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The State of Ohio,
County of Cuyahoga.
IN THE COURT OF COMMON PLEAS
Holly Hutchinson,
Plaintiff,
-vs- Case No. 05-553884
Fairview General Judge Ann T. Mannen
Hospital, et al.,

Defendants.

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Videotaped Deposition of SHARON MIKOL, M.D., the Witness herein, being called by the Plaintiffs as if upon cross-examination under the statute, and taken before Kristin A. Beutler, RPR and Notary Public for the State of Ohio, pursuant to the further stipulations of counsel herein contained, on Tuesday, the 29th of November, 2005, at 8:00 a.m. at Lakewood Hospital, Detroit Road, City of Lakewood, County of Cuyahoga, and State, of Ohio.

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APPEARANCES:
On behalf of the Plaintiff:
Michael F. Becker, Esq.
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On behalf of the Defendants:
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ALSO PRESENT:

David Tackla, Videographer

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SHARON MIKOL, M.D., of lawful age, having been first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. BECKER:

Q. Good morning, Doctor.
A. Good morning.
Q. Would you tell me your full name, please.
A. Sharon J. Mikol.
Q. And what is your professional or business address?
A. 1450 Belle Avenue, Suite 300, Lakewood.
Q. Are you a solo practitioner, or are you a member of a group?
A. I'm solo.
Q. How long have you been solo?
A. Fourteen-and-a-half years.
Q. What hospitals do you have privileges at?
A. Currently, at Lakewood and Fairview.
Q. I know you've had your deposition taken before, I just want to review the ground rules with you. This is a question

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and answer session under oath. It's very important you understand the question that I ask; if the question doesn't make sense or is unartfully phrased, I want you to stop me, tell me so, and I'd be more than pleased to attempt to rephrase or restate the question. Fair enough?
A. Yes.
Q. However, unless you indicate otherwise to me, I'm going to assume that you have fully understood the question that I posed and you have given me your best and most complete answer today. Fair enough?
A. Yes.
Q. What have you reviewed in preparation for today's deposition?
A. The patient's chart, as provided by my attorneys.
Q. Anything else?
A. No.
Q. Have you done any research in preparation for today's deposition?
A. No, I haven't.
Q. Pursuant to a subpoena duces tecum or a notice duces tecum, did you bring a copy

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of the collaborative agreement with midwives?

MR. BECKER: Is this my copy?

MS. CALLSEN: Yes.

MR. BECKER: Okay, thanks. Why don't we just mark that.

(Plaintiff's Exhibit 1 marked.)

Q. Doctor, for the record, I'm going to hand you what's been marked as Plaintiff's Exhibit 1. Would you identify it for me and tell me how many pages it consists of.

A. It's a Standard Care Arrangement, and it has seven pages.

Q. Backing up a moment relative to your education and training, where did you go to medical school?

A. I went to Ohio State.

Q. And then your residency?

A. Riverside in Columbus.

Q. And was that a four year program?

A. Yes, it was.

Q. Did you do a fellowship?

A. No.

Q. So you would be considered a general obstetrician/gynecologist?

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A. Yes.

Q. As compared to a maternal-fetal specialist, correct?

A. Correct.

Q. When you finished your training, did you come back to Cleveland?

A. Yes, I did.

Q. Were you originally from the Cleveland area?

A. Yes.

Q. All right. And then you started in a group, or did you start solo?

A. I was in a group initially.

Q. What was the name of the group?

A. It was called Torbenson Medical Associates.

Q. Okay. And that group is dissolved?

A. Yes.

Q. How long were you with that group?

A. About three years.

Q. As I recall, you've generally been based around the Lakewood or Fairview area for your care; is that accurate?

A. Initially, no, I was on the east side the first five years I practiced.

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Q. Okay. What hospital were you associated with over there?

A. Torbenson Medical Associates was based mainly at Booth Hospital.

Q. Okay.

(A short break was taken.)

(Record read.)

BY MR. BECKER:

Q. Doctor, will you describe for me your current obstetrical practice.

A. Currently, I personally do about 10 to 15 deliveries a month.

Q. And are there any type of patients that you refer out to other obstetricians, whether maternal-fetal or otherwise?

A. I frequently refer patients for consultation with fetomaternal specialists.

Q. Okay. Could you give me some examples?

A. For example, an insulin-dependent diabetic who is pregnant; a patient who is over 35 or who has an abnormal quad screening and wants to have an amniocentesis or wants to be counseled as to her options; a patient who has an

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ultrasound that shows twins or other multiples; a patient who on ultrasound has some abnormality of the fetus detected and needs further evaluation; patients in preterm labor; patients with preterm ruptured membranes.

Q. Do you deliver twins yourself?

A. Oh, yes.

Q. And do you manage gestational diabetics yourself?

A. Yes, I do.

Q. What causes one to place a gestational diabetic on insulin, what's the criteria?

A. If the sugars are not properly managed with diet alone.

Q. Do you look for just high sugars at one event, two events of high sugar?

A. I generally look for a consistent pattern; one or two isolated incidents is not enough.

Q. I want to understand the relationship between you and the Lakewood Midwifery Services. If you could kind of give me an overview of that history, first of all,

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between that group and yourself.
A. Currently, I have been the consultant for this group for about three years.
Q. Okay.
A. I'm called Clinical Director of Midwifery, I think, is my title.
Q. And what does that mean?
A. It means I'm handling the clinical issues in the practice. They have a business-type manager who directs that sort of stuff, who is a hospital administrator.
Q. Are you an employee?
A. I have a contract, I am not specifically a hospital employee. I have a service contract and am paid a stipend for it.
Q. You have a service contract with the midwifery group?
A. To provide -- not with the midwifery group, with the Cleveland Clinic System to provide consultation and services to the midwives.
Q. So the contract is between you and the hospital --
A. Right.

