James J. Nocon, M.D. - May 21, 1998

Circle City Reporting

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CONDENSED TRANSCRIPT AND CONCORDANCE
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STATE OF OHIO)
) SS:
COUNTY OF CUYAHOGA)

IN THE COURT OF COMMON PLEAS
CAUSE NO. 327020

ROBERT PAOLONI, et. al.,)
)
Plaintiffs,)
)
-vs-)
)
ERAST J. HAFTKOWYCZ M.D., et. al.,)
)
Defendants)

The deposition upon oral examination of JAMES J. NOCON. M.D . a witness produced and sworn before me, Sherry R. Reckas. a Notary Public in and for the County of Marion. State of Indiana, taken on behalf of the Plaintiffs at the offices of the deponent, Wishard Hospital, 1001 West 10th Street, Room F-5, Indianapolis, Marion County, Indiana. on the 21st day of May, 1998. pursuant to the Indiana Rules of Trial Procedure.

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APPEARANCES

FOR THE PLAINTIFFS: John G Lancione
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FOR THE DEFENDANT: Stephen E Walters
(Dr Haftkowycz) REMINGER & REMINGER
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FOR THE DEFENDANT: Thomas H. Allison
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INDEX OF EXAMINATION

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JAMES J. NOCON, M. D., having been first duly sworn to tell the truth, the whole truth and nothing but the truth relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION,

QUESTIONS BY JOHN G. LANCIONE:

Q Would you state your full name, please, for the record.

A James Jeffrey Nocon.

Q Where do you reside?

A I949 Huckleberry Court, Indianapolis, Indiana 46260.

Q Dr. Nocon, I know that your deposition has been taken a number of times in the past so that I assume that you are familiar with the procedure and I don't need to go through any explanation for you.

A Yes, sir.

Q Okay. When is the last time you gave a deposition?

A I think in February.

Q When is the last time you testified in trial?

A I don't recall. I would have to - I can tell you. I can look back in my records, but

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I don't remember.

Q You do keep records of the cases that you review and participate in as an expert witness, do you?

A Yes, I keep basic housekeeping records, who the attorneys are and billing records. I don't have a particular database of what the cases are and so forth, although I'm in the process of creating one.

Q Have you ever worked as an expert witness for either of the law firms represented here in this case, Reminger & Reminger and Arter & Hadden?

A No, sir, that I recall.

Q Do you know how you were - how it came about that you became involved in this case?

A Specifically I don't recall, other than the way it almost always occurs is I get a phone call from somebody in a law firm asking me if I would be interested in reviewing a case. I'll call them back and ask them what's it about, who it involves. And if I have time to do it, I'll usually say, "Yes, I'll review the case" and take it from there. Try and get some basic information

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rounds with the students every morning from 6:30 to 7 and then a meeting with them from 7:15 to 8, a didactic meeting. And then I hold one-hour seminar sessions with them about four days a week on basic obstetrics and gynecology. So my duties here are primarily service in terms of taking care of patients at Wishard, and administrative in terms of running the student education program.

Q How many hours a week do you spend doing these things that you have just told me about?

A Oh, sometimes it seems like hundreds. I put in about 60 hours a week.

Q How much time do you spend on your medical/legal consulting business per week?

A Per week? Some weeks one or two hours, some weeks six or seven hours, some weeks no hours.

Q How many cases do you review a month?

A I try and limit it to one or two a month, and I've been doing a pretty good job of limiting it to no more than two a month.

Q How many depositions do you give per month or

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per year?

A Oh, looking back at exact numbers, I think it's probably about somewhere between six and ten depositions in a year. I would say closer to the lower number.

Q And how many times do you testify in court by - well, by video deposition or live?

A All my trial testimony has been live, maybe but for one case. Over the last ten years, probably about a dozen times.

Q Of the number of cases you review as a medical/legal consultant, can you tell me what percentage of those would involve shoulder dystocia cases?

A Probably about 70 percent.

Q What is your professional fee for performing consulting services?

A Three hundred dollars an hour.

