CERTIFIED COPY

COMMON PLEAS COURT OF

HURON COUNTY, OHIO

- - -

Doc. 340

ANGELIA FORTNER, ADMINISTRATRIX) OF THE ESTATE OF CIARA RENEE) SAMS, DECEASED)

Plaintiff,)

vs.) NO. CVA-96-756

FISHER TITUS MEDICAL CENTER,) et al.) VOLUME I

Defendants.)

_____)

DEPOSITION OF

PHILIP THEODORE NOWICKI, M.D.

COLUMBUS OHIO

JUNE 4, 1998

ATKINSON-BAKER, INC.
CERTIFIED SHORTHAND REPORTERS
330 North Brand Boulevard, Suite 250
Glendale, California 91203
(818) 551-7300

REPORTED BY: Mary A. Frazier, R.M.R., C.R.R.

FILE NO.: 9808544

COMMON PLEAS COURT OF

HURON COUNTY, OHIO

- - -

ANGELIA FORTNER, ADMINISTRATRIX OF THE ESTATE OF CIARA RENEE SAMS, DECEASED	)	
Plaintiff,	)	
vs.	)	NO. CVA-96-756
FISHER TITUS MEDICAL CENTER, et al.	)	VOLUME I
Defendants.	)	

Deposition of PHILIP THEODORE NOWICKI, M.D., taken on behalf of plaintiff, at Children's Hospital, 700 Children's Drive, Columbus, Ohio, commencing at 1:30 p.m., on Thursday, June 4, 1998, before Mary A. Frazier, R.M.R., C.R.R.

A P P E A R A N C E S

FOR THE PLAINTIFF

LOWE, EKLUND, WAKEFIELD CO., L.P.A.
BY: CLAUDIA R. EKLUND, ESQ.
610 Skylight Office Tower
1660 West Second Street
Cleveland, OH 44113-1454

FOR THE DEFENDANT, DR. MAY

REMINGER & REMINGER
BY: P.J. MALNAR, ESQ.
The 113 St. Clair Building
Cleveland, OH 44114

FOR THE DEFENDANT, DR. KASTEN

FAUVER, TATTERSALL & GALLAGHER, P.L.L.
BY: J. C. WILLIAM TATTERSALL, ESQ.
5333 Meadow Lane Court
Elyria, OH 44035-1469

I N D E X

WITNESS: PHILIP THEODORE NOWICKI, M.D.

EXHIBITS:

(None)

QUESTIONS WITNESS INSTRUCTED NOT TO ANSWER:

(None)

INFORMATION TO BE SUPPLIED:

PAGE	LINE
18	6

PHILIP THEODORE NOWICKI, M.D.,
having been first duly sworn, was
examined and testified as follows:

CROSS EXAMINATION

BY MS. EKLUND:

Q Doctor, would you please state your full name for the record, and spell your last name?

A Philip Theodore Nowicki, N-O-W-I-C-K-I.

Q You are a medical doctor?

A. Yes.

Q What is your business address?

A Children's Hospital, 700 Children's Drive, Columbus, Ohio, 43205.

Q What position do you hold at that facility?

A I am a professor of pediatrics and physiology at the Ohio State University, and I am a neonatologist at Children's Hospital and University Hospital.

Q How long have you held the position in neonatology at Children's Hospital?

A Sixteen years.

Q How many neonatologists are on

staff at Children's Hospital at the present time?

A. Good question. Seven.

Q. Are you the chair of that department?

A. No.

Q. Do you hold any title wit in that department?

A. Actually I'm not a member of that department. My division is the Division of Molecular Medicine, because of my research activity, but my clinical practice is in newborn medicine. When I was hired, I was hired in the Division of Newborn Medicine or Neonatology, but several years ago, because of my research activity, I shifted over to molecular medicine, and have been there since.

Q. What do you mean by molecular medicine? Can you give me a lay person's description?

A. Molecular medicine is the branch of medicine that deals with gene therapy, understanding the means by which genes affect the human condition.

Q. What kind of areas of study are you working on at the present time?

A. My primary area of interest is in the regulation of the gastrointestinal circulation of the newborn. Premature infants have a difficult time digesting food and often have a problem with maintaining intestinal integrity after birth, and the basis for that is very unclear. My laboratory has been looking at the mechanisms by which blood flow is regulated into the intestine, and that's basically it.

Q. Am I to understand then blood flow into the digestive system is controlled by genes?

A. Oh, yes, um-hmm.

Q. How long has that study been going on?

A. Sixteen years. As long as I've been here.

Q. Have you published any results of your study?

A. Yes.

Q. In what publication did they appear?

A. The American Journal of Physiology, Pediatric Research, Journal of Pediatrics.

Q. Are you studying under a grant?

A. Yes.

Q. Who's the sponsor of that great?

A. National Institutes of Health.

MR. TATTERSALL: I am sorry, I missed that

THE WITNESS: The NIH.

Q. BY MS. EKLUND: Any other areas of research study that you are involved in at the present time?

A. No.

Q. How much of your professional time is devoted to your research studies?

A About 60 percent.

Q. In terms of your division of your time between teaching of pediatrics and physiology at Ohio State and your work in neonatology, can you give me a breakdown of the remaining 40 percent?

A. I attend the intensive care nursery three months a year, and in that capacity I'm completely responsible for all the infants admitted to the nursery for the entire month. And I also cover the nursery nights and weekends every other night and every other weekend for the duration of the year. So I spend a lot of time

in clinical practice.

It's always hard when you talk about percentages. As I'm sure, as yours, my work week is far beyond 40 hours. It's more like 90.

Q As between your duties in neonatology and I guess your teaching responsibilities at Ohio State, how is that time apportioned?

A Most of my teaching occurs when I'm on service.

Q So it's a clinical setting?

A Yes. I teach seminars in the department of physiology, but those are two- to three-hour episodes that occur several times, usually during winter quarter, and it's a very small commitment.

Q In your clinical teaching in conjunction with Ohio State, is that at Ohio State University Hospitals?

A. Yes.

Q Do you spend a set number of days per week at Ohio State University Hospitals?

A No. When I'm on service at University, I'm there the entire month. I don't

even come here. I go from my home to University Hospital. I also have an office there, and I stay there the entire month. I don't even come here.

Q. So is it alternating months?

A. Yes. July, December, and March of each year I spend at University Hospital.

Q. The other months are at Children's Hospital?

A. Here, right here in the research lab. When I take night call at University, what I'll do is I'll go home, I'll stop by the nursery on my way home. So I'll leave here, say, at 6 o'clock, go to University Hospital, make rounds with the residents, and then go from there to my house. If I'm on call the weekend, I'll go from my home to the nursery and back.

Q. Your on-call practice, is that solely in the area of neonatology?

A. Yes.

Q. Do you have privileges at any other hospital other than Children's and University?

A. Mount Carmel East Hospital.

Q. In what division?

A. Pediatrics, newborn medicine.

Q. Is there a difference between newborn medicine and neonatology?

A. No.

Q. It's the same --

A. Yes.

Q. -- patient population that you carry?

A. Exactly. Those of us with speech impediments that have a problem with ology say newborn medicine.

Q. It's easier for me, too. Would newborn medicine also encompass the infant in the pre-delivery stage?

A Yes, um-hmm.

Q So it is broad enough to cover?

A Yes, it is.

Q Have you ever taught the Neonatal Resuscitation course, or Newborn Resuscitation?