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Q. -- association --
A. Correct.
Q. -- whether it's Lakewood or the Cleveland Clinic?
A. I believe it's Cleveland Clinic, Western Region, specifically.
Q. Okay.
A. That's what it says on the contract, and it is for this and for other services.
Q. So as the consultant, what are your duties and responsibilities?
A. My -- I -- we have a weekly session where the midwives bring questions or problems with patients. We have a clinical meeting, in other words, every week, where we discuss individual patients and their problems. During the day I am available for consultation with the midwife, while she -- either while she's seeing a patient or about a phone call or other issues. In addition, when a patient is in labor, if I'm on call for them, then I am also present and/or can be called to for any issues that might arise.
Q. Is there a set day and time for this

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weekly meeting?
A. Fridays at 8:00, currently.
Q. Now, what does the midwifery group do when you're unavailable?
A. There are other physicians that provide backup.
Q. So they also have a similar contract?
A. We have a -- I don't know what their contracts say, I have never seen them.
Q. Okay.
A. We have a call schedule and they call the physician who is scheduled to be their backup on any given day.
Q. And how does the -- so it would simply be if you are unavailable they would call your backup, the midwives?
A. It's their backup, it's the physician that the hospital has designated as their backup. I don't hire these people, they were hired by Cleveland Clinic to provide backup services. There are three of us and we split the call.
Q. But they're hired to provide backup service for obstetrical patients or for the midwives?

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A. For midwives specifically.
Q. Okay. And just give me a couple names of obstetricians that might be potentially backups.
A. Currently, it's Dr. Gitiforooz and Dr. Miller, however, neither one of them were working here three years ago, two years ago.
Q. At the time of this particular birth, who was the backup?
A. I don't even remember. We used multiple house doctors and I can't even remember who it all was. It was Dr. Christian, Dr. Light, Dr. Arora, there was some, multiple doctors.
Q. Doctor, do you have any idea why this patient, Holly Hutchinson, was sent over to Fairview for an NST rather than have it done at Lakewood?
MS. CALLSEN: Objection to the extent that any of the information comes from me.
A. Yeah, I was not involved in that decision at the time, so no, I don't know specifically.

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Q. So you have no knowledge?
A. I know what the midwife told me.
Q. Other than -- I'm not interested in what your counsel told you, but if your midwife told you something --
A. The midwife the next day told me why the patient was sent to Fairview.
Q. That's what I want to hear.
A. The reason was because there was no house pediatrician in Lakewood that night, I don't know the reason. Normally there is a pediatrician in Lakewood 24 hours, but there was some emergent issue occurred, the house doctor was not there. And so her concern was if the patient needed delivered that there wasn't a pediatrician at Lakewood, and so she sent her to Fairview, so that if the baby needed delivered emergently there would be a pediatrician present.
Q. Then which midwife would that have been?
A. That was Joy Naughton.
Q. Showing you what's been marked as Plaintiff's Exhibit 1, did I have you

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identify this yet?
A. Yes.
Q. Okay. And did I ask you whether or not this was in existence at the time of the Hutchinson child's birth?
A. I don't think you did, but I think it was.
Q. It was?
A. It's dated March of 2003.
Q. Okay. Does this document spell out under what circumstances you are to be consulted?
A. Some of them, yes.
Q. Okay. And as I skim through this, what do you recall about this particular pregnancy or delivery?
A. I don't really recall anything about Mrs. Hutchinson's pregnancy, I never saw her during the pregnancy except for a bad Pap smear, which I vaguely recall performing a colposcopy on her for. And as far as the delivery, I was never called, so I don't recall anything about the delivery, and I didn't hear about it until the next day.

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Q. Is it fair for me to conclude that you were never aware that this mom, Holly Hutchinson, was diagnosed by the midwives as having gestational diabetes?
A. I believe we did discuss her at a meeting, because she had declined to do the three-hour GTT. I recall that there was a patient who had declined at that point that we talked about. I cannot specifically say for certain it was Holly, however, I don't know of any other patient who had declined to do a three-hour test, so I think it was probably her.
Q. Why do you think it was probably?
A. Because I don't know of any other patient of the midwifes in the last three years who's refused to do the three-hour test other than Holly, so I think it was probably her we talked about.
Q. Well, is there any indication in Holly's chart that she refused a three-hour GTT?
A. Well, the only indication is that it wasn't done, that it was -- there's a midwifery note that it was, she should have

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one, but yet it wasn't done.
Q. You're presuming she refused it versus it wasn't ordered?
A. The midwife has a note that she was going to order it, so I have to presume that she was intending to order it, but I don't specific -- I was not present at any of these conversations, I do not know any of the details of this.
Q. In your experience with these midwives, if there is ever a circumstance where a patient refuses a recommendation, isn't that generally charted?
MS. CALLSEN: Objection.
A. Not always, no.
Q. Generally?
A. I wouldn't say generally even.
Q. Do you have a recollection that the midwife said she refused a three-hour GTT?
A. I have a recollection of discussing a patient at conference, I do not recall the name. The patient, I was told the patient did a one-hour Glucola, it was abnormal. The patient wanted to repeat the test, which I told them I didn't think was

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necessary, but it was repeated and was still abnormal. And I was told that the patient did not want to do the three-hour test and therefore we talked about how that would be managed, and I suggested she simply be treated as though she was diabetic without the test, that, if anything, we should do then more than we would normally do, which is to get her diabetic counseling and have her test her sugars, to err on the side of caution.

