Part 2 of 2

Jan 2006 until
Present

03-1268-CD D. Rhoades et VS M. Kruszewski: D.O. et

Current Judge: Fredric Joseph Ammerman

Dennis R. Rhoades, Kimberly Rhoades, Mikayla Rhoades, Estate vs. Mary C. Kruszewski, DuBois Regional Medical Center

Civil Other

| Date | Selected Items | Judge |
|---|---|---|
| 01/04/2006 | Order NOW, this 3rd day of January, 2006, it is the ORDER of this Court that this matter shall be continued until the next Call of the List, scheduled for Tuesday, April 4, 2006, with jury selection to be held on Tuesday, May 2, 2006. BY THE COURT: /s/ Fredric J. Ammerman, P. Judge. 1CC Attys: Ging, Pribanic, Blasko and Johnson. | Fredric Joseph Ammerman |
| 01/10/2006 | Amended Order, NOW, this 3rd day of Jan., 2006, Ordered that this matter shall be continued until the next call of the List, scheduled for Tuesday, April 4, 2006, with jury selection to be held on Thursday, April 27, 2006. By The Court, /s/ Fredric J. Ammerman, Pres. Judge. CC to Attys: Ging, Blasko, D. Johnson, Pabanic | Fredric Joseph Ammerman |
| | Order, NOW, this 9th day of Jan., 2006, Ordered: ( Re: proposed schedule, see original). By The Court, /s/ Fredric J. Ammerman, Pres. Judge. 1CC Attys: Ging, Pribanic, Blasko, D. Johnson | Fredric Joseph Ammerman |
| 03/14/2006 | Certificate of Service, filed. That a true and correct copy of Supplemental Answers to Plaintiffs' First Set of Interrogatories Directed to Dr. Kruszewski, in the above-referenced matter were sent to Robert P. Ging Jr. Esq., Victor H. Pribanic Esq., David R. Johnson Esq., filed by s/ John W. Blasko Esq. No CC. | Fredric Joseph Ammerman |
| 03/29/2006 | Notice of Service of Interrogatories to Dr. Kruszewski & Request for Production of Documents on March 27, 2006, filed by s/ Robert P. Ging Jr. Esq. No CC. | Fredric Joseph Ammerman |
| | Notice of Internt to Serve A Subpoena to Produce Documents & Things for Discovery Pursuant to Rule 4009.21, filed by s/ Robert P. Ging Jr Esq. No CC. (in Re: William W. Fox, M.D.) | Fredric Joseph Ammerman |
| | Notice of Intent to Serve a Subpoena to Produce Documents & Things for Discovery Pursuant to Rule 4009.21, filed by s/ Robert P. Ging Jr. Esq. No CC (In Re: O. Richard Depp III) | Fredric Joseph Ammerman |
| 04/07/2006 | Objections to Subpoena, Per Rule 4009.21, filed by Defendant, Mary C. Kruszewski D.O., filed by s/ Allen P. Neely Esq. No CC. | Fredric Joseph Ammerman |
| | Answers and Objections to Interrogatories Reponses and Objections to Request for Production of Documents, filed by s/ Allen P. Neely Esq. NO CC. | Fredric Joseph Ammerman |
| 04/20/2006 | Motion To Strike The Objections to The Subpoena Pursuant to Rule 4009.21, filed by s/ Robert P. Ging, Jr., Esquire. No CC | Fredric Joseph Ammerman |
| | Motion To Reopen Discovery & Compel Answers to Interrogatories, filed by s/ Robert P. Ging, Jr., Esquire. No CC | Fredric Joseph Ammerman |

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

EVA JANE HERTLEIN, EDITH M. HERTLEIN, PATSY L. HERTLEIN KIMBLE, FRANK T. HERTLEIN, JR., GLENN R. HERTLEIN, TIMOTHY L. HERTLEIN, LOUISE E. HERTLEIN KIRKWOOD, and G. LEE HERTLEIN, Individually, and as Attorney-in-Fact for the heirs of FRANK T. HERTLEIN and IVY E. HERTLEIN,
Plaintiffs,

v.

RIVER HILL COAL COMPANY, INC., A Pennsylvania corporation,
Defendant.

No. 06 - 903 - CD

Type of Pleading:

**COMPLAINT**

Filed on behalf of:
Plaintiffs

Counsel of Record for this party:

James A. Naddeo, Esq.
Pa I.D. 06820

207 East Market Street
P.O. Box 552
Clearfield, PA 16830
(814) 765-1601

FILED
10/3:48 BM
APR 25 2006
1cc Atty
Atty pd. 85.00
William A. Shaw
Prothonotary/Clerk of Courts

**Clearfield County Court of Common Pleas**

ROA Report

Case: 2003-01268-CD

Current Judge: Fredric Joseph Ammerman

Dennis R. Rhoades, Kimberly Rhoades, Mikayla Rhoades, Estate vs. Mary C. Kruszewski, DuBois Regional Medical Center



Civil Other

| Date | Selected Items | Judge |
|---|---|---|
| 04/24/2006 | Order NOW, this 21st day of April 2006, following Pre-Trial Conference with counsel for the parties as set forth above, it is the ORDER of this Court as follows:<br>1. Jury selection will be held on April 27, 2006 commencing at 9:00 a.m. in Courtroom No. 1 of the Clearfield County Courthouse, Clearfield PA.<br>2. Jury Trial is hereby scheduled for August 7, 8, 9, 10, 11, 14, 15 and 16, 2006 commencing at 9:00 a.m. in Courtroom No. 14 of the Clearfield County Courthouse, Clearfiled PA.<br>3. Any party making objections relative the testimony to be provided by any witness in the form of a deposition at the time of Trial shall submit said objections to the Court, in writing, no later than thirty (30) days prior to the commencement of trial. All Objections shall reference specific page and line numbers within the dposition(s) in question, along with that party's brief relative same. The oposing party shall submit its brief in opposition to said objections no later than fifteen (15) days prior to the commencement of Trial.<br>4. Any party filing any Motion to Petition regarding limitation of exclusion of evidence or testimony to be presented at time of trial, including but no limited to Motions in Limine, shall file the same no more that thirty (30) days prior to the trial date. The party's Petition or Motion shall be accompained by an appropriate brief. The responding party thereto shall file its Answer and submit appropriate response brief no later that fifteen (15) days prior to trial. BY THE COURT: /s/ Fredric J. Ammerman, P. Judge. 1CC to Attys: R. Ging, Blasko, D. Johnson, V. Pribanic. | Fredric Joseph Ammerman |
| 04/27/2006 | Answer of Defendant Mary C. Kruszewski, D.O. to Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21, filed by s/ John W. Blasko, Esquire. No CC | Fredric Joseph Ammerman |
| | Answer of Defendant Mary C. Kruszewski D.O. to Plaintiffs' Motion to Reopen Discovery and to Compel Answers to Interrogatories, filed by s/ John W. Blasko, Esquire. No CC | Fredric Joseph Ammerman |
| 05/03/2006 | Rule to Show Cause, NOW, this 3rd day of May, 2006, a rule is issued upon the respondent. The respondent shall file an answer to the Motion within 15 days. Argument shall be held on June 7, 2006, at 2:00 p.m. in Courtroom No. 1. By The Court, /s/ Fredric J. Ammerman, Pres. Judge. 4CC Atty. Ging | Fredric Joseph Ammerman |
| 05/15/2006 | Motion to Strike Juror, filed by Atty. David Johnson no cert. copies. | Fredric Joseph Ammerman |
| 05/19/2006 | Motion To Enlarge Time Within Which To Conduct Trial Depositions, filed by s/ Victor H. Pribanic, Esquire. 2CC Atty. Pribanic | Fredric Joseph Ammerman |
| 05/22/2006 | Response to the Motion to Strike Juror, filed by s/ Robert P. Ging Jr. Esq. No CC. | Fredric Joseph Ammerman |
| | Order, NOW, this 22nd day of May, 2006, Ordered that the deposition testimony for use at trial of Ronald L. Hamilton, M.D. and Sarangarajan Ranganathan, M.D. may be recorded on or before June 28, 2006. By The Court, /s/ Fredric J. Ammerman, Pres. Judge. 4CC Atty. Pribanic | Fredric Joseph Ammerman |
| 05/24/2006 | Motion to Join in Motion of DuBois Regional Medical Center to Strike a Juror, filled by Atty. Blasko no cert. copies. | Fredric Joseph Ammerman |
| | Order, NOW, this 23rd day of May, 2006, Ordered that oral argument on defendant's motion to strike juror is scheduled for the 24th day of July, 2006, at 9:00 a.m. before Judge Reilly in Courtroom No. 2. By The Court, /s/ Fredric J. Ammerman, Pres. Judge. 1CC Atty. Johnson | Fredric Joseph Ammerman |

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| EVA JANE HERTLEIN, EDITH M. HERTLEIN, PATSY L. HERTLEIN KIMBLE, FRANK T. HERTLEIN, JR., GLENN R. HERTLEIN, TIMOTHY L. HERTLEIN, LOUISE E. HERTLEIN KIRKWOOD, and G. LEE HERTLEIN, Individually, and as Attorney-in-Fact for the heirs of FRANK T. HERTLEIN and IVY E. HERTLEIN, Plaintiffs, | * | |
| v. | * | No. 06 - - CD |
| RIVER HILL COAL COMPANY, INC., A Pennsylvania corporation, Defendant. | * | |

COMPLAINT

NOW COME the Plaintiffs and by their attorney, James A. Naddeo, Esquire, sets forth the following:

1. That the Plaintiff, Eva Jane Hertlein, is an adult individual who resides in Frenchville, Pennsylvania.

2. That the Plaintiff, Edith M. Hertlein, is an adult individual who resides in Frenchville, Pennsylvania.

3. That the Plaintiff, Patsy L. Hertlein Kimble, is an adult individual who resides in Frenchville, Pennsylvania.

4. That the Plaintiff, Frank T. Hertlein, Jr., is an adult individual who resides at Karthaus, Pennsylvania.

5. That the Plaintiff, Glenn R. Hertlein, is an adult individual who resides at Karthaus, Pennsylvania.

**Clearfield County Court of Common Pleas**

ROA Report

Case: 2003-01268-CD

Current Judge: Fredric Joseph Ammerman

Dennis R. Rhoades, Kimberly Rhoades, Mikayla Rhoades, Estate vs. Mary C. Kruszewski, DuBois Regional Medical Center



Civil Other

| Date | Selected Items | Judge |
|---|---|---|
| 05/24/2006 | Order, NOW, this 24th day of May, 2006, outstanding motions and/or petitions shall be scheduled to be heard on July 24, 2006, at 9:00 a.m. in Courtroom No. 2. Further Ordered that counsel shall present to the Court on or before July 10, 2006 any brief relating to any motions and/or petitions to be argued that day. By The Court, /s/ Fredric J. Ammerman, Pres. Judge. 1CC Attys: Ging, Pribanic, Blasko, Johnson | Fredric Joseph Ammerman |
| 06/02/2006 | Certificate of Service, filed. Service has been made by U.S. mail to all counsel of Record of the order dated May 23, 2006, scheduling argument on the motion to strike juror for July 24, 2006 at 9:00 a.m. before Judge Reilly in Courtroom 2, filed by s/ David R. Johnson Esq. No CC. | Fredric Joseph Ammerman |
| 06/12/2006 | Motion To Compel Records And/Or Subpoena, Filed by s/ John W. Blasko, Esquire No CC | Fredric Joseph Ammerman |
| | Order AND NOW, this 7th day of June, 2006, following argument on the Plaintiffs' Motion to Strike Objection to Subpoena and Motion to Reopen Discovery and Compel Answers to Interrogatories, it is the ORDER of this Court that each party provide a proposed Order to the Court by no late than Friday, June 9, 2006 (submission by fax is acceptable), with the proposed Order to presume that the Court may grant the Plaintiffs' Motion. BY THE COURT: /s/ Fredric J. Ammerman, P. Judge. 1CC Attys: Ging, Pribanic, Blasko and D. Johnson. | Fredric Joseph Ammerman |
| 06/16/2006 | Order, NOW, this 14th day of June, 2006, it is the Order of the Court that a settlement conference has been scheduled for Friday, July 14, 2006 at 9:00 a.m. in Courtroom No. 1. (see original). By The Court, /s/ fredric J. Ammerman, Pres. Judge1CC Attys: ging, Pribanic J. Blasko, D. Johnson, Carol Hess, Claims examiner | Fredric Joseph Ammerman |
| 06/19/2006 | Motion to Exclude Scientific Testimony Pursuant to Pa. R.C.P. 207.1 & Request for Hearing Pursuant to Rule 207.1 (a) (3) Prior to Trial. filed by Atty. Ging no cert. copies. | Fredric Joseph Ammerman |
| | Order, NOW, this 16th day of June, 2006, it is Ordered: (see original). By the Court, /s/ Fredric J. Ammerman, Pres. Judge. 1CC Attys: Ging, Pribanic, Blasko, D. Johnson | Fredric Joseph Ammerman |
| 06/20/2006 | Motions of Defendant Dr. Kruszewski, Re: Motion for a Partial Summary Judgment, Motion for Summary Judgment, and Motions in Limine (see orig. for details), filed by s/ John W. Blasko, Esquire. No CC | Fredric Joseph Ammerman |
| | Rule To Show Cause Order, NOW, this 20th day of June, 2006, upon consideration of the Motion of the Plaintiffs to exclude expert testimony at the time of trial, it is Ordered that: A rule is issued upon Respondent, Argument shall be held on July 24, 2006 @ 9:00 a.m. in Courtroom No. 2 of the Clfd. Co. Courthouse, and Notice of the entry of this order shall be provided to all parties by the moving party. by The Court, /s/ Fredric J. Ammerman, Pres. Judge. 4CC Atty. Ging | Fredric Joseph Ammerman |
| 06/22/2006 | Motion To Request Accommodations With Respect to Order of Court Dated June 14, 2006, filed by s/ David R. Johnson, Esquire. No CC | Fredric Joseph Ammerman |

6. That the Plaintiff, Timothy L. Hertlein, is an adult individual who resides at Drifting, Pennsylvania.

7. That the Plaintiff, Louise E. Hertlein Kirkwood, is an adult individual who resides at Karthaus, Pennsylvania.

8. That the Plaintiff, G. Lee Hertlein, is an adult individual who resides at Frenchville, Pennsylvania.

9. That the Plaintiff, G. Lee Hertlein, brings this action individually and as attorney-in-fact for the Plaintiff identified in Paragraphs 1 through 8 hereof all of whom are the sole heirs at law of Frank T. Hertlein and Ivy E. Hertlein. A copy of the Power of Attorney of G Lee Hertlein dated August 30, 1995 is attached hereto as Exhibit "A".

10. That the Defendant, River Hill Coal Company, Inc., is a Pennsylvania corporation having its principal place of business located in Kylertown, Pennsylvania.

11. That Frank T. Hertlein, entered into a Lease Agreement with Leitzinger Bros. Realty Company and Edward Redding dated January 1950 pertaining to certain land and mineral interests of the Cataract Coal Company, Inc., a copy of which Lease is attached hereto as Exhibit "B".

12. That Paragraph (1) of the Lease attached hereto as Exhibit "B" provides in part as follows:

> ALL that tract of land located in Karthaus Township, Clearfield County, Pennsylvania, containing approximately 1500 acres, formerly known as the

Dennis R. Rhoades, Kimberly Rhoades, Mikayla Rhoades Estate vs. Mary C. Kruszewski, DuBois Regional Medical Center

Civil Other

| Date | Selected Items | Judge |
|---|---|---|
| 06/26/2006 | Motion To Modify June 16, 2006 Order of Court, filed by s/ Victor H. Pribanic, Esquire. 2CC Atty. Pribanic | Fredric Joseph Ammerman |
| | Order NOW, this 23rd day of June 2006, in consideration of the Motion to Request Accommodations with Respect to order of Court dated June 14, 2006. filed on behalf of DuBois Regional Medical Center, it is the ORDER of this Court as follows:<br>1. Substitute counsel may appear for David R. Johnson Esquire. Substitute counsel will be fully apprised of all relevant issues, and will have the same ability to participate in settlement discussions as Attorney Johnson;<br>2. An alternate PMSLIC claims representative may appear for the insuance company. The claims representative will appear at the settlement conference in person. The request for a PMSLIC representative to be available only by telephone is denied. BY THE COURT: /s/ Fredric J. Ammerman, P. Judge. 2CC Attys: Johnson, Blasko, Pribanic and Ging. | Fredric Joseph Ammerman |
| | Order, NOW, this 22nd day of June, 2006, it is the Order of the Court that Mary C. Kruszewski, D.O. is excused from attending the scheduled settlement conference on July 14, 2006. 1CC Attys: R. Ging, V. Pribanic, J. Blasko, D. Johnson | Fredric Joseph Ammerman |

Current Judge: Fredric Joseph Ammerman

Dennis R. Rhoades, Kimberly Rhoades, Mikayla Rhoades Estate vs. Mary C. Kruszewski, DuBois Regional Medical Center

Civil Other

| Date | Selected Items | Judge |
|---|---|---|
| 07/06/2006 | Motion In Limine To Preclude Testimony of The Defendant's Experts Dr. William W. Fox, And Dr. Richard Depp, Which Contradicts The Pathologist And Neuropathologist Who Conducted The Autopsy Report, Filed by s/ Robert P. Ging, Jr., Esquire. No CC | Fredric Joseph Ammerman |
| 07/10/2006 | Motion In Limine to Preclude Reference to Circumstances Surrounding Vacum Extraction Delivery, filed by s/ Brad R. Korinski, Esquire. No CC | Fredric Joseph Ammerman |
| | Motion In Limine to Prohibit Plaintiffs From Pursuing Liability Therories At Trial Which Have Not Been In Their Amended Complaint, Filed by s/ Brad R. Korinski, Esquire. No CC | Fredric Joseph Ammerman |
| | Motion In Limine to Preclude Plaintiffs' Expert Dr. Mollick From Offering Any Opinion As To The Nursing Standard of Care, filed by s/ Brad R. Korinski, Esquire. No CC | Fredric Joseph Ammerman |
| | Rule To Show Cause Order, NOW, this 10th day of July, 2006, upon consideration of the Motion in Limine of the Plaintiffs to preclude the testimony of Drs. Depp and Fox on issues relating to pathology and neuropathology, it is Ordered that: A rule is issued upon the Respondent to show cause why the moving party is not entitled to the relief requested; The Respondent shall file an answer to the Motion within 10 days of this date. Argument shall be held on July 24, 2006 @ 9:00 a.m. in Courtroom No. 1. By The Court, /s/ Fredric J. Ammerman, Pres. Judge. 3CC Atty. Ging | Fredric Joseph Ammerman |
| | Joinder in Dr, Kruszewski's Motion in Limine to Preclude Plaintiffs' Ecomonic Loss Expert, filed by s/ David R. Johnson Esq. No CC. | Fredric Joseph Ammerman |
| 07/14/2006 | Response to Plaintiffs' Motion to Exclude Scientific Testimony Pursuant to Pa.R.C.P. 207.1 and a Request for a Hearing Pursuant to Rule 207(a)(b) Prior to Trial, filed by s/ John W. Blasko, Esquire. No CC | Fredric Joseph Ammerman |
| 07/17/2006 | Notice of Service, filed. That the Order of this Court dated July 10, 2006 in the nature of a Rule to Show Cause regarding the Motion in Limine of the Plaintiffs to preclude the testimoney of Drs. Depp and Fox was served on this day, filed by s/ Robert P. Ging Esq. No CC. | Fredric Joseph Ammerman |

CA

IN THE COURT OF COMMON PLEAS

OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES | : | |
| -vs- | : | No. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DUBOIS REGIONAL MEDICAL CENTER | : | |

O R D E R

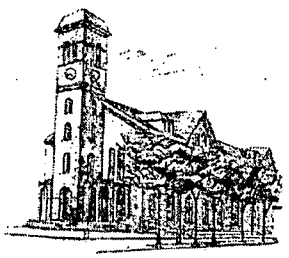
NOW, this 3rd day of January, 2006, it is the ORDER of this Court that this matter shall be continued until the next Call of the List, scheduled for Tuesday, April 4, 2006, with jury selection to be held on Tuesday, May 2, 2006.

BY THE COURT,

President Judge

FILED
01:43 BDL
JAN 04 2006
William A. Shaw
Prothonotary/Clerk of Courts

1CC Attys:
Ging
Pribanic
Blasko
Johnson



# Clearfield County Office of the Prothonotary and Clerk of Courts


**William A. Shaw** Prothonotary/Clerk of Courts
**David S. Ammerman** Solicitor
**Jacki Kendrick** Deputy Prothonotary
**Bonnie Hudson** Administrative Assistant


To: All Concerned Parties

From: William A. Shaw, Prothonotary

It has come to my attention that there is some confusion on court orders over the issue of service. To attempt to clear up this question, from this date forward until further notice, this or a similar memo will be attached to each order, indicating responsibility for service on each order or rule. If you have any questions, please contact me at (814) 765-2641, ext. 1331. Thank you.

Sincerely,

William A. Shaw
Prothonotary

DATE: 11/4/06

_____You are responsible for serving all appropriate parties.

__X__The Prothonotary's office has provided service to the following parties:

__X__Plaintiff(s)/Attorney(s)

__X__Defendant(s)/Attorney(s)

_____Other

_____Special Instructions:

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES<br>individually and as personal representatives<br>of the ESTATE OF MIKAYLA RHOADES,<br>Plaintiffs | * | |
| vs. | * | NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O. and<br>DuBOIS REGIONAL MEDICAL CENTER,<br>Defendants | * | |

**AMENDED ORDER**

NOW, this 3rd day of January, 2006, it is the ORDER of this Court that this matter shall be continued until the next call of the List, scheduled for Tuesday, April 4, 2006, with jury selection to be held on **Thursday, April 27, 2006.**

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge

FILED

JAN 10 2006
01:30 (W
William A. Shaw
Prothonotary/Clerk of Courts

CERT TO ATTY'S
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BLASKO
JOHNSON, D
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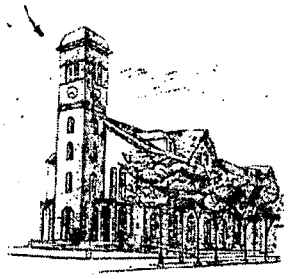

# Clearfield County Office of the Prothonotary and Clerk of Courts


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**David S. Ammerman** Solicitor
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**Bonnie Hudson** Administrative Assistant


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Sincerely,

William A. Shaw
Prothonotary

DATE: 1-10-06

_____You are responsible for serving all appropriate parties.

__X__The Prothonotary's office has provided service to the following parties:

__X__Plaintiff(s)/Attorney(s)

__XX__Defendant(s)/Attorney(s)

_____Other

_____Special Instructions:

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

FILED
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JAN 10 2006
William A. Shaw
Prothonotary/Clerk of Courts
1 cc Attys: Ging
Pribanic
Blasko
S. Johnson

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | * | |
| vs. | * | NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, Defendants | * | |

**ORDER**

NOW, this 9th day of January, 2006, following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule, it is the ORDER of this Court as follows:

1. By no later than March 15, 2006 the Defendants shall have provided all expert reports and discovery in the case shall be completed.

2. The case will be on the civil trial list for call on April 4, 2006.

3. The civil pre-trial conference will be held as per the Court's schedule on April 19, 20, or 21, 2006, as will be determined at civil call.

4. The jury selection will be on April 27, 2006.

5. Jury trial is hereby scheduled for eight (8) days being August 7th through 11th and August 14th, 15th and 16th, 2006, Courtroom No. 1, Clearfield County Courthouse, Clearfield, Pennsylvania.

6. Any mediation of the case shall be conducted at least thirty (30) days prior to the trial date.

7. Any party filing any motion or petition regarding limitation or exclusion of evidence or testimony to be presented at trial, including but not limited to motions in limine, shall be filed no more than thirty (30) days prior to the trial date.

8. The party's petition or motion shall be accompanied by an appropriate brief. The responding party thereto shall file an answer and submit an appropriate response no later than fifteen (15) days prior to trial.

9. All depositions which are to be used for trial purposes shall be completed no later than forty (40) days prior to the commencement of trial or the same will not be available for use at trial. A copy of the transcript of any such deposition shall be provided to opposing counsel within no more than ten (10) days following completion of the deposition.

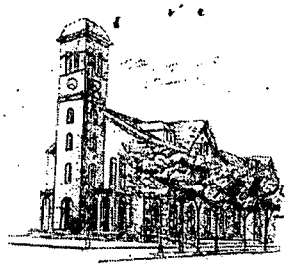
10. Any party making objections relative to testimony provided by a witness in the form of a deposition at the time of trial shall submit the objections to the Court, in writing, no later than thirty (30) days prior to commencement of trial. All objections shall reference specific page and line numbers within the deposition in question along with party's brief relative to same. The opposing party shall submit a brief in opposition to the objections no later than fifteen (15) days prior to the commencement of trial.

11. At the time of jury selection, the Plaintiffs shall have four pre-emptory challenges, Dr. Kruszewski shall have two pre-emptory challenges and DRMC shall have two pre-emptory challenges.

12. Plaintiff's Motion to Preclude Filing of Additional Expert Reports to Preclude Expert Testimony of Dr. Mary Kruszewski is withdrawn.

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge



# Clearfield County Office of the Prothonotary and Clerk of Courts


**William A. Shaw** Prothonotary/Clerk of Courts
**David S. Ammerman** Solicitor
**Jacki Kendrick** Deputy Prothonotary
**Bonnie Hudson** Administrative Assistant


To: All Concerned Parties

From: William A. Shaw, Prothonotary

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Sincerely,

William A. Shaw
Prothonotary

DATE: 11/10/06

_____You are responsible for serving all appropriate parties.

__X__The Prothonotary's office has provided service to the following parties:

__X__Plaintiff(s)/Attorney(s)

__X__Defendant(s)/Attorney(s)

_____Other

_____Special Instructions:

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Supplemental Answers to Plaintiffs' First Set of Interrogatories Directed to Dr. Kruszewski , in the above-referenced matter were sent via facsimile and Federal Express, this 13th day of March, 2006, to:

**Original:**
Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

**Copy:**
David R. Johnson, Esquire
1010 Two Chatham Center
Pittsburgh, PA 15219

McQUAIDE, BLASKO, SCHWARTZ,
FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.

FILED no cc
m/1:53 BK
MAR 14 2006

William A. Shaw
Prothonotary/Clerk of Courts

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03–1268–CD

TYPE OF PLEADING:
**NOTICE OF SERVICE OF INTERROGATORIES TO DR. KRUSZEWSKI & REQUEST FOR PRODUCTION OF DOCUMENTS**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

FILED
MAR 29 2006
m/12:55/cw
William A. Shaw
Prothonotary/Clerk of Courts
no c/c

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF SERVICE OF INTERROGATORIES TO DR. KRUSZEWSKI & REQUEST FOR PRODUCTION OF DOCUMENTS**

TO: WILLIAM SHAW, PROTHONOTARY

Please take notice that Plaintiffs served Defendant Kruszewski with Interrogatories & Request for Production of Documents on March 27, 2006.

Respectfully submitted,

Robert P. Ging, Jr., Esquire

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Service of Interrogatories was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

FILED
MAR 29 2006
M/ 12:55(W)
William A. Shaw
Prothonotary/Clerk of Courts
No C/C

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

Plaintiffs intend to serve a subpoena identical to the one that is attached to this Notice. You have twenty (20) days from the date listed below in which to file a record and serve upon the undersigned an objection to the subpoena. If no objection is made the subpoena may be served.

DATED: March 31, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**COMMONWEALTH OF PENNSYLVANIA**
**CLEARFIELD COUNTY**

Dennis R. Rhoades
Kimberly Rhoades
Mikayla Rhoades, Estate
Plaintiff(s)
Vs.
Mary C. Kruszewski
DuBois Regional Medical Center
Defendant(s)

No. 2003-01268-CD

SUBPOENA TO ATTEND AND TESTIFY

TO: William W. Fox, M.D.
411 Penn Valley Road
Narberth, PA 19072

1. You are ordered by the Court to come to (See attached Addendum to Subpoena.)
(Specify Courtroom or other place)
at _____ County, Pennsylvania, on _____ at _____
o'clock, __ M., to testify on behalf of _____
_____ in the
above case, and to remain until excused.

2. And bring with you the following: See attached Addendum to Subpoena.

If you fail to attend or to produce the documents or things required by this subpoena, you may be subject to the sanctions authorized by Rule 234.5 of the Pennsylvania Rules of Civil Procedure, including but not limited to costs, attorney fees and imprisonment.

ISSUED BY A PARTY/COUNSEL IN COMPLIANCE WITH PA.R.C.P. No. 234.2(a)

NAME: Robert P. Ging, Jr., Esquire
ADDRESS: 2095 Humbert Road
Confluence, PA 15424-2371
TELEPHONE: (814) 395-3661
SUPREME COURT ID # 25459

BY THE COURT:

William A. Shaw
Prothonotary/Clerk, Civil Division

Deputy

DATE: Wednesday, December 10, 2003
Seal of the Court

OFFICIAL NOTE: This form of subpoena shall be used whenever a subpoena is issuable, including hearings in connection with depositions and before arbitrators, masters, commissioners, etc. in compliance with PA.R.C.P. No. 234.1 . If a subpoena for production of documents, records or things is desired, complete Paragraph 2.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ADDENDUM TO SUBPOENA**

TO: WILLIAM W. FOX, M.D.

Within twenty (20) days after the service of the attached Subpoena you are Ordered by the Court to produce the following documents or things:

1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

These documents shall be produced at the Law Office of Robert P. Ging, Jr., 2095 Humbert Road, Confluence, Pennsylvania 15424.

You may deliver or mail legible copies of the documents or produce things requested by this Subpoena, together with the Certificate of Compliance to the party making this request at the address listed above. You have the right to seek in advance the reasonable costs of preparing the copies or

producing the things sought. If you fail to produce the documents or things required by this Subpoena within twenty (20) days after its service, the party serving the Subpoena may seek a Court Order compelling you to comply with it. The Subpoena was issued at the request of the following person: Robert P. Ging, Jr., Pa. Supreme Court Id. 25459, 2095 Humbert Road, Confluence, Pennsylvania 15424, (814) 395-3661, attorney for the Plaintiffs.

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Intent was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 31, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

FILED
MAR 29 2006
m/12:55(W)
William A. Shaw
Prothonotary/Clerk of Courts
no c/c

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF INTENT TO SERVE**
**A SUBPOENA TO PRODUCE DOCUMENTS & THINGS**
**FOR DISCOVERY PURSUANT TO RULE 4009.21**

Plaintiffs intend to serve a subpoena identical to the one that is attached to this Notice. You have twenty (20) days from the date listed below in which to file a record and serve upon the undersigned an objection to the subpoena. If no objection is made the subpoena may be served.

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**COMMONWEALTH OF PENNSYLVANIA**
**CLEARFIELD COUNTY**

Dennis R. Rhoades
Kimberly Rhoades
Mikayla Rhoades, Estate
Plaintiff(s)
Vs. No. 2003-01268-CD
Mary C. Kruszewski
DuBois Regional Medical Center
Defendant(s)

SUBPOENA TO ATTEND AND TESTIFY

TO: O. Richard Depp, III
1280 Clubhouse Road
Gladwin, PA 19025

1. You are ordered by the Court to come to (See attached Addendum to Subpoena)

(Specify Courtroom or other place)
at _____ County, Pennsylvania, on _____ at _____
o'clock, __ M., to testify on behalf of _____
_____ in the
above case, and to remain until excused.

2. And bring with you the following: See attached Addendum to Subpoena.

If you fail to attend or to produce the documents or things required by this subpoena, you may be subject to the sanctions authorized by Rule 234.5 of the Pennsylvania Rules of Civil Procedure, including but not limited to costs, attorney fees and imprisonment.

ISSUED BY A PARTY/COUNSEL IN COMPLIANCE WITH PA.R.C.P. No. 234.2(a)

NAME: Robert P. Ging, Jr., Esquire
ADDRESS: 2095 Humbert Road
Confluence, PA 15424-2371
TELEPHONE: (814) 395-3661
SUPREME COURT ID # 25459

BY THE COURT:

William A. Shaw
Prothonotary/Clerk, Civil Division

Deputy

DATE: Wednesday, December 10, 2003
Seal of the Court

OFFICIAL NOTE: This form of subpoena shall be used whenever a subpoena is issuable, including hearings in connection with depositions and before arbitrators, masters, commissioners, etc. in compliance with PA.R.C.P. No. 234.1 . If a subpoena for production of documents, records or things is desired, complete Paragraph 2.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ADDENDUM TO SUBPOENA**

TO: RICHARD DEPP, M.D.

Within twenty (20) days after the service of the attached Subpoena you are Ordered by the Court to produce the following documents or things:

1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

These documents shall be produced at the Law Office of Robert P. Ging, Jr., 2095 Humbert Road, Confluence, Pennsylvania 15424.

You may deliver or mail legible copies of the documents or produce things requested by this Subpoena, together with the Certificate of Compliance to the party making this request at the address listed above. You have the right to seek in advance the reasonable costs of preparing the copies or

producing the things sought. If you fail to produce the documents or things required by this Subpoena within twenty (20) days after its service, the party serving the Subpoena may seek a Court Order compelling you to comply with it. The Subpoena was issued at the request of the following person: Robert P. Ging, Jr., Pa. Supreme Court Id. 25459, 2095 Humbert Road, Confluence, Pennsylvania 15424, (814) 395-3661, attorney for the Plaintiffs.

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Intent was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
Objections to Subpoena Per Rule 4009.21

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for
Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED NO CC
m/ 1:28 BH
APR 07 2006
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**OBJECTIONS TO SUBPOENA, PER RULE 4009.21, FILED BY DEFENDANT, MARY C. KRUSZEWSKI, D.O.**

Defendant, Mary C. Kruszewski, D.O. by and through her attorneys, McQuaide, Blasko objects to Plaintiffs' proposed subpoenas to this Defendant's expert witnesses. In support of her objections, Defendant avers as follows:

1. This is a medical malpractice action wherein Plaintiffs allege that the negligence of the Defendants caused the death of the baby, Mikayla Rhoades.

2. On March 27, 2006, Plaintiffs' counsel served a Notice of Intent to Serve Subpoenas and proposed subpoenas upon the Defendant's expert witnesses: Richard Depp, M.D., and William W. Fox, M.D.

3. Plaintiffs are proposing to serve subpoenas directly upon the Defendant's expert witnesses.

4. Attached to the proposed subpoenas is an addendum, demanding that Doctors Depp and Fox each produce the following items:

(1) Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

(2) Any and all reports which you have prepared for defense counsel, insurance companies and/or attorneys in personal injury cases over the past five years.

(3) Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

5. The Defendant objects to the proposed subpoenas on several bases:

- The proposed subpoenas violate Pa.R.C.P. 4003.5 in terms of the scope of information sought and the means by which the information is sought (by subpoena);

- The proposed subpoenas violate Pa.R.C.P. 4003.5 in that same would include discovery of expert reports in cases where the physicians were consulted but were not anticipated to testify at trial;

- The proposed subpoenas are overly broad and compliance therewith would be unduly burdensome;

- The proposed subpoenas are not reasonably calculated to lead to the discovery of relevant evidence;

- The proposed subpoenas would potentially require the physicians to reveal confidential and protected medical information from other cases;

- The proposed subpoenas violate Pa.R.C.P. 4011 in that same would cause unreasonable annoyance, oppression, burden and expense to the expert witnesses.

6. All of the information sought exceeds the scope of permissible expert discovery as delineated by Pa.R.C.P. 4003.5. Pursuant to this rule, a party may inquire through interrogatories about the identity of a trial expert, as well as the substance of the facts and opinions to which he is expected to testify. Pa.R.C.P. 4003.5(a)(1).

7. Reports of these experts have already been provided and therefore, Plaintiffs have been apprized of their identities and the substance of their anticipated trial testimony.

8. Plaintiffs' attempt to obtain any and all 1099 forms related to personal injury litigation and reports to counsel or insurance companies is beyond the scope of this rule. The request for "all letters, memos, or articles" about medical malpractice is likewise outside the scope of Rule 4003.5.

9. The subpoenas to expert witnesses is *per se* in violation of Rule 4003.5. This Rule does not provide for discovery of information about an expert by way of subpoena served directly upon the expert witness. The Rule provides for expert discovery only through interrogatories. Pa.R.C.P. 4003.5(a)(1).

10. Only by way of an order of court, issued upon good cause shown, may a party obtain further expert discovery through other means. Pa.R.C.P. 4003.5(a)(2). Plaintiffs have not sought an order of court seeking further discovery by other means, i.e., a subpoena served directly upon an expert. Furthermore, any such effort would be fruitless, given that there can be no good cause shown in support of disclosure to the extent sought by the proposed subpoenas.

11. Rule 4003.5(a) applies only to experts who are anticipated to testify at trial. Pa.R.C.P. 4003.5(a)(3). The request for any and all reports which these physicians prepared in personal injury cases over the last five years is so broad as to include cases where the doctors may have been retained as consultants only and who were not trial witnesses.

12. The proposed subpoenas are overly broad. Plaintiffs seek all 1099 forms from and reports to any insurance companies or attorneys within the past five years. The requests are not limited to this case, nor are the requests limited to work done for defendants in litigation.

13. The request for "any and all letters, memos, or articles" on the subject of medical malpractice is likewise overly broad. As stated, an informal e-mail to a colleague about the malpractice crisis in this state would be included, as would any writings by these doctors to their own malpractice carriers on the subject of their own insurance coverage.

14. The proposed subpoenas are not reasonably calculated to lead to the discovery of admissible evidence. Expert reports to attorneys (for the plaintiff or the defense) in other cases and tax forms related to involvement in personal injury cases (for the plaintiff or the defense) are not relevant. A letter or memo by an expert "on the subject of medical malpractice" is likewise irrelevant to this case.

15. Disclosure of reports from other cases could also potentially lead to the disclosure of confidential medical information about patients involved in cases which are totally collateral to the instant case.

16. Finally, the Defendant submits that these proposed subpoenas violate Rule 4011's prohibition of discovery which would cause unreasonable annoyance, oppression, burden or expense.

17. Pennsylvania has traditionally asserted tight control over the scope and means of discovery concerning an opponent's expert. Unlike many other states, discovery depositions of expert witnesses are not permitted unless good cause is shown, and this virtually never happens.

18. Plaintiffs' attempt to bypass the Rules of Civil Procedure by directly subpoenaing information from the Defendant's expert is improper and should not be countenanced by this Court.

WHEREFORE, Defendant, Mary C. Kruszewski, D.O., objects to Plaintiffs' subpoenas to Richard Depp, M.D., and William W. Fox, M.D., and demands that Plaintiffs refrain from attempting to serve the aforementioned subpoenas consistent with Pennsylvania Rule of Civil Procedure 4009.21(d)(1).

McQUAIDE BLASKO

By: _____

ALLEN P. NEELY
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814) 238-4926

Dated: 4-6-06

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| | ) | NO. 03-1268 CD |
| Plaintiffs, | ) | JURY TRIAL DEMANDED |
| vs. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

CERTIFICATE OF SERVICE

I hereby certify that the Objections to Subpoena Per Rule 4009.21 of Defendant Mary C. Kruszewski, D.O., in the above-referenced matter were mailed by regular mail, first class, at the Post Office, State College, Pennsylvania, postage prepaid, this 6th day of April, 2006 to:

***Regular Mail and Via Facsimile***
Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

***Copy***
David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

***Copy***
Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

FILED
APR 07 2006
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
Answers and Objections to Interrogatories
Responses and Objections to Request for Production of Documents

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED NO CC
APR 07 2005
11:28 BH
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

CERTIFICATE OF SERVICE

I hereby certify that the Answers and Objections to Interrogatories and Responses and Objections to Request for Production of Documents directed to Defendant Mary C. Kruszewski, D.O., in the above-referenced matter were mailed by regular mail, first class, at the Post Office, State College, Pennsylvania, postage prepaid, this 6th day of April, 2006 to:

***Original***
Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

***Copy***
David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

***Copy***
Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

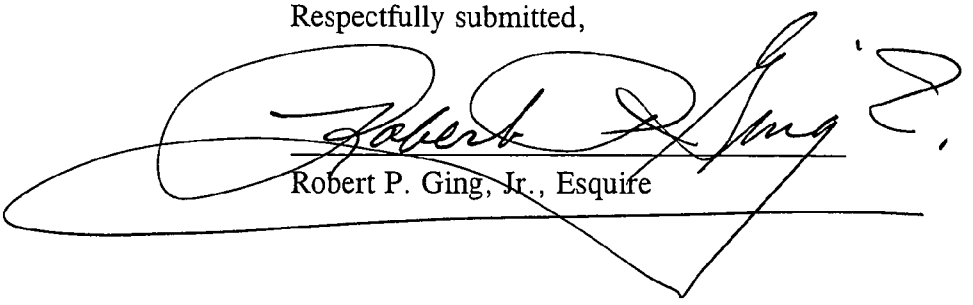
| | |
|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | MEDICAL PROFESSIONAL LIABILITY ACTION |
| VS. | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | TYPE OF PLEADING: **MOTION TO STRIKE THE OBJECTIONS TO THE SUBPOENA PURSUANT TO RULE 4009.21** |
| | FILED ON BEHALF OF: Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades |
| | COUNSEL OF RECORD: |
| | ROBERT P. GING, JR., ESQUIRE<br>SUPREME CT. No. 25459<br>2095 Humbert Road<br>Confluence, PA 15424-2371<br>(814) 395-3661 |
| | VICTOR H. PRIBANIC, ESQUIRE<br>SUPREME CT. No. 30785<br>1735 Lincoln Way<br>White Oak, PA 15131<br>(412) 672-558 |

FILED
02:53/01 NO CC
APR 20 2006
William A. Shaw
Prothonotary/Clerk of Courts

# NOTICE TO PLEAD

Please take notice that the attached pleading may require a response to be made by you, so as to protect your rights. Please file a responsive pleading in the time and manner provided by law.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03–1268–CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**RULE TO SHOW CAUSE**

**ORDER**

AND NOW this _____ day of _____, 2006, upon consideration of the foregoing Motion, it is hereby Ordered that:

(1) a rule is issued upon the respondent to show cause why the moving party is not entitled to the relief requested;

(2) the respondent shall file an answer to the Motion within ____days of this date;

(3) the Motion shall be decided under Pa.R.C.P. 206.7; and

(4) notice of the entry of this Order shall be provided to all parties by the moving party.

