many things.

3 Q. Is it likely that it was related to  
4 the pitocin induction?

5 A. It's one of the possibilities, yes.

6 Q. Is it likely, though?

7 A. It's possible.

8 Q. Possible, okay. I apologize for  
9 jumping around a little bit.

10 A. As long as you give us time to go  
11 back.

12 Q. We are going to go on. I would like  
13 to go to the note at 1940. I guess this was  
14 your first face-to-face contact with Kelly  
15 Fiktus, to the best of your recollection?

16 A. My note, 1940, got it.

17 Q. This is the note we talked about  
18 earlier, where you agreed with Dr. McHugh's  
19 assessment, and to the best of your  
20 recollection, this may have been the first time  
21 you actually were face-to-face with Kelly  
22 Fiktus; correct?

23 A. Correct.

24 Q. I want you to look at the monitor  
25 strips too. Was there an episode of bradycardia

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

3             A.     19 hours?

4             Q.     1919.

5             A.     1919, an episode of bradycardia.

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

8             A.     Okay.

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

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

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

25            A.     Again, it's sometimes difficult,

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

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

18            Q.     Did you --

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

22            Q.     Look back at that labor flowsheet at  
23    1930. It's the nurses flowsheet.

24            A.     Yes.

25            Q.     Do you see that there is an entry

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

3 A. 19 --

4 Q. -- 30?

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

7 Q. If you look now at the strips at  
8 2100.

9 A. Okay.

10 Q. Starting at 2102 or so.

11 A. Correct.

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

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

19 Q. Look on the next page.

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

22 Q. Would you consider that a  
23 bradycardia?

24 A. Change in baseline.

25 Q. Do you know if the pitocin was on or

1 off at this time?

2 A. What's the hour?

3 Q. 9:02 to 9:13.

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

6 Q. Do you know what the cause of this  
7 change in baseline or bradycardia was between  
8 9:02 and 9:13?

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

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

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

19 Q. 2130, back to the progress notes.

20 A. Yes.

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

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

25 Q. The progress notes, I'm sorry.

1 A. Okay. I think that's Dr. Wang.

2 Q. Okay. And this is again something  
3 you would have reviewed?

4 A. Yes.

5 Q. Would you have reviewed the monitor  
6 tracings at that time?

7 A. I probably did. Since there was a  
8 question about the monitor, I'm certain that I  
9 would have.

10 Q. By this time, at this point at 2130,  
11 how dilated was Kelly Fiktus?

12 A. Four to five centimeters and  
13 completely effaced, so she entered at that  
14 particular point in time -- I'm looking at the  
15 previous -- could you find the previous vaginal  
16 exam? We have a vaginal exam at 1650.

17 MS. ROLLER: 1740.

18 THE WITNESS: 1740.

19 MS. ROLLER: VE.

20 A. VE not done. And then objective,  
21 blah, blah, blah, so there was no vaginal from  
22 1650 when she was in latent phase of labor, not  
23 in active labor yet and became active labor at  
24 that particular point in time.

25 Q. Which particular point in time?

1           A.     The 2130 hours.

2                     So she entered labor at that point in  
3     time.

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

7           A.     Correct.

8           Q.     She had come into the hospital  
9     contracting?

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

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

16          A.     That morning.

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

20          A.     Could you repeat that?

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

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



1           Q.     You wouldn't consider this a failure  
2     to progress --

3           A.     No.

4           Q.     -- at this point?

5           A.     No.

6           Q.     2130, okay.

7           A.     So she is responding within a normal  
8     pattern. Her membranes ruptured around 9:00 in  
9     the morning or at least that was documented at  
10    the time, and she was in an active labor pattern  
11    within 12 hours.

12          Q.     Did you agree at the time that the  
13    tracings around 2130 were reassuring?

14          A.     At 2130 hours, yes.

15          Q.     What about beyond 2130?

16          A.     Past 2130?

17          Q.     Look at 2134 through 2150. Do you  
18    consider those to be reassuring tracings?

19          A.     Yes. There was an acceleration in  
20    the heart rate of the baby with good -- with  
21    variability.

22          Q.     And look on the next page.

23          A.     Say that again.

24          Q.     2143, would you consider that page to  
25    be reassuring?

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

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

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

12          Q.     And also at the next page between  
13    2151 and 2159?

14          A.     That would be reassuring, as well.

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

20          A.     Yes.

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

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

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

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

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

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

14 A. I don't remember.

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

18 A. No, I don't.

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

23 A. No.

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

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

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

6           A.     Yes.

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

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

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

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

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

24          A.     Right.

25          Q.     And that indicates to you that you

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

4 A. Correct.

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

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

12 Q. When you say --

13 A. Several, two or more.

14 Q. Which one earlier do you mean?

15 A. There was a deceleration at 2140  
16 hours.

17 Q. Okay.

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

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

22 A. Correct.

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

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

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

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

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

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

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

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

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

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

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

25           Q.       I'm asking another question. Were

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

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

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

8 A. Correct.

9 Q. And then let's back up so we get the  
10 sequence. The last sentence in your note at  
11 2200 hours said what?

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

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

21 A. Correct.

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

24 A. Correct.

25 Q. So there was something that occurred



1 that concerned you about the scalp pH?