Q. Absolutely. And when you -- we can agree that once you make a, the midwives and you, make a diagnosis of gestational diabetes, then she should be treated as if she has gestational diabetes?

A. Well, in this case, the diagnosis couldn't be made because the test wasn't done, but yes, she was treated as if she had gestational diabetes.

Q. And how is the care to a gestational diabetic different than a nongestational diabetic?

A. She is put on a diet --

Q. Okay.

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A. -- counseled usually by a dietitian, and is also taught to test her own blood sugars.

Q. And which dietitian is generally used?

A. It would be the hospital's dietitian, and they've got multiple, whoever is available for the counseling.

Q. Is the surveillance, fetal surveillance, increased --

A. No.

Q. -- in any way with gestational diabetes?

A. Not routinely in a gestational diabetic who does not need, who does not need insulin, no.

Q. What are the concerns about gestational diabetic from risk factors?

A. The Major risk factor that can occur in a diabetic is that her baby may be unusually large, over nine pounds at birth.

Q. Macrosomia?

A. Exactly.

Q. Now, is there a risk, is there a greater risk of sudden fetal death in

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gestational diabetes?

A. No, I don't think there is.

Q. You're not familiar with any literature to that effect?

A. Not in a non-insulin-dependent gestational diabetic, no.

Q. Do you know whether or not the placenta is impacted by gestational diabetic -- gestational diabetes in a negative way?

A. They can have a larger than typical placenta, they could have a larger than average baby.

Q. Do you know whether or not a gestational diabetic's placenta is generally considered not as functional as a nongestational diabetic?

A. No, that would not usually be the case, they would usually be not -- they would usually be treated as a normal placenta.

Q. On the issue of surveillance, then, unless there is an insulin-dependent gestational diabetic, the surveillance level would not change?

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A. Correct.

Q. Okay. We can agree that if a woman fails a one-hour GTT, the standard of care for obstetrical care is to proceed to a three-hour GTT?

A. Absolutely.

Q. And we can agree that once the obstetrical care giver makes a diagnosis of gestational diabetes, he or she is then bound to treat the patient as if she has gestational diabetes?

A. Correct.

Q. On the issue of when to place someone on insulin, it's when they have greater than, I guess, multiple high sugars?

A. Correct.

Q. After --

A. A consistent pattern of high sugars.

Q. After consultation with a dietitian?

A. Well, the patient, yeah, after the patient's been placed on the diet, is that what you mean?

Q. Yes.

A. Yes, yes, she would be placed on the diet first, unless her three-hour GTT was

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so completely out of whack that it was obvious a diet wasn't going to be enough.
Q. Now, is it your general practice to try to deliver gestational diabetics at term?
A. Generally, yes.
Q. Why?
A. Because the large baby risk.
Q. Can we agree that when a gestational diabetic is at or near term and has complaints of decreased fetal movement and her cervix is ripe, standard of care is to get her delivered?
A. Not in all cases, no.
Q. In some cases?
A. In some cases, yes.
Q. What cases?
A. In some cases where the patient is agreeable to doing it, where -- I'm sorry, could you repeat the specifics?
Q. Yeah, we have a gestational diabetic that's at or near term, has complaints of decreased fetal movement, she has a ripe cervix.
A. If the movement remains decreased,

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yes, you could do that. If in fact she then has normal movement and a reactive strip and she prefers to wait for the onset of labor, I don't see anything wrong with that.
Q. Well, if the movement doesn't change and she has decreased movement, then prudent is to get her delivered?
A. Then, yes, I would recommend to that patient that she consider being induced.
Q. Do you know whether or not the midwifery group has privileges at Lakewood Hospital?
A. They all have privileges at Lakewood, yes.
Q. Do you know whether or not they have privileges at Fairview General Hospital?
A. None of them have privileges at Fairview.
Q. Can we agree that a patient who is managed by a midwife and arrives at a hospital for which the midwife does not have privileges, that patient should be seen by an attending or the collaborative physician?

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A. No.
MS. CALLSEN: Objection.
Q. Can we agree that a midwife who doesn't have privileges at a hospital should not be calling in orders to that hospital?
MS. CALLSEN: Objection.
A. No.
Q. Do you think nurses should accept orders from midwives or physicians who don't have privileges at a particular hospital?
MS. CALLSEN: Objection.
A. I don't work at Fairview Hospital, I don't know as a nurse, and I don't know what their rules are for or against receiving orders from outside physicians, I really don't. I couldn't speak to what their standards are for their employees.
Q. Relative to an induction, if there's a nonreassuring fetal heart tone, or heart strips, can we agree that it is not prudent to begin Pitocin?
A. If a strip is nonreassuring, I would be reluctant to begin Pitocin.

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Q. And, in fact, if someone is started, induced with Pitocin, and the strips become nonreassuring, the appropriate prudent care would be then to discontinue the Pitocin?
MS. CALLSEN: Objection. Can you repeat that?
MR. BECKER: Sure.
Q. We have an induction with Pitocin starting off with reassuring strips and they become nonreassuring, the standard of care is then to discontinue the Pitocin?
A. Not always.
Q. Or minimally to cut down, back off the Pitocin?
A. Not always.
Q. Because a woman has been diagnosed as gestational diabetic, is she considered a high-risk patient compared to the average obstetrical patient?
A. She's at risk for fetal macrosomia.
Q. Now, when an NST is done for decreased fetal movement, are there guidelines that a nurse should be assessing?
A. Yes.