A. I teach residents the art of caring for the infant in the delivery room. I do not use the course offered by the American Heart Association because I disagree with it, and I've been doing this for a long time, and I just, I mean the same concepts are taught, but I don't

use their structure What took right there, I don't use that structured format

Q The course that I am asking you about. I think I didn't -- may not have said it correctly It's the Neonatal Resuscitation course?

A Right. My AAP and American Heart, yes

Q Do other physicians use that at Children's Hospital or University Hospital?

A Yes

Q Is it taught as, I guess, the course is taught by other physicians?

A It's part of the training while the residents are in the nursery In other words, a resident will spend one or two months in the nursery per year, and during that time he or she will actively be introduced to a whole host of topics relevant to newborn medicine One of the things that we focus on clearly is the issue of care of the infant in the delivery room.

When I am on service, my house staff is given this material, and we go through it, but I had prepared lectures and

presentations well before this became standardized. Instead of changing my approach, I simply will give them this to read, and I will use my own notes and my own slides and such.

Q Is there any difference in, I guess, the major principles --

A. No.

Q -- between the American Heart Association course and the course that you teach?

A Absolutely not, no.

Q So it is more of an approach to avocation --

A Precisely.

Q - where you differ?

A Precisely. I'm a crusty curmudgeon. It's hard to change slides.

Q Is the course or the guidelines put out by the American Heart Association considered the standard for newborn resuscitation?

MS. MALNAR: Objection.

THE WITNESS: No. It is a teaching module. I would not construe it as standard of care. It is something that has been prepared initially by the American Heart Association, and

then thereafter went through the American Academy of Pediatricians as a means to introduce pediatric house staff and family practitioners to the care of the infant in the delivery room. It does not in the text proscribe standard of care, no.

Q BY MS. EKLUND: Does it give a step-by-step process for resuscitating newborns?

A Yes, it does.

Q My understanding of the idea behind this publication and the course work is to standardize the practice throughout the country so that family practitioners and others, not family neonatologists, can resuscitate newborns?

MS. MALNAR: Objection.

THE WITNESS: The basis for it was really to provide individuals instructing others in care of the newborn with a tool to help them or assist them in that teaching process. The idea was not to standardize the care, it was to provide a document to assist in teaching.

This comes with not only the book, but it also comes with slides, it comes with outlines and the whole nine yards. It's

designed -- and it can be given at different levels, it can be given to people without a medical background, it can be given to people with a medical background. The idea is it's a teaching tool.

And the purpose of the American Heart Association when they put this together was not to standardize care but was rather to assist in the education of those who were going to be caring for infants.

Q BY MS. EKLUND: Could this course be taught to nonmedical people, such as an attorney?

A Well, actually it has been taught to fisefighters and police officers, so yes.

Q So this would have the same ability or teaching skills --

A. No, no.

Q They would be able to resuscitate a newborn?

A Basically it's the same thing. This is nothing more than an extension of the classic **CPR** technique. **CPR** is used for adults that have had cardiopulmonary distress. This is used for infants that have had distress after

birth. And it's nothing more than a derivation of classic CPR. It is taught to individuals, paramedics, firefighters who might be in a position where they would have to assist a newborn after birth when access to a hospital was not possible. So, yes, it is taught in that regard. The principles are very simple.

Q. Have you taught this course to people other than medical residents?

A. Myself, no.

Q. The medical residents whom you have taught, are they -- what branch of medicine are they?

A. Pediatrics, family practice.

Q. For how long have you been teaching neonatal resuscitation?

A. Sixteen years.

Q. I don't want to go too much into your background, because I assume most of it will be in your CV.

A. Right.

Q. And it just doesn't seem fruitful to me, so although I may ask you just because I don't have it in front of me.

A. Sure.

Q. Other than your research in molecular biology, have you published any other articles specific to resuscitation of the newborn?

A. No.

Q. You do have written course materials and instructions for the resuscitation courses that you teach?

A. Yes.

Q. Are they published in the hospital library?

A. No.

Q. If I asked you, through your attorney, to provide me with a copy of that material, would you be able to do that?

A. It would take some time, but we could get it together, yes.

Q. Is it voluminous or just ··

A. No, it's just a series of notes. I give lectures with a piece of chalk. I'm an old fashioned person, and I have lecture outlines that I provide the residents, and I use that as a means for them to take notes so they can follow me as I speak.

I used to have a series of

slides, I probably still have them some place, but as I've gotten older, I have learned that teaching is more effective if it's done on a one-to-one basis in a small room such as this with two or three residents and a chalkboard.

Q. If you could get that together and provide it to counsel and to me.

A. Yes.

Q. When was the last time you taught the course?

A. December. No, wait a minute, hold on. Yes, December.

Q. December of '973

A. Yes.

Q. You taught it here at Children's Hospital?

A. No, University Hospital.

Q. Have you served as an expert witness prior to this case?

A. Yes.

Q. How many times?

A. I don't keep a record. I probably do so about two or three times a year, and I've been doing that for about the past seven or eight years.

Q. Do you testify primarily for defendants?

A. No, it's been both plaintiff and defense.

Q. Evenly divided, would you say?

A. No. I've been approached more by attorneys for the defense than for the plaintiffs. I'd say probably 30/70, plaintiff/defense.

Q. Have you ever testified in a case other than this involving the resuscitation of a newborn?

A Yes

Q Can you tell me how many times?

A Once or twice.

Q Do you know the name of the case in which you testified?

A No, I don't.

Q Do you recall the name of the attorney?

A No, sorry.

Q Either attorney?

A No

Q The attorney who hired you?

A. No.

MR. TATTERSALL: Are you referring to deposition or testifying at trial? I didn't get the distinction.

MS. EKLUND: I didn't make a distinction.

THE WITNESS: Like I said, I didn't keep records. My office is too small. I've got limited space. I don't recall the names or cases, no.

Q. BY MS. EKLUND: Was this deposition by way -- or testimony by way of deposition or in person?

A. By deposition.

Q. I assume it was here in Columbus?

A. Yes.

Q. Did you testify in those cases on behalf of a defendant?

A. Yes.

Q. Do you recall any of the specifics of the case or what the alleged malpractice was?

A. No. But it's important to note that the case did not involve just the care of the infant after delivery. It was, part of the case was what the pediatricians had done after the child had been born. But it was more global

than that. It was the issue of birth injury, when did the injury occur, trying to set a point at which you could determine when the child's damage occurred.

Q That is by looking at MRIs or things like that?

A Exactly, records, and exactly.

Q Have you ever testified on behalf of any physicians from Fisher Titus Hospital in Norwalk, Ohio?

A. No

Q Have you ever testified at the request of Beverly Sandacz?

A I don't think so.

MS. MALNAR: I'm not Beverly.

THE WITNESS: I have worked for Reminger and Reminger before, but I don't believe for Beverly, no.

Q BY MS. EKLUND: Has Reminger and Reminger been the defense firm that has hired you the most --

A. No

Q. over the last few years? Which firm has, if you can say?

A I'm national. I don't know where

these people get my name. I get these phone calls. I've done -- my most recent case was from Houston, Texas. I think it's of my national profile of my expertise in physiology and such, is where they come from, but I've done cases in Houston, Florida, Tennessee, some in Ohio, I mean some in Ohio, but all over the country.

Q. Are you registered with any type of --

A. No.

Q. -- research firm?

A. No.

Q. Or expert search place or anything like that?

A. No. It kind of amazes me that I get these phone calls. They come out of the blue.

Q. Do you know how many times previously you've testified for someone from Reminger's office?

A. I think probably twice, I would think twice.

Q. Who's your malpractice insurance carrier?

MS. MALNAR: Objection.