BY THE COURT

_____

Frederic J. Ammerman, President Judge

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03–1268–CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**MOTION TO STRIKE THE OBJECTIONS TO THE SUBPOENA PURSUANT TO RULE 4009.21**

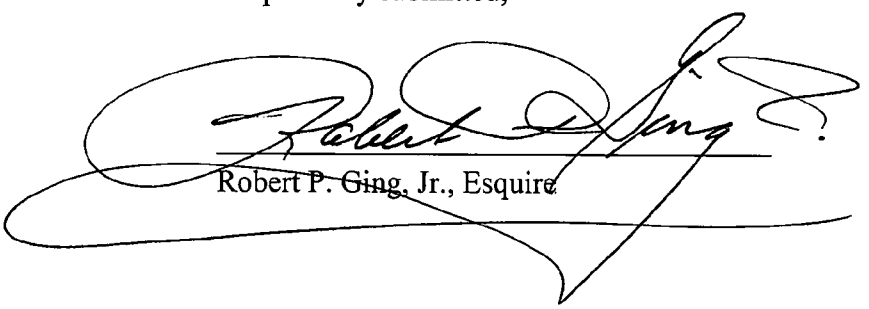
AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and set forth the following Motion to Strike the Objections to the Subpoena.

The Plaintiffs incorporate herein by reference the argument made in their Brief in Support of their Motion for Sanctions. Additionally Rule 4003.5(a)(2) indicates that "upon cause shown the Court may order further discovery by other means, subject to such restrictions as to scope and such provisions as the Court may deem appropriate.

As indicated in the Plaintiffs' Brief in Support of the Motion for Sanctions the Superior Court has ruled that the very information objected to is discoverable, and if the Defendant continues to refuse to respond to Interrogatories and Request for Production of Documents, the Court may allow

service of a Subpoena pursuant to Rule 4009.21. Additionally, Plaintiffs could not have propounded companion Interrogatories and Request for Production prior to close of discovery since the identity of Defendant's experts were not disclosed until March 14, 2006.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Motion to Strike the Objections was served on the following parties on this date via hand delivery.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: April 30, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

FILED

APR 20 2006

William A. Shaw
Prothonotary/Clerk of Courts

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | |
|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | CASE NO. 03–1268–CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | TYPE OF PLEADING: **MOTION TO REOPEN DISCOVERY & COMPEL ANSWERS TO INTERROGATORIES** |
| | FILED ON BEHALF OF: Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades |
| | COUNSEL OF RECORD: |


ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

VICTOR H. PRIBANIC, ESQUIRE
SUPREME CT. No. 30785
1735 Lincoln Way
White Oak, PA 15131
(412) 672-558

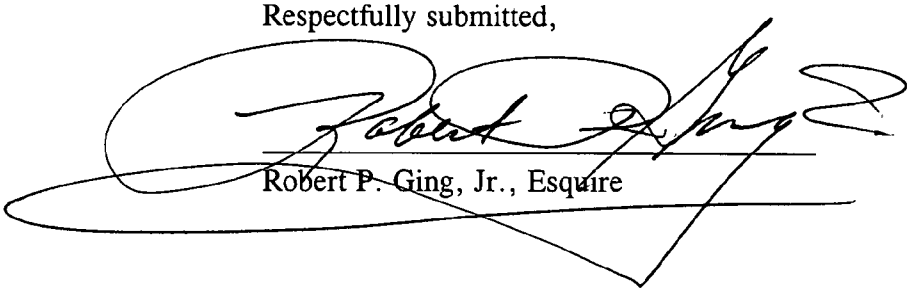


FILED NO CC
01:53 BH
APR 20 2006
William A. Shaw
Prothonotary/Clerk of Courts

# NOTICE TO PLEAD

Please take notice that the attached pleading may require a response to be made by you, so as to protect your rights. Please file a responsive pleading in the time and manner provided by law.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03–1268–CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**RULE TO SHOW CAUSE**

**ORDER**

AND NOW this _____ day of _____, 2006, upon consideration of the foregoing Motion, it is hereby Ordered that:

(1) a rule is issued upon the respondent to show cause why the moving party is not entitled to the relief requested;

(2) the respondent shall file an answer to the Motion within ____days of this date;

(3) the Motion shall be decided under Pa.R.C.P. 206.7; and

(4) notice of the entry of this Order shall be provided to all parties by the moving party.

BY THE COURT

_____

Frederic J. Ammerman, President Judge

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03–1268–CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**MOTION TO REOPEN DISCOVERY**
**&**
**TO COMPEL ANSWERS TO INTERROGATORIES**

AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and set forth the following Motion to Reopen Discovery & to Compel Answers to Interrogatories pursuant to Rule 4019 of the Pennsylvania Rules of Civil Procedure.

1. The Defendant's expert reports in the above captioned case were required to be served on or before March 15, 2006.

2. The date of Dr. Depp's report was March 8, 2006 and Dr. Fox's report was dated March 7, 2006.

3. The expert reports were received in the office of counsel for the Plaintiffs March 14, 2006, in the afternoon.

4. Plaintiffs diligently served Interrogatories and Request for Production of Documents upon

upon the Defendant Mary C. Kruszewski, shortly after receipt of the Defendants expert reports. The identity of Drs. Fox and Depp had not been disclosed prior to March 14,2006.

5. On or about April 6, 2006 Defendant filed Answers and Objections to Interrogatories, Responses and Objections to the Request for Production of Documents. A true and correct copy of the Answers and Objections to the Interrogatories and Request for Production of Documents is attached hereto and incorporated herein by reference as if fully set forth.

6. Defendant objected to each and every Interrogatory and Request for Production of Documents, using largely boiler plate language as the basis for the objection.

7. Rule 4019 allows the Court to make an appropriate Order of a party fails to serve answers, sufficient answers, or objections to written Interrogatories under Rule 4005.

8. The matters inquired into by the Plaintiffs in the Interrogatories and Request for Production of Documents do not exceed the scope of permissible discovery, are not broad and unduly burdensome, and are reasonably calculated to lead to the discovery of relevant evidence. See *J.S. and C.S. vs. Whetzel.* 2004 Pa. Super. 406; 860 A.2d 1112.

9. Counsel for the Plaintiffs conferred with counsel for the Defendant and he was uncooperative.

WHEREFORE, the Court is requested to enter the attached Order.

Respectfully submitted,

Robert P. Ging, Jr., Esquire

# ATTACHMENT

APR 10 2006

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
Answers and Objections to Interrogatories
Responses and Objections to Request for Production of Documents

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for
Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

***ANSWERS AND OBJECTIONS TO INTERROGATORIES DIRECTED TO DEFENDANT***

1. Has Dr. O. Richard Depp, III testified or consulted for any defense counsel, insurance companies and/or attorneys in personal injury cases in the last five [5] years?

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome;
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

2. Please identify each and every attorney, insurance company, or defense counsel for whom O. Richard Depp, III has testified within the last five [5] years?

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

3. Has Dr. William W. Fox testified or consulted for any defense counsel, insurance companies and/or attorneys in personal injury cases in the last five [5] years?

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

4. Please identify each and every attorney, insurance company, or defense counsel for whom William W. Fox has testified within the last five [5] years.

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

McQUAIDE, BLASKO
FLEMING & FAULKNER, INC.

BY _____
JOHN W. BLASKO
ALLEN P. NEELY
Counsel for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814)238-4926

Dated: 4/6/06

***RESPONSES AND OBJECTIONS TO REQUEST FOR PRODUCTION OF DOCUMENTS OF DEFENDANT, MARY C. KRUSZEWSKI, D.O.***

Pursuant to Pa.R.C.P. 4009.11 you are hereby requested to produce for inspection and copying the documents set forth below:

1. Any and all reports prepared by Dr. O. Richard Depp, III in the last five years, related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome;
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence; and
(4) This Interrogatory would potentially require the disclosure of confidential and protected medical information from other cases.

ALLEN P. NEELY

2. Copies of the IRS 1099 Form issued to Dr Depp for professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

3. Any and all letters, documents, or articles authored by O. Richard Depp, III related to medical malpractice.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

4. Any and all reports prepared by Dr. William W. Fox in the last five years, related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome;
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence; and
(4) This Interrogatory would potentially require the disclosure of confidential and protected medical information from other cases.

ALLEN P. NEELY

5. Copies of IRS 1099 Form issued to Dr. Fox for professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

6. Any and all letters, documents, or articles authored by William W. Fox related to medical malpractice.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

McQUAIDE, BLASKO
FLEMING & FAULKNER, INC.

BY _____
JOHN W. BLASKO
ALLEN P. NEELY
Counsel for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814)238-4926

Dated: 4-6-06

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

CERTIFICATE OF SERVICE

I hereby certify that the Answers and Objections to Interrogatories and Responses and Objections to Request for Production of Documents directed to Defendant Mary C. Kruszewski, D.O., in the above-referenced matter were mailed by regular mail, first class, at the Post Office, State College, Pennsylvania, postage prepaid, this 6th day of April, 2006 to:

***Original***
Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

***Copy***
David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

***Copy***
Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ORDER**

AND NOW, to wit, this _____ day of _____, 2006, it is hereby Ordered that discovery is reopened for a limited time and that Mary C. Kruszewski shall file full and complete answers to the Interrogatories and Request for Production of Documents attached to Plaintiffs' Motion, without objection, within thirty (30) days hereof. In the event that Mary C. Kruszewski fails to file full and complete answers to the Interrogatories and Request for Production of Documents, it is hereby Ordered that Dr. Oren Richard Depp, III and Dr. William W. Fox shall be precluded from testifying at the trial of this case.

BY THE COURT

_____

Frederic J. Ammerman, President Judge

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Motion to Reopen Discovery & Compel Answers to Interrogatories was served on the following parties on this date via hand delivery.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: April 20, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

LA

FILED
0/9:50 cm
APR 24 2006
William A. Shaw
Prothonotary

Atty R. Ging
Atty Blasko
Atty D. Johnson
Atty V. Pribanic

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs
vs.
MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

NO. 03-1268-CD

**ORDER**

NOW, this 21st day of April, 2006, following Pre-Trial Conference with counsel for the parties as set forth above, it is the ORDER of this Court as follows:

1. Jury Selection will be held on **April 27, 2006** commencing at **9:00 a.m.** in Courtroom No. 1 of the Clearfield County Courthouse, Clearfield, Pennsylvania.

2. Jury Trial is hereby scheduled for **August 7, 8, 9, 10, 11, 14, 15, and 16, 2006** commencing at **9:00 a.m.** in Courtroom No. 1 of the Clearfield County Courthouse, Clearfield, Pennsylvania.

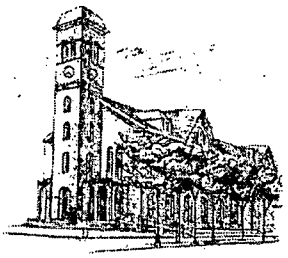
3. Any party making objections relative the testimony to be provided by any witness in the form of a deposition at the time of Trial shall submit said objections to the Court, in writing, no later than thirty (30) days prior to the commencement of Trial. All objections shall reference specific page and line numbers within the deposition(s) in question, along with that party's brief relative same. The opposing party shall submit its brief in opposition to said objections no later than fifteen (15) days prior to the commencement of Trial.

4. Any party filing any Motion or Petition regarding limitation or exclusion of evidence or testimony to be presented at time of trial, including but not limited to Motions in Limine, shall file the same no more than thirty (30) days prior to the trial

date. The party's Petition or Motion shall be accompanied by an appropriate brief. The responding party thereto shall file its Answer and submit appropriate response brief no later than fifteen (15) days prior to trial.

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge



# Clearfield County Office of the Prothonotary and Clerk of Courts


**William A. Shaw** Prothonotary/Clerk of Courts
**David S. Ammerman** Solicitor
**Jacki Kendrick** Deputy Prothonotary
**Bonnie Hudson** Administrative Assistant


To: All Concerned Parties

From: William A. Shaw, Prothonotary

It has come to my attention that there is some confusion on court orders over the issue of service. To attempt to clear up this question, from this date forward until further notice, this or a similar memo will be attached to each order, indicating responsibility for service on each order or rule. If you have any questions, please contact me at (814) 765-2641, ext. 1331. Thank you.

Sincerely,

William A. Shaw
Prothonotary

DATE: 04-24-06

---

_____You are responsible for serving all appropriate parties.

__X__The Prothonotary's office has provided service to the following parties:

__X__Plaintiff(s)/Attorney(s)

__X__Defendant(s)/Attorney(s)

_____Other

_____Special Instructions:

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES )
individually and as personal representatives )
of the ESTATE OF MIKAYLA RHOADES,)
)
Plaintiffs,
)
vs.
)
MARY C. KRUSZEWSKI, D.O. and )
DUBOIS REGIONAL MEDICAL )
CENTER,
)
)
Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:

Answer of Defendant Mary C. Kruszewski, D.O. to Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for
Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED
m 19:38 BN
APR 27 2006
William A. Shaw
Prothonotary/Clerk of Courts

I hereby certify this to be a true and attested copy of the original statement filed in this case.
APR 27 2006
Attest.
Prothonotary/
Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiffs,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,)<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

**ANSWER OF DEFENDANT MARY C. KRUSZEWSKI, D.O. TO PLAINTIFFS' MOTION TO STRIKE THE OBJECTIONS TO THE SUBPOENA PURSUANT TO RULE 4009.21**

AND NOW, comes Defendant Mary C. Kruszewski, D.O. by and through her attorneys, McQuaide, Blasko, Fleming & Faulkner, Inc., and files the following Answer to Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21, and in support thereof avers as follows:

1. As a preliminary issue, Plaintiffs' "Motion to Strike the Subpoena Pursuant to Rule 4009.21" does not comply with the procedural and substantive requirements for Motions which are set forth in Pennsylvania and Clearfield County law. The "Motion" fails to set forth with particularity, the material facts constituting grounds for relief and is not written in a numbered paragraph format which would allow for a precise coherent response. See, Pa. R.C.P. 208.2; 46 J.D.R.C.P 208.3(a)(1)(C)-(D). Rather, Plaintiffs' attempt to avoid drafting a complete Motion by merely incorporating by reference arguments raised in their Brief in Support of Motion to Reopen Discovery and Compel Answers to Interrogatories.

2. Despite Plaintiffs' failure to comply with the above referenced Rules of Civil Procedure, Answering Defendant will attempt address the substance of the argument, as best understood by the Defendant. Plaintiffs' Motion appears to raise two grounds for why, after the expiration of Court-ordered discovery deadlines, they should be permitted to serve Defendant's experts with subpoenas which seek the following information:

> "1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.
> 2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.
> 3. Any and all letter, memos, or articles which you have authored on the subject of medical malpractice within the last five years."

See, Notices of Intent to Serve a Subpoena to Produce Documents & Things for Discovery Pursuant to Rule 4009.21 and Addendum to Subpoena attached hereto collectively as Exhibit "A". Plaintiffs' assertions are denied by the Answering Defendant. See also, Order dated January 9, 2006 attached hereto as Exhibit "B" setting a discovery deadline of March 15, 2006.

3. First, Plaintiffs claim that "the very information objected to is discoverable" under Superior Court precedent. It is specifically denied that the Superior Court case cited by the Plaintiffs within their supporting brief permits blanket discovery of the three categories of documents requested within Plaintiffs' proposed subpoena. Compare, J.S. and C.S. v. Whetzel, 2004 PA Superior 406; 860 A.2d 1112 (2004); with, Exhibit "A".

4. Importantly, Plaintiffs do not dispute the vast majority of the objections raised within Defendant's Objection to Subpoenas. Namely, that the Subpoenas with respect to the requested reports, letters, memos, and/or articles are overly broad, not calculated to lead to the discovery of admissible evidence, seek the disclosure of confidential medical information about

patients unrelated to this case, and violate Rule 4011 as causing an unreasonable annoyance, oppression, burden or expense. Rather, within their Motion they only contend that Plaintiffs are entitled to certain 1099 forms of the Defense experts.

5. Secondly, it is denied that the Plaintiffs "could not have propounded companion Interrogatories and Requests for Production prior to close of discovery since the identity of Defendant's experts were not disclosed until March 14, 2006." As set forth at length in Defendant's New Matter within the Answer to Plaintiffs' Motion to Reopen Discovery and Compel Answer to Interrogatories, the discovery request sought could easily have been submitted before the expiration of the discovery deadline. Plaintiffs did not require the specific names of the experts in order to fashion and serve timely discovery. Plaintiffs' unilateral failure to diligently perform discovery within the deadline is not a sufficient reason to reopen discovery.

In sum, Plaintiffs' two Notices of Intent to Serve a Subpoena were filed without leave of Court after the expiration of the Court Ordered deadline to complete discovery and seek information which is outside the scope of permissible discovery, and therefore, Plaintiffs' Motion to Strike the Objections to the Subpoena should be denied.

WHEREFORE, Defendant Kruszewski requests that Plaintiffs' Motion to Strike Objections to the Subpoena Pursuant to Rule 4009.21 be denied.

McQUAIDE BLASKO

Date: April 26, 2006

By: _____
ALLEN P. NEELY
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814) 238-4926

COPY

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

Plaintiffs intend to serve a subpoena identical to the one that is attached to this Notice. You have twenty (20) days from the date listed below in which to file a record and serve upon the undersigned an objection to the subpoena. If no objection is made the subpoena may be served.

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

COMMONWEALTH OF PENNSYLVANIA
CLEARFIELD COUNTY

Dennis R. Rhoades
Kimberly Rhoades
Mikayla Rhoades, Estate
Plaintiff(s)
Vs.
Mary C. Kruszewski
DuBois Regional Medical Center
Defendant(s)

No. 2003-01268-CD

SUBPOENA TO ATTEND AND TESTIFY

TO: O. Richard Depp, III
1280 Clubhouse Road
Gladwin, PA 19025

1. You are ordered by the Court to come to (See attached Addendum to Subpoena)

(Specify Courtroom or other place)
at _____ County, Pennsylvania, on _____ at _____
o'clock, __ M., to testify on behalf of _____
_____ in the
above case, and to remain until excused.

2. And bring with you the following: See attached Addendum to Subpoena.

If you fail to attend or to produce the documents or things required by this subpoena, you may be subject to the sanctions authorized by Rule 234.5 of the Pennsylvania Rules of Civil Procedure, including but not limited to costs, attorney fees and imprisonment.

ISSUED BY A PARTY/COUNSEL IN COMPLIANCE WITH PA.R.C.P. No. 234.2(a)

NAME: Robert P. Ging, Jr., Esquire
ADDRESS: 2095 Humbert Road
Confluence, PA 15424-2371
TELEPHONE: (814) 395-3661
SUPREME COURT ID # 25459

BY THE COURT:

William A. Shaw
Prothonotary/Clerk, Civil Division

Deputy

DATE: Wednesday, December 10, 2003
Seal of the Court

OFFICIAL NOTE: This form of subpoena shall be used whenever a subpoena is issuable, including hearings in connection with depositions and before arbitrators, masters, commissioners, etc. in compliance with PA.R.C.P. No. 234.1 . If a subpoena for production of documents, records or things is desired, complete Paragraph 2.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ADDENDUM TO SUBPOENA**

TO: RICHARD DEPP, M.D.

Within twenty (20) days after the service of the attached Subpoena you are Ordered by the Court to produce the following documents or things:

1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

These documents shall be produced at the Law Office of Robert P. Ging, Jr., 2095 Humbert Road, Confluence, Pennsylvania 15424.

You may deliver or mail legible copies of the documents or produce things requested by this Subpoena, together with the Certificate of Compliance to the party making this request at the address listed above. You have the right to seek in advance the reasonable costs of preparing the copies or

producing the things sought. If you fail to produce the documents or things required by this Subpoena within twenty (20) days after its service, the party serving the Subpoena may seek a Court Order compelling you to comply with it. The Subpoena was issued at the request of the following person: Robert P. Ging, Jr., Pa. Supreme Court Id. 25459, 2095 Humbert Road, Confluence, Pennsylvania 15424, (814) 395-3661, attorney for the Plaintiffs.

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Intent was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

COPY

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | |
|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | |
| VS. | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | |
| | TYPE OF PLEADING: **NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21** |
| | FILED ON BEHALF OF: Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades |
| | COUNSEL OF RECORD: |
| | ROBERT P. GING, JR., ESQUIRE<br>SUPREME CT. No. 25459<br>2095 Humbert Road<br>Confluence, PA 15424-2371<br>(814) 395-3661 |

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF INTENT TO SERVE**
**A SUBPOENA TO PRODUCE DOCUMENTS & THINGS**
**FOR DISCOVERY PURSUANT TO RULE 4009.21**

Plaintiffs intend to serve a subpoena identical to the one that is attached to this Notice. You have twenty (20) days from the date listed below in which to file a record and serve upon the undersigned an objection to the subpoena. If no objection is made the subpoena may be served.

DATED: March 31, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

COMMONWEALTH OF PENNSYLVANIA
CLEARFIELD COUNTY

Dennis R. Rhoades
Kimberly Rhoades
Mikayla Rhoades, Estate
Plaintiff(s)
Vs.
Mary C. Kruszewski
DuBois Regional Medical Center
Defendant(s)

No. 2003-01268-CD

SUBPOENA TO ATTEND AND TESTIFY

TO: William W. Fox, M.D.
411 Penn Valley Road
Narberth, PA 19072

1. You are ordered by the Court to come to (See attached Addendum to Subpoena.)
(Specify Courtroom or other place)
at _____ County, Pennsylvania, on _____ at _____
o'clock, __ M., to testify on behalf of _____
in the above case, and to remain until excused.

2. And bring with you the following: See attached Addendum to Subpoena.

If you fail to attend or to produce the documents or things required by this subpoena, you may be subject to the sanctions authorized by Rule 234.5 of the Pennsylvania Rules of Civil Procedure, including but not limited to costs, attorney fees and imprisonment.

ISSUED BY A PARTY/COUNSEL IN COMPLIANCE WITH PA.R.C.P. No. 234.2(a)

NAME: Robert P. Ging, Jr., Esquire
ADDRESS: 2095 Humbert Road
Confluence, PA 15424-2371
TELEPHONE: (814) 395-3661
SUPREME COURT ID # 25459

BY THE COURT:

William A. Shaw
Prothonotary/Clerk, Civil Division

Deputy

DATE: Wednesday, December 10, 2003
Seal of the Court

OFFICIAL NOTE: This form of subpoena shall be used whenever a subpoena is issuable, including hearings in connection with depositions and before arbitrators, masters, commissioners, etc. in compliance with PA.R.C.P. No. 234.1 . If a subpoena for production of documents, records or things is desired, complete Paragraph 2.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ADDENDUM TO SUBPOENA**

TO: WILLIAM W. FOX, M.D.

Within twenty (20) days after the service of the attached Subpoena you are Ordered by the Court to produce the following documents or things:

1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

These documents shall be produced at the Law Office of Robert P. Ging, Jr., 2095 Humbert Road, Confluence, Pennsylvania 15424.

You may deliver or mail legible copies of the documents or produce things requested by this Subpoena, together with the Certificate of Compliance to the party making this request at the address listed above. You have the right to seek in advance the reasonable costs of preparing the copies or

producing the things sought. If you fail to produce the documents or things required by this Subpoena within twenty (20) days after its service, the party serving the Subpoena may seek a Court Order compelling you to comply with it. The Subpoena was issued at the request of the following person: Robert P. Ging, Jr., Pa. Supreme Court Id. 25459, 2095 Humbert Road, Confluence, Pennsylvania 15424, (814) 395-3661, attorney for the Plaintiffs.

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Intent was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 31, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

Exhibit B

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

I hereby certify this to be a true and attested copy of the original statement filed in this case.

JAN 10 2006

Attest.

Prothonotary/
Clerk of Courts

DENNIS R. and KIMBERLY RHOADES *
individually and as personal representatives *
of the ESTATE OF MIKAYLA RHOADES, *
Plaintiffs *
vs. * NO. 03-1268-CD
MARY C. KRUSZEWSKI, D.O. and *
DuBOIS REGIONAL MEDICAL CENTER, *
Defendants *

**ORDER**

NOW, this 9th day of January, 2006, following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule, it is the ORDER of this Court as follows:

1. By no later than March 15, 2006 the Defendants shall have provided all expert reports and discovery in the case shall be completed.

2. The case will be on the civil trial list for call on April 4, 2006.

3. The civil pre-trial conference will be held as per the Court's schedule on April 19, 20, or 21, 2006, as will be determined at civil call.

4. The jury selection will be on April 27, 2006.

5. Jury trial is hereby scheduled for eight (8) days being August 7th through 11th and August 14th, 15th and 16th, 2006, Courtroom No. 1, Clearfield County Courthouse, Clearfield, Pennsylvania.

6. Any mediation of the case shall be conducted at least thirty (30) days prior to the trial date.

7. Any party filing any motion or petition regarding limitation or exclusion of evidence or testimony to be presented at trial, including but not limited to motions in limine, shall be filed no more than thirty (30) days prior to the trial date.

8. The party's petition or motion shall be accompanied by an appropriate brief. The responding party thereto shall file an answer and submit an appropriate response no later than fifteen (15) days prior to trial.

9. All depositions which are to be used for trial purposes shall be completed no later than forty (40) days prior to the commencement of trial or the same will not be available for use at trial. A copy of the transcript of any such deposition shall be provided to opposing counsel within no more than ten (10) days following completion of the deposition.

10. Any party making objections relative to testimony provided by a witness in the form of a deposition at the time of trial shall submit the objections to the Court, in writing, no later than thirty (30) days prior to commencement of trial. All objections shall reference specific page and line numbers within the deposition in question along with party's brief relative to same. The opposing party shall submit a brief in opposition to the objections no later than fifteen (15) days prior to the commencement of trial.

11. At the time of jury selection, the Plaintiffs shall have four pre-emptory challenges, Dr. Kruszewski shall have two pre-emptory challenges and DRMC shall have two pre-emptory challenges.

12. Plaintiff's Motion to Preclude Filing of Additional Expert Reports to Preclude Expert Testimony of Dr. Mary Kruszewski is withdrawn.

BY THE COURT,

/s/ Fredric J. Ammerman

FREDRIC J. AMMERMAN
President Judge

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| | ) | NO. 03-1268 CD |
| Plaintiffs, | ) | JURY TRIAL DEMANDED |
| vs. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that Answer of Defendant Mary C. Kruszewski, D.O. to Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21 in the above-referenced matter was served via hand delivery this 27th day of April, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiff, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**ORDER**

AND NOW, this _____ day of_____, 2006, upon consideration of Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21 and upon consideration of Defendant's Response, it is hereby ORDERED that Plaintiffs' Motion is DENIED.

BY THE COURT:

_____
J.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:

Answer of Defendant Mary C. Kruszewski, D.O. to Plaintiffs' Motion to Reopen Discovery and to Compel Answers to Interrogatories

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED
m/9:38/6TT
APR 27 2006
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiff,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

**ANSWER OF DEFENDANT MARY C. KRUSZEWSKI, D.O. TO PLAINTIFFS' MOTION TO REOPEN DISCOVERY AND TO COMPEL ANSWERS TO INTERROGATORIES**

AND NOW, comes Defendant Mary C. Kruszewski, D.O. by and through her undersigned attorneys, McQuaide, Blasko, Fleming & Faulkner, Inc., and files the following Answer to Plaintiffs' Motion to Reopen Discovery and to Compel Answers to Interrogatories, and in support thereof avers as follows:

1. Admitted.

2. Admitted.

3. Admitted.

4. Denied. To the extent that Plaintiffs allege that they were diligent in serving Interrogatories and Requests for Production that allegation is denied for the reasons hereinafter set forth as New Matter.

5. Admitted.

6. Admitted, except to the extent Plaintiffs allege that the objections were boilerplate language. The objections asserted were in strict conformity with the law of the Commonwealth.

7. Paragraph 7 is a statement of Plaintiffs' legal position to which no response is required. To the extent a response is deemed required all allegations are denied.

8. Denied. It is specifically denied that J.S. and C.S. v. Whetzel, 2004 Pa.Super. 406; 860 A.2d 1112 permits the broad inquires within Plaintiffs' Interrogatories and Request for Production of Documents directed to Defendant Mary C. Kruszewski, D.O. Answering Defendant disputes Plaintiffs' contention that J.S and C.S. stands for the proposition that a Plaintiff in a medical malpractice case may seek all of an experts' 1099 forms from work done in any personal injury case regardless of the nature of the current or previous lawsuit. Moreover, the Court in J.S. and C.S. did not directly address whether the financial records of professionals are probative of bias or whether the prejudicial effect on a fair trial (loss of a party's expert who refused to supply his tax information) outweighs any probative value. Moreover, it is specifically denied that J.S. and C.S. allows for discovery of all reports which the expert has prepared for defense counsel, insurance companies and/or attorneys in personal injury cases over the past five years or all letters, memos, or articles which the expert has authored relating to the subject of medical malpractice within the last five years.

9. Denied as stated. Plaintiffs' counsel confirmed with Defendant's counsel as to concurrence in the instant Motion, and, Plaintiffs' counsel was advised that the Motion was inappropriate because pursuant to a Court Order, the deadline for discovery passed on March 15, 2006.

**NEW MATTER**

10. Defendant herein incorporates paragraphs 1 through 9 as if set forth at length.

11. The instant New Matter requests that in addition to entering an Order denying the Plaintiffs' Motion to Reopen Discovery that the Court also enter a Protective Order precluding Plaintiffs from serving any additional discovery requests or subpoenas.

12. Defendant also specifically seeks a Protective Order with respect to Interrogatories, Requests for the Production of Documents, Requests for Admission, and two Notices of Intent to Serve a Subpoena to Produce Documents & Things for Discovery Pursuant to Rule 4009.21 which were served by Plaintiffs on or about March 27, 2006 almost two weeks after the Court-Ordered deadline for completion of discovery in this case.

13. On January 9, 2006, the Court entered a Scheduling Order "following argument of counsel and with the Court having received correspondence from each of the parties' counsel setting forth a proposed schedule." A copy of the Order issued by the Honorable Frederic J. Ammerman is attached hereto and marked Exhibit "A."

14. The Scheduling Order was the result of a December 7, 2005 Status Scheduling Conference. On December 7, 2005, all counsel appeared before the Court, and, the Court requested correspondence concerning each counsel's position concerning deadlines for discovery, motions, and trial.

15. Pursuant to the Court's request, there was voluminous correspondence exchanged concerning scheduling as follows:

(a) Plaintiffs' counsel's letter dated December 8, 2005 together with a proposed order is attached hereto and marked Exhibit "B." The Plaintiffs' proposed order indicated they wanted Defendants to file all reports by January 15, 2006. However, the proposed order and accompanying letter did not allow for Plaintiffs to file rebuttal reports or provide for any discovery deadlines.

(b) On December 12, 2005, Defendant Kruszewski through correspondence provided the Court with a proposed order, a copy of which is attached hereto and marked Exhibit "C." The proposed order proposed, *inter alia*, that by no later than February 28, 2006, Defendants "shall have provided all expert reports and discovery in the case shall be completed."

(c) On December 12, 2005, the Plaintiffs responded to Defendant Kruszewski's proposed scheduling order, a copy of which is attached and marked Exhibit "D." Plaintiffs' counsel did not object to Defendant's suggestion that the discovery deadline be set, nor did Plaintiffs' counsel request leave to file rebuttal reports.

(d) On December 13, 2005, counsel for the Defendant Hospital responded to Plaintiffs' correspondence, a copy of which is attached hereto and marked Exhibit "E."

16. At no time relevant to the negotiation of the scheduling order did the Plaintiffs object to scheduling a deadline for discovery, nor, did the Plaintiffs request a date for filing rebuttal reports.

17. The Court's Order of January 9, 2006 scheduled March 15, 2006 as the time for Defendants to file expert reports and discovery be completed. The Order was served on the Plaintiffs. Plaintiffs never filed an exception or otherwise objected to any of the deadlines set by the Court.

18. The Plaintiffs failed to exercise diligence in pursuing discovery in this matter. Prior to March 15, 2006, Plaintiffs could have-- but did not --file the Interrogatories and Request for Production currently proposed. Plaintiffs have been aware of the need for expert discovery in this matter for the past three (3) years.

19. For example, the Plaintiffs on or about October 1, 2003 filed Interrogatories on Dr. Kruszewski requesting the following:

(a) "41. Please identify each person who you intend to call as expert witness at the time of trial and state the subject matter on which the expert is expected to testify."

(b) "42. Please have each expert identified in the previous answer state the substance of the facts and opinions to which the expert is expected to testify and provide a summary of the grounds for each opinion."

20. The Plaintiffs filed the above Interrogatories without knowing the identity of Defendant's experts. These Interrogatories were "generic," and likewise the Plaintiffs at any time from the filing of this case in September 2003 through March 15, 2006 did not need the name of Defendants' experts to frame the Interrogatories they now seek to propose. For instance, although objectionable, the Plaintiffs could have filed Interrogatories requesting that Defendant's expert "please identify the number of times the expert has testified for or was consulted by defense counsel or for insurance companies." The Interrogatories Plaintiffs now seek are general Interrogatories which could have been proposed without the identity of the experts prior to March 15, 2006, the deadline for discovery.

21. Plaintiffs, by not proposing the generic Interrogatories to experts prior to March 15, 2006, have waived the right. The Court should prohibit the discovery now sought pursuant to Pennsylvania Rule of Civil Procedure 4012 because it is unreasonable, overly burdensome, and in violation of a Court Order.

22. The Court, having entered a scheduling order after argument and correspondence with all counsel, should confirm that order and deny Plaintiffs' request to reopen discovery in that the proposed Interrogatories could have been filed prior to March 15, 2006.

WHEREFORE, Defendant Kruszewski requests that Plaintiffs' Motion to Reopen Discovery and to Compel Answers to Interrogatories be denied.

McQUAIDE BLASKO

Date: April 26, 2006

By: _____

ALLEN P. NEELY
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814) 238-4926

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

I hereby certify this to be a true and attested copy of the original statement filed in this case.

JAN 10 2006

Attest.

Prothonotary/
Clerk of Courts

DENNIS R. and KIMBERLY RHOADES *
individually and as personal representatives *
of the ESTATE OF MIKAYLA RHOADES, *
Plaintiffs *
vs. * NO. 03-1268-CD
MARY C. KRUSZEWSKI, D.O. and *
DuBOIS REGIONAL MEDICAL CENTER, *
Defendants *

**ORDER**

NOW, this 9th day of January, 2006, following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule, it is the ORDER of this Court as follows:

1. By no later than March 15, 2006 the Defendants shall have provided all expert reports and discovery in the case shall be completed.

2. The case will be on the civil trial list for call on April 4, 2006.

3. The civil pre-trial conference will be held as per the Court's schedule on April 19, 20, or 21, 2006, as will be determined at civil call.

4. The jury selection will be on April 27, 2006.

5. Jury trial is hereby scheduled for eight (8) days being August 7th through 11th and August 14th, 15th and 16th, 2006, Courtroom No. 1, Clearfield County Courthouse, Clearfield, Pennsylvania.

6. Any mediation of the case shall be conducted at least thirty (30) days prior to the trial date.

7. Any party filing any motion or petition regarding limitation or exclusion of evidence or testimony to be presented at trial, including but not limited to motions in limine, shall be filed no more than thirty (30) days prior to the trial date.

8. The party's petition or motion shall be accompanied by an appropriate brief. The responding party thereto shall file an answer and submit an appropriate response no later than fifteen (15) days prior to trial.

9. All depositions which are to be used for trial purposes shall be completed no later than forty (40) days prior to the commencement of trial or the same will not be available for use at trial. A copy of the transcript of any such deposition shall be provided to opposing counsel within no more than ten (10) days following completion of the deposition.

10. Any party making objections relative to testimony provided by a witness in the form of a deposition at the time of trial shall submit the objections to the Court, in writing, no later than thirty (30) days prior to commencement of trial. All objections shall reference specific page and line numbers within the deposition in question along with party's brief relative to same. The opposing party shall submit a brief in opposition to the objections no later than fifteen (15) days prior to the commencement of trial.

11. At the time of jury selection, the Plaintiffs shall have four pre-emptory challenges, Dr. Kruszewski shall have two pre-emptory challenges and DRMC shall have two pre-emptory challenges.

12. Plaintiff's Motion to Preclude Filing of Additional Expert Reports to Preclude Expert Testimony of Dr. Mary Kruszewski is withdrawn.

BY THE COURT,

/s/ Fredric J. Ammerman

FREDRIC J. AMMERMAN
President Judge

LAW OFFICE OF:

**ROBERT P. GING, JR., P.C.**
COUNSELOR AND ATTORNEY AT LAW
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

December 8, 2005

Honorable Frederic J. Ammerman
President Judge
Court of Common Pleas of Clearfield County
230 E. Market Street
Clearfield, PA 16830

RE: DENNIS R. AND KIMBERLY RHOADES ET AL. VS.
MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER
CASE NO. 03-1268-CD

Dear Judge Ammerman,

As per your request, we are forwarding a letter regarding proposed scheduling for the above captioned case, as well as a proposed Court Order.

The proposed Court Order contains the deadlines which we feel can be reasonably met by all of the parties in order to bring this matter to trial.

While we are certainly willing to cooperate with other counsel in scheduling this matter, particularly with respect to Mr. Blasko's trip to South Africa, we need to acknowledge that we are all quite busy, and all have numerous trials coming up not only during the current trial term, but during the trial term commencing in May.

While accommodations of other counsel's schedules are important, there is a compelling and overriding need to get this matter to trial.

We feel that the interest of the litigants in obtaining closure and being able to go on with their lives supercedes the desires of counsel to take additional time on this matter.

The proposed Order recognizes the fact that Plaintiffs' expert report has been in the hands of the Defendants for ten months, and we believe that under the proposed Scheduling Order ample time for a review of that report by Dr. Kruszewski's expert is provided.

We have suggested that the case be tried during the weeks of February 21st or 27th based

upon representations as to the availability of counsel made at oral argument.

In the event that the Court is unable to schedule during that time, the case could be scheduled for trial in April, after Mr. Blasko returns from his son's wedding. There will still be two weeks left in the trial term after Mr. Blasko's return. We feel that this would be a fair balance between Mr. Blasko's commitments, and the obvious desires of the Plaintiffs to continue their lives as normally as possible under the circumstances.

We thank you for your courtesy and cooperation in this matter, and appreciate your consideration of Mr. and Mrs. Rhoades with respect to bringing this matter to trial.

Bob Ging

BG/rae
c/Dennis & Kimberly Rhoades
Victor H. Pribanic, Esquire
John W. Blasko, Esquire
David R. Johnson, Esquire

Enclosure

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ORDER**

AND NOW, to wit, this _____day of _____, 2005, the Plaintiffs having filed a Praecipe to list the above captioned case for trial, the Defendants having filed Objections thereto, after argument and consideration of the matter, the following Order is entered:

1. Defendants shall serve any and all expert reports on counsel for the Plaintiffs on or before January 15, 2006.

2. The parties shall file any amended pleadings on or before January 31, 2006.

3. All pre-trial motions shall be filed on or before January 31, 2006.

4. Jury selection shall take place on February 2, 2006.

5. Trial shall commence on February 21, 2006 (or February 27, 2006).

6. Pre-trial conferences will be held on January 19 & 20, 2006. The parties shall submit their pre-trial statements in accordance with Local Rule of Civil Procedure

212.4, however the parties may supplement their pre-trial statements in accordance with this Order should additional expert reports be obtained.

BY THE COURT

Frederic J. Ammerman, President Judge

**MCQUAIDE BLASKO** ATTORNEYS AT LAW

811 University Drive, State College, Pennsylvania 16801-6699 (814) 238-4926 FAX (814) 234-5620
Additional offices in Hershey and Hollidaysburg www.mqblaw.com

December 12, 2005

*Via Facsimile: (814) 765-7649 and Regular Mail*
Honorable Fredric J. Ammerman, P.J.
Clearfield County Courthouse
230 East Market Street
Clearfield, PA 16830

**In Re: Rhoades vs. Kruszewski, et al.**
**Docket No: 03-1268-CD**

Dear Judge Ammerman:

We enclose a proposed Scheduling Order.

This is a 2003 case. The case has never been listed for trial, and, a Scheduling Order has not been previously issued. The case will take at least 7 days to try. I base this, in part, on the witness scheduling. The Plaintiffs have 5 expert witnesses. In addition, to the Plaintiffs' testimony, it is anticipated the Plaintiffs may call 6 lay witnesses who have provided written statements of their observations before, during, and after delivery. The Plaintiffs have also taken depositions of the 7 nurses involved in the delivery and post delivery. There are also 2 doctors in the NICU who may be witnesses. The Defendants will also have the testimony of their clients as well as at least 2 expert witnesses. This gives a potential of 7 expert witnesses, at least 4 treating physicians, 7 nurses, and, the lay witnesses. Under these circumstances it is more realistic to plan for a minimum of 7 trial days.

As I indicated at argument, I am presently scheduled for trial the first week of March in McKean County, and, in June in Lycoming County. Enclosed are copies of the Court Orders scheduling these trials. I also have a pre-paid trip outside the jurisdiction for March 27, 2006 through April 17, 2006.

Scheduling the trial in July or August is only 4 months beyond the trial date requested by the Plaintiffs. However, our proposed scheduling order will provide for an orderly procedure to conclude the case. It is fair to all parties.

MCQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

State College Office: John W. Blasko R. Mark Faulkner David M. Weixel Steven S. Hurvitz James M. Horne Wendell V. Courtney Darryl R. Slimak Mark Righter Daniel E. Bright Paul J. Tomczuk Janine C. Gismondi John A. Snyder April C. Simpson Allen P. Neely Pamela A. Ruest Katherine V. Oliver Katherine M. Allen Wayne L. Mowery, Jr. Chena L. Glenn-Hart Livinia N. Jones Cristin R. Long Matthew T. Rogers Frederick R. Battaglia Anthony A. Simon

Hershey Office: Grant H. Fleming Maureen A. Gallagher Michael J. Mohr Jonathan B. Stepanian Britt D. Russell

Hollidaysburg Office: Thomas M. Reese J. Benjamin Yeager Sean M. Burke

John G. Love (1893-1966) Roy Wilkinson, Jr. (1915-1995) Delbert J. McQuaide (1936-1997)

Similar to the Plaintiffs, our client also wants to conclude the case. Plaintiffs' suggestions that the case be scheduled for February 21, or, after may return on April 17 is unreasonable. There is no way I can return on April 17, 2006, and, go to trial. This is a complex case, requiring extensive preparation. The same is true for the trial in March.

Very truly yours,

McQUAIDE, BLASKO

By: JOHN W. BLASKO

JWB/nls
Enclosure
cc: Robert P. Ging, Jr., Esquire [w/enc.] (*Via Facsimile: (814) 395-5376 and Regular Mail)*
cc: Victor H. Pribanic, Esquire [w/enc.] (*Via Facsimile: (412) 672-3715 and Regular Mail)*
cc: David R. Johnson, Esquire [w/enc.] *(Via Facsimile: (412) 232-3498 and Regular Mail)*

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | Medical Professional Liability Action |
| Defendants. | ) | |

***ORDER***

AND NOW, this _____day of _____, 2005, following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule, it is the Order of this Court as follows:

1. By no later than February 28, 2006, the Defendants shall have provided all expert reports, and, discovery in the case shall be completed.