Q How long has that been true?

A Years. Five or six -

Q Ten years?

A Maybe eight.

Q What about deposition testimony?

A Three hundred dollars an hour.

Q Trial testimony?

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A Depends on where the trial is. If I have to go out of town for a trial, I bill on the basis of a full day, for me is a ten-hour day, so that would be three thousand dollars. If it's local and I'm in for half a day, then it's a half a day, which would be fifteen hundred dollars.

Q That's plus expenses if you are traveling?

A That's correct.

Q How much time have you spent on this case up to date?

A Up to date I'm going to say about sixteen hours.

Q Are you able to generate records that would verify that?

A Yeah, because I sent my biil in for ten hours and since that bill I've put in another six hours.

Q If -

A Not including this deposition.

Q All right. At the time that you testify at trial in this case, would you bring your records which would verify the total number of hours that you have spent?

A That's easy, sure.

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Q Good. What are the numbers of reviews that you have performed as a reviewer for obstetrics and gynecology in the past year? Have you done any reviews for them?

A Yeah. I got about one every four or five - probably - I've never had more than three a year. I usually get two or three a year. So in the last year I have probably reviewed two.

Q Is that the same for the American Journal of Obstetrics And Gynecology?

A It would be about the same for that and Academic Medicine, I ger about two peer review articles to Look at about every year, sometimes three.

Q On your specialty board status, you have the American Boards, you are certified in OB/GYN; is that right?

A That's correct.

Q And you are not qualified to sit for the examination in perinatology?

A That's correct.

Q Or in fetal - maternal fetal medicine?

A That's correct.

Q And what is the American College of

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Wishard.
Whereas, Gabbe's textbook comes out of Ohio State University. It would be more pertinent to the general population at large and not necessarily an indigent population. And for those reasons, I can't say one is any more authoritative or one is authoritative and the other isn't. I think that's true of all books. There is -

Q Goahead.

A I think it's true of all textbooks. I mean a textbook is a conglomeration of authors' opinions; and because they are opinions, they are not considered authoritative.

Q So there would be no medical book in existence that you would recognize as authoritative; is that what you're saying?

A Yeah, if I stay consistent with that logic, I would have to say that. And I believe that. I think there is some good scientific literature that is authoritative because the objective data would indicate that everyone would agree that that particular fact or principle is true. A good example of that would be that cigarette smoking is linked to

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lung cancer.

Q What about the book that you wrote a chapter on shoulder dystocia?

A Very good book, excellent contributors, very honored to be asked to write a chapter on shoulder dystocia in that book. No more authoritative than any other book.

Q Have you written any reports or do you have any notes about the reports that you have written other than the report of February 5, 1998?

A That's my report.

Q And do you still hold all of those opinions that you expressed in that report?

A Yes, sir.

Q Have you changed any of those opinions or altered them in any way?

A Without rereading the report, I can't think of anything that I would have changed or altered.

Q If you do change or alter any of your opinions to be expressed in this case, would you agree to providing specific information to Mr. Walters so that he can communicate that with me before trial?

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A Absolutely.

Q I take it that it's your opinion that there was no requirement that Dr. Haftkowycz perform an additional ultrasound in addition to the two ultrasounds he had performed earlier; is that right?

A That's correct.

Q Do you believe that there is any significance to the difference in gestational age - or of the fetus and the fundal measurements of Mrs. Paoloni?

A I missed the question. Could you repeat it?

Q Do you believe there is any significance to the difference in the measurements of the fundal - the fundus and the gestational age of the baby?

A I'm still not sure I really understand what you're asking me. Do I believe that there is a significance in the difference between the fundal height and the gestational age? At any particular time or throughout the whole pregnancy?

Q Yes, right. You expressed something in your report about it, as I recall.

A Yeah. I think that it was very - that there

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was a difference between the fundal height and the gestational age in December, and she was about 24 weeks with a fundal height of 29 centimeters. That was a significant difference and needed to be evaluated.

Q And what did he do to evaluate it?