THE WITNESS: Good question. It just got changed. We were with **PIE,** and of course that's all gone down the tubes.

Q. **BY MS. EKLUND:** Yes.

A. You know, to be honest with you, **I'm** all part of a big corporation here, and I'm not really even sure. **I'm** not really sure. I'm covered.

Q. You are sure about that, okay. Have you ever been sued in a malpractice case?

A. Oh, yes, four times.

Q. In what capacity were you involved with the patient?

MS. **MALNAR:** Can I have a continuing objection to this line of questioning?

MS. **EKLUND:** Sure.

THE WITNESS: I have been named in four suits. In each of the cases I was a co-defendant. In each of the cases, once the information about the case became obvious during discovery, I was excluded as a defendant. In other words, **I** have never been -- **I** have been deposed only once. Of those four cases, I was removed from the case before I was even deposed. In one case I was deposed, and as a consequence

of that deposition I was removed from the case.

Q. BY MS. EKLUND: Did those cases involve any resuscitation of the infant?

A. No.

Q. In the case where you were deposed, do you recall the name of the patient?

A. You know, I should. I'm blocking on it. Not offhand. No, I don't.

Q. Do you know any of the physicians involved in this litigation?

A. No.

Q. Do you know any of the expert witnesses?

A. No.

Q. Did you have a conversation with Miss Sandacz when she retained you to review this matter?

A. Yes.

Q. What do you recall of that conversation?

A. She introduced me to the case, asked me if I would be willing to review the case for her. I told her I would. She sent me the material. I reviewed it, and I called her back and told her what I thought was going on.

Q. In terms of introducing you to the case, what did she tell you about the case?

A. That it was a child born prematurely, there was a difficult time at birth. The child had eventually been taken off the ventilator at the tertiary care center because of hypoxic ischemic encephalopathy. That's pretty much it.

Q. Did she ask you to review the file from a certain perspective?

A. Basically she requested me to look at it from a perspective of whether Dr. May and Dr. Trippe had done the appropriate things. Particularly Dr. May.

Q. After reviewing the file, you called her back and told her what your opinions were?

A. Yes.

Q. What did you tell her?

A. I told her that in my opinion, Dr. May had done the appropriate things.

Q. What about Dr. Trippe?

A. That he had done the appropriate things.

Q. Did you have any criticism of any

physician involved in the care of this infant?

MS. MALNAR: Objection.

THE WITNESS: I only would talk about the pediatric side of things. The obstetrician, Dr. Kasten, is -- I'm not an obstetrician and I can render no opinion regarding the care of the mother or the care of the infant before the child was delivered. I can only comment regarding the care delivered by Dr. May and Dr. Trippe. And I don't find any fault with what they did, no.

Q. BY MS. EKLUND: Does neonatology in its patient population cover the child in the laboring process?

A. Yes, it does.

Q. In your practice, are you ever consulted by OB/GYNs as to decisions concerning induction of labor?

A. Realistically, no. What I'm consulted on is whether or not, if the child is delivered, the child could be construed as viable. In other words, obstetricians or perinatologists don't come to me and say, Phil, should I deliver this baby now. They come into me and say, I've got a problem. If I deliver this baby now, what are its chances. And I will

tell them, of the situation, the estimated fetal weight, the estimated gestational age, what I believe the potential outcome for the child will be. They then use that as a factor in determining whether they should or should not deliver the child.

Q. Have you been consulted in cases -- in a case involving a 34-week premature ruptured membranes?

A. Yes.

Q. What has been your opinion regarding delivery of those infants?

A. Generally speaking, at 34 weeks gestation, with rupture of membranes, at 34 weeks the potential viability of the child is excellent. With the advent of surfactant replacement and modern ventilation techniques, the outcome of these infants is outstanding. And, therefore, I routinely would suggest to my obstetrician colleagues that we would be capable of caring for these infants and provide them with a good outcome.

Q. Surfactant medication is a 48-hour time period for --

A. No, no, you are confusing the

steroid with surfactant. Mothers are given the corticosteroid betamethasone antenatally. That induces the enzymes in the fetus' lung which produce surfactant. We now have available the actual surfactant itself which we place directly into the child's lungs after birth, so if the child is born and has evidence of hyaline membrane disease, and that's H-Y-A-L-I-N-E. Every time I see it, it's H-I-G-H-L-A-N-D.

Q. We've seen it every way you can dream of.

MR. TATTERSALL: H-Y.

THE WITNESS: H-Y-A-L-I-N-E. If the child shows clinical evidence of hyaline membrane disease, we will give surfactant down the endotracheal tube and the child will recover remarkably. It's been a tremendous boon in the field.

BY MS. EKLUND: When did that become available?

A. About seven years commercially. It was worked on primarily in the '80s. Commercially available at the beginning of this decade. It has revolutionized newborn care.

Q. What about betamethasone, is it

still used?

A. Obstetricians argue back and forth about who should be receiving it, who should not be receiving it. The two big arguments usually are how far along is the mother. If the mother's beyond 33, 34 weeks gestation, the argument is it probably is not necessary. The other argument usually is if their membranes have been ruptured, there is a risk of infection. That's been pretty much put to rest, however. One or two doses of Betamethasone will not induce infection in the mother, so that's usually now not considered a contraindication.

Q. Is two doses the --

A. Standard.

Q. And that's over a 48-hour period of time?

A. Right, and it would be repeated on a two-hour basis if the mother is not delivered.

Q. Is she kept in the hospital or discharged home?

A That depends on the insurance company.

Q Unfortunately, insurance aside, medically what is --

A. It would depend on her situation, her living conditions, whether she has ruptured or not. If she's dilated beyond two centimeters and ruptured, it probably would be safer to keep her in the hospital.

Q. What if she's ruptured but only one centimeter dilated?

A. Probably safer to keep her in the hospital.

Q. Do you know how to define labor?

A. Labor is uterine contractions which lead to the progressive effacement and dilatation of the cervix.

Q. Do you have any opinions about the obstetrician care given to Angelia Fortner in this case?

A. No.

Q. By that, I assume then you have no criticism of anything Dr. Kasten did or did not do?

A. I have no opinion.

Q. Do you agree that Ciara, the infant involved in this case, at 34-plus weeks was a viable infant?

A. Yes.

Q Did she have seizures

discuss?

A Of her chest x-rays, no. She did not

Q. What was the cause of death of this infant?

A This infant died of hypoxic ischemic encephalopathy. A process wherein the brain has been deprived of oxygen and other substrates it requires to maintain viability This process occurred well before the child was delivered and extended through the time of the child's birth

Q So is it your testimony that this hypoxic encephalopathy --

A We do use big words

Q You tell me you can't spell neonatology

A. Hypoxic ischemic encephalopathy

Q. occurred in utero?

A Yes

Q When this child was delivered, the hypoxic event did not occur at that time?

A No This child was born flaccid, with profound bradycardia, no tone, and no gag

The one minute Apgar score was one. The only way that can happen is if the brain has been turned off. Two of the things that we score on the Apgar scoring system are muscle tone and gag reflex, and they are both indicators of central nervous system function. If an infant is born flaccid, there can only be two reasons, one, the child has been given drugs via the mother that caused that to occur, which did not happen here, or there is some pathology between the brain, the spinal cord, the peripheral nerve, and the muscle.