2. The case will be on the civil trial list for call on April 4, 2006.

3. The civil pre-trial conference will be held as per the Court's schedule on April 19, 20 or 21, 2006.

4. The jury selection will be on April 26, 2006.

5. Jury trial is hereby scheduled for seven (7) days in July or August, 2006 in conformity with the Court's trial schedule.

6. Any mediation of the case shall be conducted at least thirty (30) days prior to the trial date.

7. Any party filing any motion or petition regarding limitation or exclusion of evidence or testimony to be presented at trial, including but not limited to motions in limine, shall be filed no more than thirty (30) days prior to the trial date.

8. The party's petition or motion shall be accompanied by an appropriate brief. The responding party thereto shall file an answer and submit an appropriate response no later than fifteen (15) days prior to trial.

9. All depositions which are to be used for trial purposes shall be completed no later than forty (40) days prior to the commencement of trial or the same will not be available for use at trial. A copy of the transcript of any such deposition shall be provided to opposing counsel within no more than ten (10) days following completion of the deposition.

10. Any party making objections relative to testimony provided by a witness in the form of a deposition at the time of trial shall submit the objections to the Court, in writing, no later than thirty (30) days prior to commencement of trial. All objections shall reference specific page and line numbers within the deposition in question along with party's brief relative to same. The opposing party shall submit a brief in opposition to the objections no later than fifteen (15) days prior to the commencement of trial.

11. At the time of jury selection, the plaintiffs shall have four pre-emptory challenges, Dr. Kruszewski shall have two pre-emptory challenges and DRMC shall have two pre-emptory challenges.

BY THE COURT,

_____

J.

20 OCT 11/3

GRETCHEN STRAUB SMITH, an individual; and GRETCHEN STRAUB SMITH and GARY E. SMITH, as husband and wife,

Plaintiffs

vs.

ROSS HORSLEY, M.D. an individual; and BRADFORD REGIONAL MEDICAL CENTER,

Defendants

IN THE COURT OF COMMON PLEAS OF

McKEAN COUNTY, PENNSYLVANIA

CIVIL DIVISION

NO. 91 CD 2000

**ORDER**

**AND NOW,** this 28th day of October, 2005, jury selection and trial in this matter is hereby scheduled for March 6, 7, 8, 9, 2006, at 9:00 a.m., in Courtroom 1, McKean County Courthouse, Smethport, Pennsylvania.

**BY THE COURT:**

JOANNE L. BLY
COURT ADMINISTRATOR

2005 OCT 31 AM 8:39

10-31-05

I hereby certify the within to be a true & correct copy thereof as filed in the office of the Prothonotary of McKean County, Pennsylvania.

Bonnie Moore Howard
Prothonotary

10-31-05
cc: N. Lorenzo
J. Blasko
T. Buhl

| | |
|---|---|
| Alexis Hippenstiel | : IN THE COURT OF COMMON PLEAS OF |
| | : LYCOMING COUNTY, PENNSYLVANIA |
| Plaintiff | : |
| | : |
| vs. | : NO. 04-00392 |
| SHS, et al. | : |
| | : CIVIL ACTION |
| | : |
| Defendants | : SCHEDULING ORDER |

## AMENDED *SCHEDULING ORDER*

***AND NOW***, upon agreement of the parties, it is ORDERED AND DIRECTED as follows:

1. This is a ✓ JURY _____ NON-JURY _____ ARBITRATION LIMITS case.

2. Case monitoring tracks: ___ NORMAL, ✓ COMPLEX, ___ ADMINISTRATIVE

3. (a) Trial for this case will be in the term of June 5-16, 2006
**Counsel are attached and shall immediately notify witnesses to be available.**
**Jury Selection Dates:** ~~May 1, 2, 9, 12, 2006~~ May 30, 31, 2006

(b) Pre-trial conference dates are: May 2, 9, 12, 2006
The Deputy Court Administrator will schedule the exact date and time by future notice.
**Settlement Conference Dates, if needed:** May 19, 2006

4. The case will be listed for arbitration on or after N/A

5. The cut-off date for discovery will be March 3, 2006

6. Expert reports shall be furnished as follows:
(a) By plaintiff(s) January 20, 2006
(b) By defendant(s) March 3, 2006

7. The cut-off date for dispositive motions, **including motions to exclude expert testimony under PA. R.C.P. 207.1** will be March 17, 2006

8. (a) The parties agree to use an alternative dispute resolution (ADR)? ___YES ___NO
(b) If yes, ADR will be completed by

9. ~~This Order cancels the case scheduling conference which had previously been scheduled for the date of~~

FILED
LYCOMING COUNTY
2005 SEP 27 A 10:
WILLIAM J. BURD
PROTHONOTARY &
CLERK OF COURTS

J. D. Anderson 9/27/05
Dudley N. Anderson, Judge Date

cc: Eileen A. Dgien, Deputy Court Administrator
all counsel on attached page

LAW OFFICE OF:

**ROBERT P. GING, JR., P.C.**
COUNSELOR AND ATTORNEY AT LAW
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

December 12, 2005

Honorable Frederic J. Ammerman
President Judge
Court of Common Pleas of Clearfield County
230 E. Market Street
Clearfield, PA 16830

VIA FACSIMILE
(814) 765-7649

RE: DENNIS R. AND KIMBERLY RHOADES ET AL. VS.
MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER
CASE NO. 03-1268-CD

Dear Judge Ammerman,

I would like to respond to Mr. Blasko's letter and Proposed Scheduling Order.

The letter anticipates a trial which Plaintiffs do not believe reflects a likely scenario. Plaintiffs have filed a number of expert reports, however have not determined who would be called. Likewise, although the Plaintiffs took the deposition of seven of the nurses, not all were involved in the treatment of the baby during critical times.

Likewise, Mr. Blasko should not anticipate that doctors in the NICU are likely to be witnesses for the Plaintiffs.

While I recognize that Blasko and Mr. Johnson both have other trials and vacations planned, the rights of the litigants should be paramount in this matter.

At the very least, if the trial cannot be completed during the current trial term, there would be no reason why it could not be tried in April or May of 2006.

With respect to the Proposed Order, if the Court in fact grants an extension of time, we would appreciate the case being scheduled in April or May rather than July or August as suggested in paragraph 5, and have some questions about being required to provide a copy of the transcript of the depositions to opposing counsel. It is customary that all counsel purchase their own transcripts from the court reporter, and this is not an obligation generally placed on counsel.

While I have no objection to Dr. Kruszewski and DRMC each having two premptory challenges, Dennis R. and Kimberly Rhoades are both Plaintiffs, in their own right, and are Plaintiffs as the personal representatives of the Estate of Mikayla Rhoades.

HONORABLE FREDERIC J AMMERMAN
PRESIDENT JUDGE
COURT OF COMMON PLEAS OF CLEARFIELD CO
December 12, 2005
Page Two

Each party is entitled to four premptory challenges, pursuant to Rule 221.

While we are not necessarily requesting twelve premptory challenges, under the circumstances of the case we believe it would be appropriate to allow the Plaintiffs individually and as personal representatives of the Estate of Mikayla Rhoades a minimum of eight premptory challenges.

I would like to thank you for your anticipated courtesy and cooperation in this matter.

Bob Ging

BG/rae
c/Dennis & Kim Rhoades
Victor Pribanic, Esquire via facsimile
John Blasko, Esquire via facsimile
David Johnson, Esquire via facsimile

ALL-STATE® LEGAL 800-222-0510 ED11 RECYCLED

**THOMSON, RHODES & COWIE, P. C.**

Attorneys At Law

TWO CHATHAM CENTER, TENTH FLOOR
PITTSBURGH, PENNSYLVANIA 15219-3499

*Facsimile (412) 232-3498*
*www.trc-law.com*

Writer's Direct Dial
(412) 316-8662

David R. Johnson

E-mail: drj@trc-law.com

December 13, 2005

Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades vs. Mary C. Kruszewski, D.O. and DuBois Regional Medical Center. In the Court of Common Pleas of Clearfield County, Pennsylvania. Civil Division No. 03-1268 CD. Our File No. 13376.

Honorable Frederic J. Ammerman (via facsimile to 814-765-7649)
President Judge
Court of Common Pleas of Clearfield County
230 E. Market Street
Clearfield, PA 16830

Dear Judge Ammerman:

I write to you for the purpose of expressing my opinion that the scheduling sought by the plaintiffs, as crystallized in Mr. Ging's letter dated December 12, 2005 is totally unrealistic. Trial of this case during the Summer of 2006 will not in any manner impact negatively upon any of the parties. On the other hand, if efforts were undertaken to unnecessarily expedite the trial so as to conflict with one of the attorneys' previously scheduled cases, it would be unfair to that party adversely impacted.

Contrary to the assessment of Mr. Ging, I believe that trial in this case is a likely scenario.

With regard to the issue of peremptory challenges it is my belief, that each party is entitled to 4 peremptory challenges unless there is a unity of interest. There is not a unity of interest between Dr. Kruszewski and the hospital, as evidenced by plaintiff's diverse attacks on each of these defendants. Accordingly, Dr. Kruszewski and the hospital are each entitled to 4 peremptory challenges. Unquestionably, however, there is unity of interest by and among the plaintiffs and the various claims asserted by the plaintiffs. Under no circumstances should the plaintiffs be entitled to more than 4 peremptory challenges.

Thank you.

Very truly yours,

David R. Johnson

DRJ/pko
cc: Robert P. Ging, Jr., Esquire (via e-mail to ging@qcol.net)
Victor H. Pribanic, Esquire (via facsimile to 412-672-3715)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that Answer of Defendant Mary C. Kruszewski, D.O. to Plaintiffs' Motion to Reopen Discovery and to Compel Answers to Interrogatories in the above-referenced matter was served via hand delivery on this the 27th day of April, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By:_____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiff,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

**ORDER**

AND NOW, this _____ day of _____, 2006, upon consideration of Plaintiffs' Motion to Reopen Discovery and Compel Answers to Interrogatories and upon consideration of Defendant's Response, it is hereby ORDERED that Plaintiffs' Motion is DENIED.

BY THE COURT:

_____
J.

cA

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

FILED 4cc
10:43 61 Amy
MAY 03 2006 G.ng
William A. Shaw
Prothonotary/Clerk of Courts

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**RULE TO SHOW CAUSE**

**ORDER**

AND NOW this 3rd day of May, 2006, upon consideration of the foregoing Motion, it is hereby Ordered that:

(1) a rule is issued upon the respondent to show cause why the moving party is not entitled to the relief requested;

(2) the respondent shall file an answer to the Motion within 15 days of this date;

(3) the Motion shall be decided under Pa.R.C.P. 206.7; and

(4) argument shall be held on June 7 2006, at 2:00 P.M in Courtroom No. 1 of the Clearfield County Courthouse, and

(5) notice of the entry of this Order shall be provided to all parties by the moving party.

BY THE COURT

Fred Ammerman

Frederic J. Ammerman, President Judge

FILED

MAY 03 2006

William A. Shaw
Prothonotary/Clerk of Courts

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

MOTION TO STRIKE JUROR

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.


COUNSEL:
Robert P. Ging, Jr., Esquire
Victor H. Pribanic, Esquire
John W. Blasko, Esquire

Counsel of Record for This Party:

David R. Johnson, Esquire
PA I.D. #26409

Thomas B. Anderson, Esquire
PA I.D. #79990

THOMSON, RHODES & COWIE, P.C.
Firm #720
1010 Two Chatham Center
Pittsburgh, PA 15219

(412) 232-3400



FILED
MAY 15 2006
m 12:45
William A. Shaw
Prothonotary/Clerk of Courts
No C/C

MOTION TO STRIKE JUROR

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and files the following motion to strike a juror for the reasons set forth below:

1. Jury selection occurred in this case on April 27, 2006. On May 5, 2006, counsel received a letter from Judge Ammerman dated May 3, 2006, a copy of which is attached hereto as Exhibit A, enclosing a letter from a juror, Jeffrey Parks, a copy of which is attached hereto as Exhibit B.

2. Mr. Parks states in his letter that he does not believe that he would be able to be a fair juror. In the letter, he identifies two reasons, both associated with personal experiences at DuBois Regional Medical Center.

3. Defendant respectfully requests that Mr. Parks be discharged as a juror because of his professed inability to be a fair juror.

4. Separate and apart from the above reason, defendant requests that Mr. Parks be dismissed as a juror for his failure to disclose information at the time of jury selection. Although counsel does not have a transcript available from the voir dire, it is counsel's recollection that jurors were specifically asked whether or not there was anything involved in the circumstances of a child dying shortly after birth at DuBois

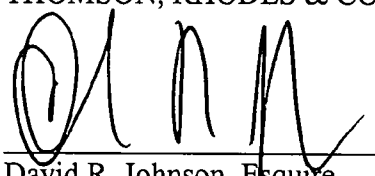
Regional Medical Center that would be so similar to their personal circumstances or those of others in their family, that they could not be a fair and impartial juror. Mr. Parks did not affirmatively respond to that inquiry during voir dire, but, clearly, his letter suggests that he should have answered affirmatively when the above query was posed. Later in the voir dire, it is counsel's recollection that jurors were specifically asked if they had had any of their own children die. Mr. Parks did not answer affirmatively. One juror, who subsequently was stricken by the defendant, answered that question affirmatively. Thus, Mr. Parks should be stricken as a juror because of his failure to disclose the information in his letter in response to direct questions asked of all jurors during voir dire.

5. In addition to the preceding two reasons, Mr. Parks should be stricken as a juror because this defendant would have utilized one of its two strikes to disqualify Mr. Parks as a juror even if he had not been challenged for cause, because his circumstances of having a daughter die shortly after birth are so similar to those involving the plaintiff. In fact, as indicated above, the one juror who answered the voir dire question in a similar fashion was stricken by DRMC.

WHEREFORE, for all of the above reasons, DuBois Regional Medical Center respectfully requests that the court strike Mr. Parks from the jury and replace him with an alternate juror.

Respectfully submitted,

THOMSON, RHODES & COWIE, P.C.



David R. Johnson, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

JUDGE'S CHAMBERS
FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA
CLEARFIELD COUNTY
230 EAST MARKET STREET
CLEARFIELD, PENNSYLVANIA 16830

Received DRJ
COPY
MAY 5 2006
Place ( ) Dictated on ( )
Diary/ Note ( )
Copy to DRJ ( ) Copy Key Doc.( )

FREDRIC J. AMMERMAN
PRESIDENT JUDGE

PAUL E. CHERRY
JUDGE

JOHN K. REILLY, JR.
SENIOR JUDGE

May 3, 2006

Jeffrey L. Parks
689 Woods Hollow Road
West Decatur, PA 16878

Re: Rhoades vs. Kruszewski, et al

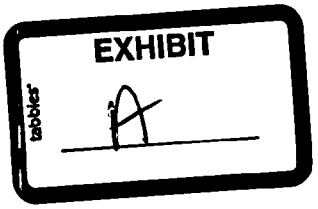
Dear Mr. Parks:

I am in receipt of your letter of May 1, 2006 concerning your request to be removed from the above-captioned medical malpractice case. You are not being excused from the Jury at this time and I think it appropriate to let you know that I am very unhappy with your request and the manner in which you conducted yourself at jury selection on April 27, 2006.

To begin with, you were originally scheduled to appear for jury duty on February 23, 2006 and failed to appear despite receiving notice thereof. It would have been within my discretion to issue a warrant for your arrest and have you brought before the Court. However, due to your letter to us of February 28, 2006 it was determined that you should be given the benefit of the doubt. Therefore, you were summoned to appear for the jury selection on April 27, 2006.

During the selection process, the prospective jurors were asked any number of times as to whether there was anything which would cause them any difficulty whatsoever with the case. However, you failed to indicate that you had any difficulties and did not bring up any of the issues as are set forth in your letter of May 1, 2006. I certainly noticed how disgusted you appeared to be when your name was called as a member of the jury.

Thereafter, during the criminal jury selection it was also clear to me that you were purposefully answering questions in a manner that was calculated to ensure that you were not selected for any further jury service. In any event, you are not being excused from jury duty for the Rhoades trial. However, I will share your letter with the attorneys involved and it is possible that you may be further questioned by counsel and the Court prior to the beginning of trial.




Sincerely,

Fredric J. Ammerman
President Judge

bcc: Letter from Judge Ammerman to Jeffrey Parks

John W. Blasko, Esquire
McQuaide Blaski
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Thomson, Rhodes & Cowie, P.C.
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424

Received DRJ
MAY 5 2006
Place ( ) Discussed on ( )
Diary/ Note ( )
Copy to DRJ ( ) Copy Key Doc.( )

COPY

May 1, 2006
The Office of Judge Ammerman
Clearfield County Court House
230 East Market St.
Clearfield, Pa.16830

Dear Honorable Judge Ammerman,

I am writing to ask you to excuse me from Jury Duty on August 7-16 the "Rhoades vs Krusewski" case, due to the following reasons.

I had a daughter who was born in Philipsburg Hospital in 1987; she was transferred to Dubois Hospital. Seven days later she died at the Dubois Hospital.

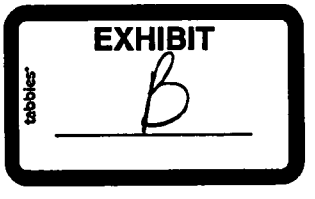
In 1989, I had a son who was born at Dubois Hospital. He stayed for 30 days before coming home. The Physician assured me my son was healthy. Nine months later he still did not reach any milestones. My son has several disabilities.

Given my history with Dubois Physicians and Hospital, I honestly feel if I am a part of this jury I will not be able to be fair.

Sincerely,

Jeffrey L. Parks

Jeffrey L. Parks
689 Woods Hollow Rd.
West Decatur, Pa. 16878
814-553-0578



**CERTIFICATION OF SERVICE**

I hereby certify that a true and correct copy of the within MOTION TO STRIKE JUROR has been served upon the following counsel of record and same placed in the U.S. Mails on this 11th day of May, 2006:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424

Victor H. Pribanic, Esquire
Pribanic & Pribanic
1735 Lincoln Way
White Oak, PA 15131

John W. Blasko, Esquire
McQuaide Blasko Schwartz Fleming & Faulkner, Inc.
811 University Drive
State College, PA 16801

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| | ) | No. 03-1268 CD |
| Plaintiffs, | ) | |
| vs. | ) | |
| MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

ORDER OF COURT

AND NOW, this _____ day of _____, 2006, it is hereby ordered that defendant's motion is granted. Jeffrey Parks is stricken as a juror and is replaced by Alternate No. 1.

BY THE COURT:

_____J.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| | ) | No. 03-1268 CD |
| Plaintiffs, | ) | |
| vs. | ) | |
| MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

ORDER OF COURT

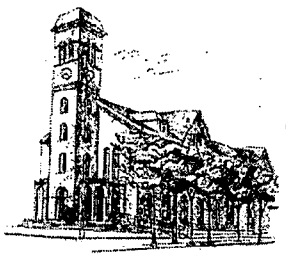
AND NOW on this 23 day of May, 2006, it is hereby ORDERED, ADJUDGED and DECREED that oral argument on defendant's motion to strike juror is scheduled for the 24th day of July, 2006, at 9:00 a.m./p.m. before Judge Reilly in Courtroom No. 2 of the Clearfield County Courthouse.

BY THE COURT:

_____ J.

FILED 1 cc
0/2:36 BOL Atty Johnson
MAY 24 2006 GK

William A. Shaw
Prothonotary/Clerk of Courts



# Clearfield County Office of the Prothonotary and Clerk of Courts


**William A. Shaw** Prothonotary/Clerk of Courts
**David S. Ammerman** Solicitor
**Jacki Kendrick** Deputy Prothonotary
**Bonnie Hudson** Administrative Assistant


To: All Concerned Parties

From: William A. Shaw, Prothonotary

It has come to my attention that there is some confusion on court orders over the issue of service. To attempt to clear up this question, from this date forward until further notice, this or a similar memo will be attached to each order, indicating responsibility for service on each order or rule. If you have any questions, please contact me at (814) 765-2641, ext. 1331. Thank you.

Sincerely,

William A. Shaw
Prothonotary

DATE: 5/24/06

___X___ You are responsible for serving all appropriate parties.

_____ The Prothonotary's office has provided service to the following parties:

_____ Plaintiff(s)/Attorney(s)

_____ Defendant(s)/Attorney(s)

_____ Other

_____ Special Instructions:

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

v.

MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

CASE NO.: 03-1268-CD

**MOTION TO ENLARGE TIME WITHIN WHICH TO CONDUCT TRIAL DEPOSITIONS**

Filed on behalf of Plaintiffs: Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades

Counsel of Record for this Party:

Victor H. Pribanic
Pa. I.D. No.: 30785

PRIBANIC & PRIBANIC, L.L.C.
1735 Lincoln Way
White Oak, PA 15131

(412) 672-5444

**JURY TRIAL DEMANDED**

FILED 2cc
m 1:31 61 Atty Pribanic
MAY 19 2006
GR
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| | ) | CASE NO.: 03-1268-CD |
| Plaintiffs, | ) | |
| v. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**MOTION TO ENLARGE TIME WITHIN WHICH TO CONDUCT TRIAL DEPOSITIONS**

AND NOW, come the Plaintiffs, Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades, by and through their counsel, Victor H. Pribanic and the law firm of Pribanic & Pribanic, L.L.C., and Robert P. Ging, Jr., and file the within Motion to Enlarge Time Within Which to Conduct Trial Depositions, and in support thereof aver as follows:

1. The Plaintiffs are conducting two videotape depositions for use at trial in this matter of Ronald L. Hamilton, M.D. and Sarangarajan Ranganathan, M.D.

2. The only date upon which all counsel are available is June 28, 2006, one (1) day after the Court's forty (40) day limit prior to trial within which deposition testimony must be recorded.

3. All counsel agree to the enlargement of time to accommodate this deposition date.

WHEREFORE, Plaintiffs request that the Court enter an Order allowing the deposition for use at trial of Drs. Hamilton and Ranganathan on June 28, 2006.

Respectfully submitted,

PRIBANIC & PRIBANIC, L.L.C.

By: _____

Victor H. Pribanic
1735 Lincoln Way
White Oak, PA 15131
(412) 672-5444

Counsel for Plaintiffs, Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades

## CERTIFICATE OF SERVICE

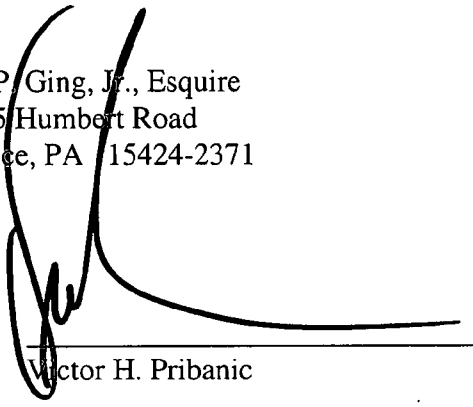
I hereby certify that a true and correct copy of the foregoing has been served via first class United States mail, postage prepaid, this 16th day of May, 2006, upon the following:

Stephen M. Houghton, Esquire
Dickie, McCamey & Chilcote, P.A.
Two PPG Place, Suite 400
Pittsburgh, PA 15222

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371



Victor H. Pribanic

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| Plaintiffs, | ) | CASE NO.: 03-1268-CD |
| v. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**ORDER OF COURT**

AND NOW, to-wit, this 22 day of May, 2006, it is hereby ORDERED that the deposition testimony for use at trial of Ronald L. Hamilton, M.D. and Sarangarajan Ranganathan, M.D. may be recorded on or before June 28, 2006.

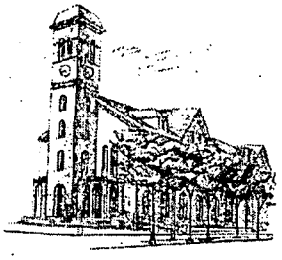
BY THE COURT:

_____, J.

FILED 4cc
01 11:07 BL Atty Pribanic
MAY 22 2006

William A. Shaw
Prothonotary/Clerk of Courts

FILED
MAY 22 2006
William A. Shaw
Prothonotary/Clerk of Courts



# Clearfield County Office of the Prothonotary and Clerk of Courts


**William A. Shaw** Prothonotary/Clerk of Courts
**David S. Ammerman** Solicitor
**Jacki Kendrick** Deputy Prothonotary
**Bonnie Hudson** Administrative Assistant


To: All Concerned Parties

From: William A. Shaw, Prothonotary

It has come to my attention that there is some confusion on court orders over the issue of service. To attempt to clear up this question, from this date forward until further notice, this or a similar memo will be attached to each order, indicating responsibility for service on each order or rule. If you have any questions, please contact me at (814) 765-2641, ext. 1331. Thank you.

Sincerely,

William A. Shaw
Prothonotary

DATE: 5/22/06

__X__ You are responsible for serving all appropriate parties.

_____ The Prothonotary's office has provided service to the following parties:

_____ Plaintiff(s)/Attorney(s)

_____ Defendant(s)/Attorney(s)

_____ Other

_____ Special Instructions:

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**RESPONSE TO THE MOTION TO STRIKE JUROR**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

VICTOR H. PRIBANIC, ESQUIRE
SUPREME CT. No. 30785
1735 Lincoln Way
White Oak, PA 15131
(412) 672-558

FILED
MAY 22 2006
William A. Shaw
Prothonotary/Clerk of Courts

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**RESPONSE TO THE MOTION TO STRIKE JUROR**

AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and set forth the following Response to the Motion to Strike Juror filed on behalf of the DuBois Regional Medical Center.

1. Paragraph 1 is admitted.

2. Paragraph 2 is admitted. Mr. Parks, however, indicated during voir dire that he was not aware of any reason why he could not be a fair and impartial juror, and make a decision based on the law and the evidence.

3. Paragraph 3 is denied. As stated by the Court, in its May 3, 2006 letter, Mr. Parks indicated that he did not have any difficulties being a juror, but rather it became clear to the Court during criminal jury selection that he was answering questions in a manner that was calculated to

ensure he was not selected for any further jury service. Based upon the Court's observations and the lack of responses during voir dire, it is more likely that Mr. Parks simply does not want to spend eight days in a civil jury trial, or to be selected for any further jury service.

4. Paragraph 4 is denied. It is conceded that a transcript is not available, however the specifics of the voir dire are not recalled identically by counsel for the Plaintiffs, as they are by counsel for the DuBois Regional Medical Center. It is unclear that Mr. Parks failed to disclose information in good faith to questions which were directed to the jurors during voir dire.

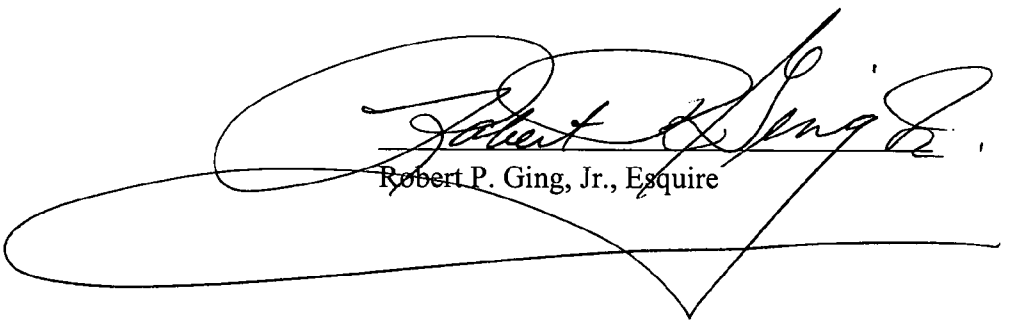
5. Paragraph 5 is denied. DuBois Regional Medical Center states in hindsight it would have stricken Mr. Parks as a juror with a peremptory challenge, had he set forth the information recited in his letter. This may or may not have been the case, as a peremptory challenge to Mr. Parks may have resulted in other challenges by the Defendant, and/or the Plaintiffs. Similarly, the circumstances of having a daughter die shortly after birth are only discussed generally in Mr. Parks' letter, and the actual facts cannot be ascertained from the information set forth therein.

6. The Plaintiffs had requested a challenge for cause as to a former patient of Dr. Kruszewski, however the Court denied the challenge based on the fact that the juror indicated she could be fair and impartial at the time of trial. Plaintiffs believe that the Court's observations and conclusions that Mr. Parks simply does not want to be a juror are the basis for his letter, and that he should not be dismissed. If Mr. Parks is dismissed there will only be thirteen jurors available for the trial in August, and it is conceivable that other jurors may request to be excused from the jury between now and then.

WHEREFORE, Plaintiffs respectfully request that the DuBois Regional Medical Center's

Motion be denied.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Response to the Motion to Strike Juror was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: May 18, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

JA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading: Motion to Join in Motion of DuBois Regional Medical Center to Strike a Juror

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this Party: JOHN W. BLASKO
Court I.D. No.: 06787

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED
MAY 24 2006
m/12:20/cc
William A. Shaw
Prothonotary/Clerk of Courts
no c/c

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiff, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**MOTION TO JOIN IN THE MOTION OF DUBOIS REGIONAL MEDICAL CENTER TO STRIKE A JUROR ON BEHALF OF DEFENDANT MARY C. KRUSZEWSKI, D.O.**

AND NOW, comes Defendant Mary C. Kruszewski, D.O. by and through her undersigned attorneys, McQuaide, Blasko, Fleming & Faulkner, Inc., and joins in the Motion to Strike a Juror, Jeffrey Parks, for the additional reason that in his letter to the Court dated May 1, 2006, he indicates a clear prejudice against a physician who evidently assured him concerning his son's health and subsequent disabilities.

WHEREFORE, for the reasons set forth in the DuBois Regional Medical Center's Motion, as well as the above reason, we request the Court remove and strike Mr. Parks from the jury panel and replace him with an alternate juror.

McQUAIDE BLASKO

Date: May 23, 2006

By: _____
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814) 238-4926

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the **MOTION TO JOIN IN THE MOTION OF DUBOIS REGIONAL MEDICAL CENTER TO STRIKE A JUROR ON BEHALF OF DEFENDANT MARY C. KRUSZEWSKI, D.O.** in the above-referenced matter was served by Regular First Class Mail at State College, Pennsylvania, this 23rd day of May, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY,
PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES | : | |
| vs. | : | |
| MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER | : | No. 03-1268-CD |

**ORDER**

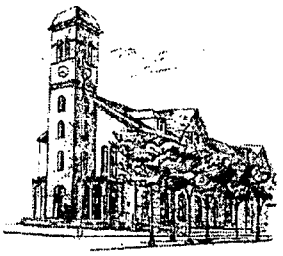
NOW, this 24th day of May 2006, upon the Court's Directive and consistent therewith, it is the ORDER of this Court that counsel shall file with this Court any and all remaining pre-trial motions and/or petitions, forthwith. Said outstanding motions and/or petitions shall be scheduled to be heard on Monday, July 24, 2006, at 9:00 a.m. before the Honorable John K. Reilly, Jr., Senior Judge, specially presiding, in Court Room No. 2 of the Clearfield County Courthouse, Clearfield, PA. It is the FURTHER ORDER of this Court that counsel shall present to the Court on or before July 10, 2006 any brief(s) relating to any motions and/or petitions to be argued that day.

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge

FILED 1cc Attys: Ging, Pribanic, Blasko, Johnson
MAY 24 2006 @ 4:00 BOL
William A. Shaw
Prothonotary/Clerk of Courts

FILED
MAY 24 2006
William A. Shaw
Prothonotary/Clerk of Courts



# Clearfield County Office of the Prothonotary and Clerk of Courts


**William A. Shaw**
Prothonotary/Clerk of Courts

**David S. Ammerman**
Solicitor

**Jacki Kendrick**
Deputy Prothonotary

**Bonnie Hudson**
Administrative Assistant


To: All Concerned Parties

From: William A. Shaw, Prothonotary

It has come to my attention that there is some confusion on court orders over the issue of service. To attempt to clear up this question, from this date forward until further notice, this or a similar memo will be attached to each order, indicating responsibility for service on each order or rule. If you have any questions, please contact me at (814) 765-2641, ext. 1331. Thank you.

Sincerely,

William A. Shaw
Prothonotary

DATE: 5/24/06

_____You are responsible for serving all appropriate parties.

__X__The Prothonotary's office has provided service to the following parties:

__X__Plaintiff(s)/Attorney(s)

__X__Defendant(s)/Attorney(s)

_____Other

_____Special Instructions:

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

CERTIFICATE OF SERVICE

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.


COUNSEL FOR PLAINTIFFS:
Robert P. Ging, Jr., Esquire

AND

Victor H. Pribanic, Esquire

COUNSEL FOR DR. KRUSZEWSKI:
John W. Blasko, Esquire

Counsel of Record for This Party:

David R. Johnson, Esquire
PA I.D. #26409

Thomas B. Anderson, Esquire
PA I.D. #79990

THOMSON, RHODES & COWIE, P.C.
Firm #720
1010 Two Chatham Center
Pittsburgh, PA 15219

(412) 232-3400



FILED NO CC
JUN 02 2006
William A. Shaw
Prothonotary/Clerk of Courts

CERTIFICATE OF SERVICE

Service has been made by U.S. Mail to all counsel of Record of the order dated May 23, 2006, scheduling argument on the motion to strike juror for July 24, 2006 at 9:00 a.m. before Judge Reilly in Courtroom 2, Clearfield County Courthouse.

Respectfully submitted,

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Attorneys for DuBois Regional Medical Center and Russell E. Cameron, two of the defendants.

FILED

JUN 02 2006

William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
MOTION TO COMPEL RECORDS AND/OR SUBPOENA

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this Party: JOHN W. BLASKO
Court I.D. No.: 06787

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED no cc
m/1:50 BK
JUN 12 2006 (GP)

William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

***MOTION TO COMPEL RECORDS AND/OR SUBPOENA***

The Defendant Mary C. Kruszewski, D.O. by and through her undersigned attorney, John W. Blasko moves that the Court enter an Order compelling the Plaintiffs and their experts, James Mollick, M.D., Frederick Gonzales, M.D. and William H. Reed to produce evidence and records of the same information that Defendant, Mary Kruszewski, is required by Order of Court for Dr. O. Richard Depp, III and Dr. William W. Fox.

Date: June 9, 2006

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.

By: _____
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814) 238-4926

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiffs,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the Motion to Compel Records and/or Subpoena in the above-referenced matter was served by via facsimile and first class regular mail, this 9th day of June, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

Derek J Rykaczewski, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
Attorneys for Defendant
Mary C. Kruszewski, D.O.

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES | : | |
| VS. | : | NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER | : | |

O R D E R

AND NOW, this 7th day of June, 2006, following argument on the Plaintiffs' Motion to Strike Objection to Subpoena and Motion to Reopen Discovery and Compel Answers to Interrogatories, it is the ORDER of this Court that each party provide a proposed Order to the Court by no late than Friday, June 9, 2006 (submission by fax is acceptable), with the proposed Order to presume that the Court may grant the Plaintiffs' motions.

BY THE COURT,

President Judge

FILED
9:30 4 BK
JUN 12 2006
William A. Shaw
Prothonotary/Clerk of Courts

Atty: Ging
Pribanic
Blasko
D. Johnson

FILED

JUN 12 2006

William A. Shaw
Prothonotary/Clerk of Courts

DATE: 6/12/06

____ You are responsible for serving all appropriate parties.

__X__ The Prothonotay's office has provided service to the following parties:

____ Plaintiff(s) __X__ Plaintiff(s) Attorney ____ Other

____ Defendant(s) __X__ Defendant(s) Attorney

____ Special Instructions:

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY,
PENNSYLVANIA
CIVIL DIVISION

FILED
02:47 BL
JUN 14 2006
William A. Shaw
Prothonotary/Clerk of Courts

1 cc Attys: Ging
Pribanic
J. Blasko
D Johnson
Carol Hess,
Claims
Examiner
GP

DENNIS R. RHOADES AND KIMBERLY RHOADES, Individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES
vs.
MARY C. KRUSZEWSKI, D.O. AND DUBOIS REGIONAL MEDICAL CENTER:

No. 03-1268-CD

**ORDER**

AND NOW, this 14TH day of June, 2006, it is the ORDER of the Court that a settlement conference in the above-captioned matter has been scheduled for **Friday, July 14, 2006 at 9:00 A.M.** in Courtroom No. 1, Clearfield County Courthouse, Clearfield, PA.

The individual parties reflected in the above caption along with their respective Attorney of Record, named below, shall be required to attend.

1. Robert P. Ging, Esquire;
2. Victor H. Pribanic, Esquire;
3. David R. Johnson, Esquire; and
4. John W. Blasko, Esquire

It is the FURTHER ORDER of this Court that Carol Hess of the MCARE Fund shall appear on behalf of the Commonwealth of Pennsylvania. Defense Counsel will either have full authority to settle or Insurance Company Representatives with full authority to settle shall also be present.

BY THE COURT:

FREDRIC J. AMMERMAN
President Judge

DATE: 6/14/06

William A. Shaw
Prothonotary/Clerk of Courts

_____ You are responsible for serving all appropriate parties.

JUN 14 2006 _X_ The Prothonotary's office has provided service to the following parties:

FILED

_____ Plaintiff(s) _X_ Plaintiff(s) Attorney _X_ Other Carol Hess, Claims Examiner

_____ Defendant(s) _X_ Defendant(s) Attorney

_____ Special Instructions:

## D. Payne

**To:** Rhonda Wisor
**Subject:** Rhoades v. Kruscewski & D.R.M.C.

Contact information for MCARE Fund Representative.

Carol Hess, Claims Examiner
30 North Third Street
8th Floor
Harrisburg, PA 17101
717-783-3770, Ext. 210
MCARE Case No. 03730-B

* Please Serve

Daniel A. Payne, Esquire
Judicial Law Clerk
Clearfield County Court of Common Pleas
230 East Market Street
Clearfield, PA 16830

Phone: 814-765-2641, Ext. 1306
Email: dpayne@clearfieldco.org

CA

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

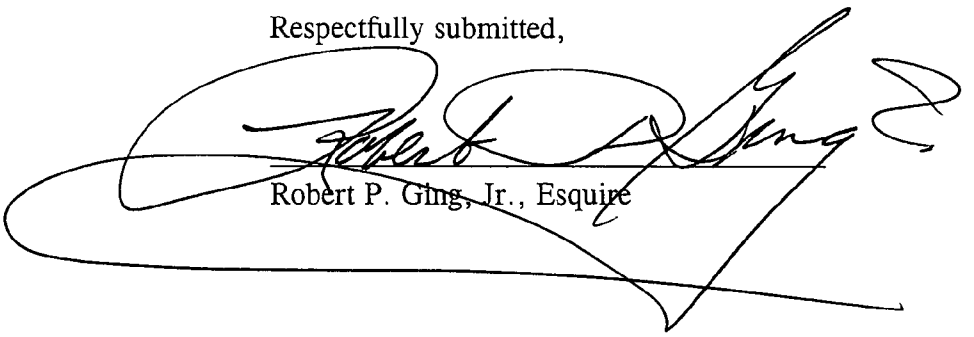
| | |
|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | TYPE OF PLEADING: **MOTION TO EXCLUDE SCIENTIFIC TESTIMONY PURSUANT TO PA. R.C.P. 207.1 & A REQUEST FOR HEARING PURSUANT TO RULE 207.1(a)(3) PRIOR TO TRIAL** |
| | FILED ON BEHALF OF: Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades |
| | COUNSEL OF RECORD: |
| | ROBERT P. GING, JR., ESQUIRE<br>SUPREME CT. No. 25459<br>2095 Humbert Road<br>Confluence, PA 15424-2371<br>(814) 395-3661 |
| | VICTOR H. PRIBANIC, ESQUIRE<br>SUPREME CT. No. 30785<br>1735 Lincoln Way<br>White Oak, PA 15131<br>(412) 672-558 |

FILED
JUN 19 2006
m/ 2:10 lm
William A. Shaw
Prothonotary/Clerk of Courts
No Cert Copies

# NOTICE TO PLEAD

Please take notice that the attached pleading may require a response to be made by you, so as to protect your rights. Please file a responsive pleading in the time and manner provided by law.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**MOTION TO EXCLUDE SCIENTIFIC TESTIMONY PURSUANT TO PA. R.C.P. 207.1 & A REQUEST FOR HEARING PURSUANT TO RULE 207.1(a)(3) PRIOR TO TRIAL.**

AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and file this Motion to Exclude Expert Testimony and Request for a Hearing and in support thereof as follows:

1. The Plaintiffs seek to exclude the testimony of Defendant Mary C. Kruszewski's experts Dr. William Fox, and Dr. Oren Depp.

2. Dr. Depp is believed to be a retired physician, and former professor of obstetrics and gynecology at Drexel University College of Medicine. A copy of Dr. Depp's curriculum vitae is attached hereto as Exhibit 1.

3. Dr. Fox is believed to be a professor of pediatrics at the University of Pennsylvania. A copy of Dr. Fox's curriculum vitae is attached hereto as Exhibit 2.

3. The Defendant Kruszewski has identified Drs. Fox and Depp as expert witnesses who Plaintiffs believe are likely to testify on her behalf, if permitted, at the time of trial. Copies of

their respective expert reports are attached hereto as Exhibits 3 and 4.

4. Neither Dr. Depp nor Dr. Fox were ever treating physicians in this case.

5. Based upon the report of Dr. Fox, dated March 7, 2006, it appears that Dr. Fox reviewed the DuBois Regional Medical Center records of the Plaintiff Kimberly Rhoades, the DuBois Regional Medical Center records of the deceased infant, Mikayla Rhoades, records from Children's Hospital of Pittsburgh, and autopsy reports provided by the Children's Hospital of Pittsburgh.

6. Based upon the report of Dr. Depp, dated March 8, 2006, it appears that he reviewed the prenatal records from the office of Dr. Kruszewski, the maternal admission records of the DuBois Regional Medical Center, FHR records, newborn records at DuBois Regional Medical Center, newborn records at Children's Hospital of Pittsburgh, the autopsy report of the infant Mikayla Rhoades, depositions, including the deposition of Richard Grout, the neonatologist at the DuBois Regional Medical Center, and various expert reports.

7. Dr. James Mollick is a medical doctor, licensed in the Commonwealth of Pennsylvania, and also Board certified by the American College of Obstetrics and Gynecology. Dr. Mollick has been identified as an expert who may present testimony on behalf of the Plaintiffs. A copy of Dr. Mollick's curriculum vitae is attached hereto as Exhibit 5.

8. At the request of the Plaintiffs, Dr. Mollick has reviewed the reports of Dr. Depp, and Dr. Fox, to determine whether the methodology used in reaching the opinions of these medical doctors is generally accepted in the medical community. Based upon a review of the reports of Dr. Depp, and Dr. Fox, available medical literature, and the code of professional ethics of the American College of Obstetrics & Gynecology related to presentation of expert testimony Dr.

Mollick has prepared a report, and has determined that the methodology used by Drs. Depp and Fox to reach the hypotheses set forth in their reports is not a methodology generally accepted by the medical community to formulate opinions. (A copy of that report is attached hereto as Exhibit 6.) The conclusions reached by Drs. Depp and Fox are "novel science" to the extent that the conclusions are unsupported by facts in the medical records and were reached after employing a methodology not generally acceptable in the medical community.