A Well, what would be required would be an ultrasound to make sure that he wasn't dealing with twins, but he already knew that from the previous ultrasound. But still he would be required to see if - whether there was an excess of fluid or whether he was dealing with an abnormally large baby. So he did exactly what he was required to do and the ultrasound report showed that he was not dealing with an excess amount of fluid and that the baby was, I believe, around the 72nd percentile for weight, and that the gestational age was appropriate for the other measurements showing that the baby was appropriate for gestational age. The other factor here is that Mrs. Paoloni is a very large woman and we all accept that the fat around in the abdomen

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worry that the continuation of the fundus measurement to be much larger than the estimated gestational age that would require another ultrasound?

MR. WALTERS: Objection to the form. Go ahead.

A *Yeah, I don't understand the question.*

MR. LANCIONE: Let me try it again.

Q First of all, Dr. Haftkowycz determined from his ultrasounds that there was no significant difference because of the fundal height being measured at 29 centimeters because the gestational age was at the appropriate time in accordance with his estimate of the date of delivery; right?

A *I don't know if that's exactly what he was thinking but, you know, I would agree with the premise that you just - that you put out that he saw a difference, checked it out to see if this was an excessively large baby, it wasn't, and that the gestational age was consistent with where it should be. So at that point he has to say to himself, well, a lot of this difference between the size, the fundal height size -*

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or my measurement, rather, not the fundal height - the difference between my measurement and the gestational age may very well be this woman's abdominal girth.

Q He continued to assume that; correct?

A *I don't know if he continued to assume that or not, but it would be reasonable for him to assume that because she was gaining the bulk of her weight from that time thereafter.*

Q And the fetus would be, too; is that correct? The fetus is growing at a greater rate later on in the pregnancy?

A *In terms of grams per week, somewhere in the last eight weeks the baby's weight gain was relatively steady, but at 24 weeks that baby in the 75th percentile or 72nd percentile would probably weigh somewhere around a pound and a half. So the baby gained the difference in that time, yeah. So that would be the bulk of its weight, too. That's exactly what we would expect in any pregnancy.*

Q Is there a method to gauge the sue of the baby by the measurement of fundal height?

A *There is some old formulas that we used to*

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use that we found to be fairly unreliable.

Q When were they disregarded as being reliable?

A *I know when I was a student I was taught that they were not very reliable. That goes back at least 30 years.*

Q That would be subtracting thirteen and dividing by three?

A *That would be correct, you would subtract thirteen from the fundal height, divide by three. It's funny because I still do that, and then - and that's out of pure academic curiosity to see how well that correlates with ultrasound and my own estimate of fetal weight.*

Q If you do that in this case of 47, it would be over five thousand grams; correct?

A *That would be correct.*

Q And at the point in time when Dr. Haftkowycz suspected a large for gestational age baby on the 29th of March, he estimated the weight at four thousand grams; is that right?

A *That's correct.*

Q About a nine-pound baby?

A *That would be a nine-pound baby in round numbers.*

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Q And what he had was about a thirteen-pound baby? Two ounces off. Twelve pounds, fourteen ounces?

A *That sounds close.*

Q Is there any difficulty in your experience when you have a lady that weighs over 300 pounds and in judging, from doing a clinical examination, judging the size of the baby?

A *I would say that the degree of difficulty is about as high as it gets in judging the estimated fetal weight, and when I'm taking care of a patient who weighs 300 pounds and - actually we've had a couple 400-pound patients very recently - there is no way of knowing how big the baby is even with ultrasound. Once we get up into that weight range, not only are our clinical judgments - I don't want to say unreliable, but they are poor. They have a high margin of error. Ultrasound has a high margin of error. And I wish we could accurately determine baby weights.*

Q So knowing that we had about a 5,400 gram baby, you don't find it unusual that the