Now if you look at Ciara, congenital myotonic dystrophy, the muscle disease, clearly was not there. She did not have peripheral nerve damage because she was totally flaccid, not just flaccid in one arm or one leg. There was no evidence of spinal cord trauma, so you are left by elimination to believe the child's cerebral cortex had been turned off or damaged.

a. On autopsy is there any evidence of cerebral cortex damage?

A. There was evidence of it on the MRI. She had profound cerebral edema.

Q. Is that something that could come from not breathing when she's born?

A. It would come from a lack of oxygen that occurred both before she was born and after she was born.

Q. Is there any indication of fetal distress in the labor and delivery records?

A. That's where this gets dicey. One of the problems that you guys, and when I say you guys, I mean attorneys, have is that they look at this issue of proximate cause. Just let me run with this for a second. There are sometimes events that occur just at the time of partuition, birth, or labor that can be recorded on fetal rate tracings, cause aberrant fetal scalp pH and such, that will cause asphyxia.

However, it is also possible, and happens quite frequently, unfortunately, that events occur days before the actual delivery of the child, such that by the time the child is delivered, the footprints of asphyxia changes the blood gases, changes in fetal heart rate tracing are gone.

To provide an analogy, if a child falls into a pool and is down at the bottom of

the pool for ten minutes, and he's pulled up, and he's intubated by the squad, he'll get his heart back, his lungs back, his kidneys back, his gut back, but he won't get his brain back. He will be in the ICU hooked up to a machine breathing for him. He'll be brain dead, but his vital signs will be perfectly stable, his blood gases will be perfectly normal.

Similarly, a fetus can undergo an asphyxia insult days before delivery of a substantial nature, and because of the time between the insult and the actual birth, recovery could occur, so that the footprints of asphyxia, acidosis, fetal heart rate tracing abnormalities are not there.

The fact is very simple. This child had reasonably normal cord blood gas, but had a one minute Apgar score of one. Now those are profoundly discrepant bits of information, and the only logical conclusion is that something had happened to this child a long time before the actual delivery of the infant.

Q. Would you expect a child who had an earlier asphyxia event to survive and go through the laboring process as the records

indicate this infant did?

A. Absolutely, sure. An example for that would be a child with an encephali, a birth defect where the brain is simply not there. Those children do fine in labor, and are born, and except for the absence of a brain, look just fine.

Q If the one minute Apgar score is incorrect, would that change your conclusions?

A But it isn't, because it's, not only is the Apgar score recorded, but all through the chart is written flaccid, not breathing, limp. I mean, the child is clearly described as being profoundly depressed at birth.

Q So your opinion is based upon the description of the infant at birth?

A Absolutely.

Q There is nothing else in the record or the autopsy that indicates what, if anything, occurred or when it occurred?

A Not necessarily. The autopsy and the MRI showed significant hypoxic ischemic encephalopathy cerebral edema. Let's for argument say that Ciara was born in a pristine condition, and for some reason had a plug in her

airway and couldn't breath. Nine minutes elapsed -- well, four minutes elapsed between the time she was born and Dr. May first intubated her, although he was bagging her during that time. He intubated her. He got no response, and, therefore, he appropriately pulled the tube out, prepared himself for reintubation.

This is what we train people to do. If you put the tube in and the child has not come back, you take the tube out, you assume that you have not put the tube in the right place or that the tube is not big enough or that something has to be done different. Take the tube out.

By the time he was ready to put the tube back in, Dr. Trippe was there. He put the tube in. He put in a **3.0** at five minutes, didn't see a response. Took it out appropriately. Put in a **3.5** at nine minutes. That period of nine minutes, if the child had been born in a pristine state, is simply not sufficient to cause the degree of brain damage that Ciara had experienced.

In other words, what I am saying is that clearly the events that occurred after her birth could not, by themselves, explain why

she had such a massive degree of brain damage. It's just, it's not there.

Q. Are you telling me that nine minutes without oxygen won't cause this brain damage?

A. But she wasn't without oxygen. Look at the chart.

Q. Let me just start this question.

A. Go ahead.

Q. Nine minutes without oxygen would cause this type of severe brain damage; wouldn't it?

A. No, no.

Q. You are saying no.

A. No. Because the question, it's an irrelevant question, because she was not without oxygen.

Q. That's not my question. I am saying nine minutes without oxygen, Doctor, are you telling me that will not cause brain damage, this type of brain damage?

S. MALNAR: Are you asking him in a vacuum?

Q. BY MS. EKLUND: I am asking the question just like it is. I am not saying this

infant that no oxygen for nine minutes I am saying, nine minutes without oxygen.

Q If you took a human being, perfectly healthy, and completely eliminated oxygen from their environment for nine minutes, it would not be sufficient to cause this degree of damage, no.

Q How about nine minutes of no oxygen in a newborn?

A No. In fact, newborns are specifically designed to withstand this kind of insult They have -- I will put it to you this way The oxygen level in your blood right now, your PO2, is about 85 Now if you were pregnant, your fetus' PO2 would only be about 35 The fetus lives in a very low oxygen environment for a sustained period of time during fetal development The fetus is specifically designed to live in a low oxygen environment It thrives in it It happens because his hemoglobin is different, his carbiac function is different, and his circulation is different

Q Once that infant is born, that changes; doesn't it?

Q. Very slowly This is the blood

gas taken after the child was born. The child's oxygen level is 90 which is normal This child was not deprived of oxygen.

Q At birth

A At this particular moment in time, when this gas was obtained, this child's oxygen level was normal.

Q At what point in time is that blood gas obtained?

A 1848 She was born at 1730, I think, isn't it, or 1740?

Q Something like that But that's well over an hour from birth

A Well, that's the first evidence they had, the first time they could get a gas

Q Well, there were cord gases drawn at birth by the OB.

A. Right.

Q And that s normal, isn't it?

A Actually the arterial px and the cord is a little bit on the lowish side, but it's not out of the real of normal.

Q So i s within normal range?

A Yes, it's not too bad

Q The next blood gas, there is a

blood gas before 1:40; isn't there, Doctor?

A I don't see it With a minute to go, that's 1:40, 1:37 So, I don't see one You know, I just realized something as well The case blood gases were run an hour later they were drawn during that time, oxygen -- oxygen and hemoglobin like each other a lot In other words, the pain on the X of my hand is blue, right, But if I cut my pain the blood that comes out will become instantaneously because the oxygen in the tissues there will bind to the hemoglobin and make it red.

So these I'll pass out for a long time before they were run, which makes me wonder about the feasibility of the blood core samples

Q Aren't they maintained in an environment so that the core results are accurate and correct?

A. Not necessarily If there are any bubbles at all in the sample or if they are not properly chilled, if they are left at room temperature, it can change very dramatically

Q So you know anything about how this blood sample was prepared or taken?

A. No

Q. Or transported to the lab?

A. No.

Q. Can I look at your chart there?

A. Sure. That's the labs and her chart from Fisher Titus. The previous sheets are all CBCs and such, and there are four blood gases, the two cords and the one at 1848 and the one at 2000, which is on the next page.

Q. The blood gas drawn at 1840 or 1846, I can't quite read it, has a pH of 6.66.

A. Um-hmm.

Q. That's near death; isn't it?

A. It suggests a substantial acidosis.

Q. The pH taken at 1730 was 7.2?

A. Yes.

Q. The other one is 7.3, both of which are within normal ranges?

A. This is the venous blood gas, this is an arterial blood gas, this is also a venous blood gas, but this is very low, yes. The 6.6 is very low.

Q. Would you agree that there is some event that occurs between birth and when this blood gas is drawn at 1846?

MS. MALNAR: Claudia, where are you reading?