9. In his report, Dr. Mollick identifies the appropriate American College of Obstetrics & Gynecology standards of professional ethics, which require that before offering testimony an obstetrician-gynecologist must thoroughly review the medical facts of the case and all available relevant information. Likewise, the physician must respond accurately to questions about the range of the standard of care and available scientific evidence. (Mollick report, p.2)

10. Dr. Mollick found that Dr. Depp did not comply with this standard, in that he did not thoroughly evaluate the medical records and all available relevant information. Dr. Mollick found that the methodology used by Dr. Depp to reach his conclusions was not consistent with the standards required by the American College of Obstetrics & Gynecology and not generally acceptable by the medical community.

11. Dr. Mollick found that the etiology of maternal tachycardia is extensive, and that there is no scientific evidence in the information reviewed by the defense experts that in the clinical situation underlying this case that the patient was tachycardic due to infection.

12. Dr. Mollick found that there was no scientific evidence in the records reviewed by Dr. Depp which supported Dr. Depp's hypothesis, and that both the existing fetal monitor records and literature support the opinions of all the treating physicians in this case that Mikayla Rhoades

was progressively iatrogenically asphyxiated.

13. A keystone of Dr. Depp's report and hypothesis is based on what he describes in a table on page 5 of his report as an "arterial" cord gas of 7.13, being the result of a cord gas test taken at the DuBois Regional Medical Center shortly after Mikayla's birth.

14. As stated in Dr. Mollick's report, there is nothing contained in the record which indicates the specific site, artery or vein, from which the cord gas sample was obtained. Dr. Mollick also references the deposition testimony of the employee of DuBois Regional Medical Center who conducted the cord gas test, who testified that she was unable to determine whether it was a venous or arterial cord gas.

15. Dr. Mollick also references the deposition of Dr. Grout, the neonatologist at the DuBois Regional Medical Center who attended Mikayla shortly after her birth, who testified it is not always known whether the sample comes from the cord artery or the cord vein, but rather, that the technician usually tries to obtain the sample from the vein.

16. Due to the fact that Dr. Depp failed to consider the clear record from the DuBois Regional Medical Center, as well as the deposition testimony of the technician who conducted the cord gas test, and the neonatologist who attended Mikayla, Dr. Mollick determined that Dr. Depp failed to thoroughly review the medical facts of the case, and all available relevant information, and failed to respond accurately to the available scientific evidence, contrary to the American College of Obstetrics & Gynecology code of professional ethics for testifying experts.

17. In addition, Dr. Mollick has opined, with a reasonable degree of medical certainty that Dr. Depp's analysis and methodology was not a generally accepted scientific practice. On page 18 of Dr. Mollick's report, he provides a list of 11 different items found in the records, which

Dr. Depp ignored in reaching his opinion.

18. Dr. Mollick also found that in providing opinions contrary to the autopsy report, which was performed by pathologists at Children's Hospital of Pittsburgh, that both Dr. Fox and Dr. Depp rendered opinions outside of their fields of expertise.

19. Likewise, in offering opinions contrary to those of the pathologist, Dr. Depp offers opinions contrary to the findings of the neonatologist at DuBois Regional Medical Center and Children's Hospital who treated Mikayla Rhoades. Dr. Depp is an obstetric gynecologist, and not a neonatologist.

20. Dr. Depp's opinions, which largely ignore the entire clinical record, and contradicts specialists in other fields who actually treated Mikayla Rhoades, are outside of his field of expertise, and would be precluded by Pa.R.E. 702.

21. In reviewing the report of Dr. Fox, Dr. Mollick determined that he also ignored the facts of the case, including the autopsy report which was performed by a pathologist.

22. Dr. Mollick goes to great lengths to point out that there is no evidence in the records which support the opinions of Drs. Depp and Fox that Mikayla Rhoades suffered septic shock, or had sepsis, and that essentially these hypotheses by the Defendant's experts were made without any basis in the existing medical records. There is no evidence in the medical records that either Kim or Mikayla Rhoades had an infection or sepsis.

23. The Supreme Court of Pennsylvania in *Grady vs. Frito Lay*, 839 A.2d 1038 (Pa. 2003)indicated that under the "Frye Rule", that the Courts will require and continue to require that the proponent of evidence prove that the methodology of an expert used is generally accepted by scientists in the relevant field as a method for arriving at the conclusion the expert will testify

to at trial.

24. The methodology used by the Defendant's experts in this case largely ignores all of the evidence contained in the medical records and depositions, and is not generally accepted in the medical community as providing the basis for the type of hypothesis proffered by the Defendant's experts.

25. Even assuming hypothetically that the conclusions reached by the Defendant's experts are correct, since the opinions are so contrary to the facts as contained in the medical record, and the depositions, the opinions would not be admissible under Rule 702 and 703 of the Pennsylvania Rules of Civil Procedure.

26. The proponent of scientific evidence bears the burden of establishing all of the elements for its admission under Pa.R.E. 702, which includes a showing that the Frye Rule is satisfied.

27. The Supreme Court of Pennsylvania ruled in *Grady vs. Frito Lay,* that whether a witness is qualified to render opinions and whether his testimony passes the Frye test are two distinct inquiries that must be raised and developed separately by the parties, and ruled upon by the trial court.

28. Rule 207.1 of the Pennsylvania Rules of Civil Procedure sets forth the framework in which a Motion to Exclude Expert Testimony which relies upon novel scientific evidence is to be addressed by the Courts of Common Pleas.

29. Rule 207.1(a)(3) invites the Court to initially review the Motion to determine, if in the interest of justice, the matters should be addressed prior to trial.

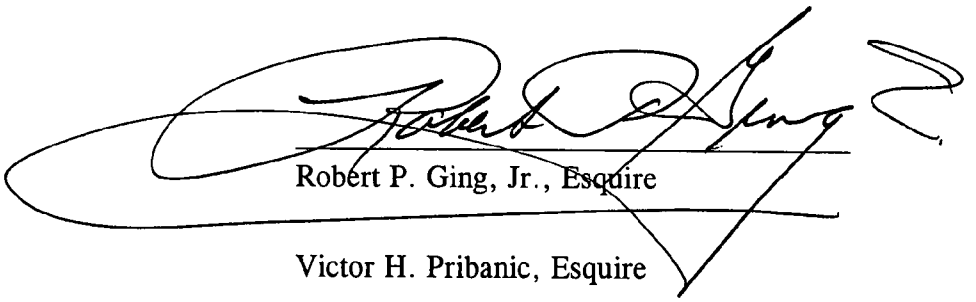
30. The commentary to the rule also indicates that depositions of expert witnesses in

evidentiary hearings are available to the Court to assist in determining the Motion.

31. This matter is currently scheduled for 8 days in trial, and given the length of trial, and because of the possible inconvenience to a jury if a "Frye hearing" were held at the commencement of the trial, as opposed to before the commencement of trial, it would be in the interest of the parties and the interest of justice to conduct the evidentiary hearing prior to trial.

WHEREFORE, the Court is respectfully requested to enter the attached Order.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

Victor H. Pribanic, Esquire

# EXHIBIT 1

MAR 2 3 2006



I have served as the founder and Chief of Maternal Fetal Medicine and Chief of Obstetrics at **Northwestern University** in Chicago (1975-1987) and subsequently as Chairman of Obstetrics and Gynecology at **Jefferson Medical College** in Philadelphia (1987-1998) and as Chair Emeritus thereafter. I have had extensive clinical experience in Obstetrics and Maternal Fetal Medicine and have founded and directed a subspecialty fellowship program in Maternal Fetal Medicine at Northwestern University Medical School for 12 years. I am currently a Professor in the department of Obstetrics and Gynecology of **Drexel University College of Medicine.**

I have not practiced clinical medicine since mid-2000, but remain active in clinical research, lecturing extensively to attendings on a national level, residents and students and have run a significant Continuing Medical Education program. I continue to run a **Fetal Heart Rate Monitoring conference** on a weekly basis for residents and attendings; difficult and controversial FHR Strips are presented to me for discussion and ultimate resolution. I have received a 5 of 5 evaluation for these conferences for the last several years.

I have extensive experience in clinical research, which I continue to do and have been the principal investigator for a Maternal Fetal Medicine Clinical Research Center for the **National Institute of Child Health and Human Development** (NICHD). I am currently a co-Principal investigator on a number of clinical trials with our MFMU – multi-center grant, funded by the (NICHD). I was a member of a select number of leaders in the field to assist in the development of a **Fetal Heart Rate Consensus Document** by the NICHD published by J.T. Parer and Ted Quilligan in the AJOG and the JOGN.

I have submitted two major grant applications in 2005; awards will not be announced until the summer of 2005.

I served as the President of the Association of Professors of Gynecology and Obstetrics (1997) and as Chairman of the Association of Professors of Gynecology and Obstetrics Medical Education Foundation (until 2003).

I have been appointed as the first ever Executive Director of the Society of Maternal Fetal Medicine (2003-) - the clinical education and research promotion organization for more than 1700 Maternal Fetal Medicine subspecialists in the United States.

I was the founder (January, 2005) and first President of the **Maternal Fetal Medicine Foundation** - a not for profit organization whose mission is to transition emerging clinical technologies into clinical application in a responsible manner. This organization is currently involved in a very large project to address quality review issues involving prenatal diagnosis on a national level. I am also one of 5 board members of this new organization

I served as one of a select number of leaders in the field invited to serve as a contributor to the **Neonatal Encephalopathy and Cerebral Palsy Monograph**, which has been endorsed by multiple specialty and subspecialty organizations in the United States as well as internationally.

I edited two volumes of a large clinical textbook in "Gynecology and Obstetrics" until 2004 and continue to review clinical papers for a number of the major journals in the field.

# CURRICULUM VITAE
## O. Richard Depp, III, M.D.

**ADDRESS:** Department of Obstetrics and Gynecology
Drexel University College of Medicine
245 N. 15th Street, 16th Floor, Mail Stop 495
Philadelphia, Pennsylvania 19102
215-762-1503 (Debra)

**MARRIED:** Kathleen Ann Kuhlman, M.D., March 7, 1981

**EDUCATION:** Tulane University, New Orleans, Louisiana, 1956-1959, B.S., Zoology
Tulane University Medical School, New Orleans, Louisiana, 1959-1963, - M.D.

**POSTGRADUATE EDUCATION:**

**Internship**: Mixed Medicine and Obstetrics and Gynecology, Charity Hospital, (Tulane) New Orleans, Louisiana, 1963-1964

**Residency**: Obstetrics and Gynecology, Southern Baptist Hospital (Tulane affiliated), New Orleans, Louisiana, 1964-1967

**Senior Research Fellow**: Reproductive Medicine, Department of Obstetrics and Gynecology, University of Washington School of Medicine Seattle, Washington, July 1967-October 1968

Program for Chiefs of Clinical Services, Executive Programs in Health Policy and Management, School of Public Health, Harvard University, Boston, Massachusetts, January 1980

APGO-Wyeth-Ayerst Executive Education Program for University Chairmen, February 1992, St. Davids, Pennsylvania, July 1992, Boston, Massachusetts

APGO-Wyeth-Ayerst Advanced Leadership Development Program: Negotiating Skills and Managed Care, July 1995, Boston Massachusetts

**LICENSURE:**

Louisiana, 1963
Washington, 1969
Pennsylvania, 1971-
Illinois, 1975-88

**SOCIAL SECURITY NUMBER:** 437-56-0651
**AMA MED. EDUC. NUMBER:** 021-01-63-021-1

BOARD CERTIFICATION:

American Board of Obstetrics and Gynecology
Part I, 1967
Part II, 1969
Division of Maternal-Fetal Medicine, American Board of Obstetrics & Gynecology
Part I, June 1975
Part II, November 1975
**Recertified 1994**

ACADEMIC APPOINTMENTS:

**Drexel University College of Medicine**
1. Professor, Department of Obstetrics & Gynecology, 2001-

**Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania**
1. Professor, Department of Obstetrics and Gynecology, 1987-
2. Chairman, Department of Obstetrics and Gynecology, 1987-97
3. Chairman Emeritus 1997-

**Northwestern University Medical School, Chicago, Illinois**
1. Professor, Dept Ob-Gyn 1981-1987
2. Associate Professor, Department of Obstetrics and Gynecology, 1975-1981
3. Head, Section on Maternal-Fetal Medicine, 1975-1987

**University of Pittsburgh**
1. Assistant Professor, Department of Obstetrics and Gynecology, and Pediatrics, 1971-1975

**University of Washington, Seattle, Washington**
1. Assistant Professor, Department of Obstetrics and Gynecology, 1970-1971
2. Instructor, Department of Obstetrics and Gynecology, 1968-1970

HOSPITAL APPOINTMENTS:

**Thomas Jefferson University Hospital**
Chief of Service, Department of Obstetrics and Gynecology, 1987-97;

**Northwestern Memorial Hospital / Prentice Women's Hospital-Chicago, Illinois**
1. Attending Staff, 1975-1987;
2. Director, Division of Obstetrics, 1975-1987

**Magee Women's Hospital, Univ. of Pittsburgh**
1. Attending Staff, 1972-1975;
2. Director, Fetal-Maternal Intensive Care Unit, 1972-1975

**Harborview Medical Center (King County Hospital) of the University of Washington, Seattle, Washington**
1. Chief, Department of Obstetrics and Gynecology, 1969-1971

PROFESSIONAL ASSOCIATIONS:

Fellow, The American College of Obstetricians and Gynecologists
Member, Association of Professors of Gynecology and Obstetrics
Member, Society of Maternal Fetal Medicine (formerly SPO)
(Founding Member)
Member, Society for Gynecologic Investigation
Member, American Gynecological and Obstetrical Society
Member, The Central Association of Obstetricians and Gynecologists (Through 1989)
Fellow, Chicago Gynecological Society (thru 1987)
Member, National Perinatal Association (thru 1987)
Member, Illinois Association of Maternal-Child Health
Member, Obstetrical Society of Philadelphia (1987-
District III Representative, Standing Committee Chairs

LEADERSHIP ROLES:

**American Board of Obstetrics & Gynecology**

1. Examiner for Oral Ob-Gyn Boards

**Association of Professors of Obstetrics and Gynecology**

1. Member, APGO Council 1994-98;
2. Member, APGO Budget Committee 1994-1998;
3. **President, 1997-98;**
4. Co-Director APGO Wyeth Executive Education Program for Department Chairs 1990-1994;
5. Program Chairman for APGO-Wyeth Ayerst Executive Education Program 1994-
6. Member, Advisory Committee Wyeth Ayerst Executive Education Program, 1991-

**Assoc. Professors of Gynecology and Obstetrics Medical Education Foundation**

1. Member, Board of Trustees, 1994-
2. Secretary-Treasurer, 1992-99
3. **President, 2000-2003 (March)**

**American College of Obstetrics and Gynecology**

1. Member, Committee to Reduce Cesarean Deliveries, 1997-99.
2. Member, Committee on Obstetric Practice, 1998-
1. Member Committee on Perinatal Brain Damage 2000-
2. Liaison to American Academy Pediatrics, 1998-
3. Vice-Chair – Committee on Obstetrical Practice 2000-

**Society of Maternal Fetal Medicine**

1. Founding Member
2. **Executive Vice President (Jan 2003 -**

**National Institute of Child Health Human Development**

1. See Grants
2. NICHD Research Workshop on Intrapartum Electronic Monitoring, Participant, Moderator and Discussion Leader, Bethesda, Maryland, May 14-15, 1995

**Maternal Fetal Medicine Foundation**

1. Founder
2. **President, 2005-**

**Council University Chairs of Obstetrics and Gynecology, (CUCOG):**

1. Founding Member
2. Program Director, 1994-2000
3. Member, Health Care Financing Committee

**Obstetrical Society of Philadelphia,**

1. Member of Council 1991-1995

**Accreditation Council for Graduate Medical Education**

1. Panel for Accreditation Appeals in Obstetrics and Gynecology 1999-

**Keystone Health Plan East**

1. Member, Ob. Advisory Panel, Keystone Health Plan East, 1994- 1998

**American Association for Maternal and Neonatal Health**

AAMANEH (1987-93) Member, Board of Directors,
Member, Chicago Maternal and Child Health Advisory Committee
Member, Subcommittee on Maternal and Perinatal Morbidity and Mortality, Chicago Maternal and Child Health, Advisory Committee
Member, Perinatal Advisory Board, National Foundation-March of Dimes, Chicago
Member, Perinatal Survey Committee, National Foundation-March of Dimes, White Plains
Member, Perinatal Advisory Committee, Dept. of Public Health, State of Illinois

PROFESSIONAL APPOINTMENTS:

THOMAS JEFFERSON UNIVERSITY

1. **Chairman**, Department of Obstetrics and Gynecology 1987-1997; (Chair Emeritus 1997-;
2. Member, Executive Council, 1987-1997;
3. Member, Executive Committee 1987-1997;
4. Member, Committee on Ethics, 1988- ;
5. Member, Comm. on Faculty Appointment, 1988-1995;
6. Chairman, Committee on Committees, 1991-1992;
7. Member, Practice Plan Advisory Committee, 1988-1997;
8. Member, Practice Plan Steering Committee, 1988-1997;
9. Member, Clinical Practice Plan Claims Committee, 1993;
10. Co-Chairman, Physician Practice Management Information System, 1993-1997;
11. Member, Clinical Advisory Committee for the Family Nurse Practitioner Program, 1995- ;
12. Member, Board of Directors, Jeff Care, Inc., 1994- ;
13. Member, Jefferson Faculty Foundation Reorganization Ad-hoc Committee, 1997

NORTHWESTERN UNIVERSITY (1975-1987)

1. **Director Division of Obstetrics**
2. **Section Head Maternal Fetal Medicine (Founder)**
3. Member, Board of Directors, Foundation for Reproductive Research and Education;
4. Member, Board of Directors; Member, Finance Committee, Northwestern Medical Faculty Foundation;
5. Executive Director, Northwestern Perinatal Center, McGaw Medical Center of Northwestern University;
6. **Chairman, Executive Committee, Northwestern Perinatal Center, McGaw Medical Center of Northwestern University;**
7. **Director, Maternal-Fetal Medicine Fellowship Training Program, Department of Obstetrics and Gynecology, 1975-1987;**
8. Member, Executive Committee;
9. Member, Committee on Clinical Privileges;
10. Member, Clinical Practice Review Committee;
11. Member, Quality Assurance Committee, Prentice Women's Hospital and Maternity Center of Northwestern Memorial Hospital;
12. Member, Research Committee, Northwestern Memorial Hospital;
13. Member, Residency Education Committee;
14. Member, Appointment and Promotions Committee; Obstetrics and Gynecology, Northwestern Univ. Medical School 1975-1987;
15. Member, Practice Committee, Department of Obstetrics and Gynecology, Northwestern Medical Faculty Foundation

DREXEL UNIVERSITY COLLEGE OF MEDICINE

1. Revenue Cycle Committee (2003-2004)
2. Resident Committee (2001 -
3. Co-Chair of IT Committee ( 2003-2004)

**HONORS:**

1. Phi Eta Sigma, Honorary Premedical Society, Tulane University Medical School, Founding Member;
2. Alpha Epsilon Delta, Honorary Premedical Society, Tulane University Medical School;
3. Society Prize for Most Outstanding Paper, Society of Perinatal Obstetricians, January 29, 1983, San Antonio, Texas
4. **Good Housekeeping, One of Top 110** Outstanding Ob-Gyn's in the United States, September, 1988 issue
5. **Honorary President**, "Standards in Gestosis Consensus Conference" Rome, Italy, May 22-26, 1991
6. **William Heath Byford Award for Outstanding Northwestern University Alumnus in Obstetrics and Gynecology, 1991-1992**
7. **The Best Doctors in America,** Directory of Experts, Woodward and White, Inc., 1994-1995
8. **The Best Doctors in America**: Northeast Region, Woodward and White, Inc., 1996-1997
9. **Good Housekeeping**, The Best Doctors for Women, August, 1997 issue

**MAJOR RESEARCH SUPPORT:**

1. Efficacy of Antenatal Steroids in Reducing Neonatal Respiratory Distress Syndrome, Principal Investigator, NICHD Grant, 1977-1983, **$850,000.**

2. Diabetes in Pregnancy Center, Co-Principal Investigator, NICHD Center Grant, 1978-1982 **$2.5 million;**

3. Clinical Trial of Hexaprenaline vs. Ritodrine, Principal Investigator, Byk-Gulden Corporation, 1979-1981, **$100,000**

4. Multicenter Preterm Birth Prevention Trial, Principal Investigator, March of Dimes Birth Defects Foundation, 1982-1987, **$410,000;**

5. Multicenter Network of Maternal-Fetal Medicine Units, Principal Investigator, NICHD Grant, 9/1/87 to 8/31/91, **$953,835.**

6. Ethnic Differences in Life Style, Psychological Factors, and Medical Care During Pregnancy, NICHD, 1986, estimated budget to be approximately **$375,000** over three years, Co-Principal Investigator

**EDITORIAL/REVIEW ACTIVITIES:**

1. **Associate Editor**, Volume II & III, Gynecology and Obstetrics, Harper & Row, Hagerstown, Maryland, 1979-
2. **Editorial Board**, Fetal Medicine, Karger Publishers, Inc.
3. **Peer Reviewer for:**
   American Journal of Obstetrics & Gynecology;
   Obstetrics & Gynecology;
   Journal of the American Medical Association;
   International Journal of Gynecology and Obstetrics;
   Journal of Reproductive Medicine

**TELEVISION:**

1. First Ob-Gyn Grand Rounds Program, Lifetime Medical Television, May 21, 1989
2. Permanent Host, Lifetime Medical Television: Ob-Gyn Update 1991-1993 (52 Productions)

**RD/ April 2005**

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**EDITORIALS:**

**THE OB/GYN RESIDENT**, SLACK Incorporated, Thorofare, New Jersey, 1992-1993

- Editorial, January/February 1992
- Disability Insurance, March/April 1992
- Malpractice, May/June 1992
- Hospital Privileges, July/August 1992
- Starting Salaries, September/October 1992
- Interviewing, November/December 1992
- Academic Medicine, January/February 1993
- Guidelines for Moonlighting, March/April 1993

- Have You Considered Becoming a Locum Tenens?, May/June 1993
- Is Group Practice for You? July/August 1993
- Infectious Diseases: Don't Let Down Your Guard, September/October 1993
- Constructing a CV, November/December 1993

## ABSTRACTS

### Society of Gynecologic Investigation (SGI)

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16. Fischer RL, Kuhlman KA, Wapner RJ, Depp R: Doppler evaluation of the umbilical and uterine-arcuate arteries in the postdate pregnancy. New Orleans, Louisiana, February, 1989.

17. Kuhlman KA, Depp R, Kaufmann M: "Dose Response" relationship between stimulus duration (SD) and FHR patterns with external low frequency acoustic stimulation (AS) in the near term fetus. Houston, Texas, January 27, 1990.

18. Sibai B, Caritis S, Phillips E, Klebanoff M, McNellis D, Rocco L, and the NICHD MFM Network. Prevention of preeclampsia: Low-dose aspirin in nulliparous women: A double-blind, placebo-controlled trial. San Francisco, California, February 8, 1993.

**Central Association of Obstetrics and Gynecology (CAOG)**

1. Depp R, Boehm JJ, Nosek JA, Dooley SL, Hobart JM: Antenatal corticosteroids to prevent neonatal respiratory distress syndrome: Risk versus benefit considerations. White Sulphur Springs, Virginia, September 1979.

2. Barglow P, Hatcher R, Walston J, Phelps R, Burns W, Depp R: Psychiatric risk factors in the pregnant diabetic. Minneapolis, Minnesota, September 1980.

**Other**

1. Detwiler JS, Depp OR: The fetal heart rate: An example of quantitative analysis of point process irregularity. 27th ACEMB, Philadelphia, Pennsylvania, October 1974.

2. Keith L, Hatcher R, Ellis RF, Berger GS, Depp R: Differential mortality rates between first and second twins. International Workshop on the "At Risk" Infant, Tel Aviv, Israel, July 1979.

3. Freinkel N, Metzger BE, Ogata ES, Sabbagha RE, Phelps RL, Depp R, Boehm JJ, Hellerstrom C, Lewis NJ, Johnson R, Lake W, Dudek RW: More concerning pregnancy as a "tissue culture" experience. 10th Congress of the International Diabetes Federation, Vienna, Austria, September 1979.

4. McKinney RD, Escarcena LE, Depp R: The evaluation of heart rate variations on the human fetus using spectral analysis techniques. In proceedings Eighth Northeast Bioengineering Conference, Massachusetts Institute of Technology, Boston, Massachusetts, March 1980, pp 188-191.

5. Sabbagha RE, Tamura RK, Vaisrub N, Depp R: Fetuses born preterm after spontaneous labor or rupture of membranes show diminished growth. American Institute of Ultrasound in Medicine, Annual Meeting, Denver, Colorado, 1982.

6. Tamura RK, Sabbagha RE, Depp R, Vaisrub N, Dooley SL, Socol ML: Fetuses born preterm after spontaneous labor or rupture of membranes show diminished growth. American Gynecologic and Obstetric Society, Annual Meeting, Phoenix, Arizona, September 1983.

7. Socol ML, Dooley SL, Tamura RK, Depp R: Perinatal outcome following prior delivery in the late second or early third trimester. Chicago Gynecological Society, Chicago, Illinois, March 1984.

8. Dooley SL, Tamura RK, Sabbagha RE, Depp R, Socol ML, Vaisrub N, Ober C: Ultrasound in timed pregnancies: Early expression of accelerated fetal somatic growth in diabetic versus control subjects. The American Gynecological and Obstetrical Society, Annual Meeting, Hot Springs, Virginia, September, 1984.

9. Keith L, Wittman R, Depp R, Lopez-Zeno J, Socol M: The Northwestern University Twin Study V: Comparative outcome of Twins A and B: Apgar scores and pH. International Workshop on Twin Pregnancies, Toulouse, France, September 25-27, 1985.

10. Wittman R, Keith L, Method M, Depp R: The Northwestern University Multi hospital twin study: VI. Factors relating to low Apgar scores in twin delivery. International Workshop on Twin Pregnancies, Toulouse, France, September 25-27, 1985.

11. Green OC, Winter RJ, Depp R, Dooley S, Boehm J, Ogata ES, Phelps R, Metzger BE, Freinkel N: Fuel-mediated teratogenesis: Prospective correlations between anthropometric development in childhood and antepartum maternal metabolism. Association of American Physicians, January 1987.

12. Sibai B, Gordon T, Phillips E, McNellis D, Caritis S, Romero R, Rocco L, Klebanoff M, Paul R, Depp R, et al.: Risk factors for preeclampsia in healthy nulliparous women: A prospective multicenter study. American College of Obstetricians and Gynecologists, May 1, 1993.

13. Goodwin TM, Paul R, Silver H, Valenzuela G, Depp R, Knuppel R, Renfroe Y, Creasy R, Creasy G, Lane R, and the Antocin study group. Dose Ranging Study of the Oxytocin Antagonist Antocin™ (Atosiban) and Comparison to Ritodrine. Poster presentation at the Annual Meeting of the American College of Obstetricians and Gynecologists, presented May 9, 1994, Orlando, Florida.

14. Bennett IM, Depp R, Perussia B: Differentiation of human natural killer cells from lineage negative umbilical cord blood progenitors. Poster presentation at the 9th International Congress of Immunology Meeting, Presented July 27, 1995, San Francisco, CA

**RD April 2005**

# EXHIBIT 2

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE
Curriculum Vitae

Date: March 2005

William W. Fox, M.D.

Home Address: 411 Penn Valley Road
Narberth, PA 19072

Office Address: Division of Neonatology
The Children's Hospital of Philadelphia
34th Street & Civic Center Boulevard
Philadelphia, PA 19104

Education:

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| 1958-62 | B.S. | Duke University, Durham, NC |
| 1962-66 | M.D. | Duke University Medical School, Durham, NC |

Postgraduate Training and Fellowship Appointments:

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| 1966-67 | Internal Medicine Internship, Presbyterian University Hospital, University of Pittsburgh, Pittsburgh, PA |
| 1969-70 | Internal Medicine Residency, Hospital of the University of Pennsylvania, Philadelphia, PA |
| 1970-72 | Pediatric Residency, The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1972-73 | Pulmonary Neonatology Fellowship, Department of Pediatrics McGill University School of Medicine and Montreal's Children's Hospital, Montreal, Canada |

Military Service:

| | |
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| 1967-69 | Teaching in Bolivia Medical School, Co-Director of Tuberculosis Control Program, Peace Corps — U.S. Public Health Service, Bolivia, South America |

Faculty Appointments:

| | |
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| 1973-74 | Associate in Pediatrics, Department of Pediatrics University of Pennsylvania School of Medicine |
| 1974-79 | Assistant Professor of Pediatrics, Department of Pediatrics The Children's Hospital of Philadelphia University of Pennsylvania School of Medicine |
| 1979-85 | Associate Professor of Pediatrics, Department of Pediatrics The Children's Hospital of Philadelphia University of Pennsylvania School of Medicine |

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| 1985- | Professor of Pediatrics, Department of Pediatrics<br>The Children's Hospital of Philadelphia<br>University of Pennsylvania School of Medicine |

Hospital and Administrative Appointments:

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|---|---|
| 1973- | Staff Neonatologist<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1973- | Staff Neonatologist<br>The Hospital of the University of Pennsylvania, Philadelphia, PA |
| 1974-82 | Director, Pulmonary Function Laboratory<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1977- | Senior Physician<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1978-94 | Medical Director, Infant Intensive Care Unit<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1982-pres/ | Director, Infant Breathing Disorder Center<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1982-85 | Attending Neonatologist, Lankenau Hospital, Philadelphia, PA |
| 1986-90 | Attending Neonatologist, Frankford Hospital, Philadelphia, PA |
| 1989-91 | Attending Neonatologist, Jeanes Hospital, Philadelphia, PA |
| 1982-pres. | Director, CHOP GCRC Scatterbed Research Nurse Program |

Specialty Certification:

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| 1974 | Diplomate of the American Board of Pediatrics |
| 1975 | Diplomate of the American Subspecialty Board of Neonatal/Perinatal Medicine |

Licensure:

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| 1966 | North Carolina |
| 1973 | Pennsylvania |

Awards Honors, and Membership in Honorary Societies:

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|---|---|
| 1964 | Davison Fellowship<br>Duke University Medical School, Durham, NC |
| 1976 | Elected to "The Best Doctors in America" |
| 1994 | Elected to "The Best Doctors in America" |
| 1997 | Elected to "The Best Doctors in the Northeast" |
| 1998 | Elected to "The Best Doctors in America" |
| 1998 | CHOP Teaching Honor Roll |
| 1999 | CHOP Teaching Honor Roll |
| 2000 | CHOP Teaching Honor Roll |
| 2002 | CHOP Teaching Honor Roll |

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| 2002 | Elected to "The Best Doctors in America" |
| 2003 | Elected to "The Best Doctors in America" |
| 2003 | CHOP Teaching Honor Roll |
| 2004 | Quality and Safety Award for the Clinical Practices of the University of Pennsylvania |
| 2004 | Elected to "The Best Doctors in America" |
| 2004 | Top Doctors, Philadelphia Magazine, Philadelphia, PA |
| 2004 | CHOP Teaching Honor Roll |

Membership in Professional and Scientific Societies:

National Societies:

Society for Pediatric Research
American Pediatric Society
American Lung Association
Fellow of the American Academy of Pediatrics
Southern Society for Pediatric Research

Local Societies:

Philadelphia Perinatal Society

Editorial Positions:

1982 Editor, Monograph Series on Sudden Infant Death Syndrome

Scientific Reviewer for Journals:

Pediatrics
Journal of Pediatrics
Critical Care Medicine
Pediatric Research
Developmental Pharmacology and Therapeutics
Pediatric Pulmonology

Scientific Reviewer for Grants:

March of Dimes
Thrasher Foundation
National Institutes of Health

Academic Committees at the University of Pennsylvania and Affiliated Hospitals:

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| 1989- | Member, Fellowship Committee<br>The Children's Hospital of Philadelphia |
| 1991- | Founder and Co-director, Research Poster Day<br>The Children's Hospital of Philadelphia |

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| 1995- | Member, Advisory Board, Clinical Research Center<br>The Children's Hospital of Philadelphia |
| 2002- | Founder and Co-director<br>Resident's International Fellowship Program<br>The Children's Hospital of Philadelphia |

Major Teaching and Clinical Responsibilities at the University of Pennsylvania:

| | |
|---|---|
| 1. | Attending Physician, Infant Intensive Care Unit, 4 months/year<br>The Children's Hospital of Philadelphia |
| 2. | Attending Physician, Infant Intensive Care Unit, 5 months/year<br>Hospital of the University of Pennsylvania |
| 3. | Pediatrics 200 Lecturer, throughout the year |
| 4. | Physiology 201 Lecturer, once/year |
| 5. | Ob-Gyn 307 Lecturer, throughout the year |
| 6. | Neonatal Fellowship Program Participant, throughout the year |
| 7. | Lecturer, Wilderness Medicine Course<br>University of Pennsylvania School of Medicine |

**Lectures by Invitation:**

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|---|---|
| February 1997 | "Liquid Ventilation" — University of Pennsylvania School of Veterinary Medicine, Philadelphia, Pennsylvania |
| March 1997 | "Liquid Ventilation" — Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| June 1997 | "Mechanical Ventilation of the Neonate"<br>"Advances in Neonatal Care/Liquid Ventilation"<br>"Pulmonary Function Evaluation"<br>Neonatology Symposium, Cochabamba Bolivia |
| June 1997 | "Mechanical Ventilation of the Neonate"<br>National Medical School of Bolivia, La Paz, Bolivia |
| October 1997 | "Liquid Ventilation in the Surgical Neonate"<br>Surgical Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| November 1997 | "Mechanical Ventilation of the Neonate"<br>1) "PPHN in the Neonate"<br>2) "Liquid Ventilation of the Neonate"<br>3) "Nitric Oxide in the Neonate"<br>International Symposium, Concepción, Chile |

**Lectures by Invitation:** ***(continued)***

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| November 1997 | "Advances in Mechanical Ventilation of the Neonate"<br>Neonatal Grand Rounds, St. Christopher's Hospital for Children, Philadelphia, Pennsylvania |
| April 1998 | "International Medicine" — Grand Rounds<br>The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania. |
| October 1998 | "Liquid Ventilation"<br>"Persistent Pulmonary Hypertension of the Newborn"<br>"Mechanical Ventilation of the Neonate"<br>"Respiratory Failure in the Neonate"<br>"High Frequency Ventilation and Cases"<br>Philadelphia-Salzburg Seminars<br>Sponsored by The American Austrian Foundation<br>Salzburg, Austria |
| March 10, 1999 | "An Update of Liquid Ventilation"<br>Philadelphia Perinatal Society, Phila., Pennsylvania |
| June, 1999 | "New Advances in Mechanical Ventilation of the Neonate"<br>"Liquid Ventilation and Respiratory Failure"<br>Cochabamba Medical School, Cochabamba Bolivia |
| June 1999 | "Neonatal Respiratory Distress Syndrome"<br>"Mechanical Ventilation of the Neonate"<br>La Paz Medical School, La Paz Bolivia |
| March 16, 2000 | "Liquid Ventilation for the Next Milennium"<br>Surgical Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| November, 2000 | "Travel Electives in South America" — International Group, University of Pennsylvania School of Medicine |
| April, 2001 | "High Altitude Pulmonary Edema"<br>Wilderness Medicine Course, International Group<br>University of Pennsylvania School of Medicine |
| April, 2002 | "High Altitude Pulmonary Edema"<br>Wilderness Medicine Course, International Group<br>University of Pennsylvania School of Medicine |
| January 24, 2003 | "Ventilating the Very Low Birthweight Infant: When, How, Why?"<br>A Day with the Newborn Seminar<br>St. Christopher's Hospital, Philadelphia, PA |

**Lectures by Invitation:** ***(continued)***

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|---|---|
| April, 2003 | "High Altitude Pulmonary Edema"<br>Wilderness Medicine Course, International Group<br>University of Pennsylvania School of Medicine |
| July 2003 | "Early Continuous Positive Airway Pressure"<br>La Paz Medical School, La Paz Bolivia |
| July 2003 | "Neonatal Mechanical Ventilation"<br>Cochabamba Medical School, Cochabamba Bolivia |

Bibliography:

Research Publications, peer reviewed:


Keck CW, Fox WW, Pantoja M, St. John RK, and Danielson DA: A description of the tuberculosis control program of the Bolivian Ministry of Public Health and the Peace Corps. The Medical Press, 11:3, 1969.

Keck CW, Fox WW, Pantoja M: The prevalence of tuberculosis in the Yungas region of Bolivia. The Medical Press, 11:1, 1969.

Fox WW, and Keck CW: An epidemiological model of tuberculosis in the Bolivian Yungas. The Medical Press, 11:17, 1969.

Fox WW, and Keck CW: A review of clinical investigations with Thiacetazone and Isoniazid for the treatment of tuberculosis. The Medical Press, 11:71, 1969.

Fox WW, Keck CW, and Pantoja M: Treatment of tuberculosis with Thiacetazone and Isoniazid in Bolivia. The Medical Press, 11:80, 1969.

Keck CW, St. John RK, Fox WW, et al: Tuberculosis in the Yungas area of Bolivia. Health Services, 88:499, 1973.

Fox WW, Bureau MA, Taussig LM, et al: Helium flow-volume curves in the detection of early small airway disease. Pediatrics, 54:293, 1974.

Fox WW: The meconium aspiration syndrome. Proc. Int. Congr. Pediatr., 4:33, 1974.

Taussig LM, Castro A, Fox WW, et al: Treatment of laryngotracheobronchitis (croup). Use of intermittent positive pressure breathing and racemic epinephrine. Am. J. Dis. Child., 129:790, 1975.

Fox WW, Berman LS, Downes JJ, and Peckham GJ: The therapeutic application of end expiratory pressure in the meconium aspiration syndrome. Pediatrics, 56:214, 1975.

Gerard PM, Fox WW, Outerbridge E, and Stern L: The early application of end expiratory pressure in the respiratory distress syndrome. Pediatrics, 56:214, 1975.

Berman LS, Fox WW, Raphaely RC, Downes JJ: Optimum levels of CPAP for tracheal extubation of newborns. J. Pediatr., 89:109, 1976.

Fox WW: Meconium aspiration syndrome. Audio Digest, 22:22, 1976.

Fox WW, Berman LS, Dinwiddie R, Shaffer TH: Tracheal extubation of the neonate at
2-3 cm $H_2O$ continuous positive airway pressure (CPAP). Pediatrics, 59:257, 1977.

Fox WW, Gewitz MH, Dinwiddie R, Drummond WH, Peckham GJ: Pulmonary hypertension in the perinatal aspiration syndromes. Pediatrics, 59:205, 1977.

Research Publications, peer reviewed: ***(continued)***

Patel BD, Dinwiddie R, Kumar SP, Fox WW: The effects of feeding on arterial blood gases and lung mechanics in newborn infants recovering from respiratory distress.
J. Pediatr., 90:435, 1977.

Fox WW, Gutsche BB, DeVore JS: A delivery room approach to the meconium aspiration syndrome (MAS). Clin. Pediatr., 16:325, 1977.

Drummond WH, Peckham GJ, Fox WW: The clinical profile of the newborn with pulmonary hypertension. Clin Pediatr., 16:335, 1977.

Fox WW, Gewitz MH, Berman LS, et al: The $PaO_2$ response to changes in end expiratory pressure in the newborn respiratory distress syndrome. Crit. Care Med., 5:226, 1977.

Fox WW: Bronchopulmonary dysplasia: Clinical course and outpatient therapy. Pediatr. Annals, 6:75, 1977.

Fox WW, Schwartz JG, Shaffer TH: Pulmonary physiotherapy in neonates: Physiologic changes and respiratory management. J. Pediatr., 92:977, 1978.

Schwartz JG, Fox WW, Shaffer TH: A method for measuring functional residual capacity (FRC) in neonates with endotracheal tubes. IEEE Trans. Biomed. Eng., 25:304, 1978.

Dinwiddie R, Patel BD, Kumar SP, and Fox WW: The effects of crying on arterial oxygen tension in infants recovering from respiratory distress. Crit. Care Med., 7:50, 1978.

Peckham GJ, and Fox WW: Physiological factors affecting pulmonary artery pressure in infants with persistent pulmonary hypertension. J. Pediatr., 93:1005, 1978.

Fox WW, Eavey RD, and Shaffer TH: A closed system device for diagnosis and evacuation of neonatal pneumothoraces. Crit. Care Med., 6:376, 1978.

Wagaman MJ, Shutack JG, Moomjian AS, Schwartz JG, Shaffer TH, and Fox WW: Improved oxygenation and lung compliance with prone positioning of neonates. J. Pediatr., 94:787, 1979.

Dinwiddie R, Pitcher-Wilmott R, Schwartz JG, Shaffer TH, and Fox WW: Cardiopulmonary changes in the crying neonate. Pediatr. Res., 13:900, 1979.

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Shutack JG, Wagaman MJ, Moomjian AS, Eavey RD, Shaffer TH, and Fox WW: A new device for diagnosis and treatment of neonatal tension pneumothorax. Pediatrics, 63:252, 1979.

Pitcher-Wilmott R, Shutack JG, and Fox WW: Decreased lung volume after nasogastric feeding of neonates recovering from respiratory disease. J. Pediatr., 95:119, 1979.

Research Publications, peer reviewed: ***(continued)***

Pereira GR, Fox WW, Stanley CA, Schwartz JG, and Baker L: The effect of intravenous fat infusions on pulmonary function and triglyceride metabolism in premature infants. Acta Clin. Scand. Supple., 494. Proceedings of the Second International Society of Parenteral and Enteral Nutrition Society, 1979.

Guinan M, Schaberg D, Fox WW, et al: Epidemic occurrence of neonatal necrotizing enterocolitis. Am. J. Dis. Child., 133:594, 1979.

Rooklin AR, Moomjian AS, Fox WW, et al: Theophylline therapy in bronchopulmonary dysplasia. J. Pediatr., 95:882, 1979.

Pereira GR, Stanley CA, Fox WW, Baker L: Decreased oxygenation and hyperlipemia during intravenous fat infusions in premature infants. Pediatrics, 66:26, 1980.

Moomjian AS, Schwartz JG, Wagaman MJ, Fox WW, et al: The effect of external expiratory resistance in intubated neonates to increase lung volume. J. Pediatr., 96:908, 1980.

Dransfield DA, and Fox WW: A noninvasive method for recording central and obstructive apnea with bradycardia in infants. Crit. Care Med., 8: 663, 1980.

Baumgart S, Engle WD, Langman CB, Fox WW, and Polin RA: Monitoring radiant energy in the critically ill newborn under a radiant warmer. Crit. Care Med., 8: 721, 1980.