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Q. Okay. And that guideline applies to you as well as midwives when interpreting the NST?
A. Yes, as well as to labor and delivery nurses.
Q. Now, have you heard the phrase equivocal, where an NST is equivocal?
A. Yes.
Q. What does that mean?
A. It means that there are, the NST technically meets the criteria, but there may be something on there that is not standard, for example, a variable deceleration that makes one think that perhaps further assessment might be needed.
Q. Okay. And when in fact an NST is equivocal, prudent care is to continue the NST to get a further evaluation of the mom at that time?
A. That would certainly be one option.
Q. Well, and what other options are there?
A. Well, you might want to do an ultrasound, for example, if you see a variable. You could look to see how much

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fluid is around the baby. If there's decreased fluid, then that might be a better test than continuing the nonstress.
Q. Would that be, are we speaking about a BPP, a biophysical profile, when you say ultrasound, or just not complete biophysical profile?
A. It depends on the circumstances. Certainly, you can do a BPP, but in some cases fluid volume might be enough to know that coupled with the nonstress.
Q. Now, some obstetricians do their own ultrasounds, do you do your own ultrasound?
A. I do some of my own. I don't do scanning for anomalies or birth defects.
Q. Is that in the Level 2 business, is that what that means, you don't do Level 2?
A. I don't think anybody is calling it Level 2 anymore, but yeah, I don't do anatomic surveys.
Q. Okay.
A. I would look for fluid volume, I would look for position of the baby, position of the placenta. I could certainly do a biophysical profile looking

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for breathing and muscle tone and things like that.
Q. You said that you currently deliver, I think you said, 10 to 15 a month?
A. Roughly, yeah.
Q. And was that the same back at the time of Holly Hutchinson's delivery?
A. It was probably about the same, yeah.
Q. And between the two hospitals, Lakewood and Fairview, where were you delivering most of your babies?
A. Lakewood, by far.
Q. If you had a choice, you would prefer to deliver at Lakewood?
MS. CALLSEN: Objection.
A. What do you mean by "a choice"?
Q. Well, let's assume one of your patients for whatever reason ended up at Fairview?
A. If a patient ended up at Fairview for some reason, then certainly I would have to deliver her there, it's not an option.
Q. Okay. Well, what if it -- what if it wasn't an urgent delivery but you wanted to start an induction, would you start the

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induction at Fairview, or would you transfer the patient to Lakewood?
A. I have been doing this for 14 years and that's never ever happened. We're talking about things that don't happen, I can't talk about things that never happen.
Q. So if in fact you're faced with a situation where you are at Fairview and an induction is indicated, you would have no hesitation to proceed with an induction right at Fairview?
A. I have done it many times.
Q. So when midwives diagnose a mom as gestational diabetic, what kind of contact would you expect them to have with you?
A. I would expect for them to tell me that she has been referred for counseling; I would expect that they would let me know how her sugars are; and certainly when the, if and when the sugars are abnormal, should that occur, they would let me know that too.
Q. So they're supposed to contact you when they have abnormal sugars after the diagnosis of gestational diabetes?

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A. A patient who is consistently abnormal sugars, yes, I should be notified.
Q. And do you know what the routine is, whether or not the, I call it the GD patient, gestational diabetic patient, is given like a form to track her sugars and then drop a copy off at the office, or what's, what's --
A. Generally, they bring it in with them at each visit.
Q. And what's the office's, to your knowledge, the group's practice relative to that form, do they make a copy of it, or do--
A. I believe they usually make a copy and put it in the chart.
Q. Okay. That would be a good thing, because that would give you an opportunity to look at it at a later time if you're not there, in the event they consult you on this mom's sugars, correct?
A. Of course.
Q. Doctor, to your knowledge, did you have occasion to look at the NST strips from Fairview as well as the, and/or, the

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strips from the labor and delivery at any time with any other person other than counsel?
A. I have never looked at those strips with anyone else, except I may have looked with Kathy after the baby was born at the fetal monitoring done at the time of the labor.
Q. Can you tell me that one more time?
A. Okay. After the baby was born and I was told that there was, the baby was not doing well, I believe that Kathy and I went to labor and delivery and looked at the monitor strips briefly and went over them, and that is the only time I have ever.
Q. Would it have been the next day, likely, been 24 hours?
A. It would have been within a day or two, I don't remember the exact date. I vaguely recall doing it, going over those strips with her.
Q. Was there anybody else present when you went over those strips --
A. Not that I recall.
Q. -- besides her?

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A. Not that I recall.
Q. Doctor, what I'd like to do now is go through your entries in the prenatal chart, Fairview records, and then the ultimate labor and delivery chart, okay.
A. Alrighty.
Q. I don't know if I brought enough copies with me. Do you have a copy of the chart right there? I want you to know that anytime, I probably should have said this when we started, anytime during this deposition you're more than free to look at the records before responding to any questions I ask.
When did you first meet Holly?
A. I believe I met her when she had a colposcopy, which I think was in January, maybe, of that year. I have to look at the chart.
MS. CALLSEN: Don't guess.
A. Let me look at the chart.
Q. Feel free to look at the chart.
A. And that is the only time I met Holly before she delivered. I met her on January 22nd, 2003. January 22nd, 2003, she had a

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colposcopy done by me, and that is the only time I believe I ever met her during this pregnancy.
Q. All right. Can you tell based on the chart what her, what the gestational age was of the child?
A. Just a second, I'll look back. On January 22nd she would have been about nine weeks pregnant.
Q. And so she had an abnormal Pap and then you did a colposcopy?
A. Correct.
Q. And is there any dangers of doing a colposcopy to a pregnant lady?
A. No, not particularly, we do them all the time.
Q. Okay. Clearly at that time she had not been diagnosed yet by the midwives as gestational diabetic, correct?
A. No, that would have been too early.
Q. Too --
A. It would have been too early to have tested her.
Q. And that's the only time you saw this mom during the pregnancy?