MS. EKLUND: Right here. It says time drawn. In those little paragraphs where you write things down.

THE WITNESS: It's obvious that two things happened. First there are two things that are going to affect the pH, the carbon dioxide level and the bicarbonate concentration, one's an acid and one's a base. And you can see that the base level has profoundly decreased, so that the child's base excess is minus 31, so the child is really devoid of buffer. At the same time, the carbon dioxide tension is high. So that this is what has occurred between this point and this point, but again, the fact that these two gases were sitting around for an hour makes me wonder about what happened.

Q. BY MS. EKLUND: I don't want you to speculate about what happened.

A. Right.

Q. Do you have any reason to believe they weren't --

A. No.

Q. -- properly stored, maintained,

transferred, whatever needed to be done with them?

A. No.

Q. So you have to assume at this point that they are accurate readings; don't you?

A. I think so, yes.

Q. You were, I think, looking for something in this chart that indicated this baby was receiving oxygen in the first nine minutes after birth?

A. Sure. When the child was born, Dr. May, in his deposition and also in the nursing notes, it's clear that the child was being given oxygen by mask, and it was being bagged and masked during the first four minutes, and then he was being bagged or she was being bagged via the endotracheal tube when the child was intubated at four minutes, and then again at five minutes when Dr. Trippe intubated the child.

Q. Is the child getting oxygen if the chest is not rising with the endotracheal tube?

A. The chest rise is another thing about this case that people have focused on which I think is curious. Chest rise in a 34-week infant is very difficult to discern. The chest

of a 34-week infant is primarily cartilage from roughly the mid axillary line up to the entire anterior chest is cartilage. I have, on hundreds of occasions, intubated a child in the delivery room who was not breathing and bagged the child properly and the child has turned pink and the heart rate has gone up and not seen a substantial chest rise. The chest rise, it can be very difficult to see sometimes, especially in premature infants.

Q. Do you have any reason to think that there was chest rise in Ciara before Dr. Trippe came into the room?

A. No.

Q. In doing a resuscitation on a newborn and ventilating the child, you tell your residents to use as much pressure as you need to get the chest rise?

A. What I tell my residents is to titrate to affect of improvement of the infant. In other words, the goal of placing the tube in a bag and mask is not to see the chest rise, it's to see the child improve. And so what I tell them is if the child is born and the child is not breathing and you stimulate the child with

tactile stimulation and the child does not respond, that you bag and mask the child. If you see no response vis-a-vis an increased heart rate or improved color, improved tone, then you intubate the child. And then you bag and mask the child. If you do not see -- you bag the child through the ET tube. If you do not see improvement in heart rate and color and tone, then you make sure that your tube is where you think it was.

Q. Isn't chest rise an indication that the child is being ventilated, the lungs are inflating?

A. Yes.

Q. If the lungs don't inflate immediately upon birth, they are more difficult to inflate as time goes on?

A. I don't know that it's any more difficult to inflate the lungs at three or four or five minutes of birth than it is at the moment of birth. The first breath obviously is a very important event. The baby has to take a deep breath to inflate the lungs. The lungs at the time of partuition are primarily water filled, and that has to be replaced with air, and that

takes a very deep breath to do.

Q. If the baby doesn't get that first breath, the lungs will collapse; won't they?

A. They come out collapsed basically. They are not air filled at birth. So they are relatively deflated at birth.

Q. If they are not inflated immediately after birth, all of the things that the body would ordinarily do to start the breathing process shuts down?

A. No, no.

Q. No?

A. The breathing process is initiated by the central nervous system, and the reason that Ciara was not breathing was that her central nervous system had been turned off. That goes back to what I was saying earlier, that this child came out and obviously had sustained a significant injury before she was even delivered.

Q. Have you looked at the MRI films of Ciara?

A. I have not seen the films. I have read the reports.

Q. When you treat children in the nursery, do you look at the MRI films yourself?

A. Yes.

Q. You read them and interpret them yourself?

A. I read them. I allow my radiology colleagues to provide the formal interpretation.

Q. Do you consult with them?

A. Yes. That way they get to drive their Lexis. It's a great field, radiology.

Q. Do you agree that four minutes to intubate this patient is too long?

A. No.

Q. What time frame do you teach your residents when you are teaching resuscitation?

A. Time frames are very difficult to use in that setting, because when you have a crisis, time flies by very fast. What I tell my residents is not to look at their watch but to look at the patient. I tell them that when the baby is put in front of you, the first thing you look at is tone. Does the child have tone, yes or no. If the answer is no, then that suggests the child has significant central nervous system depression. That means the child is not going to begin to breath by him or herself. The child needs to be bagged. I tell the residents that

they should first begin to bag the child, seal the bag properly. Oftentimes that is enough to get the child going. If that does not work, then the child should be intubated.

Q. Time plays some importance in making these decisions and going to the next action; doesn't it?

A. No. Actually it doesn't. When you are in the delivery room, you don't look at the clock. I mean, you're looking at the baby. I have never in my life looked at the clock in the DR.

Q. I am not suggesting that these doctors stand around and look at the clock and not the baby.

A. What I am saying is it's a step-wise process. You assess, determine how depressed the child is, provide bag and mask ventilation, assess for the success or failure of that technique, and then go to the next step.

Now the time frame, this should go on during the first three to five minutes of the child's life.

Q. What should go on between the first three to five minutes?

A. The point of assessment, initial bag and mask, initial intubation.

Q. Successful intubation at five minutes?

A. Yes, um-hmm.

Q. This child was not successfully intubated at five minutes.

A. You don't have any evidence of that.

Q. Do you have any evidence that she was?

A. No, but you have no evidence that she wasn't.

Q. Do you have any reason to believe this child was being -- receiving oxygen at five minutes?

A. I have no way of knowing that, except to know the child was being bagged and masked, had been intubated, and was being bagged. Whether that first tube was in the trachea or in the esophagus, both of us will learn that on the day of our death. We'll have to ask the higher power. I mean, I don't know. I mean, certainly in a crisis situation, esophageal intubation happens. I mean, that

happens all the time. But you have no evidence here one way or the other that it did or did not happen.

Q. Well, the only thing we know is that Dr. May says he did not get any chest rise.

A. Right.

Q. That would indicate the lungs were not being inflated for whatever reason?

MS. MALNAR: Objection.

THE WITNESS: No, no. It indicates that the chest didn't rise. The lungs could have been inflated and you might not have seen the chest rise. You're breathing right now, and I don't see your chest rise.

Q. BY MS. EKLUND: I would submit there is some difference. What event occurred prior to labor and delivery to cause this brain damage in this child?

A. I have no idea.

Q. What are the possibilities?

A. There are a number. Cord accidents, the child could have tangled herself in her cord. There could have been a loss of placental function for any one of a number of reasons. It's very difficult to say.

MR. TATTERSALL: Placental?

THE WITNESS: Placental functions. It's very difficult to say. One of the things you always have to remember is human gestation is supposed to go 37 to 42 weeks, so if something starts earlier than 37 weeks, you have to ask yourself, why is that happening. Whenever a perinatologist is presented with a mother who has ruptured her membranes before 37 weeks gestation, one has to wonder about what's going on with that fetus, why did those membranes rupture.

Q. BY MS. EKLUND: Is there any sign of infection?

A. Infection is one cause of rupture of membranes, but not the sole cause.

Q. Was there any sign of infection in this pregnancy?

A. In this child, no, not really.

Q. Was there any meconium?

A. No, not at birth.

Q. Was the child meconium stained?

A. No, I don't believe so.

Q. Wouldn't meconium or meconium stain in the infant indicate an earlier ischemic event?

A. No, not in this case. This child is 34 weeks gestation. Meconium is really not there until -- meconium is a term thing to do. Premature infants don't pass meconium when they are asphyxiated.