Taussig LM, Chernick V, Wood R, Fox WW, et al: Standardization of lung function testing in children. J. Pediatr., 97:668, 1980.

Engle WD, Baumgart S, Fox WW, and Polin RA: Monitoring radiant power in the critically ill newborn under a radiant warmer. Crit. Care Med., 8:721, 1980.

Morray JP, Fox WW, Kettrick RG, and Downes JJ: Clinical correlates of successful weaning from mechanical ventilation in severe bronchopulmonary dysplasia. Crit. Care Med., 9:815, 1981.

Spitzer AR, Fox WW, Delivoria-Papadopoulos M: Maximum diuresis — a factor in predicting recovery from respiratory distress syndrome and the development of bronchopulmonary dysplasia. J. Pediatr., 98:476, 1981.

Moomjian AS, Schwartz JG, Shutack JG, Rooklin AR, Shaffer TH, and Fox WW: The use of external expiratory resistance in intubated neonates to increase lung volume. Arch. Dis. Child., 56:869, 1981.

Engle WD, Baumgart S, Schwartz JG, Fox WW, and Polin RA: Combined effect of radiant warmer power and phototherapy on insensible water loss in the critically ill neonate. Am. J. Dis. Child., 135:516, 1981.

Langman CB, Engle WD, Baumgart S, Fox WW, and Polin RA: The diuretic phase of respiratory distress syndrome and its relationship to oxygenation. J. Pediatr., 98:562, 1981.

Research Publications, peer reviewed: ***(continued)***

Baumgart S, Engle WD, Fox, WW, and Polin RA: Effect of heat shielding on convective and evaporative heat losses, and radiant heat transfer in the premature neonate. J. Pediatr., 99:948, 1981.

Baumgart S, Engle WD, Fox WW, and Polin RA: Radiant warmer power and body size as determinants of insensible water loss in the critically ill neonate. Pediatr. Res., 5:1495, 1981.

Fox WW: Respiratory diseases of neonates. Argentine Archives of Pediatrics, 78:42, 1981.

Fox WW: Pulmonary function evaluation of the neonate. Argentine Archives of Pediatrics, 78:36, 1981.

Fox WW, Schwartz JG, and Shaffer TH: Successful extubation of neonates: Clinical and physiological factors. Crit. Care Med., 9:823, 1981.

Morray JP, Fox WW, Kettrick RG, and Downes JJ: Improvement in lung mechanics as a function of age in the infant with severe bronchopulmonary dysplasia. Pediatr. Res., 16:290, 1982.

Shutack JG, Fox WW, Shaffer TH, Schwartz JG, and Moomjian AS: Effect of low rate intermittent mandatory ventilation on pulmonary function of low birthweight infants. J. Pediatr., 100:799, 1982.

Baumgart S, Langman C, Sosulski R, Fox WW, and Polin RA: Fluid, electrolyte and glucose maintenance in the very low birthweight infant. Clin. Pediatr., 21:199, 1982.

Baumgart S, Fox WW, and Polin RA: Physiologic implications of two different heat shields for infants under radiant warmers. J. Pediatr., 100:787, 1982.

Heaf DP, Belik J, Spitzer AR, Gewitz MH, and Fox WW: Changes in pulmonary function during the diuretic phase of respiratory distress syndrome. J. Pediatr., 101:103, 1982.

Spitzer AR, and Fox WW: Post-extubation atelectasis — The role of oral versus nasal endotracheal tubes. J. Pediatr., 100:806, 1982.

Meijboom EJ, Gewitz MH, Wood DC Jr., and Fox WW: Contrast echocardiography in persistent pulmonary hypertension of the newborn. Europ. Arch. of Echocardio., 3:46, 1982.

Engle WD, Baumgart S, Fox WW, and Polin RA: Effect of increased radiant warmer power output on state of hydration in the critically ill neonate. Crit. Care Med., 10:673, 1982.

Fox WW, and Duara S: Clinical management of persistent pulmonary hypertension of the neonate. J. Pediatr., 103:505, 1983.

Dransfield DA, Spitzer AR, and Fox WW: Episodic airway obstruction in the recovering premature infant: Preliminary observations. Am. J. Dis. Child., 137:441, 1983.

Harris MC, Baumgart S, Rooklin AR, and Fox WW: Successful extubation of infants with respiratory distress syndrome using aminophylline. J. Pediatr., 103:303, 1983.

Research Publications, peer reviewed: *(continued)*

Bernbaum JC, Russell P, Sheridan P, Gewitz MH, Fox WW, and Peckham GJ: Long-term followup of infants with persistent pulmonary hypertension of the newborn. Crit. Care Med., 12:579, 1984.

Spear ML, Spitzer AR, and Fox WW: Hyperventilation therapy for persistent pulmonary hypertension of the newborn. Resp. Therapy, 3:58, 1984.

Spitzer AR, and Fox WW: The use of oral versus nasal endotracheal tubes in newborn infants. Journal of the Calif. Perinatal Assoc., 4:32, 1984.

Abbasi S, Duara S, Shaffer TH, and Fox WW: Effects of external inspiratory resistive loading in preterm infants. Pediatr. Res., 18:150, 1984.

Spitzer AR, and Fox WW: Sudden Infant Death Syndrome (SIDS). Guidelines for averting tragedy. Postgrad. Med., 75:125, 1984.

Spitzer AR, Boyle JT, Tuchman DN, and Fox WW: Awake apnea associated with gastroesophageal reflux — A specific clinical syndrome. J. Pediatr., 104:200, 1984.

Spitzer AR, and Fox WW: Infant Apnea: An approach to management. Clin. Pediatr., 23:374, 1984.

Serota FT, August CS, Koch PA, Fox WW, and D'Angio GJ: Pulmonary function in patients undergoing bone marrow transplantation. Med. & Pediatr. Oncology, 12:137, 1984.

Duara S, Boutwell WC, Shutack JG, Spackman T, and Fox WW: Segmental reticulogranular lung disease in infants of diabetic mothers. In press, Am. J. of Roentgen., 1984.

Sosulski R, and Fox WW: The transitional phase during hyperventilation therapy for persistent pulmonary hypertension of the neonate. Crit. Care Med. 13(a):715-719, 1985.

Duara S, Abbasi S, Shaffer TH, and Fox WW: Ventilatory response to hypercapnea and inspiratory loading in infants recovered from respiratory distress syndrome. In press, J. Appl. Physio., 1984.

Stefano JL, Spitzer AR, Baumgart S, et al: Inductive plethysmography — A facilitated calibration technique for rapid and accurate tidal volume determination in low birthweight infants. Amer. Rev. Resp. Dis., 134:1020-1024, 1986.

Bhutani VK, Shaffer TH, Spitzer AR, Fox WW: Effect of high frequency jet ventilation in neonatal tracheal mechanics. Pediatr. Pulm., 2:327-331, 1986.

Davis JM, Spitzer AR, Stefano JL, Bhutani VK, and Fox WW: The use of caffeine in infants unresponsive to theophylline in apnea of prematurity. Pediatr. Pulm., 3:90-93, 1987.

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Research Publications, peer reviewed: ***(continued)***

Davis JM, Spitzer AR, Cox C, Fox WW: Predicting survival in infants with persistent pulmonary hypertension of the newborn. Pediatr. Pulm., 5:6-9, 1988.

Clancy R, Legido A, Newell R, Bruce D, Baumgart S, Fox WW: Continuous Intracranial Pressure Monitoring and Serial Electroencephalographic recordings in severely asphyxiated term neonates. Am. J. Dis. Child., 142:740-747, 1988.

The HIFI Group: A collaborative randomized trial of high frequency oscillatory ventilation versus conventional mechanical ventilation in the treatment of respiratory failure in preterm infants. New Engl. J. Med., 320:88-93, 1989.

Davis JM, Stefano JL, Bhutani VK, Fox WW, Spitzer AR: Changes in pulmonary mechanics following caffeine administration in infants with BPD. Pediatr. Pulm., 6:49-52, 1989.

Spitzer AR, Butler S, and Fox WW: The ventilatory response to combined high frequency jet ventilation and conventional mechanical ventilation in the rescue treatment of severe neonatal lung disease. Pediatr. Pulm., 7:244-250, 1989.

Stefano JL, Anday EK, Davis JM, Fox WW, Spitzer AR: Pneumocardiograms in Healthy Premature Infants — A Study of Normative Longitudinal Data. American Journal of Perinatology, 8(3):170, 1991.

Stefano JL, Bhutani VK, Fox WW: A randomized placebo-controlled study to evaluate the effects of oral albuterol on pulmonary mechanics in ventilator-dependent infants at risk of developing BPD. Pediatric Pulmonology, 10:183-190, 1991.

The HIFI Group: Clinical and pulmonary function follow-up of neonates ventilated conventionally and by high frequency oscillation. J. Pediatr., 116(6):933-941, 1990.

Spitzer AR, Gibson E, Fox WW: Pseudoreflux syndrome — Increased periodic breathing during the neonatal period presented as feeding-related difficulties. Clinical Pediatrics, 30(9):531-537, 1991.

Abbasi S, Bhutani VK, Spitzer AR, Fox WW: Pulmonary mechanics in preterm neonates with respiratory failure treated with high frequency oscillatory ventilation compared to conventional mechanical ventilation. Pediatrics, 87:487-493, 1991.

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The HIFI Group: Trial of oscillatory ventilation of premature infants: analysis of crossover. In preparation.

Research Publications, peer reviewed: ***(continued)***

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Neonatal Pulmonary Research, sponsored by Ohmeda Medical
December 2002 to July 2004 — $3,600.

NIH-CRC Neonatal Scatterbed Nurse Program
July 2000 to June 2005 — $175,000/year x 5 years.

A Collaborative Clinical Trial on High Frequency Jet Ventilation in Premature Infants,
National Institutes of Health, $820,000, 1984-1990.

Burroughs-Wellcome Co., Beta-Casomorphin Study. $30,000/2 years, 1989-1991

Glaxo Inc., Effects of Albuterol on Pulmonary Mechanics in Infants with Bronchopulmonary Dysplasia, $15,000, 1987-1989

Parker B. Francis Foundation, Fellowship Training Grant, $50,000/year, 1978-1983

# EXHIBIT 3

MAR 2 0 2006

March 7, 2006

Mr. John Blasko, Esquire
McQuaide, Blasko
811 University Drive
State College, Pennsylvania 16801-6699

Re: Rhoades vs. Kruszewski, et al

Dear Mr. Blasko:

I have reviewed records on the case of Rhoades vs. Dr. Kruszewski, et al. These include the following:

1. Duboise Regional Medical Center Records 5/10/02 to 5/11/02 of the mother;
2. DRMC records, 5/10/02 to 5/11/02, the baby;
3. Records from Children's Hospital of Pittsburgh, 5/11/02 to 5/14/02;
4. Autopsy reports on the infant.

The baby was born on 5/10/02 from a 34-year-old mother, gravida 1 para 0. It was a term gestation. The mother's blood pressure had been increasing over 2-3 weeks. There was an increase in temperature noted on three occasions in the mother. These were 99°, 100°, and 98.9°. Preeclamptic maternal labs, the biophysical profile, and non-stress test were all reported to be normal. On 4/18/02 the mother was Group B Strep negative. The maternal monitor showed good fetal heart tone variability. A clinical exam was performed and the membranes ruptured during the exam. Cervix was noted to be 3-4 cm dilated, and then futher rupture of the membranes produced a large amount of clear fluid. This is a note from 7:40 a.m. At 9:30 a.m., a note reveals the labor was progressing slowly. The fetal heart tones have been good throughout. The epidural was working well. The cervix was 8-9 cm dilated, and the infant was being monitored and they anticipated a vaginal delivery. On 5/10/02 at 12:55 a.m. the patient was completely dilated at 10 cm. in vertex position. During labor the baby sustained a bradycardia and vacuum was applied. Delivery was accomplished in 1-2 minutes after the vacuum was applied. A midline episiotomy was performed. The baby was limp, and the NICU personnel were called for resuscitation. Birth time was 11:52 p.m. The placenta was delivered at 11:54 p.m. Cord pH was 7.13. The initial Apgars were 0 at one min., 3 at

five min, 4 at 10 min., and 5 at 20 min. The infant was suctioned and stimulated and given chest compression at less than 30 seconds, after which the heart rate increased to greater than 100 per min. A second gas at 00:20 on 5/11 showed a pH of 6.9, $pCO_2$ of 49, $pO_2$ of 102, bicarbonate of 8.2, base deficit –27. CBC at that time showed a white blood count of 32,000 with a platelet count of 185,000. There were 5% bands, and the hemoglobin was 16. The baby's weight was 4.4 kg. Blood pressure was 67/32. The baby was noted to have nasal flaring and pursing of the lips. At 00:25 the baby had a pH of 6.6 with a $pCO_2$ of 95 and a $pO_2$ of 73. At 00:30 a.m., pH of 6.9 with a $pCO_2$ of 49, $pO_2$ of 102, base deficit –27. By 1:30 a.m. pH was 7.3 with a $pCO_2$ of 23, $pO_2$ of 197, bicarb of 11, base deficit –14; and at 1:55 a.m., the pH was 7.34, $pCO_2$ 24, $pO_2$ 94, base deficit –11. The baby was noted to have some tremors and was treated with Phenobarbital — 10/kg x2. The infant was cultured, placed on a ventilator at 24/4 with a rate of 60 in 50%. A nursing progress note at 1:20 a.m. shows $O_2$ sats of 96%. The baby was on the vent and was noted to be on 30% oxygen with sats in the 97-98% range. Blood pressure was 68/39. Throughout the rest of the early morning, the blood pressure was noted to be 73/41, $O_2$ sats 97%. The baby had been weaned down to 18/4 on the ventilator with a rate of 45; and, subsequently, by approximately 4:30 a.m. was weaned to 16/4 with a rate of 40 in 25% oxygen. Subsequently the infant was transferred to Children's Hospital of Pittsburgh, and there a white count was noted to be 42,200 with 13% bands. Platelet count was 193,000 on this occasion, and antibiotics were on board. Again, at Children's Hospital of Pittsburgh on 5/11/02, the baby was extubated at 8:30 p.m. and initially did well with good $O_2$ sats, but at 23:00 on the 11th began having desats to the high 80's, and at 23:30 had a major desat that required bag-mask ventilation. The infant was reintubated with a 3.5 endotracheal tube. The baby remained on Phenobarbital, and there was no seizure activity noted. On the 13th, a repeat complete blood count showed a white blood count of 37,000 with 7% bands. The baby was cultured for HSV. It should be noted that at Dubois Hospital an AST was 403 and an ALT was 272, both of which were elevated. A creatinine was 1.1, calcium was normal; but subsequently by the 13th, calcium decreased to 7.5 and liver function tests improved slightly to an AST of 281 and ALT of 221. The platelet count continued to drop to 124,000, and the baby had a fever of 39.3. There was a CT scan done x2 that showed a slight increase in density of the cortex, small temporal bleeds, and minimal soft tissue swelling.

**Summary**

This baby was born critically ill and appeared to be in septic shock with a white blood count initially of 32,000, which subsequently increased to 42,000 with up to 13% band count. This is indicative of an acute infection, and this acute infection was responsible for the shock and clinical deterioration of this infant. This septic process was occurring intrauterinely and at least 24 hours prior to the baby's delivery. The mother was noted to have fever; and the baby, after delivery, was noted to have fever. This baby clearly had problems related to sepsis. I am not concerned that the neonatal blood cultures were negative, as up to 50% of neonatal blood cultures are negative in acute sepsis such as this infant experienced. After antibiotic treatment was instituted, the white count continued to decrease over the next 2-3 days and liver function enzymes, which were initially elevated (indicative of sepsis), decreased subsequently. The placenta does

not have to show chorioamnionitis in order to have a major cytokine reaction and shock in a neonate such as this baby. It only takes sepsis from a few bacteria to produce the kind of shock this baby experienced. There is no other explanation in this baby's case for white counts as high as 42,000. Resuscitation alone would not have produced a white count in that range. I, therefore, feel that all the care administered to this infant was within the standards of medical care at both Dubois Medical Center and at the University of Pittsburgh Medical Center.

I hold these opinions to be within a reasonable degree of medical certainty as based on 33 years of experience in the Newborn Intensive Care Unit at The Children's Hospital of Philadelphia. I reserve the right to amend this report at any time.

Sincerely,

William W. Fox, M.D.
Professor of Pediatrics
University of Pennsylvania School of Medicine

WWF:er

# EXHIBIT 4

*Richard Depp, MD*
*1280 Club House Road*
*Gladwyne, PA 19025*
*610 527 6294*

John W. Blasko
McQuaide and Blasko
811 University Drive
State College, PA 16801-6699

**Re: Rhoades vs. Kruszewski**

Dear Mr. Blasko

I am doubly board certified in both Obstetrics & Gynecology and as a subspecialist in Maternal Fetal Medicine. I have had extensive experience in obstetrics and maternal fetal medicine, having managed and directed several large obstetric services over more than 30 years of clinical practice. I have founded and managed a large maternal-fetal medicine fellowship program and directed a large Obstetric clinical service at Northwestern University directing both MFM and Obstetrics. I have visited, lectured and consulted at numerous hospitals in my career and am aware of the standard of care.

I have served as the chair of the department of Obstetrics and Gynecology at Jefferson Medical College through 1997. I currently do not practice, but am actively involved in weekly teaching of residents and students and academic pursuits including clinical research, I continues to manage a weekly FHR conference for residents and attending physicians as I have done for many years. I have led several national Fetal Monitoring courses for the ACOG. I also continue to lecture attending physicians at Postgraduate courses.

I have been elected by my peers to several significant leadership positions in my specialty and continue to be involved in developing educational programs as well as strategies to improve the quality of care provided to patients on a national basis

I have had an opportunity to review the above case in which your firm represents the hospital and its nurses I would like to summarize my opinions at this time. As of this date I have had the opportunity to review the following:

**LEGAL PAPERS:**
Plaintiff Complaint

**MEDICAL RECORDS:**
Prenatal Records from office of Dr. Kruszewski
Maternal Admission to Dubois Regional Medical Center
FHR Records
Newborn records at Dubois Regional Medical Center
Newborn records at Childrens Hospital of Pittsburgh
Autopsy report including placenta

**DEPOSITIONS:**

Dennis R. Rhoades
Gloria Bennett, RN
Mary C Kruszewski, D.O. (Defendant OB)
Richard Grout, MD (Neonatology)

**EXPERT OPINIONS:**

Frederick A Gonzales, MD - Plaintif OB expert
James Mollick, MD

**RELEVANT LITERATURE:**

1. National Institute of Child Health and Human Development Research Planning workshop. **Electronic fetal heart rate monitoring: Research guidelines for interpretation**. Am. J. Obstet. Gynecol. 1997; 177: 1385-90
2. National Institute of Child Health and Human Development Research Planning Workshop. **Electronic fetal heart rate monitoring: Research guidelines for interpretation.** JOGN Nursing 26: 635-640 1997.(same as 1a, but in nursing journal)

**OVERVIEW:**

Ms. Kim Rhoades at the time of her initial presentation was a 33 year old gravida 1 who was 5 foot 6 inches and weighed 123 pounds. Her LMP was 8.3.01 and her EDC was 5.10.01 (3.4.02 by ultrasound at 13 plus weeks gestation. Other than two borderline blood pressures (the last on 5.9.02) with no associated significant proteinuria, the pregnancy was relatively uncomplicated, within the limitations of prenatal evaluation with limited ability to assess fetal condition. Preeclamptic labs, BPP and NST were done 4.18.02 and were normal. GBS culture was also negative.

Ms. Rhoades was scheduled for induction on the morning of May 10, 2002. Upon admission the FHR was thought to show "good FHT variability and mild contractions every 1-2 minutes. The initial cervical examination was 3-4 / 75% / -3 vertex. Artificial rupture of membranes released "large amount o f clear fluid". The admitting clinician, Dr. Kruzewski appropriately recommended augmentation of labor if necessary, anticipating a vaginal delivery.

Of interest there was a progressive rise in maternal temperature to the last recording of 100.1 at 8pm several hours before delivery and an associated rise in maternal pulse. Serial maternal pulse rates over the last several hours and recorded on the FHR strip reflect significant maternal tachycardia. In the absence of terbutaline or maternal heart disease, a change in maternal pulse of the magnitude observed from the time of admission to the time of delivery, especially when taken in the context of the relative rise in maternal temperature is highly suspicious of chorioamnionitis which would place the fetus at risk for infection or sepsis and / or fetal inflammatory response syndrome. The latter would account for why the FHR pattern observed over the last hour is consistent with the observed cord pH of 7.13 and base deficit of -13, but not consistent with the first umbilical blood gas of 6.60 which was observed at approximately 35-36 minutes of life following placement on a ventilator. Greater specifics of labor are presented below.

Newborn laboratory evaluation at Dubois Regional Medical Center revealed a significantly elevated newborn WBC count with 5% bands, 36% segs and 185,000 platelets.

Later findings at Children's Hospital of Pittsburgh are also of interest. Infectious disease was number 3 of 5 of initial assessment and plans by Beverly Brozanski. She made note of a further elevation of the WBC to 42.2 with 55 polys, 13 bands.

In view of the surprising appearance of the fetus at birth with a pH of only 7.13 which correlates well with the observed FHR pattern, it is likely that there is an independent process which accounts for the inability of the fetus to transition to newborn condition in the first hour and the associated drop in pH. Continuous FHR does not screen for fetal infection, but instead is limited to screening for varying degrees of cord compression and uteroplacental insufficiency.

Infection / sepsis / and / or fetal inflammatory response would be a good independent candidate to explain the newborn transitioning difficulty and the laboratory findings. Infection / sepsis / FIRs can present a clinical picture identical to that of severe metabolic acidosis including the Apgar scores (which conflict with the observed cord blood gases) and such a difficulty in transitioning. The maternal findings of a rising maternal temperature and increasing pulse rate to frank tachycardia are clearly supportive of such a cause. Negative cultures would not eliminate that consideration because of sensitivity limitations of cultures.

**LMP:** 8.3.01 **EDC:** 5.10.01 **DELIVERY DATE:**
**US EDD 1:** 5.4.02 by ultrasound at 13 plus weeks

**PRENATAL CARE:**
**First Visit:** November 1, 2001 at 12.5 weeks
**At Risk Factors:**
AFP refused
**Biophysical Testing:**
4.18.02 BPP 8 of 8; with normal fluid and EFW 3382 gms.
**Diabetes Screening:** 126 at 1 hour
**GBS Screen:** Negative on 4.18.02

**ADMISSION of May 10, 2002 at ~ 40 wks gestation to Dubois Regional Medical Center**

0653: Admission
97.4; Pulse 70; Fundal height 39 cm.
0714 **97.4** / P=70
0725: Artificial rupture of membranes

1145: Order for pitocin protocol
1240: 2 mU pitocin
1300: Recorded time of onset of labor
1535: 4-5 / 70 /-2 8 mU pitocin
1710: 5 / 75 / -2 14 mU pitocin
1850 Unchanged

1900 99.1 / P = 111
2000 100.1 / P = 104
2030: Late Entry: Dr. Kruszewski informed of patient's increased temperature. Bolus of LR given.

2010: 4-5 / 80 / 0 to -1 24 mU
2030 4-5 / 80-90 / 0 to -1 24 mU
2120 Dr. Kruszewski arrives at hospital
2130: Kruszewski Note: 8-9 / 100 / -1 to 0 vertex; Anticipate vaginal delivery

2159: Recorded time of complete dilation 16 mU

**2212 forward:** See late entry at 0100
2225 Epidural infusion stopped for more effective pushing; variable decelerations
2244: IV fluid bolus (Note: Fluid replacement)
2246: Oxygen increased
2300 Variable deceleration continue
2342: FHR capture lost on EFM
2347: Vacuum ordered
2349: Vacuum applied with continuous effort
2352: Female infant - limp and NICU staff called for resuscitation
Cord blood pH 7.13 and BD -13.

**MAY 11, 2002**

**12:55A Delivery Note:** ..... complete approximately 10:00 pm....came down to +1 / +2 station.. Baby had a sustained bradycardia and vacuum was applied.. Delivery was accomplished in 1-2 minutes after vacuum applied.

Baby was delivered from LOA position; Birth time was 11:52 pm...Cord pH was 7.13Baby was limp and NICU personnel were called for resuscitation.

***0100: Late Entry:*** *Dr. Kruszewski in attendance assisting patient with pushing from 2212. FHR baseline 150s with average LTV at onset of pushing.*

*2330: Variable decels to 58-72 bpm, lasting 30-80 sec.....push verte4x to +2 station.*

*FHR returned to normal parameter; FHR with scalp stim by Dr. K with variables.*

*2342: FHR capture lost on EFM;* ***Pitocin d/c'd*** *per nursing measures at 2343*
*2344: FHR audible 60s-70s; Fetal scalp stim by Dr. K.*
*2346; FHR audible 50 bpm*
*2347: Order received for vacuum*
***2349: Vacuum extractor applied by Dr. K....to delivery***

PLACENTAL PATHOLOGY:

Mature placenta with mild subchorionic and intervillous fibrin deposition, and areas of calcification.

Trivascular umbilical cord with **partial velamentous insertion**

Amnion nodosum, with focal squamous metaplasia, as may be seen in cases of **oligohydramnios.** No evidence of acute chorioamnionitis or funisitis.

NEWBORN:

**Delivery at** **2349**
**Birthweight:** 4420 gms; HC 38; AC 36 cm; L: 54.5
**Nuchal Cord?** Loose loop around neck (Ped records)

| APGAR | 1 Minute | 5 Minutes | 10 minute | 20 minutes |
|---|---|---|---|---|
| Heart Rate | | 2 | 2 | 2 |
| Respirations | | | | |
| Muscle Tone | | | | |
| Reflex Irritabil. | | | | 1 |
| Color | 0 | 1 | 2 | 2 |
| TOTAL | 0 | 3 | 4 | 5 |

RESUSCITATION
- 1103: Ped arrived in Delivery room to infant being vigorously stimulated by Dr. K; no spontaneous respirations
- Chest compression for less than 30 seconds for low heart rate of 60 bpm for less than 30 seconds, after which ...up to over 100 bpm
- Intubated within 1 minute of birth due to respiratory depression w 3.5 ET - (see Neon Admission Data sheet)
- Transferred right away to NICU
- Later transferred to Children's Hospital of Pittsburgh

Early Newborn Gases

| | FiO2 | pH | pCO2 | pO2 | HCO3 | BE | |
|---|---|---|---|---|---|---|---|
| CORD GASES | | | | | | | |
| • Arterial | @2349 | 7.13 | 50 | 31 | 16 | -13 | |
| • Venous | | | | | | | |
| NEWBORN | | | | | | | |
| 0025 | To vent. | 6.60 | 95 | 73 | 8.6 | ? | |
| 0030 | | 6.90 | 49 | 102 | 8.2 | -27 | |
| 0130 | | 7.30 | 23 | 197 | 11 | -14 | |
| | | | | | | | |

**LATER COURSE:**

Baby Mikayla was subsequently transferred to Children's Hospital of Pittsburgh and died later on May 14 2002 at 4:31 pm. Reference to WBC results is mentioned above.

An autopsy was performed - the principal diagnosis being - full term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic ischemic encephalopathy.

**MY OPINIONS:**

**My opinions are presented below linked to allegations by plaintiff:**

***1. No Estimated fetal weight - clinically or sonographically***

Estimation of the fetal weight is not required and in fact is largely inaccurate. See also below.

***2. No mention of informed consent or discussion regarding options for delivery of macrosomic baby.***

The newborn weighed 4420 grams and was Large for Gestational age. By current ACOG guidelines macrosomia is above 4500 gms and may even be greater than 5000 gms for a non-IDM newborn. Importantly if ultrasound were used to estimate fetal weight, the range would be 900 gms on each side of the actual weight. Even if the ultrasound were to identify the actual weight there would be no way for the Ob to know it was correct and furthermore there is no reason to electively offer a cesarean delivery at an estimated weight of 4420 gms.

***3. Fetal bradycardia at 3:37 pm - pitocin not discontinued and no precautions were taken as a result of the bradycardia.***

There is considerable doubt that there was a fetal bradycardia at this time interval. There is considerable likelihood that the heart rate recorded following this time was maternal in origin. Even if fetal, the variability is sufficient to provide reassurance that the fetal acid base status was well within normal limits.

***4. A scalp pH was not performed / unable to be performed***

There is no requirement to perform scalp pH relating to the presence of variability described above or alternatively that the heart rate referred to is maternal in origin. Very few hospitals offer access to scalp capillary blood pH determinations.

***5. Severe and progressive variable decelerations at 10:46 pm and pitocin was not discontinued until 11:43 pm.***

Variable decelerations are noted at 10:46. They are only moderate to moderately severe. Severe variables are generally below 70 bpm in excess of 60 seconds each repeatedly.

Variable decelerations are very common in the second stage. In general as long as the variability between the decelerations is normal, it is assumed there is no significant metabolic acidosis.

At the end the variables are less than 70 bmp for 30-40 seconds and variability is maintained at a baseline rate in the 150 plus range with accelerations above that baseline rate.

Importantly the FHR is consistent with the cord pH of 7.13 with a base deficit of only -13. Both are generally acknowledged to be insufficient to account for a strictly hypoxic etiology for the subsequent course.

***6. Oxytocin Usage***

*Oxytocin use was appropriate and indicated. Labor disorders have criteria and have prognostic significance. However the presence of a disorder is not synonymous with an indication to proceed to cesarean once an interval is achieved. A significant number of patients with labor disorders will deliver vaginally.*

***7. Vacuum pressure between pulls was not reduced between contractions***

Vacuum delivery was appropriately performed in a reasonable time interval. There are no consequences of the vacuum delivery. There is no evidence that can be reliably attributable to trauma in excess of what is commonly encountered in the labor and delivery process.

***8. Severely asphyxiated baby was born with Apgars of 0, 3, 4, and 5 at 1, 5, 10 and 20 minutes. The cord pH was 7.13 with a base excess of -13, which represents metabolic acidosis.***

The newborn was not "severely asphyxiated". The Cord pH was only 7.13 and the Base deficit only -13, both values with 2 standard deviations of normal and well above the values required to cause CP, much less more severe - death.

***9. Causation***

As mentioned above, chorioamnionitis and associated fetal infection or sepsis and / or fetal inflammatory response syndrome is a likely consideration in view of the poor matching of the cord blood with the subsequent newborn course, but good match with the FHR findings observed. There is supportive evidence in terms of maternal temperature and pulse changes as well as rising WBC, polys / segs as well as bands in the newborn first at Dubois Regional Medical Center and later at Childrens Hospital of Pittsburgh.

**SUMMARY:**

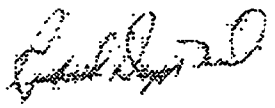
In summary, Dr. Mary Kruszewski and nurses who were involved in the management of Ms. Rhoades were not negligent and did not breach the standard. Their conduct did not increase the risk of harm to the mother or the fetus. There is a high likelihood that infection / sepsis and /or the fetal inflammatory response is responsible for the difficulty

the newborn had in transitioning, despite a relatively common cord pH of 7.13 and base deficit of only -13. Neither is consistent with hypoxia arising in labor as the cause, but is more consistent with infection and its consequences. A negative culture of the newborn would not rule this out because of the sensitivity limitations of blood culture under the circumstances of the case.

My opinions are expressed to a reasonable degree of medical certainty, after considering the complex totality of the specifics of this case. I base my opinions on my expertise and extensive reading and clinical experience in the specialty of Obstetrics and Gynecology and the subspecialty of Maternal Fetal Medicine. I reserve the right to modify or supplement my opinions as additional information and detail becomes available.

Please let me know if there is a need for clarification or additional information.

Best regards,



Richard Depp, M.D.

# EXHIBIT 5

JAMES L. MOLLICK, M.D.
2114 Country View Lane
Lansdale, Pa. 19446
215-661-1066

## EDUCATION

**ALBRIGHT COLLEGE**
Reading, Pa — Graduated: 1982

Bachelor of Science (Magna Cum Laude)... Major: Biology

**TEMPLE UNIVERSITY SCHOOL OF MEDICINE** — Graduated: 1986
Philadelphia, PA

Doctor of Medicine

## PROFESSIONAL EXPERIENCE

**TEMPLE UNIVERSITY HOSPITAL**
Philadelphia, PA

OB/GYN Resident — 1986 to 1990

Academic Chief Resident — 1989 to 1990

## CERTIFICATIONS

Laser Certification-Temple University Hospital — 1990
Clinical Instructor-Temple University Hospital
Laser Course

American Board of Obstetrics and Gynecology — 1992

Diplomate National Board of Medical Examiners

AMA Physicians Recognition Award — 11/1/90 to Present

JAMES L. MOLLICK, M.D.

## EXTENDED EDUCATION

| | |
|---|---|
| Advances in Maternal-Fetal Medicine<br>Vail, Colorado | 1987 |
| Ultrasonography (Dr. Hobbins)<br>Yale University | 1988 |
| Advances in Maternal-Fetal Medicine<br>Vail, Colorado | 1990 |
| American College of Obstretrics and Gynecology<br>Annual Meeting<br>San Francisco, California | 1990 |
| Vaginal Surgery "A Panorama"<br>Temple University | 1991 |
| Hysteroscopy- Master's Course<br>San Francisco, California | 1992 |
| Laparoscopy - "The Easy Way"<br>Orlando, Florida | 1992 |
| Laparoscopy/LEEP Seminar<br>Wyoming, Wisconsin | 1991 |
| Laparascopic Hysterectomy ( Dr. Reich)<br>Kingston, Pennsylvania | 1991 |
| Osler Institute Review Course<br>Nashville, Tennessee | 1992 |

## AWARDS AND HONORS

| | |
|---|---|
| Who's Who's<br>Among outstanding business executives | 1996 |
| Resident of the Year<br>Awarded by Ortho Pharmaceuticals | 1990 |
| Berlex Education Award<br>For Academic Excellence | 1989 |
| Chief Resident Recorder<br>Awarded by Syntex Pharmaceuticals for<br>1990 ACOG meeting, San Francisco, California | 1990 |
| Ortho Pharmaceutical Resident's Day Bowl<br>Third Place | 1990 |

JAMES L. MOLLICK, M.D.

## MANUSCRIPTS IN PREPARATION

Incidence of Actinomycosis Associated with IUD use

Follow-Up Treatment/Response of IUD Related Actinomycosis Infection

Case Report: Meckel's Gruber Syndrome

Retrospective Study: The Biophysical Profile as a Method of Antenatal Surveillance in Premature Rupture of Membranes

## PROFESSIONAL MEMBERSHIPS

1. American Medical Association
2. Pennsylvania Medical Society
3. Montgomery County Medical Society
4. Fellow of the American College of Obstetrics and Gynecology
5. The Society of Laparoendoscopic Surgeons
6. Society of Gynecological Laparoscopists.
7. The Cincinnatus Society

## SPEAKING ENGAGEMENTS

| | |
|---|---|
| Women During the Reproductive Years<br>Sacred Heart Hospital | 1992 |
| Diabetes/Sexuality<br>Sacred Heart Hospital<br>OB/GYN Department | 1992 |
| Women's Issues<br>Business Women's Association of Montgomery County | 1992 |
| Genital Cancer<br>Sacred Heart Hospital | 1991 |
| Women's Health Issues<br>Montgomery Hospital | 1999 to 2001 |
| Montgomery County Bar Association<br>Topic - The expert witness | 2004 |
| Pennsylvania Bar Institute<br>Topic - Birth Trauma<br>Pittsburgh and Philadelphia | 2004 |

James L. Mollick, M.D.

HOSPITAL COMMITTEES

Suburban General Hospital
Norristown, PA
- Surgical Audit Committee
- Quality Assurance Committee

Montgomery Hospital
Norristown, PA
-Tissue (Invasive Procedure) Committee 2000 to 2004
Quality Assurance Committee 2004 to Present

Sacred Heart Hospital
Norristown, Pa.
- Credentials Committee
- JOAH Review Coordinator
- Ethics Committee

Special Committees:

Independence Blue Cross Cesarean Section
advisory committee 1996

Appointments:

Assistant Chairman- Dept. OB/GYN
Montgomery Hospital 1999 to Present

PERSONAL DATA

Date of Birth: 12-01-59
PA Medical License Number: MD-039900-E
DEA Number: BM-1354442

REFERENCES

Personal and professional references will be furnished upon request.

# EXHIBIT 6

James L. Mollick MD FACOG
2114 Country View Ln
Lansdale, PA 19446

Attorney Robert Ging
2095 Humbert Road
Confluence, PA 15424-2371

Dear Mr. Ging,

At your request I reviewed the Defense expert reports of Dr. Depp and Dr. Fox. After review of the reports I have prepared my analysis regarding the methodology used by Dr.s Depp and Fox to reach their hypothesis and the acceptability of the methodology used by Dr.s Depp and Fox to reach their hypothesis by the medical community.

**In my opinion to a reasonable degree of medical certainty, Dr. Depp's analysis and methodology was not a generally accepted scientific practice;**

- First, Dr. Depp bears the burden of proving his hypothesis.
- Secondly, it is incumbent upon Dr. Depp to prove that the methodology that he used to conclude that Ms. Rhoades had chorioamnionitis and that this baby died of sepsis/fetal inflammatory syndrome is generally accepted by scientists in the relevant field as a method of arriving at the conclusion that he will testify to at trial.
- Dr. Depp ignored the facts, deposition testimony, and autopsy report that indicated that Ms. Rhoades did not have chorioamnionitis, that the baby was exposed to hypoxia and asphyxia and died not from sepsis/fetal inflammatory syndrome but from hypoxic ischemic encephalopathy as a result of perinatal birth asphyxia.

Dr. Depp noted in his report that "other than two borderline blood pressures, (the last one on 5/9/02), with no associated significant proteinuria, the pregnancy was relatively uncomplicated within the limits of prenatal evaluation, with limited ability to assess fetal condition.

He also noted that "GBS culture was also negative."

He then goes on to reference,

***"progressive rise in maternal temperature to the last recording of 100.1 at 8 pm several hours before delivery and an associated rise in maternal pulse." "Serial maternal pulse rates over the last several hours and recorded on the FHR strip reflect significant maternal tachycardia. In the absence of terbutaline or maternal heart disease, a change in maternal pulse of the magnitude observed from the time of admission to the time of delivery, especially when taken in the context of the relative rise in maternal temperature is highly suspicious of chorioamnionitis which would place the fetus at risk for infection or sepsis and/or fetal inflammatory response syndrome."***

**According to ACOG,**

**(Article V, section 6)**, "Before offering testimony, the obstetrician-gynecologist **must thoroughly review the medical facts of the case and all available relevant information."**[1]

**(Article V , section 5)**, "The Obstetrician-Gynecologist testifying as an expert witness must have knowledge and experience about the range of the standard of care and the available scientific evidence for the condition in question during the relevant time and **must respond accurately to questions about the range of the standard of care and the available scientific evidence."**[2]

**IN MY OPINION, THE METHODOLOGY USED BY DR. DEPP TO REACH HIS CONCLUSIONS AND HYPOTHESESIS WERE NOT CONSISTENT WITH ARTICLE V, SECTIONS 5 AND 6 AND WERE NOT GENERALLY ACCEPTED BY THE MEDICAL COMMUNITY;**

**1. THERE IS NOTHING TO SUPPORT THAT THIS PATIENT WAS EVER FEBRILE.**

It is my opinion that Dr. Depp did not thoroughly review the medical facts of the case and all available relevant information.

Dr. Depp incorrectly noted that ***"the last recording of 100.1 at 8 pm several hours before delivery"***.

The last temperature recorded prior to delivery was 98.9F at 9:50pm not at 8pm. **(See Pg. 22)**

The last recorded temperature at **9:50pm** was 98.9 F, which was normal. **(See Pg. 22)**

**In review of the data sheet below the patient's temperatures were noted to be normal before, during, and after delivery.**

Vital Signs Sheet Summary,

| VITAL SIGNS | 05/10 | | 05/11 | | | |
|---|---|---|---|---|---|---|
| Vital Signs | 07:49 | 09:50 | 09:38 | 09:50 | 10:40 | 10:50 |
| TEMP #1 | 97.4F | | | 97.1F | | |
| PULSE #1 | 70 | 111 | 111 | 113 | 116 | 117 |
| RESPIRATIONS | 18 | 22 | 22 | 20 | 20 | 18 |
| BP #1 | 110/70 | 101/64 | 119/84 | 110/71 | 126/89 | 109/67 |
| WGHT | 170lb | | | | | |
| HGHT | 66in | | | | | |
| BP equipment | | Accutron | Accutron | | | |
| CARE PROVIDERS | SJK | GAB | GAB | GAB | GAB | GAB |

| VITAL SIGNS | 05/11 | | |
|---|---|---|---|
| Vital Signs | 04:37 | 06:20 | 10:00 |
| TEMP #1 | 98.9F | 97.8F | 98F |
| PULSE #1 | 124 | 98 | 112 |
| RESPIRATIONS | 22 | 20 | 20 |
| BP #1 | 110/70 | 140/80 | 110/70 |
| Insulins | | 75% | |
| dr visits | | Dr Rousseau | |
| CARE PROVIDERS | MAD | SKH | LAB |

[1] ACOG, Code of Professional Ethics, Article V, section 6, 2004.
[2] ACOG, Code of Professional Ethics, Article V, section 5, 2004

**2. THERE IS NO SCEINTIFIC EVIDENCE THAT IN THIS CLINICAL SITUATION THE PATIENT WAS TACHYCARDIC DUE TO INFECTION.**

The patient was noted to have fluctuations of her heart rate throughout her labor course. The patient was noted to have episodes of tachycardia as early as 1505.

Dr. Depp failed to reference a normal heart rate of 87 taken 10 minutes after the temperature of 100.1. He also failed to reference the patient's pulse rates after delivery and upon discharge.

If his contention is that tachycardia in this case was due to infection, then the patient was allowed to labor and deliver without being treated with antibiotics and was discharged with an undiagnosed and untreated infection.

The etiology of maternal tachycardia is extensive.

**According to Harrison's, with reference to tachycardia,**

"It represents a **physiologic response** to a variety of stresses, such as fever, volume depletion, anxiety, exercise, thyrotoxicosis, hypoxemia, or congestive heart failure."[3]

Tachycardia, because of its multiple etiologies, is not a specific finding indicating infection.

Dr. Depp failed to mention normal heart rates at 8:10, 8:40, 8:50, 9:00, 9:20, 11:10 and 11:30.

Dr. Depp failed to reference that the patient was noted to have a "spotty" or "one sided" epidural requiring repeated reinjections. Dr. Depp failed to reference the anesthesia record which indicated that the epidural catheter was removed due to "patchy epidural" and the epidural was again reinserted at around 2100. The epidural was discontinued according to the nurse's notation at around 10:30. These notations indicate that the patient's pain relief was not continuous and in my opinion resulted in the episodic increases in her pulse rate due to pain and anxiety.