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coming out through a C-section could also be injured.
Q That's a possibility?
A Yeah, that's correct.
Q When you review medical/legal cases on behalf of a doctor, do you consider that in every case there is a - every case is defensible?
A I wouldn't - I don't know how to answer that question. Because when I agree to review a case on behalf of a defendant doctor, that's one of the clinical judgments that - clinical judgments that I'm trying to come to for the attorney who is asking me to review the case. You know, if - what did the doctor do, what was the doctor required to do, what was his duty, what did he do or what did she do, and I have reviewed a number of cases where I felt that the doctor did not follow a standard of care and that resulted in an injury and told the referring attorney that that was the case in my opinion. So I think there are cases where doctors clearly don't follow their duties or do something that the standard - failed to do

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something that the standard requires, and I think there are cases where the doctor does something the standard forbids and doesn't result in any injury or harm. I mean -
Q Let's take a case where in your opinion the doctor does something that is - violates the standard of care and the doctor and his attorney decide to go ahead and defend the case. Under that scenario, is every case defensible?
MR. WALTERS: I'll object to the form. I don't understand it.
MR. ALLISON: Objection.
A I can't answer that question. Well, I'll do my best. My best shot at that question is if I felt the case - f I felt the doctor breached a duty of care and that caused an injury, I would tell the referring attorney so. If they would want me to help them defend the case, you know, I would have to understand on what grounds I would be asked to help. Because I wouldn't think that that case would be defensible from the standpoint of liability.

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But it may be defensible from the standpoint of injury. In other words, the injuries may not reflect or may not be that damaging. There may be something I could offer in the way of objective medical expertise that might help in this, in that respect. Flipping it around, every doctor deserves to have a reasonable defense just like every patient deserves to have reasonable care. But if I can't participate in it, I won't. That's about the best that I could do with that. I'm not sure -
Q That was done nicely, thank you. I know that your opinion generally is that shoulder dystocia is not predictable.
A That's -
Q Generally speaking.
A That's clearly my opinion more than generally speaking, almost always.
Q But as babies get bigger and bigger, it gets more predictable; is that true?
A It doesn't get predictable.
Q More predictable, I said.
A No, it's not predictable, that's the point.

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I just looked at our data on - from my research at all of our five thousand gram babies that we had in our study. We only had three. Out of 12,500 vaginal deliveries, only three of them had shoulder dystocia. Only three of the five thousand gram babies had shoulder dystocia, and none of them had any injuries. That's one of the reasons why I say it's just not predictable. When we get into legal crireria for more likely than not, I would certainly agree that the bigger the baby there is a greater likelihood that a shoulder dystocia may occur. But from the standpoint of scientific predictability, absolutely not.
Q You just wouldn't use those terms, you wouldn't describe it in terms of shoulder dystocia gets much more predictable as babies get bigger and bigger?
A I wouldn't use the term predictable. If I had, I misspoke. I would say that doctors in all honesty should think in terms that the likelihood of a shoulder dystocia increases with the size of the baby. And I think our research showed that

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back and thinking about the prior questions.
A Me, too, so –
MR. LANCIONE: Well, would you read the question that I asked and see if I get an answer. I just want to make sure I got an answer.
(The previous question was read back by the reporter.)
A No.
Q That would be negligent to do that, wouldn't it?
A Not necessarily.
Q You don't think it would be reckless behavior by whoever was allowing or permitting fundal pressure while there is an established shoulder dystocia during the – when the patient is in the McRoberts position?
MR. ALLISON: Objection.
A We teach that we should not use fundal pressure under these circumstances. As one of the conditions in which you asked me earlier, when fundal pressure was allowed if everything else had failed and that was the only way of saving the baby's life, then it would not be reckless. So – but given the

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situation that you implied that –
Q First.
A McRoberts was put up and the person gave fundal pressure, I would say that that deviates from the standard that's been established in the literature.
Q Permanent – do you agree with this, Doctor, a permanent injury from a shoulder dystocia during delivery is rare and tends to occur when the physician is not following standard and appropriate care?
A I completely agree that it's rare. I think that it becomes a medical liability when the doctor didn't follow standard and appropriate care, but I don't think there is a cause and effect there, a provable cause and effect.
Q Okay.
A And my basis for that is I just read an article by Morrison published in 1991, of all times, that showed that 75 percent of babies that were delivered with fundal pressure alone, called excessive traction, had absolutely no injury.
Q Do you base your opinion on that?
A Absolutely. It's an excellently-done