2 A. Say that again.

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

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

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

18 A. Correct.

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

21 A. Correct.

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

1 A. You mean the whole procedure?

2 Q. Yes.

3 A. From beginning to end?

4 Q. To delivery. From the time a  
5 decision is made to do an urgent or stat  
6 C-section to the time a baby is delivered, can  
7 that generally be accomplished within 30  
8 minutes?

9 A. Yes.

10 Q. Would you agree that you did  
11 accomplish those stat or emergency sections  
12 quickly because if you decided to do one, you  
13 are concerned about fetal distress for one  
14 reason or another?

15 A. I didn't think this baby was in  
16 distress.

17 Q. I'm not asking about this baby, I'm  
18 asking generally.

19 A. Yes. If your indication is fetal  
20 distress, yes.

21 Q. You did do an ultrasound, as well;  
22 correct?

23 A. Yes.

24 Q. Do you have any independent  
25 recollection as we sit here today about what you

1 observed on that ultrasound?

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

10 Q. Okay.

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

16 Q. What about the baby's head?

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

23 Q. Would you have, yourself, examined in  
24 all likelihood Kelly Fiktus' abdomen at around  
25 2200 hours?

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

3                   Have you ever been in a delivery  
4 room?

5           Q.     Yes.

6           A.     You got to see everything?

7           Q.     Yes.

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

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

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

18          A.     No.

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

22          A.     I would expect it to be palpable  
23 externally.

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

1 A. Correct, I did not.

2 Q. Am I correct that the first time you  
3 appreciated that there was a Bandl's ring in  
4 this case was in the midst of this cesarean  
5 section?

6 A. Correct.

7 Q. When do you believe that the Bandl's  
8 ring formed, if you have any idea?

9 A. Based on my understanding of Bandl's  
10 ring, probably many hours before.

11 Q. What is it about your understanding  
12 of Bandl's rings that indicates to you that it  
13 would have formed many hours before?

14 A. The edema of the baby's head. That's  
15 something that didn't happen in one hour or two  
16 hours or three hours, it was too large. This is  
17 probably something that happened earlier than  
18 this tracing that we are looking at.

19 Did you see pictures of him?

20 Q. I have not seen pictures. Do you  
21 have pictures?

22 A. No, I don't. I wish I did. But I  
23 think the pediatricians did take pictures,  
24 because it was very unusual.

25 MR. PESKIN: I don't know that anyone

1 has seen pictures.

2 MS. ROLLER: I have not.

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

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

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

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

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

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

17 A. Yes.

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

20 A. No.

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

25 A. Yes.

1 Q. And that's because you believe that  
2 the Bandl's ring had been present for some time,  
3 several hours probably?

4 A. Yes.

5 Q. You are aware that Jacob Fiktus  
6 sustained some neurologic damage?

7 A. No.

8 Q. You didn't know that?

9 A. Well, I believe that that's what is  
10 the claim in the case, but I have not reviewed  
11 any information as to that effect. It's all  
12 been verbally communicated.

13 Q. You understood that --

14 A. Yes.

15 Q. -- that it's alleged.

16 Have you ever looked at any of the  
17 records from University Hospitals prior to his  
18 discharge, Jacob Fiktus' discharge?

19 A. I haven't reviewed it in some time,  
20 and my understanding was that neurology and  
21 everyone else in pediatrics felt that this baby  
22 did very well and went home fairly quickly, all  
23 things considered.

24 Q. Were you aware that there were some  
25 abnormalities noted on a CAT scan prior to Jacob

1 Fiktus' discharge?

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

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

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

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

10 A. Okay.

11 Q. And a right intraventricular  
12 hemorrhage?

13 A. Yes.

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

18 A. It's possible. We do not do CT scans  
19 on every baby that's born, so we don't know what  
20 the background of intraventricular hemorrhage  
21 is, we really don't. All I know is, for  
22 example, going here and seeing a note from  
23 11-25-97 at 11:30 in the morning, the next  
24 morning, and it says no neurological  
25 abnormality. This is all the information I



1 have.

2 Q. Right.

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

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

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

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

19 A. Yes.

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

22 Thank you, doctor.

23 MS. ROLLER: No questions.

24 - - - - -

25 (Thereupon, LORET DE MOLA Deposition

1                   Exhibit 3 was marked for  
2                   purposes of identification.)  
3                   - - - - -  
4  
5                   - - - - -  
6                   (Deposition concluded at 6:45 p.m.)  
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1 AFFIDAVIT

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

5 PAGE LINE REQUESTED CHANGE

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RICARDO LORET de MOLA, M.D.

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19

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

22

23 Notary Public

24

25 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, Notary Public  
Within and for the State of Ohio

My commission expires June 8, 2004.

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