A common reason for maternal fluctuations of heart rate in labor would be pain/anxiety and its relationship to a contraction.

The patient's recorded temperatures (documented above) before, during and after delivery were in the normal range.

**Dr. Depp ignored the following scientific evidence in formulating his hypothesis;**

1. The patient had a negative Group B strep culture.
2. She had a normal WBC count. The Patient's white blood cell count was not elevated and was noted to be 10.84 on 5/10/02 at 0720. Dr. Kruszewski did not order a post delivery WBC count.
3. The patient was **never** noted to be febrile (T-100.4 or 38 Degrees C).
4. There is no documentation in the record or deposition testimony to support that the patient complained of or had uterine tenderness, and or foul smelling discharge or amniotic fluid.
5. There was no documented tachypnea or hypotension that would accompany severe infection or maternal sepsis.
6. Dr. Kruszenski never does a workup and/or treats the patient for infection (chorioamnionitis) either before, during or after delivery.
7. There is no documentation in the record supporting anyone ever made the diagnosis of chorioamnionitis.
8. The placental pathology report stated that there was **NO** evidence of Chorioamnionitis.
9. There was nothing to support that there was evidence of sustained fetal tachycardia.

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[3] Harrison's Principals of Internal Medicine, Fauci et al., 15th edition, 2001, pg. 1295

**According to Williams (with reference to diagnosis of chorioamnionitis),**
"Fever is the only reliable indicator for making this diagnosis; a temperature of 38 degrees centigrade (100.4) or higher accompanying ruptured membranes implies infection."[4]

**According to Creasy (with reference to intra-amniotic infection),**
"With onset of labor or with rupture of the membranes, bacteria from the lower genital tract commonly ascend into the amniotic cavity.

"Diagnosis is usually based upon maternal fever, maternal or fetal tachycardia, uterine tenderness, foul odor of the amniotic fluid, and leukocytosis. In patients with fever, two sets of blood cultures should be drawn."... "Because peripheral blood leukocytosis occurs commonly in normal labor, this result is not always indicative of infection."[5]

**According to Fanaroff with reference to intra-amniotic infection,**
**"The clinical diagnosis of IAI is made on the basis of maternal fever, foul odor of the amniotic fluid, and leukocytosis (Box 22-1).** Ruptured membranes are invariably present and, along with fever and leukocytosis, are the most common findings. **Uterine tenderness and foul smelling amniotic fluid are more specific but present in a minority of cases."**[6]

"Laboratory criteria, likewise, tend to be nonspecific. Peripheral blood leukocytosis commonly occurs in normal labor. Maternal bacteremia occurs in only 10% of patients. Positive gram stains and colony counts of greater than 100/ml of amniotic fluid are associated with clinical infection. However, on unselected patients with ruptured membranes, bacteria is often demonstrated in the amniotic fluid despite a lack of clinical evidence of infection."[7]

"Clinical risk factors associated with IAI include duration of membrane rupture, transcervical instrumentation, and digital examinations."[8]

"Patients with premature PROM are more likely to experience IAI. In patients with intact membranes, IAI has been seen occasionally in patients who have undergone amniocentesis or percutaneous umbilical blood sampling and more frequently in patients who have had a cervical cerclage placed."[9]

Dr. Depp also makes reference to an ***"elevated newborn WBC count"*** and ***"further elevation of the WBC count to 42.2 with 55 polys, 13 bands."***

**According to Fanaroff,** "In the newborn the absolute neutrophil count is elevated for the first few days of life (table 44-11).

**According to Creasy,** "perinatal mortality is increased in cases of IAI, but little of the excess mortality can be attributed to infection per se."[10]

**According to Williams Obstetrics (with regards to neonatal infection and sepsis),**
"The response to sepsis may be hypothermia rather than hyperthermia and the total leukocyte count and neutrophil count may be depressed or not influenced by sepsis."[11]

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[4] Williams Obstetrics, 21st Edition, Cunningham et al, 2001, pg 706.
[5] Creasy/Resnick, Maternal Fetal Medicine, 1989, 667-668.
[6] Neonatal-Perinatal Medicine, Fanarof et al, 7th edition, 2002, 373.
[7] Neonatal-Perinatal Medicine, Fanarof et al, 7th edition, 2002, 373.
[8] Neonatal-Perinatal Medicine, Fanarof et al, 7th edition, 2002, 373.
[9] Neonatal-Perinatal Medicine, Fanarof et al, 7th edition, 2002, 373.
[10] Maternal Fetal Medicine, Second Edition, Creasy/Resnick, 1989, 669..

[11] Williams Obstetrics, 21st Edition, Cunningham et al, 2001, pg. 1462

Dr. Depp goes on to note,

***"The latter would account for why the FHR pattern observed over the last hour is consistent with the observed cord ph of 7.13 and base deficit of -13, but not consistent with the first umbilical blood gas of 6.60 which was observed at approximately 35-36 minutes of life following placement on a ventilator."*****.....**

***"In view of the surprising appearance of the fetus at birth with a pH of only 7.13 which correlates well with the observed fetal heart rate pattern, it is likely that there is an independent process which accounts for the inability of the fetus to transition to newborn condition in the first hour and the associated dropping pH. Continuous FHR does not screen for fetal infection, but instead is limited to screening for varying degrees of cord compression and uteroplacental insufficiency."***

**THE SCIENTIFIC EVIDENCE DOES NOT SUPPORT DR. DEPP'S ASSUMPTIONS AND HYPOTHESIS SUGGESTING MATERNAL AND OR FETAL INFECTION.**

Although Dr. Depp states that the fetal heart tracing ***"does not screen for fetal infection"*** he ignores the fact that the absence of fetal tachycardia supports that the patient did not have chorioamnionitis and that the baby was not infected.

Dr. Depp references the ***""surprising appearance"*** of the fetus at birth and a pH of 7.13 which correlates with the observed fetal heart rate pattern." I can find nothing to support this assumption.

The baby's profound depression at birth was consistent with the fetal tracing, the first **reliable arterial gases** obtained in the nursery of 6.60, the findings on the fetal heart tracing, and those documented by Dr. Chandrasekhar in his History and Physical.

The first arterial gas in the NICU showed a **pH of 6.60.**

**According to the History and Physical exam of Dr. Chandrasekhar,**

"The baby was limp at birth and with **no heart rate or respirations.** Apgar at one minute was 0, at five minutes was 3, at 10 minutes was 4 and at 20 minutes was 5." **"Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds."**

Dr. Depp references a ***"ph of 7.13"*** but ignores that the cord ph slip did not mention the site from which it was obtained, the deposition testimony of Dr. Grout and Karen Constantino questioning the validity of the value, the findings on the fetal tracing, and medical literature.

**1. THERE IS NO DOCUMENTATION ON THE CORD PH SLIP AS TO WHAT SITE IT WAS OBTAINED FROM. (See Page 26)**

Dr. Depp bases his hypothesis of chorioamnionitis and sepsis on a "PH of 7.13" but did not question how and from where the "PH of 7.13" was drawn.

He goes on to note on page 5 in his chart that it was an **"Arterial Cord Gas" @2349.**

According to the Cord gas slip the sample was drawn at **0010** on 5/11/02 by KC and was labeled "Cord Gas". There is nothing on the slip indicating the specific site it was obtained from. (Artery or Vein).

**2. DR. DEPP IGNORED THE DEPOSITION TESTIMONY OF KAREN CONSTANINO AND DR. GROUT.**

**According to the Deposition Testimony of Karen Constantino**, she was called Stat close to midnight to the delivery room to obtain the ph.

Question - "Did you perform a blood gas or did you extract the blood to submit to the lab for a blood gas test from the cord?"(7)

Answer - "We don't submit them to the lab. We run them and draw and them, it's a respiratory function."

Question - "So you do both testing and the obtaining of the blood sample to be tested?"(7)

Answer - "Right"

Question - "Did you do that in this case? (7)

Answer - "Yes I did."

Question - "How did you obtain the blood gas sample in this case?"(7)

Answer - "I used they -- we have pre-Heparinized syringes for drawing blood and just insert the needle in either the vein or the artery of the cord and draw sufficient amount to which each usually around 3 cc and then we put them in the blood gas machine which reads the values.

Question - "Do you keep a record of whether you put the needle in the vein or the artery?"(7)

Answer - "**No, because sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed.**"

Question - "OK. In this case would the chart show or would you have any record of where the sample actually came from?"

Answer - "No, it's just I would have marked it a cord gas."

**According to the deposition testimony of Richard Grout,**

Question - "Dr. Chandrasrasekar also noted a cord pH of 7.1 of 3, what was the significance of that finding to you when you took over Mikayla's care?"(15)

Answer - "That indicates the infant had acidosis at the time of birth. The accuracy of that finding is difficult to assess sometimes because **it's not always known whether that sample comes from the cord artery or the cord vein.**"

**"Or it can be a mixture of the two together."**

"And **it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two.**"(16)

Question - "When you stated on the cord gas which I think was around midnight was taken, you indicated that was **not reliable because you didn't know what vessel it came from?**" (38)

Answer - "Correct"

Question - "And is that because of the person taking the sample, could you explain that a little more, I know you explained there were a vessel and an artery?"(38)

Answer - "I believe it has to do with the technique that's used to do it."

Question - "Do you know what technique was used here" (38)

Answer - "They still do it the same way. It is basically, the sample of the cord is isolated between two clamps, and a needle attached or syringe is inserted in the cord and they attempt to aspirate back blood and hopefully -- **usually they try to go to the vein.**

Question - "We have no evidence here, other than the fact there was the cord gas, **we don't know whether they were in the vein or an artery, is that what you're saying?"(38)**

Answer - "Correct, you don't know for absolute certainty which one."

Question - "So indeed he could be a valid test to?"(39)

Answer - "Well, its validity is, it certainly couldn't be any better than it was. I mean the best -- the sample coming from the vein with the blood going to the baby, and hopefully that would be the best that he could be."

Question - "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that is evidence of acidosis?(39)

Answer - "Correct."

The significance of this testimony is that according to Dr. Grout, they **"usually try to go to the vein."(38)** Venous cord blood is a reflection of maternal metabolic parameters since venous blood flows from the mother to the baby. Arterial blood reflects fetal metabolic parameters because it flow from fetus to mother.

**In this situation, the Cord Ph at delivery was unreliable because the tech who drew the blood did not document a specific site from which it was drawn, and by her own admission she did not know exactly what value was being obtained and that sometimes the blood is mixed.**

**Dr. Grout admitted that they usually obtain the ph specimen from the VEIN, that "it's not always known whether that sample comes from the cord artery or the cord vein", that "it can be a mixture of the two together", and "it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two."(16)**

The cord blood values obtained in the nursery of 6.6 and 6.9 were consistent with severe periodic changes and bradycardia seen on the fetal tracing, and the profound depression documented by Dr. Chandrasekhar including the need for **"CHEST COMPRESSIONS"**.

The Apgar score of 3 at 5 minutes and findings in the nursery of neonatal neurological sequelae including seizures, were all consistent with intrapartum asphyxia.

**3. THE FETAL HEART PATTERN WAS CONSISTENT WITH HYPOXIA AND ASPHYXIA. THIS WAS SUPPORTED BY THE LITERATURE, THE FINDINGS BY THE PEDIATRICIANS, NEONATOLOGISTS, AND THE AUTOPSY REPORT.**

**A. THE FETAL TRACING DEMONSTRATED FINDINGS CONSISTENT WITH HYPOXIA AND ASPHYXIA,**

The fetal tracing indicates that from 2250, the baby was exposed to variable decelerations which became severe and continued through 2338 terminating in a severe bradycardia with an audible FHR in the 60-70's.

According to the Nursing Progress Notes,

At 2300, **"the depth of the variable deceleration reached FHR low 60's and returned to baseline 130's to 140's."**

At 2330, **"variable decels to 58-72bpm lasting 30-80 sec"**

At 2344, **"FHR audible 60-70"**

At 2346, **"FHR audible @ 50bpm and dropping."**

The fetal tracing revealed repetitive severe variable deceleration, with loss of short term variability on the external monitor eventually ending in terminal bradycardia. These findings were consistent with hypoxia and asphyxia.

**B. THE LITERATURE SUPPORTS THE FINDINGS ON THE FETAL TRACING WERE CONSISTENT WITH HYPOXIA AND ASPHYXIA AND THAT THIS BABY WAS ASPHYXIATED,**

**According to Parer,**

"Fetal asphyxia almost always occurs as a result of insufficient umbilical or insufficient uterine blood flow."[12]

**According to Parer,**

"There is also general agreement that the fetus with absent FHR variability, a heart rate within or outside the normal range, and deep variable or late decelerations, is presumed to be **asphyxiated**, and expeditious delivery is indicated."[13]

**According to Parer,**

"In the presence of normal FHR variability, no matter what other FHR patterns may be present, the fetus is not suffering cerebral tissue asphyxia, because it has been able to successfully centralize the available oxygen and is thus is physiologically compensated. In the presence of excessive asphyxial stress, however, as evidenced by severe periodic changes or prolonged bradycardia, this compensation may break down, and the fetus may have progressive central tissue asphyxia (i.e., hypoxia in cerebral and myocardial tissues). In this case, it is theorized that fetal heart rate variability decreases and eventually is lost."[14]

**According to Parer,**

"The presence of FHR variability indicates central (nervous system and or myocardial) normoxia, while its decrease in the presence of distress patterns indicates a decrease in the oxygenation of these organs."[15]

**According to Parer, with reference to the external fetal monitor,**

"Although this device is simple to apply and can be used before rupture of the membranes, it sometimes is unreliable during labor because of maternal and fetal movement. **A greater disadvantage is that it may not always give a valid indication of beat to beat variability**, because the Doppler signal is broad and slurred, and the machine is not always able to select accurately and consistently a point on this slurred curve to represent the exact time of a cardiac event. Hence, an artificial short term variability can be portrayed by the apparatus. Long term variability, however may be displayed reasonably accurately."[16]

**According to Parer, with reference to a fetal scalp electrode,**

"This mode gives the most valid FHR tracing because of the discreteness of the signal; therefore, it best depicts beat to beat variability."[17]

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[12] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg198.
[13] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 201
[14] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 157.
[15] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 202.
[16] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 103
[17] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 102.

**According to Parer, severe variable decelerations are described as,**

"A. Below 60 beats per minute and

B. Longer than 60 seconds in duration."[18]

Other practitioners may use the "rule of 60s" as a guideline.

**"When severe variable decelerations are present, vigorous efforts should be made to abolish them, because it is likely that even the normally grown fetus with normal placental function eventually will decompensate, although usually not before 30 minutes."**[19]

**According to Parer,**

"During severe variable decelerations the heart rate pattern must be observed for an intermittent reduction in FHR variability during and following the variable deceleration. Should this begin to occur and still abolition of the decelerations can not be achieved by the means outlined above (resuscitation maneuvers), then delivery is recommended. Delivery is recommended before the total loss of variability because this may signify asphyxial decompensation, and indeed must be present to do so unless asphyxia can be ruled out by ancillary methods."[20]

**"Severe variable decelerations in the presence of frequent uterine activity may become confluent and form a prolonged deceleration, and eventually a bradycardia.** Therefore in the presence of persistent severe variable decelerations it is prudent to attempt to maintain uterine contractions more than two minutes apart."[21]

**According to ACOG,**

"The term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia, and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damage, including all of the following:

1. Profound metabolic or mixed acidemia (pH less than 7.00) on an umbilical cord **arterial** blood sample, if obtained.

2. Persistent Apgar scores of 0-3 for longer than five minutes.

3. Evidence of neonatal neurological sequelae (e.g., seizures, coma, hypotonia, and one or more of the following: cardiovascular, gastrointestinal, hematologic, pulmonary, or renal system dysfunction)."[22]

## C. INTRAPARTUM ASPHYXIA WAS ALSO SUPPORTED BY THE HISTORY AND PHYSICAL EXAM OF DR. CHANDRASEKHAR, THE NEONATAL/NEUROLOGICAL NOTES AND THE AUTOPSY REPORT.

Dr. Depp ignored the History and Physical examination of Dr. Chandrasekhar, the Neonatal/Neurological notes and the Autopsy Report.

**According to the History and Physical exam of Dr. Chandrasekhar,**

"The baby was limp at birth and with **no heart rate or respirations.** Apgar at one minute was 0, at five minutes was 3, at 10 minutes was 4 and at 20 minutes was 5." "Chest compressions were provided

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[18] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.
[19] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.
[20] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.
[21] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.
[22] ACOG Committee Opinion, No. 197, February 1998.

for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds." The first gas in the NICU showed a **pH of 6.60**.

Excerpts from the physical exam revealed that the central nervous system examination shows anterior fontanel open, **pupils were small but did not appear to react to light. The baby did not have any response to painful stimuli. Deep tendon reflexes were not elicitable.**

The baby's neurological exam was markedly abnormal and the baby was placed on prophylactic Phenobarbital for seizures.

Dr. Grout admitted in his deposition that the cord pH obtained at delivery indicated fetal acidosis.

**According to the Discharge Summary dictated by Dr. Richard Grout,**

This patient was transferred to Children's Hospital because of **"birth asphyxia."**

The transferred diagnosis was, **"severe birth asphyxia, term birth."** After evaluation at the Children's Hospital of Pittsburgh revealed no baseline brain activity, the baby was withdrawn from life support and died.

**Excerpts from the Children's Hospital of Pittsburgh Inpatient Discharge Summary dated 6/28/02 by Carol Gilmour M.D. indicate that;**

"She did have chest compressions for less than 30 seconds for low heart rate."

"Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace.

The baby was evaluated for sepsis.

We also had neurology evaluate her. **Her EEG times two showed no baseline activity**, just intermittent focal sharp waves. She had a CT scan times two that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had lost a spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of **severe hypoxic ischemic encephalopathy.**

Over the next several days there was no change in Mikayla's exam. There continued to be fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with neonatology, neurology, social work in the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life-support. **The etiology is suspected to be acute perinatal total asphyxia**. -- This was discussed thoroughly with the parents so the family did continue support of this infant."

**Excerpts from the Initial Consultation on 5/11/02 at 12:50 by Neurology indicate that,**

Asked to see Mikayla secondary to **"perinatal asphyxia and neonatal seizures."**

**According to the Autopsy Report,**

The final autopsy report indicated, **"A five day old female with hypoxic encephalopathy (clinical)" and a brain with "acute ischemic encephalopathy, severe."**

**According to the Autopsy Summary/Discussion,**

"At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." **---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."**

Dr. Depp goes on to note, ***"Infection/sepsis/and/or fetal inflammatory response would be a good independent candidate to explain the newborn transitioning difficulty and the laboratory findings. Infection/sepsis/FIRs can present a clinical picture identical to that of severe metabolic acidosis including the Apgar scores (which conflict with the observed cord blood gases) in such a difficulty in transitioning. The maternal findings of a rising maternal temperature and increasing pulse rate to frank tachycardia are clearly supportive of such a cause. Negative cultures would not eliminate that consideration because of sensitivity limitations of cultures.***

Dr. Depp suggests that the newborn had "transitioning difficulty" when in fact the baby was profoundly depressed and asphyxiated requiring cardiopulmonary resuscitation.

The only transition that the baby experienced was from life to death.

Dr. Depp relies on maternal tachycardia, a nonspecific finding, which can have numerous etiologies as already noted but then discounts negative cultures performed on the baby because of "sensitivity limitations".

As already noted, Dr. Kruszewski never documents anywhere in the chart that the patient had chorioamnionitis or an infection. The patient's WBC count was normal and was not repeated. The Group B strep culture was noted to be negative. The patient did not complain of or was noted to have uterine tenderness, foul smelling discharge or amniotic fluid. She was not febrile either before, during or after labor and delivery. The placental pathology did not show evidence of chorioamnionitis. There was nothing on the fetal tracing suggesting sustained fetal tachycardia. Dr. Kruszewski did not give this patient intravenous or oral antibiotics either during or after labor. There were no notes by any of the clinicians caring for this mother or baby indicating that the baby had or died from infection. They did document asphyxia.

The neonatal and neurology progress notes documented perinatal asphyxia and or hypoxic ischemic encephalopathy. The autopsy confirmed severe perinatal asphyxia and found no evidence of infection. The baby's blood, cerebrospinal fluid, tracheal aspirate, urine and viral cultures were documented to be negative. I can find no basis in the medical literature, the patient's medical chart, or the baby's medical chart to support Dr. Depp's hypothesis.

There was no disparity between the Apgar scores and the observed cord gases in the nursery. The cord gas is in the nursery of 6.6 and 6.9 were consistent with severe perinatal asphyxia as seen on the fetal tracings. The pH obtained near the time of delivery was not accurate because there was no notation as to how and from what site it was drawn. By the admission of the technician who drew the sample, she could not state from where the specimen was obtained. According to Dr. Grout, the sample is routinely obtained form the VEIN. He also suggests the possibility of a mixed sample. This would explain why the specimen although acidotic was not severely acidotic.

**IN HIS OPINIONS SECTION, DR. DEPP DEMONSTRATED THAT HE DID NOT THOROUGHLY REVIEW THE MEDICAL FACTS OF THE CASE AND ALL AVAILABLE RELEVANT INFORMATION BY INACCURATELY NOTING IN HIS REPORT THAT,**

**A. LATER COURSE-**

***"An autopsy was performed – the principle diagnosis being – full term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic ischemic encephalopathy."*** **(Page 6)**

This statement cannot be found in or is supported by the Autopsy report.

According to the **FINAL AUTOPSY REPORT** dated 5/15/02, the final autopsy diagnoses were;

- "A five day old female with **hypoxic ischemic encephalopathy**",
- Brain – **"Acute ischemic encephalopathy, severe."**
- Special Procedures:
  - CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord; **ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE.**
- **Microscopic Neuropathology revealed –**
  "Sections show widespread, **severe acute ischemic damage in neurons in nearly all areas of the brain** with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

- **According to the Summary/Discussion,**
  "At autopsy the most significant finding of a **severe hypoxic encephalopathy, most likely due to perinatal asphyxia."** ---- **"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."**

B. Dr. Depp goes on to note in his **OPINION** section **(page 7, No. 8),**

***"The newborn was not "severely asphyxiated".*** *"The cord pH was only 7.13 and the base deficit only -13, both values with two standard deviations of normal and well above what is required to cause CP, much less more severe -- death."*

The records do not support his assumption.

**1. DR. DEPP IGNORED THE PROGRESS NOTES AND RECORDS OF THE BABY,**

**According to History and Physical examination done by Sundar Chandrasekhar, M.D.;**

**"The baby was limp at birth with no heart rate or respirations.** Apgar at 1 minute was 0, at 5 minutes was 3, at 10 minutes was 4, at 20 minutes was 5. Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds, after which the heart rate went up to over 100 per minute. The baby was then transferred right away to the NICU for further management. First gas in the NICU showed a **pH of 6.60**, a second gas done at 12:30 a.m. showed a **pH of 6.90**, CO2 of 49, PO2 of 1021 vent settings of 100% oxygen."

Excerpts from the physical exam revealed that the central nervous system examination shows anterior fontanel open, pupils were small but did not appear to react to light. **The baby did not have any response to painful stimuli. Deep tendon reflexes were not elicitable.**

The baby's neurological exam was markedly abnormal and the baby was placed on prophylactic phenobarbital for seizures.

**After evaluation at the Children's Hospital of Pittsburgh revealed no baseline brain activity, the baby was withdrawn from life support and died.**

**According to the Pediatric Discharge Summary by Dr. Richard Grout, M.D.;**

"This patient was transferred to Children's Hospital because of **birth asphyxia** with Apgar scores at 0 at 1 minute, 3 at 5 minutes, 4 at 10 minutes, 5 at 20 minutes."

Excerpts from the physical examination revealed a birth weight of 4400 g. "The patient was noted to be minimally responsive to external stimuli with some withdrawal to noxious stimuli only. The

patient had some tremors and was given to boluses of Phenobarbital 10mg/kg for a total of20 mg/kg. The patient was catheterized and there was a small urine output which was sent for urine analysis."

The transferred diagnosis was: **"severe birth asphyxia, term birth."**

Reason for transfer was: "need for supervisory care of the pediatric neurologist and in conjunction with the familial request for transfer."

**Excerpts from the Children's Hospital of Pittsburgh inpatient discharge summary dated 6/28/02 by Carol Gilmour M.D. indicate that;**

"She did have chest compressions for less than 30 seconds for low heart rate."

"Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace.

The baby was evaluated for sepsis.

We also had neurology evaluate her. Her EEG times two showed no baseline activity, just intermittent focal sharp waves. She had a CT scan times two that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had lost a spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of **severe hypoxic ischemic encephalopathy.**

Over the next several days there was no change in Mikayla exam. There continued to be fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with neonatology, neurology, social work in the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life-support. The etiology is suspected to be **acute perinatal total asphyxia.** -- This was discussed thoroughly with the parents so the family did continue support of this infant."

**Excerpts from the Initial Consultation on 5/11/02 at 12:50 by Neurology indicate,**

Asked to see Mikayla secondary to **"perinatal asphyxia and neonatal seizures."**

**2. DR. DEPP IGNORED THE DEPOSITION TESTIMONY OF KAREN CONSTANTINO AND DR. GROUT,**

According to the Cord gas slip, the sample was drawn at **0010** on 5/11/02 by KC (Karen Constantino) and was labeled "Cord Gas". There is nothing on the slip indicating the specific site from which it was obtained from artery or vein **(See Pg. 26).** Dr. Depp did not question from where the cord gas was obtained and did not mention or consider the deposition testimony of Dr. Gout and Karen Constanino.

**According to the deposition testimony of Karen Constantino,** she was called Stat close to midnight to the delivery room to obtain the ph.

Question - **"Do you keep a record of whether you put the needle in the vein or the artery?"**(7)

Answer - **"No, because sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed."**

Question - **"OK. In this case would the chart show or would you have any record of where the sample actually came from?"**

Answer - **"No, it's just I would have marked it a cord gas."**

**According to the deposition of Richard Grout,**

Question - "Dr. Chandrasrasekar also noted a cord pH of 7.1 of 3, what was the significance of that finding to you when you took over Mikayla's care?"(15)

Answer - "That indicates the infant had acidosis at the time of birth. **The accuracy of that finding is difficult to assess sometimes because it's not always known whether that sample comes from the cord artery or the cord vein."**

**"Or it can be a mixture of the two together."**

"And **it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two."**(16)

Question - **"When you stated on the cord gas which I think was around midnight was taken, you indicated that was not reliable because you didn't know what vessel it came from?" (38)**

Answer - **"Correct"**

Question - "And is that because of the person taking the sample, could you explain that a little more, I know you explained there were a vessel and an artery?"(38)

Answer - **"I believe it has to do with the technique that's used to do it."**

Question - "Do you know what technique was used here" (38)

Answer - "They still do it the same way. It is basically, the sample of the cord is isolated between two clamps, and a needle attached or syringe is inserted in the cord and they attempt to aspirate back blood and hopefully – **usually they try to go to the vein.**

Question - **"We have no evidence here, other than the fact there was the cord gas, we don't know whether they were in the vein or an artery, is that what you're saying?"(38)**

Answer - **"Correct, you don't know for absolute certainty which one."**

**3. DR. DEPP IGNORED THE FINDINGS IN THE AUTOPSY REPORT,**

According to the **FINAL AUTOPSY REPORT** dated 5/15/02, the final autopsy diagnoses were;
"A five day old female with **hypoxic ischemic encephalopathy**",
Brain – **"Acute ischemic encephalopathy, severe."**
Edematous and congested lungs,
Biventricular hypertrophy of the heart,
Congested hepatomegaly,
Congested spleen,
Thymic depletion,
Hemorrhagic adrenal glands,
Congested kidneys,
Pericardial fluid,
Generalized pitting edema.

Special Procedures:
CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord;
**1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE**

Microscopic Neuropathology revealed – "sections show widespread, **severe acute ischemic damage in neurons in nearly all areas of the brain** with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

The final autopsy report indicated, **"A five day old female with hypoxic encephalopathy (clinical)" and a brain with "acute ischemic encephalopathy, severe."**

**According to the Summary/Discussion,**

"At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- **"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."**

C. Dr. Depp goes on to note in his **OPINION (Page 7, No. 9 – Causation)**–

***"As mentioned above, chorioamnionitis and associated fetal infection or sepsis and/or fetal inflammatory response is a likely consideration in view of the poor matching of the cord blood for subsequent newborn course, but good match with the fetal heart rate findings observed. There's support of evidence in terms of maternal temperature and pulse changes as well as rising WBC, polys/segs as well as bands in the newborn first at Dubois Regional Medical Center and later at the Children's Hospital of Pittsburgh.", and,***

He goes on to note in the summary that, ***"there is a high likelihood that infection/sepsis and/or the fetal inflammatory response is responsible for the difficulty the newborn had been transitioning, despite a relatively common cord pH is 7.13 and base deficit of only -13. Neither is consistent with hypoxia arising in labor as the cause, but is more consistent with infection and its consequences. A negative culture of the newborn would not rule this out because of the sensitivity limitations of blood culture under the circumstances of this case."***

Dr. Depp relies on the cord pH result of 7.13 in forming his hypothesis. As stated in my response, the cord pH slip does not indicate from where the sample was taken either artery or vein **(see Pg. 26).**

The deposition testimony of Karen Constantino, the technician who drew the cord pH sample indicates that, "**sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed.**" According to the deposition testimony of Dr. Grout, the accuracy of the cord pH sample was questionable, and he indicated that the usually **try to obtain blood from the vein.**

The fetal heart rate tracing was consistent with hypoxia and asphyxia with recurrent severe variable decelerations, with loss of short-term very ability, ending in terminal bradycardia. Contrary to his assumption, the patient was noted to have terminal bradycardia with the nurses documenting fetal heart tones dropping to the 60's.

Dr. Depp in his report comments on fetal variability but failed to note the only way to adequately evaluate this is through the placement of a scalp electrode.

The baby was born severely depressed, requiring CPR, with a five-minute Apgar of 3, was noted to have seizure activity requiring Phenobarbital, and had multiorgan system involvement.

The baby was diagnosed with perinatal asphyxia, the autopsy report confirmed hypoxic ischemic encephalopathy and perinatal asphyxia and it was documented in the autopsy summary that "At autopsy the most significant finding of a severe hypoxic encephalopathy, **most likely due to perinatal asphyxia.**" ---- **"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."**

**In my opinion to a reasonable degree of medical certainty, Dr. Depp's analysis and methodology was not a generally accepted scientific practice;**

- Dr. Depp bears the burden of proving his hypothesis. He did not.
- It is incumbent upon Dr. Depp to prove that the methodology that he used to conclude that Ms. Rhoades had chorioamnionitis and that this baby died of sepsis is generally accepted by scientists in the relevant field as a method of arriving at the conclusion that he will testify to at trial. He did not.
- Dr. Depp ignored the facts and deposition testimony that indicated that Ms. Rhoades did not have chorioamnionitis, that the baby was exposed to hypoxia and asphyxia and died not from sepsis but from hypoxic ischemic encephalopathy as a result of perinatal birth asphyxia.

## 1. THE PATIENT DID NOT HAVE CHORIOAMNIONITIS OR INFECTION –

Dr. Kruszewski never documented that she made the diagnosis of chorioamnionitis. The patient was never noted to be febrile and in fact had a normal temperature before and just prior to delivery. The fetal tracings did not reveal fetal tachycardia. The patient was noted to have episodes of tachycardia but also had a "Spotty" epidural which would explain the intermittent elevations in her heart rate due to pain and/or anxiety. The patient's white blood cell count was normal and not repeated. She was never noted to have uterine tenderness, foul smelling discharge or amniotic fluid. The Group B Strep culture on the patient was negative for bacteria **(See Pg. 25). The placental pathology revealed that there was no chorioamnionitis present (See Pgs. 23, 24).** The patient was never treated with antibiotics for chorioamnionitis either in labor or postpartum nor was the diagnosis of chorioamnionitis found in any of the medical records.

## 2. THE BABY DID NOT HAVE INFECTION OR SEPSIS BUT WAS SEVERELY ASPHYXIATED.

### A. In review the fetal tracings there is nothing to support that there was fetal tachycardia.

**According to Parer,**

"Tachycardia, an increase or baseline of greater then or equal to 160 beats per minute, is arbitrarily distinguished from an acceleration, or prolonged acceleration in that its duration is 10 minutes or longer."[23]

The Baseline is defined as, "the approximate mean fetal heart rate during a 10 minute segment excluding periodic or episodic changes, periods of increased fetal heart rate variability, and segments of the baseline which differ by 25 beats per minute or more."[24]

**According to Parer,**

" tachycardia seen in some cases in fetal asphyxia but virtually never alone during labor, that is, in the presence of normal fetal heart rate variability in absent periodic changes the tachycardia must be assumed to be due to some other causes besides hypoxia. Tachycardia sometimes seen on recovery from asphyxia and probably represents catecholamine activity following sympathetic nervous or adrenal medullary activity in response to this asphyxia stress, and withdrawal of bagel activity when the hypoxia

[23] Handbook of Fetal Heart Rate Monitoring, Parer, Second Edition, 1997, 152
[24] Handbook of Fetal Heart Rate Monitoring, Parer, Second Edition, 1997, 145

is relieved. **There are a number of nonessential causes of tachycardia. The most common of these is maternal or fetal infection, especially chorioamnionitis.** Some drugs will cause tachycardia, for example, Beta-mimetic agents or parasympathetic blockers such as atropine."[25]

**B. The placental pathology report on the specimen collected 5/10/02 at 2354 revealed "No evidence of acute chorioamnionitis or funisitis."**

**According to Fanaroff with reference to chorioamnionitis,**
"In the initial stages (1 to 2 hours), maternal neutrophils marginate in the fibrin just below the chorionic plate (early chorioamnionitis). Later, neutrophils, predominantly maternal, infiltrate the entire chorionic plate and the full thickness of the membranes (2 to 24 hours)."[26]

**C. The Pediatric/Neonatal/Neurological Notes and Summaries do not mention that the baby was diagnosed with "Sepsis" and the cultures performed on the baby were negative for infection.**

**According to the Pediatric Discharge Summary by Dr. Richard Grout, M.D.;**
The transferred diagnosis was: **"severe birth asphyxia, term birth."**

**Excerpts from the Children's Hospital of Pittsburgh inpatient discharge summary dated 6/28/02 by Carol Gilmour M.D. indicate that;**
Neurology's impression was that of **severe hypoxic ischemic encephalopathy.**
The etiology is suspected to be **acute perinatal total asphyxia.** -- This was discussed thoroughly with the parents so the family did continue support of this infant."

**Excerpts from the Initial Consultation on 5/11/02 at 12:50 by Neurology indicate that,**
Asked to see Mikayla secondary to **"perinatal asphyxia and neonatal seizures."**

**D. The autopsy report confirmed the diagnosis of hypoxic ischemic encephalopathy. There was no finding of sepsis.**

According to the **FINAL AUTOPSY REPORT** dated 5/15/02, the final autopsy diagnoses were;
"A five day old female with **hypoxic ischemic encephalopathy**",

Brain – **"Acute ischemic encephalopathy, severe."**
Edematous and congested lungs,
Biventricular hypertrophy of the heart,
Congested hepatomegaly,
Congested spleen,
Thymic depletion,

[25] Handbook of Fetal Heart Rate Monitoring, Parer, Second Edition, 1997, 152-156

[26] Neonatal-Perinatal Medicine, Fanarof et al, 7th edition, 2002, 397.

Hemorrhagic adrenal glands,
Congested kidneys,
Pericardial fluid,
Generalized pitting edema.

Special Procedures:
CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord;
**1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE**

**Microscopic Neuropathology revealed** – "sections show widespread, **severe acute ischemic damage in neurons in nearly all areas of the brain** with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

**According to the Summary/Discussion,**
"At autopsy the most significant finding of a **severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."**

There was no mention in the autopsy findings or conclusion regarding the possibility of "SEPSIS". The diagnosis was hypoxic ischemic encephalopathy

**Dr. Depp when hypothesizing that Ms. Rhoades had chorioamnionitis ignored the facts that;**

1. The patient's Group B Strep culture was negative **(Pg. 25)**,
2. The patient was never febrile (T of 100.4 or greater),
3. Her temperature during labor, at delivery, and postpartum was normal,
4. There were no documented complaints of foul smelling discharge or amniotic fluid,
5. There was no documented uterine tenderness,
6. The patient's WBC (white blood cell count) was normal,
7. The placental pathology report showed NO evidence of chorioamnionitis **(Pg. 23, 24)**,
8. The patient never was diagnosed by any healthcare provider before, during and after delivery with chorioamnionitis or infection,
9. The patient never received antibiotic treatment,
10. There was no evidence of sustained fetal tachycardia on the fetal tracings,
11. The epidural that was not providing adequate analgesia and that the patient's pulse rate fluctuations continued after delivery.

Further, when arriving at his hypothesis that the chorioamnionitis resulted in neonatal sepsis, he ignored the above facts that clearly demonstrated that the patient did not have chorioamnionitis and infection. He then renders an opinion contrary to the autopsy report, and outside his field of expertise. Under PaR.E. 702, "Scientific testimony be given by a witness who is qualified as an expert by knowledge, skill, experience, training, or education."

**Dr. Depp ignored** the notes, autopsy and deposition testimony of the neonatologist and pathologist that indicated that the baby was exposed to and died from hypoxia and perinatal asphyxia.

In review of the report of Dr. Fox, he also ignored the facts of this case including an autopsy report that confirmed that the baby died of acute ischemic and hypoxic encephalopathy due to "severe perinatal asphyxia".

According to the **FINAL AUTOPSY REPORT** dated 5/15/02, the final autopsy diagnoses were;

**1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE**

Microscopic Neuropathology revealed – "sections show widespread, **SEVERE ACUTE ISCHEMIC DAMAGE IN NEURONS IN NEARLY ALL AREAS OF THE BRAIN** with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

**According to the Summary/Discussion,**

"At autopsy the most significant finding of a **SEVERE HYPOXIC ENCEPHALOPATHY**, most likely due to perinatal asphyxia." ---- **"THE CAUSE OF DEATH IS ACUTE ISCHEMIC AND HYPOXIC ENCEPHALOPATHY DUE TO SEVERE PERINATAL ASPHYXIA AND MAY HAVE BEEN PRECIPITATED BY HYPOXIA DURING LABOR."**

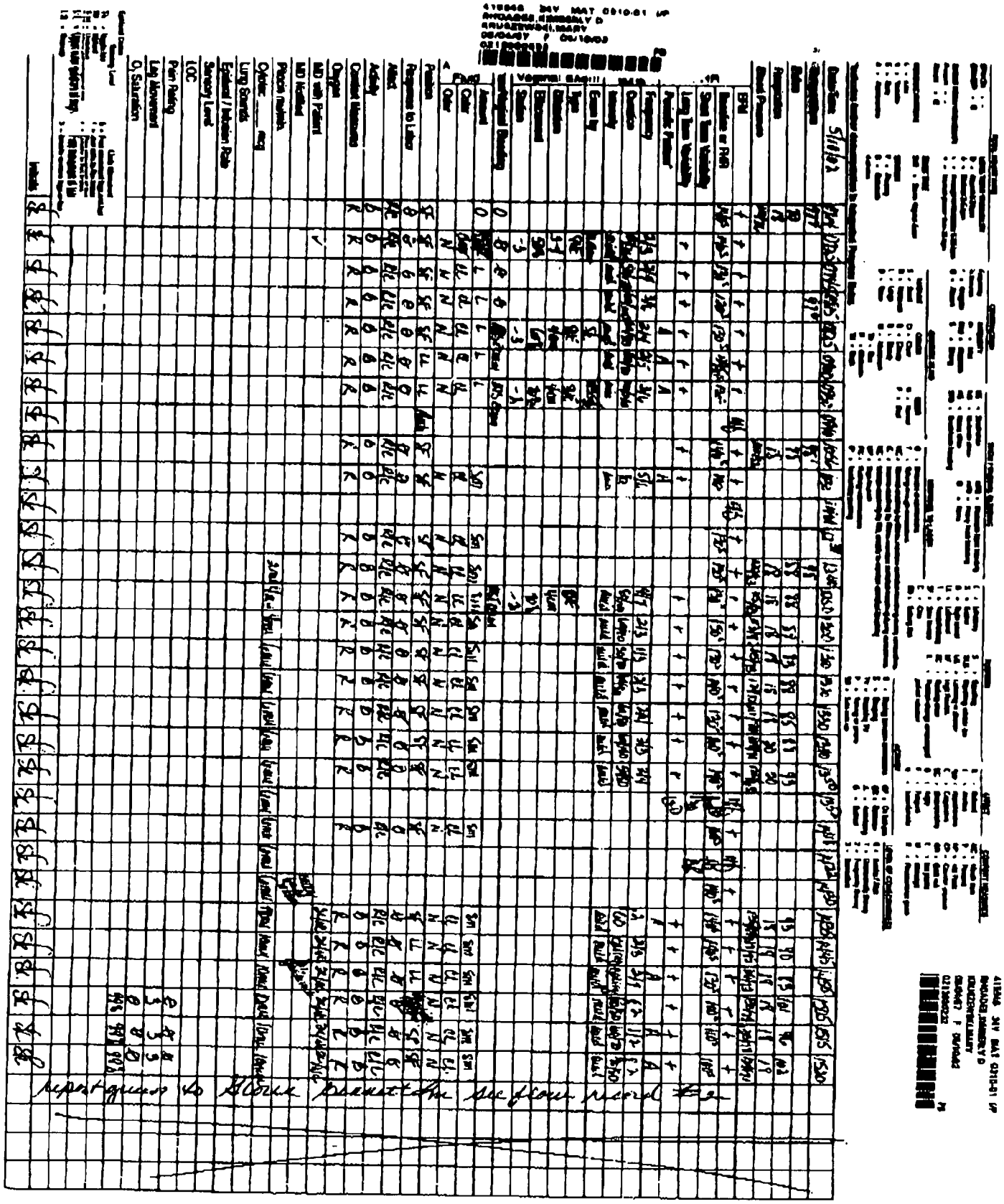
There was no mention in the autopsy findings or conclusion regarding the possibility or diagnosis of "SEPSIS".