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article. Because we found in our studies that it didn't make any difference what you did, of all the accepted procedures, that the incidents of injury ranged between 15 and 20 percent. And in Morrison's study, he showed that only 25 percent of babies with excessive traction were injured.
And I'm having a lot of difficulty in my own mind beginning to think well, where is the line here between what's excessive – what's acceptable injury and what isn't, because 20 percent and 25 percent are pretty close.
As we do in science, we often draw an arbitrary line and we say that's it and we do our best to hold to it.
Q So as a general principle then, what I hear you saying is that there is no way to establish a – by a probability a causal relationship between a physician's delivery of a shoulder dystocia and an injury to the brachial plexus?
A I wouldn't say no way. I would say hard to show a causal relationship. And I would agree in all fairness that if a doctor used

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excessive traction, and in combination with fundal pressure without doing anything else, I would consider that to be inappropriate and a deviation from the standard of care.
Q Are you saying that did not happen in this case?
A That did not happen in this case.
Q What caused the evulsion and other damage to the brachial plexus in the case?
A I have no idea, but there is absolutely no evidence in this case that Dr. Haftkowycz did any maneuver that was inappropriate.
Q Well, would you expect to see something that says the doctor used excessive traction when he first starts to lower the head when the – he first makes his determination that there is a shoulder dystocia?
A I have seen many reports where the term excessive traction or hard traction was used. So I would have to answer that if it was used, an honest doctor is going to put it down. In fact, doctors write in what they do. If I did it, I would write it in.
Q So do you always know if you have used excessive traction?

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have asked me to make in my mind. No, the doctor would not be negligent.

Q If he knew or should have known, would he be negligent?

A If he knew or should have known what?

Q The same hypothetical, that the fundal pressure was being applied when it shouldn't have been.

MR. WALTERS: I'm only going to object because you added that last part to the hypothetical, but go ahead.

MR. ALLISON: Objection.

MR. LANCIONE: The way I described it he already testified that it shouldn't be done prior to the time that the shoulder is disimpacted.

MR. WALTERS: I'm going to object because I think it assumes facts not in evidence, but go ahead.

MR. ALLISON: Objection.

A To ask that a doctor be able to control all of those variables or should have known all of those variables is unreasonable, unrealistic and beyond his capability, particularly when faced with a true

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obstetrical emergency when the baby needs to be delivered in an efficient and effective manner. So with that qualification, the doctor is not negligent.

Q **Now let me just add if he knew. If he did actually know what they were doing and didn't tell them to stop doing it.**

MR. ALLISON: Objection.

MR. WALTERS: Go ahead.

A If a doctor knew that the nurses were giving - or somebody was giving fundal pressure and that in and of itself would not cause any injury, it would have to be - because he could stop pulling on the head. Driving the shoulder -

Q That's not in there.

A That's my answer. Wait a minute. Driving the shoulder from the fundus into the pubic bone isn't going to cause a brachial plexus injury. It takes a combination of the doctor putting excessive traction on the neck and somebody driving the shoulder into the pubic bone in order to put the required stretch on the brachial plexus.

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So even if he knew and he chose - and he was able to not put traction on the neck, then he wouldn't be negligent.

Q **But if he continued in the face of them doing the fundal pressure, he would be negligent?**

A And this goes back to my original qualijication, if he was doing that to save the baby's life and other reasonable procedures hadn't worked, then he can't be negligent.

Q Is **that a defense in this case in your mind that he was doing this to save this baby's life?**

MR. WALTERS: That hasn't been a criticism to date, John, that I'm aware of.

MR. LANCIONE: Let me ask the question.

MR. WALTERS: You're asking about a defense in this case.

MR. LANCIONE: I'm asking the question.

MR. WALTERS: Go ahead.