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A. Yes.
Q. That's the only time you had hands-on care to this mother during this pregnancy?
A. Yes.
Q. And that includes the induction, labor and delivery?
MS. CALLSEN: Objection. I don't think there was an induction.
Q. Excuse me. That includes labor and delivery?
A. I did not see her in labor and delivery, no.
Q. In fact, based on the chart, was there ever a plan for an induction of the gestational diabetic mom?
MS. CALLSEN: Objection.
A. I don't see it on the chart, but I don't know what the plan was.
Q. Does one --
A. I don't recall.
Q. Does one engage in estimating fetal weight for gestational diabetic?
A. Certainly.
Q. And how is that done?
A. Well, it can be done a couple of

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different ways. In a thin person like Holly, you can pretty well tell how big the baby is going to be simply by doing Leopold's maneuvers, palpating her abdomen.
Q. So there's not, with a gestational diabetic mom, there's no requirement for an ultrasound in the last trimester to determine or estimate fetal weight?
A. Not at all.
Q. And you don't have a goal when dealing with a gestational diabetic mom to have her delivered by term?
A. Unless I am concerned that the baby is extremely large, not necessarily, no.
Q. So going back to your contact with this patient, one time, and that was performing a colposcopy at, I think you said ten weeks --
A. Nine, I think, it was. Close enough.
Q. Nine weeks, correct?
A. Mm-hmm.
Q. Now, you had some other contact with her and that's relative to an NST that was done at Fairview, didn't you?
A. The nonstress test was done at

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Fairview and I recall getting a phone call from the nurse that it looked great and she was sent home and I did not see her there, no.
Q. So you never went to Fairview to assess her?
A. There would be no reason to if the strip was normal and the baby was active.
Q. The answer would be no, you never saw her at Fairview?
A. No, I did not.
Q. Okay. Now, did you ever call in any orders to Fairview?
A. I -- this is all vague recollection. I believe that I was called by a nurse from Fairview and told that Joy had sent this patient there for a nonstress test, and that because Joy was not on staff there, she wanted to let me know what the details were, that the strip was reactive, and could she send the patient home.
Q. And what was that nurse, do you remember the name of that nurse?
A. Oh, gosh, no. I don't even know three-quarters of the nurses at Fairview.

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Q. Okay. And did you ever sign off in any orders at Fairview?
A. I signed them off afterwards, yeah. They were to go to medical records.
Q. Can you tell me approximately how many days after the orders were created that you actually signed them off at Fairview?
A. Do you have the chart and I'll tell you?
MS. CALLSEN: I've got it.
A. It's generally a goodly period of time.
MS. CALLSEN: Goodly?
A. Somewhere there is a date where I signed. It appears that she was seen there on August 25th and I finally signed off on it on October 14th.
Q. So when did you create this note that says "NST reactive per nurse"?
A. On October 14th, my signature is dated October 14th.
Q. And is that, did you actually look at the NST at that time or you just made an entry?

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A. Since I wrote "Per verbal report of R.N.," my guess is that the nonstress test was not with the chart at the time, so I could not look at it.
Q. Based on your experience at Fairview, why wouldn't the NST be with the chart?
A. You'd to ask medical records there, I don't know. This hospital, often, the medical records separates the monitor strips from the charts.
Q. You certainly were capable of coming to the hospital on the night of the NST at Fairview?
A. Absolutely. And if the nurse had any concerns at all, I would have.
Q. You didn't have any concern for this mom or you would have made a personal appearance; is that what you're saying?
MS. CALLSEN: Objection.
Q. Based on what you were told, you didn't have any concern for this mom and that's why you didn't appear at Fairview?
A. I was told by the nurse that the strip was completely reassuring, and, yes, I was not worried that there was a problem

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that I needed to address that evening. Otherwise, yes, I would have come to the hospital had she had any concerns at all.
Q. Do you feel that you have a responsibility to review strips? First of all, did you feel that she was your patient?
A. She is my patient, sure, when she's at Fairview and I'm signing off on her record, of course, she's my patient at that moment, yes.
Q. Do you feel that you have responsibility to look at the NST within a day or two after it's taken on this mom who comes in, near term, with complaints of decreased fetal movement?
A. No, I don't, because the nurses there are quite capable of assessing nonstress tests, and if they tell me that the strip is completely reactive and normal, I completely believe them. They are perfectly capable of making that determination. They have a house doctor there who can also confirm that the strip looks good, and I don't feel that I need to

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back-check their work, they're very good nurses.
Q. So in your mind you don't have an independent responsibility to review that NST on a patient of yours that comes in with complaints of decreased fetal movement?
A. No, not if there's no concern on the part of the staff who are present.
Q. Now, what did -- did you know the nurse, were you comfortable with her capability or competency?
A. I don't recall the name of the nurse, I don't know if I knew her or not. However, I have -- generally the nurses at Fairview are excellent, and they certainly can interpret a monitor strip. They also have a house physician and a nurse manager present on the unit at all times who can help them if there's any concerns at all about a monitor strip. I feel very comfortable that they are very capable, they handle high-risk patients all the time there.
Q. Doctor, you told me that within a day

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or so after delivery of this child you had a conversation or an opportunity to review the L & D strips with Kathleen?
A. Yes.
Q. Okay. And do you recall what Kathleen may have said to you that led up to you reviewing the strips about this particular labor and delivery?
A. The only thing she told me was that the baby had problems and was transferred to Fairview, and that's all I needed to hear. We needed them to review because that is what we do.
Q. Okay. Did you ever ask Kathleen if she was ever concerned about the fetal monitoring strips during labor and delivery?
A. We talked about whether she was or not.
Q. What did she say?
A. She said she felt that the strip was reassuring.
Q. Did you agree with her?
A. I felt that it was not completely reassuring, and I explained that to her.