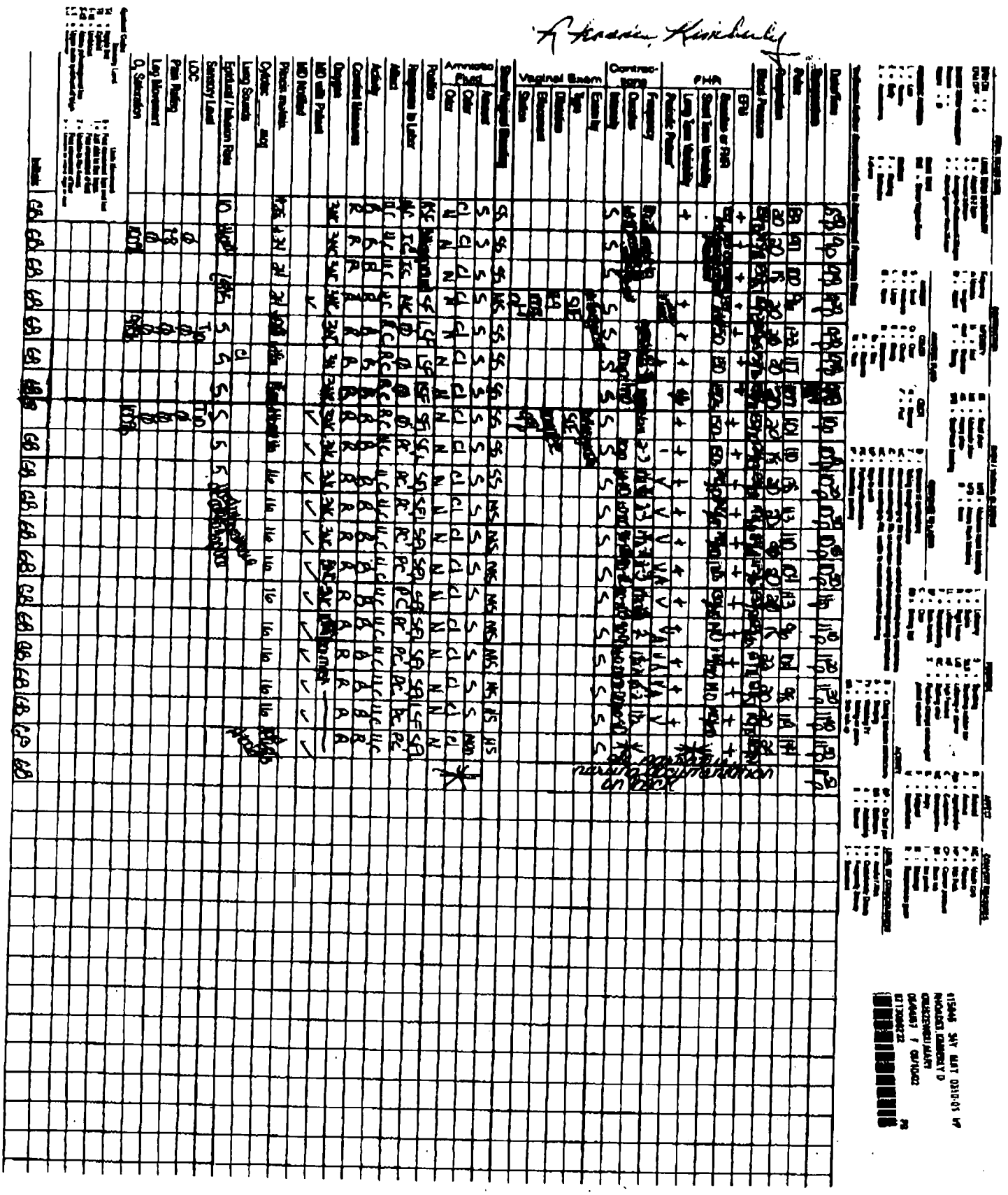
In my opinion to a reasonable degree of medical certainty, Dr. Depp and Dr. Fox did not use a methodology accepted by the scientific community to formulate their hypothesis. They ignored the facts in this case including the autopsy report that confirmed that the cause of death was "severe hypoxic encephalopathy" most likely due to perinatal asphyxia.

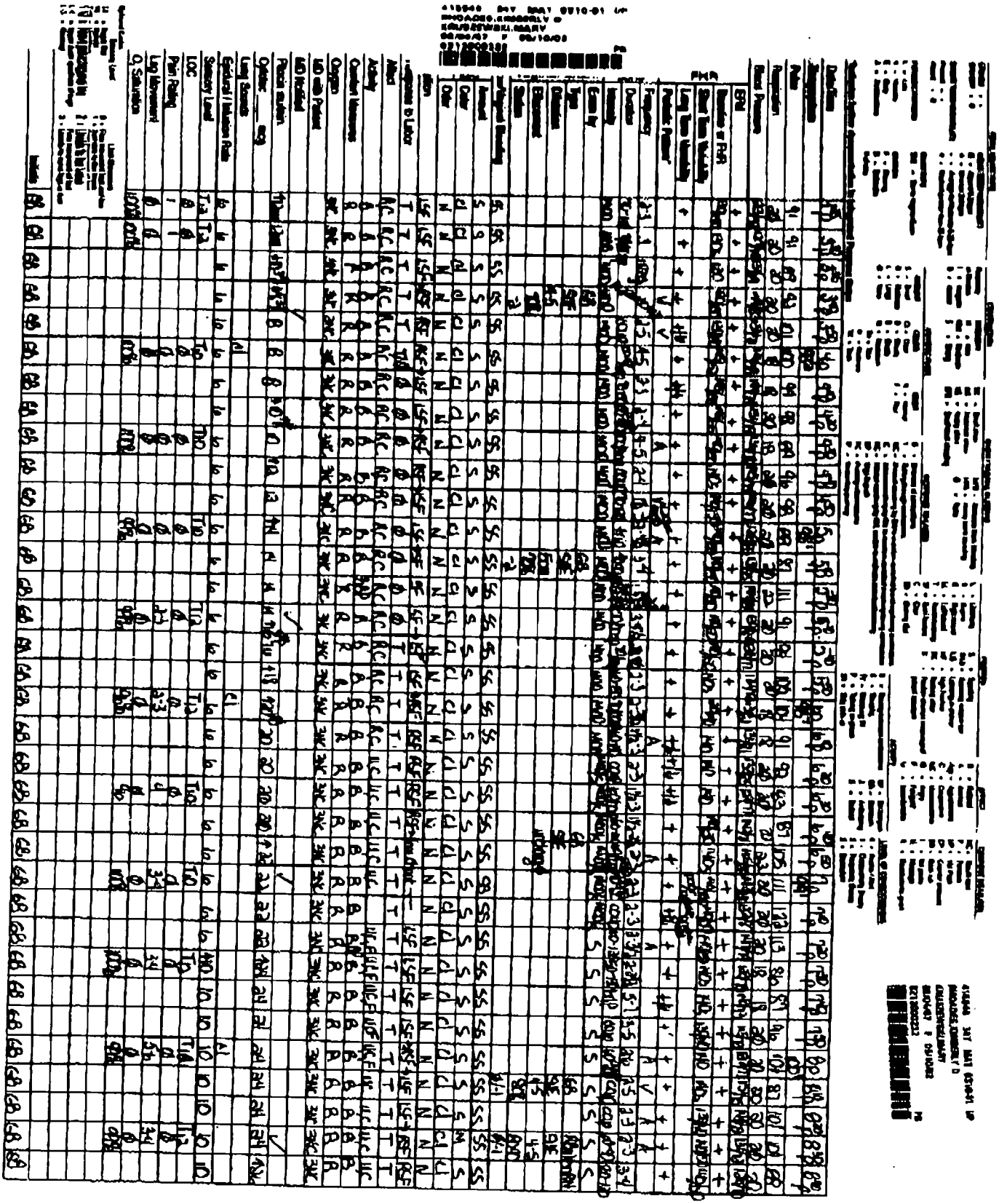
I reserve the right to amend this report if and when additional information becomes available.

Sincerely,

James L. Mollick MD, FACOG







Dubois Regional Medical Center
Tue May 14, 2002 03:41 pm
Surgical Case Number Report

Copy SURGEON

Pg 1

| | | | |
|---|---|---|---|
| Patient: | RHOADES,KIMBERLY D | Age: 34Y | Sex: F |
| Unit#/Acct#: | D000415946/D0213000232 | Case#: | S02-2629 |
| Location: | DIS | Accn#: | 1571548 |
| Att Phys-Serv: | KRUSZEWSKI,MARY - *OBSTETRICS | Completed: | 05/14/02 1541 |
| Ordering Phys: | KRUSZEWSKI,MARY | Received: | 05/12/02 0900 |
| Order Dx: | NORMAL DELIVERY | Collected: | 05/10/02 2354 |

********** SURGICAL PATHOLOGY ORDER **********

Specimen(s): Placenta

A. Placenta

Surgeon/Physician: KRUSZEWSKI

Specimen: PLACENTA

Pre-op Diag: IUP AT 40 WEEKS, VACUUM ASSISTED DELIVERY

Post-op Diag: NOT GIVEN

History: NOT GIVEN

GROSS:

Specimen labeled "placenta" is received in formalin. It consists of a placenta with attached fetal membranes with umbilical cord as well as separately received segment of umbilical cord. After trimming the membranes and cord, the placenta weighs 585.0 grams and measures 21.0 x 19.0 x 3.0 cm. The umbilical cord is eccentrically attached at 4.5 cm from the nearest placental margin, in aggregate measuring 55 cm in length by up to 1.9 cm across. On cut section, it reveals three blood vessels. Partial velamentous insertion of the cord is noted. The cotyledons on the maternal surface appear intact and, on serially sectioning, reveal a homogeneous spongy, dark red appearance. Representative sections are submitted in three cassettes labeled A1 through A3.

Gross By: Dr. Gregory Suslow M.D.

AFTER MICROSCOPIC EXAMINATION

made 5-17-02

Faxed 5-20-02

DX:

585.0 gm mature placenta with mild subchorionic and intervillous fibrin deposition, and areas of calcification.

Trivascular umbilical cord with partial velamentous insertion.



LABORATORY
Jose Costa M.D. Medical Director
Gregory Suslow M. D.

/ BJ

Dubois Regional Medical Center
Tue May 14, 2002 03:41 pm
Surgical Case Number Report

Copy SURGEON

Pg 2

| | | | |
|---|---|---|---|
| Patient: | RHOADES,KIMBERLY D | Age: 34Y | Sex: F |
| Unit#/Acct#: | D000415946/D0213000232 | Case#: | S02-2629 |
| Location: | DIS | Accn#: | 1571548 |
| Att Phys-Serv: | KRUSZEWSKI,MARY - *OBSTETRICS | Completed: | 05/14/02 1541 |
| Ordering Phys: | KRUSZEWSKI,MARY | Received: | 05/12/02 0900 |
| Order Dx: | NORMAL DELIVERY | Collected: | 05/10/02 2354 |

********** SURGICAL PATHOLOGY ORDER **********
(Continued)

Amnion nodosum, with focal squamous metaplasia, as may be seen in cases of oligohydramnios.

No evidence of acute chorioamnionitis or funisitis.

Read By: Dr. Gregory Suslow M.D.

End of Report - 05/14/02 15:41pm

mcb 5.17.02 Faxed 5-20-02

1/2

Surgical Case Number Report
Final

RHOADES,KIMBERLY D
D000415946/D0213000232

LABORATORY
Jose Costa M.D. Medical Director
Gregory Suslow M. D.

[redacted] NOV 15 20

[redacted] DUBOIS REGIONAL MEDICAL CENTER [redacted]
Thu May 02, 2002 11:25 am
Single Test Report

Pat Name: RHOADES,KIMBERLY D
Unit #/Acct #: 000415946/**MULTIPLE ACCOUNTS** Page: 1
Loc: OPE 04/18/02
Phys-Service: KRUSZEWSKI,MARY - *OUTPATIENT

**********

>> CULTURE GROUP B STREP SCREEN <<

Specimen: Vaginal
Coll. Time: 04/18/02 1605 In at: 04/18/02 1606 Acct #: D0210800616
Ordering Phys: KRUSZEWSKI,MARY Techs : VDROF
- - - -

DUBOIS REGIONAL MEDICAL CENTER

DOCTOR 415946 34Y MAT 0310-01 I/P
RHOADES,KIMBERLY D
ADDRESS KRUSZEWSKI,MARY
08/04/67 F 05/10/02
0213000232
[redacted] PS
EAS.

| | | |
|---|---|---|
| pH | 7.13 | 7.37-7.43 |
| $pCO_2$ | 50 | 37-43 mmHg |
| $pO_2$ | 31 | 90-105 mmHg |
| $HCO_3$ | 16 | 22-26 meq/L |
| B.E. | -13 | -3 - +3 |
| $O_2$ SAT. CALCULATED | 42 | > 95.0% |
| $CO_2$ | 18 | 21-30 mM/L |
| THb | | |
| % $O_2$Hb | | > 95% |
| % COHb | | < 2.0% |
| % MeTHb | | < 1.0% |
| VOL % $O_2$ | | 14-24 VOL % |

☐ INPAT. ☐ OUTPAT. ☐ ER ☐ STAT ☐ ROUTINE ☐ PRE-OP.
RR _____ ☐ LABORED ☐ NON LABORED ☐ REG. ☐ IRREG.
PT. TEMP. _____ CORR ☐ UNCORR ☐
FIO$_2$ _____

NOTES: Cord gas

| DATE | TIME SAMPLE DRAWN | TECH. |
|---|---|---|
| 5/11/02 | 0010 | KC |
| 5/11/02 | TIME REPORT RETURNED 0020 | TECH. KC |

CHART COPY

PULMONARY

DUBOIS REGIONAL MEDICAL CENTER-DUBOIS, PA

REMOVE STRIP OF TAPE
AND ATTACH SECOND REPOR

LABORATORY

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**RULE TO SHOW CAUSE**

**ORDER**

AND NOW to wit this _____ day of _____, 2006, upon consideration of the Motion of the Plaintiffs to exclude expert testimony at the time of trial, it is hereby Ordered that:

1. A rule is issued upon the Respondent to show cause why the moving party is not entitled to the relief requested;

2. The Respondent shall file an answer to the Motion within _____ days of this date.

3. The Motion shall be decided under Pa.R.C.P. 206.7.

4. Depositions and all other discovery shall be completed within _____ days of this date.

5. An evidentiary hearing on disputed issues of material fact shall be held on _____, in the Clearfield County Courthouse, Clearfield, Pennsylvania, in Courtroom No. _____.

6. Argument shall be held on _____, in Courtroom No. _____of the Clearfield County Courthouse, and

7. Notice of the entry of this Order shall be provided to all parties by the moving party.

BY THE COURT

_____

Frederic Ammerman, President Judge

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Motion was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: June 16, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES | * | |
| individually and as personal representatives | * | |
| of the ESTATE OF MIKAYLA RHOADES, | * | |
| Plaintiffs | * | |
| vs. | * | NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O. and | * | |
| DuBOIS REGIONAL MEDICAL CENTER, | * | |
| Defendants | * | |

FILED
JUN 19 2006
William A. Shaw
Prothonotary

cc Attys: Greg Pribonic
Blasko
D. Johnson
(6R)

**ORDER**

NOW, this 16th day of June, 2006, it is hereby ORDERED:

1. That Defendant, Mary C. Kruszewski, D.O. shall produce within thirty (30) days the following:

a) The percentage of the income of Dr. O. Richard Depp, III and Dr. William W. Fox which involves medical-legal cases relating to the delivery of a child and post-delivery care for the period from 2003 to date.

b) The amount of the fees paid to Dr. O. Richard Depp, III and Dr. William W. Fox for appearing and testifying in this case.

c) Any relationships of Dr. O. Richard Depp, III and Dr. William W. Fox with defense counsel and his firm.

d) Any relationship between Dr. Mary Kruszewski and Dr. O. Richard Depp, III and Dr. William W. Fox.

e) The number of medical malpractice cases in which Dr. O. Richard Depp, III and Dr. William W. Fox have reviewed and testified at trial or deposition for defense counsel and his firm, for the period from 2003 to date.

f) The percentage of medical malpractice cases which Dr. O. Richard Depp, III and Dr. William W. Fox have reviewed for other defense law firms, and/or medical malpractice insurance carriers.

g) The percentage of all cases reviewed by Dr. O. Richard Depp, III and Dr. William W. Fox on behalf of Plaintiffs and/or Plaintiff law firms compared to the percentage of cases reviewed on behalf of Defendant healthcare providers and/or their attorneys.

2. Copies of any and all articles authored, in whole or in part, by either Dr. O. Richard Depp, III or Dr. William W. Fox, on the subject of medical malpractice over the last three years.

3. The Plaintiffs, Dennis and Kimberly Rhoades, shall provide within thirty (30) days all the same type of information required to be produced by the Defendant, Mary Kruszewski, D.O. under Paragraph 1 a, b, c, d, f and g of this Order, for their experts, James Mollick, M.D., Frederick Gonzales, M.D. and William H. Reed.

4. In the event there is a failure to comply with this Order, the Court upon motion may consider appropriate jury instructions on same or other sanctions.

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge

DATE: 6-19-2006

____ You are responsible for serving all appropriate parties.

__X__ The Prothonotay's office has provided service to the following parties:

____ Plaintiff(s) __X__ Plaintiff(s) Attorney ____ Other

____ Defendant(s) __X__ Defendant(s) Attorney

____ Special Instructions:

FILED

JUN 19 2006

William A. Shaw
Prothonotary

A

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

FILED 4cc Atty Ging
01/11:22 30
JUN 20 2006
William A. Shaw
Prothonotary/Clerk of Courts

**RULE TO SHOW CAUSE**

**ORDER**

AND NOW to wit this 20 day of June, 2006, upon consideration of the Motion of the Plaintiffs to exclude expert testimony at the time of trial, it is hereby Ordered that:

1. A rule is issued upon the Respondent to show cause why the moving party is not entitled to the relief requested;

2. The Respondent shall file an answer to the Motion within _____ days of this date.

3. The Motion shall be decided under Pa.R.C.P. 206.7.

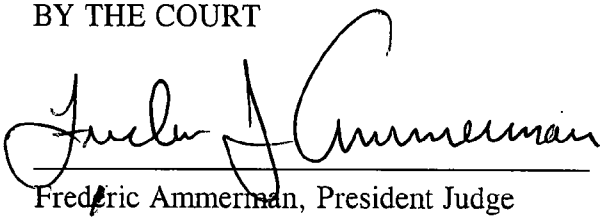
4. Depositions and all other discovery shall be completed within _____ days of this date.

5. An evidentiary hearing on disputed issues of material fact shall be held on _____, in the Clearfield County Courthouse, Clearfield, Pennsylvania, in Courtroom No. _____.

6. Argument shall be held on July 24, 2006 @ 9:00 AM, in Courtroom No. 2 of the Clearfield County Courthouse, and

7. Notice of the entry of this Order shall be provided to all parties by the moving party.

BY THE COURT



Frederic Ammerman, President Judge

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

***ORDER***

AND NOW, this ____ day of _____, 2006, the Court enters the following Order:

[1] Motion for Summary Judgment in favor of Defendant Dr. Kruszewski, and against the Plaintiffs is hereby granted and Plaintiffs' claim of negligence based on Dr. Kruszewski's decision to employ vacuum extractor, and, failure to have all necessary equipment in the delivery room is dismissed with prejudice.

[2] Motion for Summary Judgment in favor of the Defendant Dr. Kruszewski, and against the Plaintiffs is hereby granted on the failure to obtain informed consent prior to induction of labor, failure to explain risks of induction of labor or explaining augmentation thereof by Pitocin and/or failure to explain any risks of induction of labor by Pitocin with Plaintiff/wife or otherwise.

[3] The Motion in Limine of Defendant, Mary Kruszewski, is granted and Plaintiffs are hereby precluded from introducing any evidence testimony or argument on Hospital's nursing protocols or policies establishing an alleged standard of care for Dr. Kruszewski, OB/GYN specialist.

[4] The Motion in Limine of Defendant, Mary Kruszewski, is granted and Plaintiffs are hereby precluded from introducing any evidence, testimony or argument on the adequacy of Dr.

Kruszewski's medical documentation since no cause of action for negligence was pled on that theory.

[5] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted and Plaintiffs are precluded from introducing any evidence, testimony or argument on the failure to evaluate maternal pelvis or perform a clinical pelvimetry since no cause of action for negligence was pled on that theory.

[6] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted and Plaintiffs are hereby precluded from introducing any evidence, testimony or argument on the failure to place the scalp electrode and/or intrauterine pressure device since no cause of action for negligence was pled on that theory

[7] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted and Plaintiffs are hereby precluded from introducing any evidence, testimony or argument on the decision to employ intravenous induction or administration of Pitocin since no cause of action for negligence was pled on that theory.

[8] The Motion in Limine of Defendant, Mary Kruszewski is hereby granted as to any testimony contained in the report of Frederick A. Gonzales, M.D. relating to informed consent; the failure to discuss or properly counsel Plaintiff/wife concerning induction of labor by Pitocin or otherwise; the report relating to inappropriate use of vacuum extraction; the report alleging that Dr. Kruszewski was unfamiliar with protocols and procedures when dealing with distressed infants during delivery and she was unprepared to deal with fetal distress which led to birth asphyxia; the report relating that Dr. Kruszewski did not employ intrauterine resuscitation procedures; and, the portions of the report that Dr. Kruszewski was unaware that the infant was suffering from asphyxia and did not diagnose the condition at the time the child was born.

[9] The Motion in Limine of Defendant, Mary Kruszewski is hereby granted precluding Plaintiffs from introducing any medical literature as substantive evidence at the trial of this case, and, Dr. Mollick is precluded from giving any opinions on the standard of care contained in and cited by him in his report to publications and other literature.

[10] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted precluding Plaintiffs from introducing any evidence, testimony, deposition testimony, or otherwise relative to the nurses and their perceived criticism of Dr. Kruszewski's care and/or in any way referring to any comments relating to the standard of care of Dr. Kruszewski, an OB/GYN.

[11] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted and the medical opinions by Dr. Mollick are precluded under Freye standards, in that, his opinions are contrary to the ACOG standards on which he relies, and, Dr. Mollick is precluded from submitting any expert testimony regarding causation of harm, asphyxia and/or fetal monitoring strip interpretation.

[12] The Motion in Limine of Defendant, Mary Kruszewski, to preclude Plaintiffs from submitting any expert testimony from Dr. Reed regarding any alleged economic loss is hereby granted.

[13] The Motion in Limine of Defendant, Mary Kruzewski, is hereby granted and the Plaintiffs are precluded from introducing any evidence, testimony or argument on the negligent infliction of emotional distress in that this was previously excluded by a Court Order dated February 23, 2004.

[14] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted and the Plaintiffs are precluded from the presentation of cumulative expert testimony at trial by both Dr. Mollick and Dr. Gonzales, with leave to the Plaintiffs to designate or select which of the experts shall testify.

[15] The Motion in Limine of Defendant, Mary Kruszewski, is hereby granted and the Plaintiffs are precluded from introducing any evidence, testimony or any records on the subsequent birth of the Plaintiffs' child or testimony of Bart T. Matson, D.O. or the subsequent pregnancy and delivery or make an argument that the same was evidence of the standard of care.

BY THE COURT,

_____

J.

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES )
individually and as personal representatives )
of the ESTATE OF MIKAYLA RHOADES,)
)
Plaintiffs, )
)
vs. )
)
MARY C. KRUSZEWSKI, D.O. and )
DUBOIS REGIONAL MEDICAL )
CENTER, )
)
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Defendants. )
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Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
MOTIONS

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for
Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

FILED NO CC
m 11:24 BL
JUN 20 2006
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiffs,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

**MOTIONS OF DEFENDANT DR. KRUSZEWSKI**

The Defendant Mary C. Kruszewski, D.O. by and through her attorneys, McQuaide, Blasko files these Motions for the following purposes.

I. ***MOTION FOR A PARTIAL SUMMARY JUDGMENT ON THE ALLEGATIONS THAT USE OF A VACUUM EXTRACTOR WAS INAPPROPRIATE AND THAT THERE WAS A FAILURE TO HAVE ALL THE EQUIPMENT NECESSARY FOR THE USE OF THE VACUUM EXTRACTOR IN THE DELIVERY ROOM, NEITHER OF WHICH ALLEGATIONS HAVE BEEN ADDRESSED BY PLAINTIFFS' EXPERT, DR. MOLLICK IN HIS REPORT OR TO THE EXTENT THAT DR. MOLLICK'S REPORT IS INCONSISTENT WITH PLAINTIFFS' OTHER EXPERT, DR. GONZALES LEAVING THE JURY TO SPECULATE ON THE ISSUES.***

II. ***MOTION FOR SUMMARY JUDGMENT AND/OR MOTION IN LIMINE TO PRECLUDE THEORIES OF NEGLIGENCE OPINED WITHIN THE PLAINTIFFS' EXPERT REPORTS BUT WHICH ARE NOT PLED IN THE COMPLAINT OR WERE PREVIOUSLY DISMISSED BY THE COURT ORDER:***

A. The Court had previously sustained Dr. Kruszewski's demurrer to a cause of action for failure to obtain informed consent prior to induction of labor or instituting or augmentation thereof by Pitocin, and, accordingly the Plaintiffs are precluded from offering testimony or evidence relating to a failure to obtain

informed consent, failure to counsel Plaintiffs, or failure to explain the risk of induction of labor with the Plaintiffs.

B. To preclude the Plaintiffs, through their experts or otherwise, from introducing any evidence, testimony or argument on hospital nursing protocol or policies establishing standard of care for Dr. Kruszewski an OB/GYN specialist, on the basis that there are no allegations contained in the Complaint alleging the protocol or policies or violation thereof.

C. To preclude any evidence, testimony or argument on the adequacy of Dr. Kruszewski's medical documentation when no cause of action for negligence is pled on that theory.

D. To preclude any evidence, testimony or argument under failure to evaluate the maternal pelvis or perform a clinical pelvimetry when no cause of action for negligence was pled on that theory.

E. To preclude any evidence, testimony or argument on the failure to place a fetal scalp electrode and/or intrauterine pressure device when no cause of action for negligence was pled on that theory.

F. To preclude any evidence, testimony or argument on the decision to employ intravenous induction or administration of Pitocin when no cause of action for negligence was pled on that theory.

III. ***MOTION IN LIMINE AS TO REPORTS OF PLAINTIFFS' EXPERT, FRED A. GONZALES, M.D. AND SUMMARY JUDGMENT THEREON ON THE BASIS THE REPORT ADDRESSES ISSUES EXCLUDED BY THE COURT ON PRELIMINARY OBJECTIONS; THE REPORT ADDRESSES ISSUES NOT WITHIN THE ALLEGATIONS OF THE COMPLAINT; AND THE REPORT CONTAINS OPINIONS IN CONFLICT WITH DR. MOLLICK'S REPORT WHICH WOULD REQUIRE THE JURY TO SPECULATE AS TO CAUSATION, WHICH DOES NOT MEET PLAINTIFFS' BURDEN AS A MATTER OF LAW.***

IV. ***MOTION IN LIMINE TO EXCLUDE LITERATURE OR PUBLICATIONS CITED BY DR. MOLLICK AS TO THE STANDARD OF CARE, AND, ANY OPINIONS BASED THEREON.***

V. ***MOTION IN LIMINE TO EXCLUDE ANY EVIDENCE, DEPOSITION TESTIMONY, OR OTHERWISE OF ANY OF THE NURSES RELEVANT TO THE STANDARD OF CARE OF DR. KRUSZEWSKI, AN OB/GYN.***

VI. ***MOTION IN LIMINE TO PRECLUDE PRESENTATION OF CUMULATIVE EXPERT TESTIMONY AT THE TRIAL OF BOTH THE PLAINTIFFS' EXPERTS WHOSE TESTIMONY WOULD BE IDENTICAL.***

VII. ***MOTION IN LIMINE TO EXCLUDE ANY EVIDENCE OF NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS AS BEING EXCLUDED BY COURT ORDER.***

VIII. ***MOTION IN LIMINE TO PRECLUDE TESTIMONY AND OPINIONS OF DR. MOLLICK UNDER THE "FREYE" STANDARDS.***

IX. ***MOTION IN LIMINE TO PRECLUDE TESTIMONY AND OPINIONS OF WILLIAM REED, UNDER THE "FREYE" STANDARDS.***

X. ***MOTION IN LIMINE TO PRECLUDE ANY OFFICE OR CLARION HOSPITAL RECORDS, TESTIMONY, ARGUMENT, OR EVIDENCE ON THE BIRTH OF THE SUBSEQUENT CHILD OR THE SUBSEQUENT OB/GYN SPECIALIST, BART L. MATSON AS EVIDENCE OF THE STANDARD OF CARE.***

***PRELIMINARY***

1. The instant medical malpractice case is scheduled for trial beginning August 7, 2006.

2. After Preliminary Objections, the Plaintiffs filed an Amended Complaint alleging the following:

> "32. Dr. Kruszewski was negligent in that:
>
> (a) Dr. Kruszewski failed to evaluate fetal weight and properly counsel a patient with a macrosomic baby as to the prenatal risks of induced labor as opposed to other methods of delivery of a large baby;
>
> (b) The use of vacuum extraction was inappropriate in this situation, and represented a departure from good and accepted standards of medical care.
>
> (c) The failure of Dr. Kruszewski to order the discontinuance of the administration of pitocin when she became aware of severe and progressive variable decelerations was a departure from good and accepted standards of medical care.
> (d) Dr. Kruszewski's failure to deliver the infant by caesarian section represented a deviation from good and accepted medical care.

(e) Dr. Kruszewski failed to have all equipment necessary for use of vacuum assisted delivery present in the delivery room.

(f) Dr. Kruszewski failed to obtain the informed consent of the parents regarding the delivery of a macrosomic baby."

See, Amended Complaint, ¶ 32.

3. Defendant filed Preliminary Objections to the Amended Complaint on the following basis.

1. Demurrer and failure to plead a claim upon which punitive damages can be recovered.

2. Failure to plead any claim upon which relief can be granted on informed consent; and,

3. Failure to state a claim upon which relief can be granted for negligent infliction of emotional stress.

4(a). The objections on punitive damages were based on the grounds that the facts failed to establish willful or wanton conduct or reckless indifference to the rights of others.

(b). As to allegation of lack of informed consent, it was based on the allegations of Paragraphs 17, 18, 19, 32(a) to 32(f), 34, 35, 36, 39, and 45(g) on the basis that the foregoing paragraphs asserted an informed consent claim based upon Defendant's alleged failure to properly counsel Plaintiffs regarding the induction of labor and delivery of a macrosomic baby, to discuss risks of induced labor as opposed to other methods and/or to deprive Plaintiffs with alternatives to spontaneous vaginal delivery and vacuum assistant extraction during birth.

(c) The objection of failure to obtain informed consent (Count I) was to the allegations of the type of procedures which were allegedly performed without fully advising Plaintiff/wife that Mikalya was a large baby, and, the potential complications from the type of delivery for a large baby.

(d) There were further preliminary objections to Paragraphs 45(d), 48(b), 51(b), 63, 64, 72(c) as being legally unsupported claims for negligent infliction of emotional distress.

5. By Order dated January 20, 2004, the Court held:

> "5. Relative to Preliminary Objections filed by Dr. Kruszewski to Plaintiffs' Amended Complaint requesting pertinent damages Dr. Kruszewski, it is the ORDER of this Court that Defendant Dr. Kruszewski's demurrer as set forth within Count II of the Preliminary Objections as to the Plaintiffs' request for punitive damages be and is hereby granted."

6. By Order dated February 23, 2004, the Court entered the following:

> "1. Relative to the Preliminary Objections filed on behalf of Dr. Kruszewski to the Plaintiffs' remaining claim of breach of informed consent contained in their Amended Complaint, it is the ORDER of this Court that the demurrer contained in Defendants' Preliminary Objections on this point is hereby GRANTED.
>
> 2. Relative to the Preliminary Objections filed by Dr. Kruszewski to the Plaintiffs' claim of negligent infliction of emotional distress, the Court believes that the Amended Complaint does not plead sufficient facts (Count VII, paragraphs 63-64) to support a viable claim for negligent infliction of emotional distress. Lazor v. Milne, 499 A.2d 369 (Pa. Super. 1985); Love v. Cramer, 606 A.2d 1175 (Pa. Super. 1992). It is the ORDER of this Court that this demurer set forth within Defendants' Preliminary Objections on this point is hereby GRANTED. Count VII of the Amended Complaint is dismissed."

7. The following are the remaining theories of negligence against Dr. Kruszewski:

(a) Dr. Kruszewski **failed to evaluate fetal weight**;

(b) The use of vacuum extraction was inappropriate in this situation and represented departure from the good and accepted standard of medical care;

(c) The failure of Dr. Kruszewski **to order the discontinuance of the administration of Pitocin** when she became aware of severe and progressive variable decelerations was a departure from good and acceptable standards of care;

(d) Dr. Kruszewski's failure to deliver by caesarean section represented the deviation of good and accepted medical standard of care;

(e) Dr. Kruszewski **failed to have all the equipment necessary** for the use of vacuum assisted delivery present in the delivery room;

8. Thus, after granting Defendant's objections to the following theories of negligence remained against Dr. Kruszewski:

(a) Failure to evaluate fetal weight;

(b) Inappropriate use of vacuum extraction;

(c) Failure to discontinue the Pitocin when she became aware of severe and progressive decelerations;

(d) The failure to perform a cesarean section; and

(e) The failure to have necessary vacuum extraction equipment present.

9. In support of their claims, the Plaintiffs produced two expert reports: Dr. James R. Mollick, M.D. dated February 15, 2006, Exhibit "A" and, Fredric A. Gonzales, M.D. dated April 6, 2004, Exhibit "B."

10. Within his thirty six (36) page expert report Dr. Mollick sets forth the following as the theories of negligence upon which he intend to espouse at trial:

> "To a reasonable degree of medical certainty I have reached the following conclusions and opinions in addition to those already mentioned;
>
> 1. The induction of labor was not indicated and conducted below the acceptable standard of care; ... Exhibit "A", p. 10.

2. The management of the induction, augmentation and labor were below the accepted standard of care; ... Exhibit "A", p. 12.

A. Dr. Kruszewski failed to recognize that the patient was at risk for and had a labor abnormality. This was below the accepted standard of care: ... Exhibit "A", p. 12.

B. Dr. Kruszewski and the nurses failed to recognize that this patient was arrested in the active phase of labor which was a contraindication to the use of intravenous Pitocin. This was below the accepted standard of care.... Exhibit "A", p. 14.

C. Aggressive Pitocin augmentation was not indicted and below the accepted standard of care.... Exhibit "A", p. 17.

D. The patient was exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive Pitocin augmentation, resulting in progressive hypoxia, asphyxia and permanent central nervous system damage. This was below the standard of care.... Exhibit "A", p. 19.

E. The nurses and Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability. This led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damage. These actions were below the accepted standard of care... Exhibit "A", p. 22.

1. The nurses and Dr. Kruszewski were unfamiliar with the basic concepts and principles of fetal monitoring resulting in the unrecognized progressive iatrogenic fetal asphyxia... Exhibit "A", p. 22.

2. The nurses and Dr. Kruszewski were unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia.... Exhibit "A", p. 23.

3. The patient had multiple episodes of unrecognized iatrogenic asphyxial stress which required intervention by cesarean section. Not performing a cesarean section in this situation resulted in fetal asphyxia and permanent brain damage. This was below the standard of care..." Exhibit "A", p. 27.

See, Exhibit "A", pp. 10, 12, 14, 17, 19, 22, 23, 27. Within his report, Dr. Mollick also opines that the Defendant was negligent for: 1) failing to monitor the patient using scalp electrodes or an intrauterine pressure device; 2) failing to properly evaluate the material pelvis; 3) failing to properly document within the medical record; and, 4) failing to follow hospital policies.

11. Within his report Dr. Mollick repeatedly refers to theories of negligence which are not pled in the Amended Complaint. Moreover, Dr. Mollick fails to properly address several theories of negligence which are pled in the Amended Complaint.

12. Plaintiffs bear the burden of proof and pursuant to Pennsylvania Rule of Civil Procedure 1035.2, summary judgment is appropriate where after the completion of relevant discovery, "an adverse party who will bear the burden of proof at trial has failed to produce evidence of facts essential to the cause of action or defense which in a jury trial would require the issues to be submitted to a jury." See, Pa.R.C.P. 1035.2.

13. The adverse party may not rest upon the mere allegations or denials of the pleadings, but must come forth with affirmative evidence controverting the evidence cited in support of Defendants' Motion and/or identify evidence in the record establishing the facts essential to their cause of action. Pa.R.C.P. 1035.3(a).

## I. MOTION FOR PARTIAL SUMMARY JUDGMENT ON ALL ALLEGATIONS OF NEGLIGENCE, UNSUPPORTED BY THE EXPERT REPORTS

14. Defendant files this Motion for Partial Summary Judgment pursuant to Pa.R.C.P. 1035.2 on the basis that within Plaintiffs' Amended Complaint they plead negligence based on "The use of vacuum extraction was inappropriate in this situation, and represented a departure from good and acceptable standards of medical care." However, at trial Plaintiffs' will be unable to offer expert testimony which establishes a prima facie case of negligence related to the performance of the vacuum extraction. Compare, Amended Complaint, ¶ 32(b) Paragraphs 2 and 7 quoted above in this Motion, pp, 3, 5 with Exhibit "A".

15. Likewise, Plaintiffs will be unable to establish that Dr. Kruszewski personally breached a standard of care and caused harm by failing to have "all equipment necessary for use of vacuum assisted delivery present in the delivery room." Compare, Amended Complaint, ¶ 32(e), Paragraph 2 of this Motion quoted above, page 4.

16. In order to establish a cause of action for the theories of medical malpractice pled against Dr. Kruszewski, Plaintiffs must present competent expert testimony establishing that there was an applicable standard of care, a breach of that standard from acceptable medical practice by Dr. Kruszewski, and resultant harm.

17. Under Pennsylvania law, experts are limited to the four corners of their expert reports and are precluded from testifying at trial inconsistent with or beyond the scope of said reports. Pa.R.C.P. 4003.5.

18. Plaintiffs' expert report does not specifically opine that the **use of vacuum extraction** was inappropriate, that the performance of such was a breach in the standard of care, and that the breach caused harm to the decedent.

19. To the contrary, with respect to vacuum extraction Plaintiffs' expert opines the following:

> "It is my opinion that progressive, repetitive, severely variable declarations with total loss of variability associated with uterine hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, **rendering mode of delivery at this point irrelevant.**"

See, Exhibit "A", p. 32 of 36.

> "Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. **The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised.**"

See, Exhibit "A", p. 33 of 36. Further, this would be inconsistent with Plaintiffs' expert, Dr. Gonzales, and as such, excludable for it would require the jury to speculate between opinions on causation.

20. Therefore, Plaintiffs' expert should be precluded from offering testimony alleging that the **use** of vacuum extraction was inappropriate in this situation, represented a departure from good and acceptable standards of medical care, and that such act harmed the decedent. Plaintiffs' expert has stated in his report, in no uncertain terms, that the decision to employ vacuum extraction did not cause the harm alleged because he states the decision to employ vacuum extraction at that time was futile since the baby was already harmed.

21. Likewise, Plaintiffs' expert does not opine that the standard of care required Dr. Kruszewski to stock the delivery room with equipment for vacuum extraction or that the failure to have certain equipment in the delivery room harmed the decedent. Rather, it is clearly Dr. Mollick's opinion that the child was "**already asphyxiated**" at the time the vacuum extraction was considered and performed. See, Exhibit "A", p. 33 of 36.

22. It would be prejudicial to the Defendant to permit Plaintiffs to amend their expert reports to comment on the decision to employ vacuum extraction and/or the supplies available as a standard or breach, or as causing harm, in that, the Defendant relied on Plaintiffs' reports in defense of this case which failed to raise the issue in preparation of the imminent trial of this matter.

23. Because Plaintiffs will be unable to offer competent medical testimony at trial which establishes that the decision to employ vacuum extraction and/or the failure to ensure supplies were available was a breach in the applicable standard of care and caused harm,

Plaintiffs will be unable to establish a prima facie case of medical negligence based on the theories of liability found at paragraph 32(b) of the Amended Complaint.

WHEREFORE, Defendant Mary C. Kruszewski, D.O. respectfully requests that this Honorable Court grant this Motion for Partial Summary Judgment, dismiss all of Plaintiffs' claims of negligence based on her decision to employ vacuum extraction and the failure to have all necessary equipment in the delivery room, with prejudice.

## II. MOTION FOR SUMMARY JUDGMENT/MOTION IN LIMINE TO PRECLUDE THEORIES OF NEGLIGENCE OPINED WITHIN THE EXPERT REPORT WHICH ARE NOT PLED IN THE COMPLAINT OR WERE PREVIOUSLY DISMISSED BY COURT ORDER

24. Paragraphs 1 through 23 are incorporated by reference as though set forth at length herein.

25. At trial, Plaintiffs are precluded from offering testimony that is a material variance from the pleadings, such as testimony, argument or evidence raising a new cause of action. Reynolds v. Thomas Jefferson Univ. Hosp., 450 Pa. Super. 327, 336, 676 A.2d 1205, 1209 (1996).

26. A new cause of action for negligence arises if either 1) the proffered amendment of a pleading proposes a different theory or 2) a different kind of negligence than the one previously raised or 3) if the operative facts supporting the claim are changed. Id.

27. As indicated, above, the Plaintiffs' Amended Complaint was limited to five theories of liability based on negligence. Despite the Plaintiffs' decision to plead a limited number of theories in the Amended Complaint, Plaintiffs' expert report heavily focuses on a number of unpled theories of liability.

28. The statute of limitations has passed for all claims related to Mikayla Rhoades' birth and Plaintiffs failed to plead any facts which would toll the statute and allow for an additional theory of liability to be raised at this late juncture. Accordingly, a Motion for Summary Judgment should be granted as to the untimely allegations of negligence which are set forth below in Sections A through F.

29. In the alternative, Defendants seek to preclude any and all testimony, evidence, or argument related to theories of negligence which are not pled in the Amended Complaint but are espoused upon in the Plaintiffs' expert report.

**A. NEGLIGENCE IN FAILING TO PROPERLY COUNSEL REGARDING THE INDUCTION**

30. As stated above, Plaintiffs' Amended Complaint contained the various allegations relating to the failure to obtain informed consent, to properly counsel Plaintiffs regarding induction of labor and delivery of a large baby and/or provide with alternate spontaneous vaginal delivery and vacuum system extraction during birth and institution of induction. As indicated above, on Preliminary Objections, the Court dismissed all claims contained in Defendants' Preliminary Objections sounding in any way on the failure to counsel, explain risks or obtain informed consent.

31. Despite this unambiguous edict from the Court, within his expert report Plaintiffs' expert repeatedly opines that the failure to have a conversation explaining the indications for and risks of induction of labor with the patient was a breach in the standard of care. See, e.g., Exhibit "A", p. 4 of 36 (stating: "She failed to discuss the risks of and indications for induction and augmentation with the patient....These deviations were below the accepted stands of care.)

Pennsylvania does not recognize a cause of action based on negligence in the administration of medication. 40 P.S. §1303.504

32. Accordingly, Plaintiffs must be precluded from offering testimony, evidence or argument at trial related to the failure to obtain informed consent, the failure to counsel, or the failure to explain the risks of induction of labor with the patient as this theory of liability was dismissed by this Court, with prejudice.