A I don't - my opinion based on the medical record and the testimony is that the doctor did exactly what I would expect a reasonable

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competent doctor to do, and he was able to successfilly disimpact the shoulder with the Woods - with the rotation maneuver eventually, and that no fundal pressure took place. That's my opinion based on the record, so he - my opinion is he did nothing negligent. He did what he was required to do, and nobody gave fundal pressure. In the hypothetical when you asked me to assume all of that, I think there is a point where the doctor, you know, can be pulling on a baby's head and at the same time somebody giving fundal pressure and the doctor knowing about that, sure, I would be critical of that.

Q **Are you saying in this case that there was not excessive pressure on** this **baby's brachial plexus that caused the damage that you know was done to the nerves** in **the baby's neck?**

A That's correct, I'm saying that. There is no evidence of any excessive pressure being applied to the baby's neck. And the fact of the injury doesn 'tprove that excessive

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describing the – a baby in that state of distress that I mentioned, because of that physical – physiological state would be easier to deliver, you wouldn't say that?

A Well, I think logically that makes sense in – you know, you would think that. But based on the maneuver that he was doing that actually disimpacted the baby, the screw maneuver, now we're talking about mechanical and bony factors. If it were just a fat shoulder that was holding up the baby and a lot of muscle tension, that might be – you know, once the baby gets a little hypoxic it might actually slip out a little easier. So, you know, if we are all smart enough to know when that becomes a factor and when it doesn't, we might be able to act on it. But we're not, we can't predict that very well. So it could go either way.

Q Can babies of mothers with gestational diabetes upon delivery be perfectly normal in laboratory testing?

A Well, actually only about a third of babies of diabetics are big, fat babies.

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Overwhelming –

Q I'm taking about laboratory studies, not weight, Doctor.

A In *laboratory studies, babies of gestational diabetics would be perfectly normal if they didn't have a traumatic delivery, if they didn't have a hypoxia, if their Apgar scores were okay, and particularly if they were able to breastfeed rather quickly, thus getting the amount of proteins and sugars and fats into them, their blood sugars wouldn't drop. You would probably not even know they were infants of diabetic or gestational diabetic mothers even where the gestational diabetes was proved. In this case it was never documented because she didn't have gestational diabetes by criteria.*

Q Tell me what organizations you belong to that deal with the – that deal specifically with the subject of gestational diabetes.

A The American College of Obstetrics And Gynecology, and as a teacher at Indiana University I teach gestational diabetes to our residents and our students. That's part of the – there is a section on that in the seminar that I wrote for our students. That's my organization.

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Q Are you aware that there are some national organizations and regional organizations that deal with the subject matter exclusively of gestational diabetes?

A Sure, for patients who have that, yeah. It's great for them. I'm glad it's there.

Q Not for patients, for doctors that belong to and study this thing more than just generally.

A Sure, I know that doctors have interests in various areas. That's one of them, sure.

Q Okay.

A I'm glad that they are there.

Q Was the use of Pitocin appropriate in this case?

A Sure.

Q Does Pitocin sometimes cover up the normal course of labor when you have a larger than gestational age baby and you are concerned about that particular fact?

A No.

Q You're shaking your head no, is the answer –

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A The answer to the question is no, unequivocally no.

Q What do you say is the range of error in ultrasounds determining gestational weight in a term fetus?

A Between 10 and 20 percent. A year ago I would have said 15 percent. We've had a number of – I don't know if we have some new technicians, but our range of error lately has been closer to 20 percent.

Q I'm talking about on a national basis, would you argue that 15 percent is not reasonable or would you accept that?

A Oh, I would –

MR. WALTERS: He said 10 to 20, 15 fits in that range.

MR. LANCIONE: Thanks; I figured that out, too, that's why I asked the question.

MR. WALTERS: That's what I figured.