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Q. Have we covered all your contact with Holly Hutchinson, either directly or indirectly, through the time of delivery of her child?
A. Yes, that's it.
Q. Is it safe for me to assume that you were not apprised that she came in to Lakewood for delivery?
A. I did not know anything about her delivery until the next day.
Q. And just for the record, you were not contacted at any time by Kathleen Philbin during the labor and delivery?
A. No, I was not.
Q. And to your knowledge did Kathleen Philbin contact any other physician during her labor and delivery?
A. Based on reviewing the chart, it does not appear that she did.
Q. Have you had an opportunity to discuss the strips or what you saw on the strips that was concerning to you with, at a later date with Megan or Joy? That's the strips of the L & D.
A. Not that I recall.

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Q. For example, just to educate them about something you disagreed with Kathleen about so that they can learn from it?
MS. CALLSEN: Objection.
THE WITNESS: Can I answer that?
MS. CALLSEN: To the extent it is not peer review or it's not based on discussion with you and I.
A. There was a peer review process that went on because there was an outcome that was not favorable.
Q. Sure.
A. And only in the context of peer review did I ever discuss any of this with them.
Q. You say "them"?
A. With the midwives. We have a peer review process where we all sit down when there has been a bad outcome and we discuss what might have been done differently.
Q. Well, is this -- is this -- explain to me this peer review process that you're talking about. It's something different than a hospital peer review?

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MS. CALLSEN: Objection, objection to the extent that you can explain that there is a process in place, but no specifics.
A. Yes. Whenever there --
Q. Excuse me for interrupting you, because I'm confused.
A. Me too.
Q. So what I want to do is get clarified, first of all. In general, when there is a peer review process, there's proceedings with representatives -- we're talking generally now, not specifically, okay.
A. Right.
Q. In general, there's proceedings before hospital representatives, an investigation, an opportunity for one to provide input, sometimes there's, there are physicians that are involved --
A. I am not speaking to any of that.
MS. CALLSEN: Sharon, just wait.
Q. Okay?
A. Okay. When I use the phrase "peer review," that's what I mean.
A. All right.
Q. And you earlier, ten minutes ago, referenced that there was a discussion with the midwives in a general peer review?
A. Right.
Q. That's not what you were referring to?
A. No, it was a general discussion.
Q. Okay. I need to hear, I want to know which of those --
A. We did not have this chart, we were not speaking specifically about this patient.
Q. Right, but I need to know who was present --
MS. CALLSEN: Objection. Mike, if that is part of a peer review or a quality assurance discussion, that is privileged, and she is instructed not to answer.
MR. BECKER: Okay, we're going to have a fight over this.
MS. CALLSEN: Then we'll have a fight over it.

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Q. But you have to -- I'm not going to ask what was said, then, we'll talk about this later, but I want to know when it occurred, who was present, and where it occurred?
A. It would have occurred in our offices.
Q. Which location?
A. The Belle Avenue, across the street. And the only people that would have been present would have been the midwives.
Q. Okay, but --
A. A private meeting.
Q. -- would it have been all the midwives?
A. I believe that all three midwives were there when I spoke to fetal monitoring, yes.
Q. Did you ever have an opportunity to discuss the Fairview General Hospital nurses' interpretation of the NST on Holly Hutchinson with anyone?
MS. CALLSEN: Objection to the extent it was with me.
A. I have only discussed it with Julie,

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I've never talked to anyone else about it, no. I agree with the Fairview Hospital nurses' interpretation of that nonstress test.
Q. Okay.
A. I did see the strip eventually.
Q. And that's what I was going to ask you is what your interpretation is, and you felt it was perfectly normal?
A. Normal and reassuring, yes.
(Plaintiff's Exhibit 2 marked.)
Q. Showing you what's been marked as Plaintiff's Exhibit 2, would you identify that document for me.
A. It appears to be the records from Fairview Hospital from the nonstress test.
Q. Are there any electronic orders or entries or handwritten orders or entries or signatures by you within that document?
A. There are handwritten signatures by me on the orders.
Q. Okay. What I'd like to do, if you can in a chronological fashion, is tell me what you cosigned or ordered?
A. Yes. On August 24th, 2003, at 2355,

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it says, "Nonstress test for decreased fetal movement," and it's a telephone order from me and I cosigned that.
Q. When -- excuse me, I didn't mean to interrupt you.
A. It's got a nurse's name on it, but I can't read it.
Q. When did you cosign it?
A. I don't know. It would not have been that night, it would have been probably when I cosigned off on the nonstress test.
Q. Which is that October date we already talked about?
A. Probably.
Q. Okay. Next entry?
A. The next entry is, oddly enough, another order for a nonstress test for decreased fetal movement, but this one is from Joy Naughton, and I also cosigned that, and that's written by a different nurse.
Q. Can you explain that?
A. No, I don't know. The only thing I could think of is two different nurses, one called me and one called Joy and both got