Q. So only after the 37th week would you expect it?

A. Yes. The neural connections that would cause the colon to expel the meconium into the amniotic fluid are not present at 34 weeks gestation.

Q. Do I understand correctly that the only basis you have for concluding that these events occurred before labor is the Apgar score?

A. No. It's the child's condition. I mean, the Apgar score is one representation of that.

Q. What else about her condition?

A. She was flaccid.

Q. Well, that goes to the Apgar score; doesn't it?

A. Exactly, she was not breathing, and she was bradycardic.

Q. Anything else?

A. That's enough. I mean, that's --

I've seen thousands and thousands of babies born. When a child is born, they are vigorous, they cry, they have muscle tone, they move around, they breath, and they have a good heart rate. If that doesn't happen, that means that something has occurred before the child was delivered. It's as simple as that. Prematurely born babies, 34 weeks gestation, come out kicking and screaming.

Now if the child was profoundly premature, say 24, 25, 26 weeks, then you wouldn't expect that child to move very much. But at 34 weeks gestation, these kids come out, and they're very, very active, if they're delivered in a non-asphyxiated state.

Q. What was the reason for Dr. May's difficulties in ventilating this child?

A. I don't know. And that's a real perplexing issue here, and I could only tell you on a personal level that it has happened to me also, in situations just like this, with badly -- with babies that are born that are profoundly depressed at birth. The tube goes in, you know it's in, and you bag the child. And you just don't get a response. You don't see any evidence

of improvement in the child's cardiovascular status. I have long wondered what the problem is, and I don't really have any answers for you, except to say that I've seen this happen myself.

Q. In those cases, were you eventually able to ventilate the child?

A. Yes. But the outcome was almost, in those cases, the outcome was almost invariably as this case was.

Q. Death?

A. Profound brain damage.

Q. How many times has that occurred to you?

A. I don't have a number.

Q. More than a couple?

A. Over ten, yes, over 16 years, yes.

Q. Are those in premature infants?

A. Both in preterm and term infants, yes.

Q. I assume you have read the depositions that you've been supplied?

A. Yes.

Q. Dr. Trippe testified he attempted to put Epinephrine down the ET tube and it came

back.

A That's very common. That's a very frustrating thing. When you have the tube in the trachea and the lungs are noncompliant, the lungs have not expanded properly yet, you'll see the bolus of Epi kind of wash up and down the tube. It's the same thing when you give surfactant down the tube. There's a pressure gradient between the thoracic space and the atmosphere, and it's a hard way to give drugs. You can't just drip it down, because there is pressure down there, and it's very common.

Q It's common in noncompliant lungs?

A Common in situations like this, yes, absolutely.

Q She was not given any surfactant down the tube; was she?

A No, she was not.

Q Do you have any criticism of that?

A No, because by the time she got to the tertiary care center, she had a clear chest x-ray. She had a little bit of right upper lobe atelectasis, but that's just from the tube placement issue.

Q Meaning she didn't need the

surfactant?

A. Correct.

Q. How much ventilation pressure do you teach your residents to give for the first breath?

A. I teach them to give the pressure that is necessary to affect the change they need to see. In other words, that the baby should either have the mask fixed firmly into the face or the tube placed into the trachea, the bag should then be affixed to the tube or the mask, and the bag should be pushed to a point where you see a response on the part of the baby, that is the child begins to turn pink, the child's heart rate improves and the child's tone improves.

There really is no magic number as far as pressure. It can be as low as 15 centimeters of water, it can be as high as 40 centimeters of water. It varies.

Q. Can it be higher than 40?

A. I don't believe so.

Q. Can it be 60?

A. I don't think so.

Q. Would 60 cause any harm?

A. I think if you took a newborn

infant and put 60 centimeters of water pressure into his trachea, you'd probably cause a pneumothorax

Q. That's not life threatening; is it?

A Yes, it is.

Q If not treated?

A Yes.

Q If treated?

A If recognized and treated, it can be fixed, yes.

Q Do family practitioners attend premature infants at Children's or University Hospital?

A The residents do, yes

Q Are they there under somebody else's supervision?

A Yes

Q A neonatologist?

A Yes All the residents are

Q Do you have any family practitioners who are not residents who attend resuscitation of newborns?

A At University Hospital?

Q Yes

A. No.

Q. What about at Children's?

A. We don't deliver babies here. Columbus is like Cleveland. I mean, all the hospitals in Columbus have neonatologists. It's a large metropolitan area, so that you would expect to have a neonatologist present. In a smaller area, Level 1 hospital, *you* go outside Franklin County, and you are going to have family practice residents and pediatricians in the DR all the time.

Q. Is there any reason why a family practitioner at a Level 1 hospital should not attend a premature infant?

A. If he or she has been properly trained, it should not be a problem.

Q. Proper training is the newborn resuscitation course or something like that?

A. It's the entire experience in the intensive care nursery, having had the experience working with infants, helping them after birth, and providing them with assistance. Which is part of family practice training.

Q. Again, there was no sign of infection in this pregnancy?

A. No.

Q. Or on autopsy?

A. No.

Q. Any reason to think this child had a mucus plug?

A. I've read that in the -- mucus plugs occur after delivery. I think, if anything, what this child might have had was either an amniotic fluid embolus in the trachea, or alternatively, she might have had tracheomalacia, T-R-A-C-H-E-0-M-A-L-A-C-I-A, which is a condition where the smaller airways collapse down and when that happens, they are very, very, very difficult to inflate. Now on the autopsy, the autopsy report does not directly look at that, but unless you are a pediatric pathologist and looking for it, you are not going to find it.

Q. So we really don't know?

A. That's correct.

Q. These things. You are speculating about them?

a. That's correct.

Q. There is no basis for it?

MS. MALNAR: Objection.

THE WITNESS: Except that these are things that can occur that would cause these events to occur.

Q BY MR. KLUGD: What would not have occurred -- that would have occurred at the time of delivery?

A. Yes, the aspiration of amniotic fluid. Well, the tracheomalacia would have occurred, would have been a congenital condition before delivery and would have been there since the development of the lungs.

Q But it wouldn't have caused brain injury until birth?

A That is correct.

Q The Level 1 hospitals outside of Franklin County, do they send their 34 week deliveries to Columbus?

A. I don't know. I'm not an obstetrician.

Q Do you attend any of the children from outlying hospitals at University?

A I'm not sure what you are asking

Q In neonatology at University

A Right.

Q Do you see patients referred to

that institution from the outlying counties?

A. Yes.

Q. Do you know whether the policy is to send 34-week --

A. I don't know.

Q. -- pregnancies? Is there any way by looking at the MRI films to time the insult which caused the brain injury?

A. You normally will see the development of swelling of the brain generally two to three days following the insult. But that's, that's very difficult to temporally relate to back-calculate of the MRI. I think it's very hard to do.

Q. What about the microscopic examination of the placenta, wouldn't there be some indication there that an event had occurred?

A. Not necessarily. Once again, unless the placenta was examined by a perinatal pathologist who really was looking at the placenta aggressively, looking for something, then it probably would not have been seen. I mean, placentas, as you know, probably any tissue that's removed from a human in the state of Ohio has to be examined by a pathologist. And so when

a placenta comes down into the pathology lab, I mean, they are going to cut a few sections and say, yeah, that's a placenta.