A I would accept 15 percent as reasonable, but I want to qualify that in that, you know, at any given time new technicians – there is a lot of turnover in this business of

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A Very well.
Q Do you consider him a knowledgeable obstetrician?
A I consider him knowledgeable, I consider him an excellent teacher, a wonderful friend, compassionate man. He's a maternal fetal medicine specialist. His approach is that of the specialist who deals with high risk pregnancies. My judgment is that he's very aggressive in that approach and would be treating more people than other maternal fetal medicine people would be under different situations, and I have no criticism of that whatsoever. I think that's his position and his thinking and that's his approach. I respect him.
Q And you disagree with his opinions in this case?
A Yes.
Q That you have read?
A Yes.
Q Do you know Dr. Landon?
A Yes.
Q Do you consider him a competent expert in his field?

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A I sure do. Mark has written a lot of good stuff on diabetes. He wrote the chapter in Gabbe's textbook. I think it's Chapter 33 in the 2nd Edition. I reviewed that.
Q You disagree with his conclusions and opinions in the case?
A I think Dr. Landon gave some pretty straighiforward opinions. I think that - I think he failed to acknowledge that in his own chapter. In the Gabbe textbook he talks about the standard for evaluating gestational diabetes as the National Diabetic Diagnostic Group standard. That's the one that he recommends. He talked about another standard that would put this patient into the realm of diabetes.
Q Did you say you think he forgot about his chapter?
A He offered more than what was in his book chapter. If I were the average practicing obstetrician out in Ohio reading his book which was the - reading his book chapter which was the current edition, what he put in his book chapter is exactly what Dr. Haftkowycz relied upon.

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But in his deposition, Mark went on to add a little bit more, and I think that was not fair and not objective.
Q When you see an eleven-pound baby, do you presume that the mother has gestational diabetes?
A Sure, that's the first thing I think of; she's got gestational diabetes. That doesn't mean that she does. And the fact of the matter is probably 95 percent of the time I'm probably going to be wrong. But that's exactly what I think of.
Q Have you ever testified in a case involving shoulder dystocia on behalf of a patient -
A Sure.
Q - in trial?
A I believe so.
Q Where was that trial?
A I'm pretty sure it was in Michigan, and the attorney would be Bob Blaske, B-l-a-s-k-e, or it may be his brother, Tom Blaske. And Tom is Ann Arbor and Bob is in Battle Creek. And I know that I have reviewed a couple cases of shoulder dystocia for them where I testified for the patient.

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MR. LANCIONE: That's all I have.
CROSS-EXAMINATION,
QUESTIONS BY THOMAS H. ALLISON:
Q Dr. Nocon, we met right before your deposition. My name is Tom Allison. I represent the hospital in this case. I believe I'll just have a few questions for you here.
As I understand from your report and your earlier testimony, you have reviewed not only the medical records of Beth Paoloni from Dr. Haftkowycz's office but also from the time of the delivery as well as the depositions of Dr. Haftkowycz, two of the nurses, and I believe you said you have also - did you say you also reviewed Mrs. Paoloni's deposition as well?
A That's correct.
Q Doctor, in all of that information, in the office records of Dr. Haftkowycz, in the hospital chart of Beth Paoloni, the hospitai chart of the baby, the depositions of the nursing personnel, Dr. Haftkowycz and Mrs. Paoloni, did you ever see anything in there that would indicate that fundal

STATE OF INDIANA)
) SS:
COUNTY OF HENDRICKS)
I, Sherry R. Reckas, a Notary Public in and for the County of Hendricks, State of Indiana at large, do hereby certify that JAMES J. NOCON, M.D., the deponent herein, was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the above-captioned cause.
That the foregoing deposition was taken on behalf of the Plaintiffs at the offices of the deponent, Wishard Hospital, 1001 West 10th Street, Room F-5, Indianapolis, Marion County, Indiana, on the 21st day of May, 1998, pursuant to the Applicable Rules.
That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction, and that the typewritten transcript is a true record of the testimony given by said deponent; and thereafter presented to said deponent for his/her signature;
That the parties were represented by their aforementioned counsel;
I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of either party, or

otherwise interested in the event of this action, and am not in the employ of the attorneys for either party.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this day of , 1998.

Sherry R. Reckas

My Commission Expires:
September 18, 1999
County of Residence:
Hendricks