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the same order.
Q. And, again, you cosigned off on that sometime in October?
A. Right.
Q. Okay.
A. And the next page, this is electronic charting from the nursing staff.
Q. Nothing by you on the electronic charting?
A. I don't sign these, no.
Q. Nor did you create that, any entry on that document?
A. Oh, gosh, no, no, that's all nursing.
Q. Okay.
A. Same thing on this page, these are all nursing-type charting. Actually, there's like four pages of nursing charting. And then the final page is the Nonstress Test Assessment Form, and this is signed off by a care giver after the nonstress test is completed, and this is the one that I signed on October 14th. It said that verbal report of the nurse was that it was reactive.
Q. What's the purpose of signing off on

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an NST like that, why are you required to sign off on it, to your knowledge?
A. To make sure that I'm aware of what the results were.
Q. Okay. May I see that? What does this mean, "R.N." underneath "Per verbal report," does that mean from the R.N.?
A. From the R.N., from a nurse.
Q. And that is your initial under the --
A. Yeah.
Q. -- the R.N.?
A. Correct.
Q. And then under "Recommendations" it says -- what does it say there?
A. It says, "Routine, keep appointment."
Q. And so, "keep appointment," by the time that you -- did you write this in October?
A. I probably it in October, because that would have been what my orders were at that time, which was that the patient should continue on with her usual routine and keep her next appointment.
Q. What do you mean that probably was what your orders were, did you have other orders to someone?
A. No, that's the typical discharge order given after a reactive nonstress test.
Q. But actually, this is after the fact?
A. Of course.
Q. And this is after her child was born?
A. Yes.
Q. In retrospect, would you have liked to have been contacted by the midwife during this labor?
MS. CALLSEN: Objection. You can answer, but that's not a fair question.
A. Of course.
Q. At what point would you have expected to be contacted, and why?
MS. CALLSEN: Objection. Again, retrospective review.
A. As the strip persisted in being not completely reassuring, maybe 45 minutes or an hour after she had arrived.
Q. To your knowledge, on this day did they have in-house, did Lakewood have a house OB?
A. They always have a house OB.
Q. 24-hour house OB?
A. Yes, 24/7.
MR. BECKER: Off the record.
(Plaintiff's Exhibit 3 marked.)
Q. Doctor, I think you indicated earlier that you would have expected to be contacted within 45 minutes or so after seeing nonreassuring strips once Holly arrived at Lakewood, correct?
MS. CALLSEN: Objection.
A. Yes.
Q. Handing you what's been marked as Plaintiff's Exhibit 3, I want you to tell me what it is about those strips, particularly the first 45 minutes, that you find to be nonreassuring?
A. Let me make sure I have them in the right order first.
It is not completely reassuring in that there is decent long-term variability, but what we do not see are accelerations in the fetal heart rate. There are no decelerations, either, so it's really more of a not completely reassuring strip than a nonreassuring one.
Q. Besides an absence of accelerations, anything else? How is the variability?
A. Well, all you can tell, this is an external tracing, so all you can tell is long-term variability, and average long-term variability is 3 to 5 cycles a minute, and you've got that, mostly that, here, so it looks average.
Q. So it was simply a, and I don't mean to use the word "simply," it was solely the absence of accelerations that causes you to say that this was nonreassuring and you expected to be called?
MS. CALLSEN: Objection. She said it was not --
A. I said it was not completely reassuring, and I would have expected to be called or for the midwife at least to update me to as to what she was doing to try and get reactivity on this strip.
Q. And as the strip proceeds, did anything else appear that was nonreassuring? And take your time, go through it.

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A. Sure. No, we just mostly have a pretty flat strip except for one acceleration, which was at about 2140, time-wise, and it was one acceleration, but otherwise a fairly flat strip. And, once again, it's all external tracings, so you can't really talk about beat-to-beat variability.
Q. Well, do you recommend to the midwives that they rupture membranes to put an internal on when you see an absence of accelerations?
A. That is certainly one option, yes.
Q. To your knowledge, do midwives have training and authority to place internal --
A. Yes, they do.
Q. -- monitoring or electrodes themselves?
A. Yes, they do.
Q. Okay. Anything else as it developed during the balance of that labor and delivery?
A. There's some areas here where her long-term variability is somewhat decreased, but that can happen if the

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baby's asleep or with medications and such. I'm not seeing any decelerations that are persistent or anything else that is...
Q. Take your time, don't rush through it.
A. Yes, I won't, I won't. She possibly has a couple of late decelerations, but they are not persistent, they are not recurrent. And her long-term variability does become decreased.
Q. At what point?
A. Oh, gosh, see where I first noticed that. You should see 3 to 5 cycles a minute and we stop getting that at about... probably around...I'm trying to find the time stamp on this.
MS. CALLSEN: Where are you looking?
A. It's 27167-ish or so. Once again, this is all a gradual process, there's not an exact moment you can say yes, this is okay.
MS. CALLSEN: Can you see the time on there better?
A. Okay, you have a time stamp of 2150

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there. So there is a decrease in long-term variability, at least in the middle part here. Still not seeing persistent decelerations or late decels, except for occasional possible late decelerations, but they're not persistent, so they're not clinically significant.
Q. What can decreased variability mean as to what's going on with the fetus?
A. Most of the time it's because the baby's asleep or because it's been medicated.
Q. It's also consistent with developing acidosis?
A. It could be, however, towards the end here her long-term variability improves. When she was in anterior lip at 1230 she has good long-term variability, so if the baby was acidotic it apparently recovered, because it was improved.
Q. Did you look at the baby's chart in preparation for today's deposition?
A. Briefly.
Q. Was the baby acidotic at birth?
MS. CALLSEN: Objection.