But there are people that are specifically interested in looking at placental pathology, and they will do special stain and look very carefully. If that was not done, you may have missed something. I've seen that happen many times.

Q. If that was done, would that more than likely show some indication?

A. Not necessarily. It depends on what happened. You could have had a cord accident occur and the placenta could have been just fine.

Q. Is there anything in her prenatal records which would indicate any problems with the pregnancy?

A. No.

Q. For the infant? I take it you have seen her prenatal records?

A. Yes, I have.

Q. Just looking through the depositions that you have, I notice that on Dr. Trippe, you -- I believe that's your writing,

says page 39?

A Yes

Q And you circled the section where he is talking about the 3 0 secondotrochaic tube being in place and certain compressions were given

A Let me see Yes

Q Why did you circle that?

A Because this is his impression that when he arrived, that -- that Dr Map had continued the child properly and was doing what he should be doing to help the child

Q Was that important to you in formulating your opinion?

A. Yes.

Q Is your opinion based upon Dr. Tripp's opinion?

A No.

Q Why was it important to you?

A It's important because it provides me with evidence of what was happening at the time What I do is look for evidence in the medical records in that position as to what actually transpired, go back and try to figure out what actually happened I look for bits of

evidence in that regard.

Q In Dr. Carlson's, you've noted page 50. You've circled where she said, yes, I think appropriate evaluation and sequence of interventions took place. So I would offer that opinion. Was that important?

A Who is this?

Q Dr. Carlson. She's the neonatologist at Toledo hospital where the child was transferred.

A Yes. I mean I offered that, I circled it because she obviously, when she looked at the situation, she was comfortable with what had happened.

Q Was that important to you?

A Again, it's a bit of evidence.

Q You have read Dr. Walentik's deposition?

A Um-hmm.

Q You disagree with her opinions?

A She's entitled to her opinions.

Q Do you disagree with them?

A I thought the deposition was interesting.

Q In what way was it interesting?

A She's very opinionated and very outspoken, and I don't think that you can state things in such black and white terms. I also think that she missed a few very important facts about, as a neonatologist who doesn't recognize the fact that when the child was born, the child's one minute Apgar score was one, the child was flaccid, not breathing, bradycardic. To me I wonder why she didn't pick up on that,

Q What else did she miss?

A Some of her references to the physiologic activities or physiologic principles that are involved in labor and delivery are a little crude, shall we say.

Q Can you be specific?

A I'd have to go back and read it.

Q Is she wrong in her opinions?

A No. She has an opinion. I mean, her opinion is that the child should have been intubated more rapidly, and that's her opinion. In all likelihood, in her institution, the child probably would have been intubated more rapidly by her. But the fact that she does that in her institution as a Board certified neonatologist does not mean that what Dr. May did at Fisher

mitus was inappropriate

Q. How do you determine standard of care in this setting?

A. Again, you get back to this word, standard of care, which is something that lawyers come up with Doctors. I never heard that term until I began to do legal work nine years ago I mean, standard of care in this situation would be assessment of the child at birth, determination of the degree of depression, resistance of the child from the standpoint of initiating respiratory activity, with a bag and a mask If that does not work, then with an endotracheal tube, and that should be carried out within the first several minutes of life.

Q. When you say several, do you mean one, two, three?

MS MAYNARD Objection.

THE WITNESS: Five That's only because that's about how long it normally takes

Q. BY MS EKLUN : That's regardless of who's doing it?

A. Obviously if a person with a lot of experience in taking care of babies is there, it's going to happen much faster.

Q. But five minutes would be the top, no matter who's doing it?

A. I would think that if the child needs to be intubated and he's not intubated by five minutes, then I think that's reasonable, yes, that's a problem.

Q. Generally what do you understand the standard of care to mean? I don't mean specific to resuscitation, just generally.

A. As I understand it, it is lawyer speak for what medical communities should provide under a given circumstance, what the appropriate response would be under a particular circumstance to provide care to a particular patient.

Q. Do you understand it to be what a reasonable physician would do under the circumstances?

A. Correct, yes.

Q. Did you make any notes --

A. No.

Q. -- when you reviewed these records?

A. No.

Q. Any reports?

A. No.

Q. Is there anything you reviewed that's not on the table here?

A. No.

Q. Did you refer to any texts or journals?

A. No.

Q. Have we discussed all of the opinions that you intend to offer at trial?

MS. MALNAR: Objection.

THE WITNESS: Well, I do have another opinion. Just a general philosophy about malpractice in general.

Q. BY MS. EKLUND: Okay. What is it?

A. What you have here is a bad outcome. Bad outcome does not mean that malpractice happened. If I go into the delivery room right now -- I am on call tonight. If I go into the DR tonight and I do three things wrong, let's say I want to be a little bit reckless with my life and so I stop by the liquor store and get some Jack Daniels and go into the DR a little bit toasted, and I do three or four things wrong, and the child does well, I'm a hero. No problem. Even though I committed malpractice.

If, as I would do, I go home, see

my kids and my wife, have my dinner, get called back to the hospital, in a completely sober state and do everything that I should do by the book, by my training, by my instincts, by my experience, and I have a bad outcome, then I'm going to have to call the corporation lawyer the next day and say, hey, we got a potential problem here.

The problem with the system of tort in Ohio is that there's no differentiation between bad outcome and malpractice. Bad outcome happened here. This child died. It was terrible. It was a very unfortunate thing. But Dr. May and Dr. Trippe did what they should have done.

Q. That's your opinion, right?

A. Yes, it is my opinion that these individuals did everything that they could and should have done to assist this child in surviving.

Q. Do you acknowledge that sometimes doctors do commit malpractice?

A. Absolutely.

Q. And sometimes there is a bad result?

A. Absolutely.

Q. Do you concede that other doctors may have other opinions as to whether malpractice occurred or did not occur?

A. Yes.

Q. Do you have any reason to doubt Dr. Walentik's credentials or her honesty or integrity?

Q. Do you have any reason to doubt Dr. Fields' honesty or integrity?

A. No.

recourse to seek compensation for that, absolutely.

Q. Do you understand in this case that if there weren't qualified experts saying that malpractice had occurred on behalf of the Plaintiff, that this case wouldn't be in court?

MS. MALNAR: Objection.

THE WITNESS: Oh, no.

MR. TATTERSALL: Objection.

THE WITNESS: Yes, it would. You know that as well as I do.

Q BY MS. EKLUND: No, you are wrong. We can go off the record, but what makes you think a case can be maintained without qualified experts?

MS. MALNAR: Objection.

MR. TATTERSALL: Are you on the record or off the record?

MS. ERLUND: On the record.

MS. MALNAR: This has nothing to do with anything, Claudia.

MS. EKLUND: It has to do with bias.

MS. MALNAR: No, it doesn't have to do with bias. He's already testified that he doesn't have a problem with the care that was

rendered in this case and that he believed, and these are my words interpreting what he said, but that they complied with the appropriate standard of care.

As to his opinions on the tort system in Ohio, they are not relevant to discovery in the deposition. I mean, if you want to have a discussion with him after the case is over, then so be it, but it's not appropriate, and you know it as well as I do, at this juncture in this case.

MS. EKLUND: Well, I disagree with you.

THE WITNESS: Same, lawyer disagree, too.

Q. BY MS. EKLUND: Doctor, do you agree that people, anybody, doctors, lawyers, dentists, mechanics, who hold themselves out to people as skilled in a particular service or branch of medicine, are required to act in accordance with an accepted standard of care?