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A. I don't recall.
MS. CALLSEN: To the extent she just reviewed the chart from Lakewood.
A. I was going to say --
MS. CALLSEN: Let's clarify.
A. Yeah, I don't recall the specifics of the baby's lab work, I'd have to look. If you want, I will.
Q. When is an epidural indicated?
A. It's indicated for pain relief and labor. Many people feel it's indicated when the patient feels she needs it.
Q. Are there any contraindications for an epidural?
A. Certainly patients with spinal deformities or other neurologic issues might not be good candidates for epidurals.
Q. Do you want a reassuring strip before you place an epidural?
A. You want a reassuring strip on everybody. There's no reason that a patient whose strip is not completely reassuring could not have an epidural, in my opinion, as long as she's properly

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prepared for it. They, certainly, they have done them in cases where the patient was ultimately going to end up with a cesarean for nonreassuring heart rate, and, as I said, the strip is not completely reassuring.
Q. So what you're saying is that notwithstanding a nonreassuring strip, it's okay to proceed to give the patient an epidural?
A. Yes.
MR. BECKER: Let's take a break and change tape. I think I'm just wrapping up, Doctor.
(A short break was taken.)
BY MR. BECKER:
Q. Doctor, we were talking earlier about your Friday morning meetings with the midwives. Is there any type of notes that are taken at those meetings?
A. The midwives would put notes on the patient charts as to the plan, but, no, there would not be separate formal notes.
Q. There wouldn't be an agenda, which cases we're going to talk about or anything like that?
A. No, we don't do any of that.
Q. So if in fact -- a way to tell whether or not a patient's condition or patient's care was discussed at that Friday morning meeting, one would have to look at the patient's chart, and what would they look for in the patient's chart?
A. They would probably look for a note.
Q. Saying what?
A. That sets out a plan.
Q. A change in plan or any plan?
A. It might be either.
Q. Based on your review of this prenatal chart, is there any indication that Holly's case was discussed with you on that Friday morning meeting?
A. Can I take a look at the chart, please?
There is nothing that specifically states it was discussed at the meeting.
Q. We were talking earlier about high sugars. Once a mom is told watch her sugars, is consulted, you need more than one high sugar after she's put on a diet to recommend insulin, correct?
A. Yes.
Q. And midwives don't have authority to prescribe insulin, correct?
A. I believe they do have authority to prescribe it.
Q. They do?
A. They have prescriptive authority, yes.
Q. They don't have to consult with you before?
A. They would -- I would say that most of the midwifes here are pretty inexperienced at it and they would not write it, but technically, yes, they could write for insulin.
Q. You're saying based --
A. However, in this practice they don't do that.
Q. All right, now you really confused me. I'm interested in this practice --
A. Okay.
Q. -- whether or not these midwives have authority and routinely write a script for insulin.
MS. CALLSEN: Objection, that is compound, and I think that she said that they do have authority under the law.
A. Correct, legal authority, prescriptive authority, and they could write for insulin if they chose to do so.
Q. Okay.
A. In this practice they do not prescribe insulin.
Q. Okay. And how is a patient, a GD, gestationally diabetic mom, how does she get to receiving insulin? I'm assuming that the midwives then consult with you and you write the order?
A. Correct, or I would refer her on to a high risk specialist who would write the order, one way or the other.
Q. Would you, have you written orders for insulin for their patients in the past?
A. Yes.
Q. And sometimes you feel a need to even send a GD mom to an endocrinologist or a maternal-fetal doc, correct?
A. Usually a maternal-fetal medicine

person, and I do have routinely -- I might start the insulin, but I usually would refer her to a maternal-fetal physician too for further consultation.

Q. But you would expect to be notified by the midwife who's managing gestational diabetic mom if they had multiple instances of high sugar, correct?

A. Yes.

Q. Okay. And was there any evidence in the chart of multiple evidences of high sugar in Holly?

A. No, she does not have a need for insulin, based on the sugars in this chart, no.

Q. So there's not evidence of multiple instances of high sugar with her?

A. Over the course of several months, might she have had several high sugars, of course, but that is not significant.

Q. I thought we agreed that you needed something more than one or two high sugars prior to recommending someone receive insulin?

A. We did.

Q. Okay. Are you saying that they have to be persistent?

A. Correct.

Q. And I'm assuming that normal sugar is anything up to 100 or 110?

A. It depends on whether you're looking at fasting or postprandial sugars or what kind of sugars you're looking at.

Q. And just to recap, Doctor, it's your belief that unless a mom is insulin-dependent, gestationally diabetic, and reaches term or near term and has complaints of decreased fetal movement and also has a ripe cervix, there's no indication to deliver?

A. Delivery is not indicated, no, it's not required.

MR. BECKER: Okay, that's all I have.

MS. CALLSEN: You have the option to review the transcript to make sure Kristin got it right.

THE WITNESS: Of course.

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(Deposition concluded at 9:35 a.m.)

(Signature not waived.)

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SHARON MIKOL, M.D.

CERTIFICATE

The State of Ohio,
County of Cuyahoga.

I, Kristin a. Beutler, RPR a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, SHARON MIKOL, 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 then given by the above-referenced witness was by me reduced to stenotype in the presence of said witness, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a

relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio this 4th day of December, A.D., 2005.

_____

Kristin Beutler, RPR, Notary Public within and for the State of Ohio.
My Commission expires October 8, 2006