MS. MALNAR: Objection. You are asking him to interpret legal principles, and he's not going to do it. If you want me to get the rule out in terms of what's appropriate in a discovery deposition and what isn't under 26E, I will.

MS. EKLUND: P.J., you can do anything you want. You can direct him not to answer, and we will come back later.

MS. MALNAR: I will direct him not to answer.

MS. EKLUND: Of course, he is not your witness, you understand.

MS. MALNAR: I understand.

MS. EKLUND: I don't think you can direct him not to answer.

MS. MALNAR: Claudia, make up your mind. You just told me to direct him not to answer if I wanted to, and I did.

MS. EKLUND: Well, I would suggest to you that he is not your witness, so you can't do that.

Q. BY MS. EKLUND: Doctor, can you answer that question?

A. Sure. Absolutely. People, a patient comes to me, they expect that I will take care of them properly, absolutely.

Q. One thing we didn't get was your CV. I'm finished unless there is something in your CV that I might want to ask you about.

A. Okay.

(Off the record.)

Q. BY MS. EKLUND: What do you charge, Doctor, for your time?

A. For reviewing a case, $250 an hour for depositions, $300 an hour for any part of an hour. In other words, what I have to do, like for this afternoon, I blocked off.

(Interruption.)

THE WITNESS: What I mean is that because of what I do for a living in research, I had to block the afternoon off, so I couldn't do an expert, I couldn't do anything. So basically, from 12 till whenever we stop, it's $300 an hour.

Q. BY MS. EKLUND: From 12? And for testimony, courtroom or whatever?

A. I have never testified in court, but it would be $500 an hour, plus the cost of getting there or whatever.

Q. Are you presently planning on attending the trial in Norwalk, Ohio, in this case?

A. If called to do so, yes.

Q. Thank you. I am sorry, do the fees that you charge go to you or to your

department?

A. To me.

MS. EXLUND: That's all. Thank you.

CROSS EXAMINATION

BY MR. TATTERSALL:

Q. Doctor, my name is Bill Tattersall. I represent Dr. Kasten in this case, the obstetrician. I just have a few questions. A little bit about your background. What is your age?

A I'm 45.

Q Where do you live?

A In Pinkerington, Ohio.

Q Where in Pinkerington?

A 9684 Wagon Wood Drive.

Q Are you Board certified?

A. Yes.

Q In what field?

A In pediatrics and in neonatal perinatal medicine.

Q When were you certified in pediatrics?

A 1983

Q And perinatal?

A. '83.

Q. Same year?

A. Yes.

Q. Where did you go to undergraduate school?

A. Drew University.

Q. Where is that?

A. D-R-E-W. It's in Madison, New Jersey

Q. And medical school?

A. Tufts University in Boston.

Q. What year did you finish?

A. '78.

Q. Where did you do your residency?

A. New England Medical Center in Boston.

Q. Did you do a fellowship after that?

A. Yes, I did a fellowship in Providence, Rhode Island, in Woonsocket Hospital

Q And did you come out here to Ohio at that point?

A Correct

Q Doctor, was there an obstruction that prevented the breathing of this child at birth, do you think?

A. There could have been. I don't know.

Q. The failure to breath could have been not the result of an obstruction, is what you are saying?

A. Yes.

Q. If there was an obstruction, you think it could have been a possible, or a probable or a possible problem with the trachea?

MS. EKLUND: Objection.

THE WITNESS: That would be entirely speculative. I can't really say.

Q. BY MR. TATTERSALL: In other words, whether or not there was -- the amount of pressure which was applied by Dr. May and by Dr. Trippe was not relevant then as far as you are concerned?

A. At 34 weeks gestation, 20 to 30 centimeters of water should open up the lungs without any problem.

Q. Since it didn't, it had to be something else, in your opinion?

A. Right.

Q. Fair enough. Dr. Walentik, she was aware that there were, in a number of states,

places where Level 1 hospitals were the place where obstetricians delivered 34 plus premature children. Are you aware of that fact?

A. Oh, yes.

Q. Are you aware that that exists in Ohio?

A. Yes.

Q. Dr. Fields gave an opinion in his discovery deposition. Did you read that, by chance?

A. Yes.

Q. That my doctor committed malpractice because he did not have Dr. Trippe, a pediatrician, on duty to be there to resuscitate the baby at birth. Do you agree with that opinion?

A. No.

Q. Is it appropriate if the person who is there -- it is appropriate to have a person present in premature birth for purposes of resuscitation if necessary, correct?

A. Correct.

Q. In fact, that's a standard of care?

A. Yes.

Q But if that person is qualified by training and experience to resuscitate that baby, that would satisfy the standard of care

A. Yes.

Q. Do you feel that Dr. May satisfied the standard of care?

A He's a family physician trained in this country, and of what we do for our family practice residents at Ohio State University, he should have been properly trained to be able to do that

Q You are not rendering an opinion as to whether or not the decision of Dr. Kast, to, as he describes, augmentation of the labor, to bring about the delivery, was a matter that deviated from the standard of care, you are not into that area, I take it?

A No

Q So you are not going to render an opinion in that case?

A. That's correct, I have no opinion.

Q. This child, as far as your opinion is concerned, did not have hyaline membrane disease, is that correct?

A. That's correct.

Q. The baby took a hit sometime in utero?

A. Yes.

Q. That caused an episode that resulted in the HIE, right?

A. Yes.

Q. I was going to say hypoxic ischemic encephalopathy.

MS. MALNAR: Well done.

Q. BY MR. TATTERSALL: But I didn't. Was it appropriate for Dr. May, as far from a neonatology standpoint, after the delivery of the baby, to hand the baby to the attending physician who was going to help with the resuscitation, was that the appropriate thing to do at the time?

A. Yes.

MR. TATTERSALL: Thank you.

MS. MALNAR: Do you want to read or do you want to waive?

THE WITNESS: I'll read it.

MS. MALNAR: Can we have 14 days, is that okay?

MS. EKLUND: Yes. Original.

MS. MALNAR: Copy, yes, and I'll send it

to the doctor.

MR. TATTERSALL: Copy.

MS. MALNAR: Miniscript.

(Deposition concluded at 3:00 p.m.)

STATE OF _____)

) SS.

COUNTY OF_____)

I, the undersigned, declare under penalty of perjury that I have read the foregoing transcript, and I have made any corrections, additions, or deletions that I was desirous of making; that the foregoing is a true and correct transcript of my testimony contained therein.

EXECUTED this _____ day of _____, 19___, at _____, _____.

(City) (State)

_____

PHILIP THEODORE NOWICKI, M.D.

REPORTER'S CERTIFICATE

I, Mary A. Frazier, Registered Merit Reporter and Certified Realtime Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

I further certify that I am not a relative or employee of any attorney or of any of the parties, nor financially interested in the action.

I declare under penalty of perjury under the laws of the State of Ohio that the foregoing is true and correct.

Dated this 10th day of June, 199%.

Mary A. Frazier R.M.R., C.R.R.

REPORTER'S CERTIFICATION OF CERTIFIED COPY

I, Mary A. Frazier, Registered Professional Reporter, in the State of Ohio, certify that the foregoing pages 1 through 84 constitute a true and correct copy of the original deposition of PHILIP THEODORE NOWICRI, M.D. taken on June 4, 1998.

I declare under penalty of perjury under the laws of the State of Ohio that the foregoing is true and correct.

Dated this 10th day of June, 1995.

Mary A. Frazier, R.M.R., C.R.R.