**B. NEGLIGENCE IN FAILING TO FOLLOW HOSPITAL POLICIES**

33. Plaintiffs' Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on a failure to follow hospital policies or procedures. See, allegations of Amended Complaint, pp. 5 and 6 of this Motion, supra.

34. However, Plaintiffs' expert report is replete with allegations that Dr. Kruszewski breached the standard of care by not following specific hospital policies. For example, Dr. Mollick opines as follows:

> "According to Dr. Kruszewski's admission note, "Hook was used to rupture membranes further and large amount of clear fluid was obtained." Dr. Kruszewski deviated from the **Hospital's Policy and Procedures, P/PR No. 79, entitled Protocol for Amniotomy which states**: "The artificial rupture of membranes may only be carried out by a physician. The fetal head must be fully engaged in the pelvis prior to amniotomy."

See, Exhibit "A", p. 3 of 36.

> "According to the **Hospital's Policy and Procedure, P/PR No. 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor**: Intravenous induction will be used form medical indications only. The following criteria must be met:
>
> a. Patient will be at or near term with ripe, soft cervix.
> b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
> c. Patient willing to be induced.

d. Vertex presentation.

There was no indication for induction and or augmentation with pitocin. There was no notation by Dr. Kruszewski as to why the pitocin was started. She failed to discuss the risks of and indication for induction and or augmentation with the patient. She did not evaluate the baby for fetal size and failed to perform clinical pelvimetry. Therese deviations were below the accepted stand of care."

See, e.g., Exhibit "A", p. 4 of 36, p. 10 of 36; see also, p 7 of 36 (addressing Hospital Policy and Procedure Manual, P/PR No. 61.2 entitled Fetal Monitoring, Nonreassuring Patterns); p. 13 of 36 (addressing Hospital Policy and Procedure Manual, P/PR No. 76.1 entitled Active Management of Labor in Primipara); p. 18 of 36 (addressing Hospital Policy and Procedure Manual, P/PR No. 76).

35. Hospital's protocols and policies do not establish the standard of care for an OB/GYN specialist. If it were otherwise, Plaintiffs would not need experts to meet their burden of proof which is contrary to the law. Further, Plaintiffs simply did not plead any negligence, and, indeed could not plead, based on the failure to follow any hospital policies or protocols. See, allegations of Amended Complaint, pp. 5 and 6 of this Motion, supra. Plaintiffs' experts are not permitted to espouse that a hospital protocol or policies established a standard of care.

36. Moreover, the Amended Complaint does not allege that Dr. Kruszewski breached the standard of care by artificially rupturing the Plaintiffs' membrane. Therefore, criticism based on the failure to follow Policy and Procedures, P/PR No. 79 Protocol for Amniotomy, is wholly irrelevant and inappropriate under Pennsylvania law.

37. This Court in the case of Herzing v. Kruszewski, et al. entered an Order on the same issues precluding the application of Hospital policies to Dr. Kruszewski's conduct, by Order dated October 4, 2005, wherein the Court stated:

> "4. Defendant's motion to preclude application of DuBois Regional Medical Center nursing policies to the conduct of Defendant Kruszewski is HEREBY GRANTED."

38. Plaintiffs must be precluded at trial from presenting evidence, testimony, or argument to the effect that Dr. Kruszewski was negligent based on the failure to follow hospital protocols or policies.

## C. NEGLIGENCE IN FAILING TO PROPERLY DOCUMENT CARE AND TREATMENT PROVIDED WITHIN THE MEDICAL RECORD

39. Plaintiffs' Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on a failure to properly document, within the medical records, the care and treatment provided to the Plaintiffs. See, Paragraph 7 of this Motion, supra, pp. 5 and 6.

40. However, Plaintiffs' expert report repeatedly criticizes Dr. Kruszewski for failing to document at various points during labor and delivery. For example, Dr. Mollick opines:

> "I **could not find documentation** indicating the reason for the indication, and/or **any documentation** of a conversation explaining the indications for and risks of induction of labor with the patient. These deviations were below the standard of care."

See, Exhibit "A", p. 2 of 36.

> "This was the **only progress note** written by Dr. Kruszewski from the time of admission until delivery.

See, Exhibit "A," p. 3 of 36.

> "She aggressively augmented this patient without first discussing and **documenting the indications for its use**. These deviations were below the accepted standard of care."

See, Exhibit "A", p. 18 of 36.

41. Because no cause of action for negligence was pled based on the adequacy of the Defendant's documentation, Plaintiffs must be precluded at trial from presenting evidence, testimony or argument to the effect that Dr. Kruszewski was negligent based on the amount of and/or frequently of her documentation in the medical record.

## D. NEGLIGENCE IN FAILING TO PROPERLY EVALUATE THE MATERNAL PELVIS

42. Plaintiffs' Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on a failure to evaluate the maternal pelvis or performing clinical pelvimetry. See, Exhibit "A", p. 18. (Pelvimetry means measuring of distances and angles between structures of the pelvis and can be done by palpation, or on x-rays of the pelvis.) In contrast, the Amended Complaint does criticize Dr. Kruszewski for the failure to evaluate fetal weight. See, Amended Complaint ¶ 32(a), Paragraph 2 and Paragraph 7 of this Motion, pp. 3, 5 and 6, supra.

43. However, Plaintiffs' expert report contends that Dr. Kruszewski breached the standard of care by not performing clinical pelvimetry.

> "Dr. Kruszewski **failed to perform clinical pelvimetry** on this patient who presented with a macrosomic infant, and an unengaged floating head indicating cephalopelvic disproportion. ....These deviations were below the accepted standard of care"

See, Exhibit "A", p. 18 of 36.

44. Plaintiffs must be precluded at trial from presenting evidence, testimony or argument to the effect that Dr. Kruszewski was negligent based on the failure to evaluate the

maternal pelvis or perform clinical pelvimetry because this theory of negligence is not pled in the Amended Complaint.

**E. NEGLIGENCE IN FAILING TO MONITOR THE DECEDENT INCLUDING THE FAILURE TO APPLY SCALP ELECTRODES AND/OR AN INTRAUTERINE PRESSURE DEVICE**

45. The Amended Complaint does not allege a cause of action against Dr. Kruszewski for negligence based on **a failure to monitor the decedent or to utilize specific devices to monitor the decedent during labor**. (See Paragraph 2, p. 3 and Paragraph 7 of this Motion, pp. 5 and 6, supra).

46. The **issue pled** in the Amended Complaint **is the failure to recognize the significance of the informaiton gathered during monitoring**, not the failure to perform the task of monitoring or the use of an improper modality of monitoring.

47. The Amended Complaint alleges that **Defendants failed to diagnose fetal distress and failed to discontinue the administration of pitocin when the monitors they employed demonstrated fetal distress**.

48. The Amended Complaint alleges:

"21. At 3:37 p.m. on May 10, 2002, **monitors being used by nurses employed** by and under the supervision and control of the DuBois Medical Center demonstrated a fetal bradycardia, which ultimately recovered, however **administration of the drug pitocin** to Mrs. Rhoades **was never discontinued** and no precautions were taken by the hospital employees upon the occurrence of the fetal bradycardia to avoid fetal distress. The failiure to take any precautions to assure the health of the infant upon the occurrence of fetal bradycardia was a departure from good and accepted standard of medical care.

22. As the induction of labor continued severe and progressive variable decelerations, signs of fetal distress, **were revealed by the monitors** and noted by a hospital nurse...."

The above quoted allegations clearly alleged that **monitors were used**, but the data produced should have been interpreted in a manner other than what the Defendants did.

49. In contrast, Plaintiffs' expert report is replete with allegations that Dr. Kruszewski breached the standard of care **by not using the correct type of monitor** (applying a scalp electrode and/or intrauterine pressure device) and **by not reading monitoring strips**.

> "Dr. Kruszewski performed a pelvic exam at 2123 and the cervix was found to be 8 to 9 cm and 100% effaced. A note by the nurse at that time revealed that the electronic fetal monitoring strip to present was reviewed by Dr. Kruszewski. **A scalp lead was not placed during the pelvic exam.** This was below the accepted standard of care.....**Dr. Kruszewski failed to place a fetal scalp electrode and/or intrauterine pressure device**. Not doing so was below the accepted standard of care."

See, Exhibit "A", p. 6 of 36 (emphasis added).

> "Beginning at 2250 the patient was noted to be hyperstimulated associated with multiple repetitive severe variable decelerations, with loss variability, mandating discontinuing of pitocin, **placement of a scalp electrode and intrauterine pressure device,** and performing an emergency cesarean section....**The pitocin was continued a scalp electrode was not place**, and the patient was not taken to cesarean section. These deviations were below the accepted standard of care."

See, Exhibit "A", p. 7 of 36 (emphasis added).

> "Dr. Kruszewski **failed to place an intrauterine pressure** device to document contraction adequacy, and to accurately monitor the contraction pattern. ....These deviations were below the accepted standard of care."

See, Exhibit "A", p. 18 of 36.

> "An IV fluid was given at 2244; oxygen was started at 2247 via nasal cannula. **A scalp electrode and intrauterine pressure catheter were mandatory in this situation.** Not utilizing these modalities was below the accepted standard of care."

See, Exhibit "A", p. 30 of 36.

50. Plaintiffs must be precluded at trial from presenting evidence, testimony or argument to the effect that Dr. Kruszewski was negligent based on the failure to apply the correct modality of monitoring, namely scalp electrodes or an intrauterine pressure catheter and/or that the Defendants failed to monitor the patient.

## F. NEGLIGENCE IN THE INITIATION OF INTRAVENOUS INDUCTION

51. Plaintiffs' Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on the initial decision to employ intravenous induction (administration of pitocin). See, Paragraph 2 and Paragraph 7 of this Motion, pp. 5 and 6, supra. Rather, the Amended Complaint asserts that the **the pitocin should have been discontinued** at signs of fetal bradycardia and fetal distress.

52. However, Plaintiffs' expert report asserts that Dr. Kruszewski breached the standard of care by **initiating Pitocin to augment labor**. Specifically, Dr. Mollick opines as follows:

> "Dr. Kruszewski **started the pitocin augmentation** without precise knowledge of contraction adequacy and after the patient was arrested in the active phase of labor for over four hours with contractions as close as 1 minute apart....These deviations were below the accepted standard of care."

See, Exhibit "A", p. 18 of 36.

53. Plaintiffs must be precluded at trial from presenting evidence or testimony to the effect that Dr. Kruszewski was negligent based on **the initiation of pitocin augmentation** because that theory of negligence is not pled in the Amended Complaint.

54. It would be prejudicial to the Defendant to permit Plaintiffs to amend their expert reports to comment on the above-referenced theories of negligence after the expiration of the discovery deadlines including deadlines for the production of expert reports.

## G. CONCLUSION

55. Plaintiffs are precluded from offering testimony that is a material variance from the pleadings. Reynolds v. Thomas Jefferson Univ. Hosp., 450 Pa. Super. 327, 336, 676 A.2d 1205, 1209 (1996).

56. Each of the above referenced theories of negligence identified within Dr. Mollick's proposed testimony as described above is a material variance from the pleadings.

57. Under controlling Pennsylvania case law, Plaintiffs may not proceed at trial under theories which have not been pled. Therefore, Dr. Mollick should be precluded from testifying about: 1) negligence in failing to properly counsel regarding the induction; 2) negligence in failing to follow hospital policies; 3) negligence in failing to properly document care and treatment provided within the medical record; 4) negligence in failing to properly evaluate the maternal pelvis; 5) negligence in failing to monitor the decedent including the failure to apply scalp electrodes and/or an intrauterine pressure device; and 6) negligence in the initiation of intravenous induction.

58. Accordingly, Plaintiffs will be unable to present evidence at trial to support a prima facie case of negligence for: 1) failing to properly counsel regarding the induction; 2) failing to follow hospital policies; 3) failing to properly document care and treatment provided within the medical record; 4) failing to properly evaluate the maternal pelvis; 5) failing to monitor the decedent including the failure to apply scalp electrodes and/or an intrauterine

pressure device; and 6) negligence in the initiation of intravenous induction, and Defendant is entitled to partial summary judgment.

## III. MOTION IN LIMINE AS TO THE REPORT, EVIDENCE, TESTIMONY AND ARGUMENT OF PLAINTIFFS' EXPERT, FREDERICK A. GONZALES, M.D. AND SUMMARY JUDGMENT THEREON

59. The Plaintiffs have also produced the report of Dr. Frederick A. Gonzales, M.D. dated April 6, 2004, a copy of which is attached hereto being Exhibit "B."

61. The averments of Paragraph 1 through 58 are by this reference incorporated herein.

62. Similar to Plaintiffs' expert, Dr. Mollick, within Dr. Gonzales' report, he sets forth the following opinions of negligence which are beyond the remaining allegations of the Complaint. See, paragraph 7 of this Motion, pp. 5 and 6, supra.

63. The following are alleged failures of Dr. Kruszewski to comply with the standard of care and contained in Dr. Gonzales' reports but are not within the allegations of the Complaint.

(a) Page 3 of the report 5th full paragraph: "There is no mention **of informed consent or any discussion** with the parents regarding options for delivery of a macrosomic baby. In my opinion the **failure . . . to properly counsel** a patient when she has a macrosomic baby regarding an **induction of labor** as a departure from good and accepted standards of medical care. It is my opinion based upon review of the facts of the case that **if the patient had been properly advised**, and if the patient had opted for a caesarean section, the baby's birth asphyxia could have been avoided."

(i) Excluded by Court Orders, p. 5 of this Motion.
(ii) Beyond allegations of the Complaint, Paragraph 7 of this Motion.

(iii) Excludable for same reasons set forth in Paragraphs 30, 31, 32 of this Motion.

(b) Page 3, 6th fully paragraph. "A **scalp pH was not performed** due to the judging of the physician and/or inability to perform a scalp pH at the medical center. . . . Likewise, the inability to perform a scalp pH at the medical center and/or physician's failure to perform a scalp pH constitutes a departure from good and acceptable standards of practice."

(i) Beyond allegations of the Complaint, Paragraph 2, pp. 3, 4 and Paragraph 7 of this Motion, pp. 5, 6.
(ii) Excludable for same reasons set forth in Paragraphs 45-48 of this Motion.

(c) Page 4, second full paragraph. "**A scalp pH was never performed.** Failure to properly evaluate the fetus by performing a scalp pH or other diagnostic procedure is departure from good and accepted standards of care. If the physician was unable to perform a scalp pH or other diagnostic procedure at the regional medical center, the failure of the medical facility to have ability to perform a pH or a diagnostic procedure in situations as this situation described in the medical chart is a departure from good and acceptable standards of medical care."

(i) Beyond allegations of the Complaint, Paragraph 2, pp, 3, 4 and Paragraph 7 of this Motion, pp. 5, 6.
(ii) Excludable for same reasons set forth in Paragraph 49 of this Motion.

(d) Page 4, third full paragraph. "Mikayla was delivered by vacuum extraction. There were four pulls and two pop-offs. The pressure from the vacuum was not reduced between the uterine contractions. This is an inappropriate use of vacuum extraction and represents departure from the good and acceptable standards of medical care."

(i) Beyond allegations of the Complaint, Paragraph 2, pp. 3, 4 and Paragraph 7 of this Motion. Opinion on causation in direct conflict with Dr. Mollick's opinion, thus jury would have to speculate on the theory.

(f) Page 4, fourth full paragraph. "As a result of the failure of the physician and hospital personnel to use good and acceptable standards of medical care a severely asphyxiated baby was born with apgars of 0, 3, 4, 5, at one, five, ten and twenty, minutes. The cord H was 7.13 with a base excess of -13 which represents metabolic acidosis. Mikayla suffered seizures, temporal bleeding and swelling. These findings are all consistent with birth asphyxia and a traumatic delivery. In reviewing Dr. Kruszewski's deposition it become obvious to me that she has unfamiliar with protocols and procedures for dealing with a distressed infant during delivery. It was obvious to me from reading Dr. Kruszewski's deposition and the depositions of the nurses that they were unprepared to deal with the fetal distress which led to birth asphyxia."

(i) Beyond allegations of the Complaint, Paragraph 7 of this Motion, pp. 5, 6.

(g) Page 4, fifth fully paragraph. "While it appeared that Dr. Kruszewski was aware of intrauterine resuscitation procedure she **did not employ intrauterine resuscitation procedures** despite the fact that they were clinically indicated at the late stage of labor and delivery."

(i) Beyond allegations of the Complaint, Paragraph 2, pp. 3, 4 and Paragraph 7 of this Motion, pp. 5, 6.

(h) Pages 4 and 5. "Dr. Kruszewski was unaware that the infant was suffering from asphyxia, and did not have a diagnosis for her condition at the time she was born other than she was distressed. . . . Despite this post-delivery diagnosis, Dr. Kruszewski indicates she did not know if Mikayla had a heart beat at birth or if she was breathing at birth."

(i) Beyond allegations of the Complaint, Paragraph 2, pp. 3, 4 and Paragraph 7 of this Motion.

64. The above portions of the report are not within the allegations of the Amended Complaint, Paragraph 2, pp. 3, 4 and Paragraph 7 of this Motion, pp. 5, 6 and should be excluded.

65. Dr. Gonzales' report subparagraph (f) of paragraph 63 above as to the cord pH of 7.13 being consistent with birth asphyxia is contrary to ACOG standards relied on by Dr. Mollick, Plaintiffs' other expert, that in order to have asphyxia the pH must be less than 7.00, more fully alleged hereinafter in VI of this Motion. Accordingly, the Court as gatekeeper should exclude such testimony.

## IV. MOTION IN LIMINE TO EXCLUDE THE USE OF LITERATURE, OR PUBLICATION AS STANDARD OF CARE AND ANY OPINIONS BASED THEREON BY THE EXPERTS

66. The Plaintiffs' expert, Dr. Mollick, in rendering his report, does not rely on his own experience or education in establishing a standard of care, but instead relies on publications of others footnoted 44 times in his report as follows:

a. ACOG Practice Bulletin, Induction of Labor, No. 10, November, 1999, pp. 11, 12, Exhibit "A."

b. ACOG Technical Bulletin, Dystocia and Augmentation of Labor, No. 218, December. 1995, pp. 13, 15, 16, 19, 21, Exhibit "A."

c. See Williams Obstetrics, 18th Ed. Cunningham et al. Dystocia 1989, pp. 13, 14, 17, 18, 19, 20, 21, Exhibit "A."

d. Handbook of FHR Monitoring, 2nd Ed., Parer, et al., 1997, pp. 21, 23, 24, 25, 30, 31, 32, Exhibit "A."

e. ACOG Practice Bulletin, Induction of Labor, No. 10, November, 1999, Exhibit "A."

f. Dr. Mollick states that his opinions are that Dr. Kruszewski violated the standard of care as described in the above publications.

67. Dr. Mollick adopts and quotes directly from the above publications in his report as the standard of care.

68. Under Pennsylvania law, it is improper for an expert to adopt as his opinions or to introduce into evidence statements appearing in a learned treatise or literature as substantive proof of information set forth. See Majdic v. Cincinnati Machine Co., 370 Pa. Super. 611, 537 A.2d 334.

69. This Court has ruled that such are not admissible in Herzing v. Kruszewski, by Order dated October 4, 2005, stating:

> "3. Defendant's Motion to preclude medical literature as substantive evidence to establish the relevant standard of care is HEREBY GRANTED."

70. Learned writings, bulletins or treatises which are offered to prove the truth of the matter therein are hearsay and may not properly be admitted into evidence for consideration by the jury.

71. Since Plaintiffs' expert, Dr. Mollick, is simply regurgitating the publications as the standards, his report is not based on his opinions, but, on others as contained in the publications, and, as such, are excludable as not meeting the requirements of the Rules of Civil Procedure or laws of this Commonwealth.

WHEREFORE, Defendant Mary Kruszewski respectfully requests this Honorable Court grant the within Motion in Limine and thereby preclude Plaintiffs from introducing any medical literature as substantive evidence at the trial of this case, and, preclude Dr. Mollick from giving any opinions on the standard of care contained in publications of others.

## V. MOTION IN LIMINE TO EXCLUDE ANY EVIDENCE, TESTIMONY OR DEPOSITION TESTIMONY OR OTHERWISE OF ANY OF THE NURSES RELATIVE TO THEIR PERCEIVED CRITICISM OF DR. KRUSZEWSKI'S CARE OR THE STANDARD OF CARE OF DR. KRUSZEWSKI AS AN OB/GYN

72. The Plaintiffs have taken the depositions of the nurses who were present during and after the delivery.

73. In some of those depositions, the nurses were asked, for example:

"Q: Did the accelerations at this point concern you in any manner.

A: I would like to see the patient delivered." (Nurse Benner depo, p. 37).

Q: So you have worked with Dr. Kruszewski long enough or the doctors long enough that you can communicate non-verbally.

A: Uh huh.

Q: Did you communicate non-verbally with Dr. Kruszewski during the labor and delivery and express non-verbal concerns to her about the condition of the baby.

A: I can say that I probably looked at her a few times.

Q: Okay, and why would you be doing that Gloria.

A: Like I said I don't like my babies to be below 120s to 160s." Nurse Benner's Depo., NT, p. 44.

74. Pursuant to the MCare Act §512, only a physician in the same specialty of Dr. Kruszewski is qualified to render opinions on the standard of care.

75. The deposition of testimony of any of the nurses that could be construed to be critical of Dr. Kruszewski would be excludable on the basis the nurses are not competent to testify as to the standard of care of an OB/GYN, pursuant to the MCare Act §512.

WHEREFORE, Defendant Mary Kruszewski respectfully requests this Honorable Court grant the within Motion in Limine and thereby exclude any evidence, testimony or deposition testimony of the nurse relative to their perceived criticism of Dr. Kruszewski or standard of care.

## VI. PLAINTIFFS' EXPERT MEDICAL OPINION BY DR. MOLLICK MUST BE PRECLUDED UNDER THE "FREYE" STANDARDS AS NOVEL OPINIONS LACKING "GENERAL ACCEPTANCE" WHICH ARE CONTRARY TO ESTABLISHED CONSENSUS STANDARDS OF DIAGNOSIS CARE AND CAUSATION IN THIS CASE

76. The instant section of this Motion in Limine is being brought pursuant to Pennsylvania appellate court precedent which requires trial courts to make a preliminary determination as to the admissibility of novel expert testimony by ensuring that the "methodology" underlying such testimony is "generally accepted" by those scientists active in the field to which the evidence belongs. See, Grady v. Frito-Lay, Inc., 2003 WL 2310025 Pa. December 31, 2003; Trach v. Fellin, 817 A.2d 1102 (Pa. Super 2003).

77. For the reasons that follow, Plaintiffs have not and in fact cannot meet their burden of establishing the appropriate foundation for the admissibility of their proposed expert testimony and/or reports of Dr. Mollick at the trial of this matter to support the theories of negligence set forth within their Amended Complaint.

78. The courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle of discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs. Trach, supra 817 A2d at 110. Quoting Frye, 293 F.2d at 1013. Under Trach, supra the general acceptance test is satisfied only where a generally accepted scientific approach to the analysis to a problem or a scientific accepted methodology is used to analyze a problem.

79. In the report of Plaintiffs' expert, Dr. Mollick it states on page 22, Exhibit "A" that Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability shown on the monitoring strips. In his opinion this led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damages which were below the standard of care. On page 23, Exhibit "A" he concludes that Dr. Kruszewski was "unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia." On page 25, Exhibit "A" second full paragraph, he states:

> "According to ACOG, (standards published by the American College of Obstetrics and Gynecology) the term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damages including all of the following:
>
> [a] Profound metabolic or mixed acidemia (pH less than 7.0) on an umbilical cord arterial blood sample, if obtained.
>
> [b] Persistent apgar scores of 0-3 for longer than 5 minutes.
>
> [c] Evidence of neonatal neurological sequela (e.g. seizures, coma, hypotonia and one more of the following: cardiovascular, gastrointestinal, and, the two logical, pulmonary or renal dysfunction)."

80. Contrary to Dr. Mollick's report and reliance on the supposed standard, the ACOG consensus and standards are stated as follows:

> "The criteria to define an acute intrapartum event (prior to delivery) sufficient to cause cerebral palsy . . . are listed as follows:
>
> "Essential criteria (must meet all four):
>
> (1) Evidence of a metabolic acidosis and fetal umbilical cord arterial blood obtained at delivery (pH less than 7 . . .)

(2) Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation.

(3) Cerebral palsy of the spastic quadriplegic or dyskinetic type.

(4) Exclusion of other identifiable etiologies such as trauma, coagulation disorders, infectious conditions or genetic disorder."

"Criteria that collectively suggest an intrapartum timing (within close proximity to labor and delivery, e.g., 0 to 48 hours), but are non-specific asphyxial insults." All four essential criteria must be met before there can be an hypoxic event. (ACOG report, Exhibit "C", p. 74).

(1) A sentinel (signal) hypoxic event occurring immediately before or during labor.

(2) A sudden and sustained fetal bradycardia or the absence of fetal heart rate variability in the presence of persistent, late or variable decelerations, usually after hypoxic sentinel event when a pattern was previously normal.

(3) Apgar scores of 0 to 3 beyond 5 minutes.

(4) Onset of multi-system involvement within 72 hours of birth.

(5) Early imaging studies showing evidence of acute non-focal cerebral abnormality.

See attached excerpts, ACOG consensus, Exhibit "C."

81. According the ACOG criteria on which Dr. Mollick allegedly relies, the Plaintiff-baby would not have had hypoxic signs of damages, in that, the pH at the time of birth was in excess of 7.10 and the apgar scores which Dr. Mollick relies on for asphyxia and neurological damage clearly states apgars are "non-specific" to asphyxia. Further there were no other

identifiable etiologies excluded by Dr. Mollick in his report as required by the above ACOG consensus standards.

82. Under the ACOG standard cited by Dr. Mollick, the infant child would not have asphyxia which caused the death.

83. The Defendant herewith submits excerpts from the **definitive consensus** sponsored by the National Institute of Child Health and Human Development which is a joint statement by the American College of Obstetricians and Gynecologist (ACOG) and the American Academy of Pediatricians (AAP) which has been endorsed by multiple national and international specialty and subspecialty organizations that addresses the specific recognized methodology criteria required to establish causation of birth asphyxia, cerebral palsy in the case of this exact nature, and highlights the medical community's rejection of the methodology Dr. Mollick is attempting to rely on, as regard interpretation of the fetal monitoring strips. (The ACOG Neonatal Encephalopathy and Cerebral Palsy: Defining Pathogeneses and Pathophysiology is voluminous, but will be separately submitted with the Brief.)

84. In the instant case, all four essential criteria established set forth under paragraph 79 must be met before an intrapartum hypoxic event can be considered as a cause of death. Thus, Dr. Mollick's reliance and citation of ACOG standards is fictitious and contrary to those standards.

85. The Plaintiffs' expert, Dr. Mollick's' testimony does not and cannot establish that the first and fourth essential criteria were met. The ACOG Consensus Criteria requires that a sufficient level of metabolic acidosis exists in cord blood obtained at delivery and that all other causes be excluded respectively. ACOG consensus, pp. 73-75, Exhibit "C."

86. If and only if the above criteria are all met, does one properly proceed to examine the next category or criteria that need "to be present to establish the relationship between acute intrapartum hypoxia and cerebral palsy." ACOG consensus, Exhibit "C" Consequently, because at least two of the four central criteria have not and cannot be met in the case, the cause of the Plaintiff infant's condition cannot be properly considered to have intrapartum hypoxia as opined by Dr. Mollick.

87. The ACOG consensus study, portions of which are attached on Neonatal Encephalopathy and Cerebral Palsy cannot be avoided in addressing the issues of causation in this case.

88. Dr. Mollick's reliance on the fetal heart monitoring strips for the criticism of Dr. Kruszewski's management is similarly misplaced according to the ACOG standards consensus.

89. Despite Plaintiffs' expert Dr. Mollick's attempts to show error on the part of Dr. Kruszewski regarding her interpretation of the fetal heart rate (FHR) strips, the fact is that the interpretation of fetal heart rate (FHR) and strips is very subjective and a source of considerable debate as is reaffirmed by the ACOG task force on Neonatal Encephalopathy and Cerebral Palsy. See attached ACOG consensus, Exhibit "C", pp. 26-29 and ACOG consensus, Exhibit "C" attached, p. xvii which states:

> "For instance, Nelson Associates have shown that use of non-reassuring fetal heart patterns to predict subsequent cerebral palsy had a 99% false-positive rate. Use of such non-specific markers for perinatal asphyxia identifies a large number of individuals as being exposed to inappropriately diagnosed 'perinatal asphyxia.' Thus it is not surprising that removing the exposure to such non-specific markers has failed to change the risk for the disease."

90. Under the Freye standards of evidentiary admissibility, the Plaintiffs will be unable to present any expert testimony to establish the "general acceptance" of their theories that Mikayla's fetal heart rate monitoring strip records were so abnormal during labor such that alternative intervention was indicated and/or harm caused thereby. Additionally, Plaintiffs will be unable to present any "generally accepted" expert testimony to establish that acute hypoxic ischemic injury occurred during the period of labor at DRMC that resulted in the child's eventual demise. Indeed, the Plaintiffs' novel theories of causation and standard of care are just demonstratively contrary to well established general accepted medical scientific principles and consensus standards of the OB/GYN ACOG standard which have been established.

91. Based on the foregoing and the detailed factual analysis in light of the legal authorities as will be discussed in the Brief to be filed hereinafter, it is respectfully requested that this Honorable Court perform its required "gatekeeping" function with respect to the proffered medical and/or scientific evidence, and preclude Plaintiffs from submitting their inadmissible expert testimony regarding the standard of causation of harm issues in this case which are contrary to the ACOG standards which they cite.

92. In support of his conclusion, Dr. Mollick's theories are both fundamentally flawed and based on substandard non-consensus terminology and standards. Dr. Mollick's and Dr. Gonzales' C.V. are included within Exhibit "C."

WHEREFORE, Dr. Kruszewski respectfully request the Court to grant her Motion in Limine and preclude Plaintiffs from submitting any expert report testimony regarding causation of harm and fetal monitoring strip interpretation.

## VI. MOTION TO EXCLUDE TESTIMONY OF WILLIAM H. REED

93. The Plaintiffs have provided a report of William Houston Reed, vocational expert, dated May 11, 2004 stating the report was a vocational economic analysis of earning capacity of decedent, Mikayla Rhoades, a copy of which is attached hereto, Exhibit "D", together with his C.V.

94. The method used by Dr. Reed in his report of May 11, 2004 to project the infant plaintiff's earnings is not acceptable by the community of labor economist which is a community of economists that focuses its research on the earnings of the individual and accepted by the economist profession. Dr. Reed's report does not utilize the accepted standards of theories in the community of economists, and, his report directly contradicts the methodology which educators teach on economics, and, the underlying theories applied to reality as demonstrated by the empirical data.

95. In the field of labor economics, the only accepted method for projecting an individual's future earnings is by the "human capital earning function" recognized and applied by academic economists, research institutes and governments throughout the world.

96. The "human capital earning function" has become the standard for economic analysis of earnings regarding an individual and is recognized by the Bureau of Census, Bureau of Labor and Statistics, Department of Education, and, Federal Reserve Board and other national institutions. Dr. Reed's report is not scientifically based on recognized economic theories.

97. Dr. Reed's analysis is erroneous because he fails to apply accepted economic theories applicable to the professional protocol. For example, he assumes that the earnings of workers at each level of experience will rise at 4.76%. In that case, person A, in an entry level position this year, receives a pay raise of 4.76% as he or she moves next year to a position with

one year experience. That is, next year 2007, person A will earn 4.76% more than the entry level position pays today, in 2006. However, Dr. Reed also increases the wage for the entry level position by that same 4.76% because he ignores the effect of experience. Consequently, in his report the entry level person who starts in 2007 will receive 4.76% more than the entry level pays in 2006, and, because in 2007 both persons will be paid the 4.76% more than the entry level position pays in 2006 they will both earn the same amount in 2007 even though one is new and the other has a year of experience. The next year, the same effect under his fallacious theory would occur. Accordingly, under Dr. Reed's improper analysis of the earnings for all positions regardless of experiences would necessarily be equal. This is inconsistent with reality and with the economic protocols and principals of accepted methodology in the economist's profession.

98. Dr. Reed's assumption of the earnings of the infant Plaintiff that would increase an average rate of 4.76% is from data regarding increases in the average earnings of all workers in America-over 100,000,000 people. Dr. Reed ignores sound economic principles and seeks to apply simple arithmetic from the population as a whole, to an individual in the future. This method is not recognized by economists for determining the future earnings of an individual person because of the effect of changing experience and is not a method economist use for future growth in wages. The mainstream economic science and theories do not support Dr. Reed's assumptions.

99. Dr. Reed relies on so-called forensic economics written by non-economists limited to calculating damages for purposes of providing testimony in personal injury cases but are not peer reviewed economic journals or textbooks recognized by the community of economists. Neither the Journal of Forensic Economics or Journal of Legal Economics appear in any rankings of the prestigious and peer review journals in economics, and, are unreliable as

sources acceptable in the economist community. The references by Dr. Reed are to publications, neither of which authors are economists. Dr. Reed does not have any degrees in economics. Indeed, his master thesis is entitled "A Survey of Students, Teachers and Employers regarding the Effectiveness of Vocational Distributive Education in Pittsburgh Public Schools" , and, his doctoral thesis is "The differential Effect of a Vocational Training Program and a Group Therapy Program on the Frequency of Misconduct of Inmates and in a State Correctional Institution." Dr. Reed's educational degree is in rehabilitation counselling and consulting, statistical analysis and research methodology. He has an ME in vocational education, and, a BS in business administration. He hold no degree in economics.

100. Dr. Reed uses a starting point for his projected earnings of a new college graduate in the year 2024 but does not specify what it is or his source. He identifies the current population survey as a source for $30,347 as the earnings of the "average female college graduate" and what he says "would have been her age cohort" in 2002. In this regard, he has misused the CPS (Current Population Survey) data and other data available as to sex, education, and full time earners.

101. Neither earnings figures cited by Dr. Reed is consistent with earnings of $76,175 as being a starting salary for Mikayla in 2004 for which he relies on a salary survey conducted by NACE which is a very small sample and rejected as being irrelevant by accepted economic principles..

102. Dr. Reed's analysis and report is based on obvious error. The use of the growth figure of 4.76% per year is unacceptable and unsupported by the economic community principles or literature and contrary to §510 of the MCare Act, 40 P.S. §1303.510. His discount rate of 5.54% is undocumented as he only cites Gerald D. Martin, who is not an economist. He has

made an error in discounting the unreliable earnings of $6,177,403 back to present value. His present value figure of $1,414, 265 results from the assumption that Mikayla would have begun her new career at the earning level of what he calculates as the average earnings of a female college graduate in 2024, but that she begins earning this in 2013 at the age of 11, not at her age at 2024 when she would be the age of 22. Even though there is an inaccurate work life assumption, the present value of $6,177,403 under his own inaccurate analysis would be $781,525.

103. Dr. Reed also relies on Determining Economist Damages (a 3-ring binder) by Gerald D. Martin as to fringe benefits. Economists do not consider the binder a source of reliable information. However, the same are irrelevant, in that, fringe benefits include vacation pay, sick pay, holiday pay, health insurance and other benefits that do not benefit either survivor or an estate. As such they are irrelevant to damages caused by death of a single person without dependents, all of which is contrary to acceptable economic practices and theories. Dr. Reed also improperly makes speculative assumptions on personal maintenance, and assumption that Mikayla would have married. Dr. Reed's assumption fails to recognize that in such a speculative event, the expenditure data, as well as income is based on a household.

104. Dr. Reed failed to consider in his calculations in determining earning capacity the income tax consequence.

105. Dr. Reed's assumption of a constant percentage increases in earnings is nothing more than an arithmetical calculation that has no basis in economic science or empirical data. This assumption is Dr. Reed's creation used to testify for Plaintiffs for application in courtroom only, but not, supported by the economic community or standards.

WHEREFORE, it is requested that the Honorable Court grant the Defendant's Motion in Limine Precluding Plaintiffs from submitting any expert testimony from Dr. Reed regarding any alleged economic loss.

## IV. MOTION IN LIMINE TO EXCLUDE ANY EVIDENCE ON NEGLIGENT INFLICTION AND EMOTIONAL DISTRESS

106. The Plaintiffs in their Pre-Trial Statement state that there is "a claim for negligent infliction of emotional distress" (Plaintiffs' Pre-Trial Statement, p. 4.)

107. This Honorable Court by Order dated February 23, 2004 sustained Defendant Kruszewski's demurrer to Count VII of the Amended Complaint excluding such cause of action, p. 6 of this Motion, supra.

108. All evidence of any emotional distress should be excluded, and, the Plaintiffs prevented from testifying to or arguing before the jury as to such evidence as a matter of law.

WHEREFORE, it is requested that this Honorable Court grant the Defendant's Motion in Limine to Exclude any evidence, testimony or argument on negligent infliction of emotional distress.

## VII. MOTION IN LIMINE TO PRECLUDE PRESENTATION OF CUMULATIVE EXPERT TESTIMONY AT TRIAL

109. The Plaintiffs have identified J. L. Mollick, M.D. and Fredric A. Gonzales, M.D. as their sole medical liability experts and have provided reports from both.

110. Both are OB/GYN specialists, and, the Defendant anticipates Plaintiffs will utilize the testimony of both of their experts at trial.

111. Both Dr. Mollick and Dr. Gonzales identify Dr. Kruszewski as a physician who they consider to have been negligent with respect to the care and treatment rendered in this case.

112. Drs. Mollick and Gonzales are critical of the identical aspects of the care and treatment rendered by Dr. Kruszewski which they opine fell below the standard of care.

113. As a result of the foregoing, the expert testimony of Dr. Mollick and Dr. Gonzales is cumulative, in that, both doctors offer the same opinions as to the standard of care and causation with respect to Dr. Kruszewski.

114. Under Pa.R.A.P. 403, even relevant evidence may be excluded if it's probative values are outweighed by the danger of unfair prejudice, confusion, issues or misleading the jury, by consideration of undue delay, waste of time or needless presentation of cumulative evidence.

115. In this regard, Plaintiffs should be precluded from offering testimony at trial, live or otherwise, from both Dr. Mollick and Dr. Gonzales in the interest of judicial economy.

116. Moreover, Plaintiffs will not be prejudiced by being limited to eliciting testimony or otherwise referencing at trial opinions from only one of their experts of their choosing concerning the standard of care and causation.

WHEREFORE, Defendant, Mary C. Kruszewski, D.O. respectfully requests that the Honorable Court preclude Plaintiffs from eliciting testimony or otherwise referencing at trial opinions from both Dr. Mollick and Dr. Gonzales concerning the standard of care and causation, and, the Plaintiffs be limited to presenting expert testimony at trial live or otherwise from only one of their experts, either Dr. Mollick or Dr. Gonzales.

## VIII. MOTION IN LIMINE TO PRECLUDE ANY OFFICE OR CLARION HOSPITAL RECORDS OF THE BIRTH OF PLAINTIFFS' SUBSEQUENT CHILD OR TESTIMONY OF BART L. MATSON, D.O.

117. The Plaintiffs have listed Bart Matson, D.O. as a witness to be called in their case. Dr. Matson was the Plaintiff/wife's obstetrician subsequent to the birth of Mikayla in May, 2002.

118. Dr. Matson's notes indicate that Plaintiffs had Dr. Matson review the records of DRMC and Dr. Kruszewski involving the delivery of Mikayla. Dr. Matson has not provided an expert report.

119. The Plaintiff/wife became pregnant and delivered a viable male child on May 19, 2004 by caesarean section performed by Dr. Matson.

120. Any evidence, testimony or otherwise elicited from Dr. Matson concerning his prenatal care or delivery of the viable child to Plaintiff/wife would not be relevant to the issues in this case, and, would be collateral, and, to permit such testimony would, in effect, be a case within a case.

121. The Plaintiffs should be prohibited from introducing any evidence concerning the subsequent pregnancy or present any argument of the subsequent delivery by c-section which could in any way directly or indirectly be construed as support for the standard of care in this case contrary to the MCare at §512, and, the requirements that an expert report on liability be provide by Dr. Matson.

WHEREFORE, it is requested that Plaintiffs be prohibited from introducing any evidence or testimony of a subsequent pregnancy, delivery or argument concerning the subsequent pregnancy or delivery, except perhaps for the fact that a child was born to the Plaintiffs.

McQUAIDE, BLASKO,
FLEMING & FAULKNER, INC.

By: _____
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Dated: June 19, 2006

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J. J. FITZGERALD, III, D.O.

J. L. MOLLICK, M.D.

February 15, 2005

Robert P. Ging
2095 Humbert Road
Confluence, PA 15424-2371

Re: Kim Rhoades

Dear Mr. Ging,

Thank you for allowing me to review the Rhoades case. I have reviewed the following medical records:

1. Amended Complaint,

2. Answer and New Matter to Plaintiffs' Amended Complaint filed on behalf of Mary C. Kruszewski, D.O.,

3. Answers and Objections to Interrogatories to Dr. Kruszewski and Request for Production of Documents,

4. Answers to interrogatories to the Dubois Regional Medical Center and request for production of documents,

5. Supplemental answers to interrogatories to the Dubois Regional Medical Center,

6. Amended answers to interrogatories to Dubois Regional Medical Center,

7. Objections and responses to interrogatories to the Dubois Regional Medical

8. Response to request for production of expert reports,

9. Medical records of Kimberly D. Rhoades (including prenatal records 2001-02), Mary C. Kruszewski D.O. and the Dubois Regional Medical Center (2002 admission),

10. Medical records of Mikayla Rhoades (birth to death 2002) including records of Sundar Chandrasekhar, M.D., Dubois Regional Medical Center (2002), Children's Hospital of Pittsburgh (2002) and the Final autopsy Report (2002),

11. Deposition's of Mary Kruszewski, D.O., Gloria Bennett, R.N., Tina Newell, R.N., Sheri Kizina, R.N., Suzanne McCullough, R.N., Shawn Welsh, R.N., Desiree Smith, R.N., Karen Consentino, Brian Yeskevich, M.D., Richard Grout, M.D.,

12. Expert Reports of Deborah Sommer, M.D., Diane Moore, PhD, RN, William Houston Reed, PhD, and Kimberly A. Comport RN.

After review of the records, depositions, an expert reports, I have reached the following opinions and conclusions to a reasonable degree of medical certainty:

Kim Rhoades was a 33-year-old white female G1P0000 with an LMP of 8/3/02, an EDC of 5/10/02 confirmed by a 13.5 week ultrasound done on 11/1/01. Prior to becoming pregnant she had a workup for infertility including hysterosalpingogram and semen analysis.

She was followed prenatally by Mary Kruszewski, D.O., and was seen for 13 prenatal visits. The patient was noted to have several elevated blood pressures during her pregnancy with negative workups.

The patient had several ultrasound examinations during her pregnancy. Dr. Kruszewski did not recognize that the reports failed to include a percentile weight for gestational age. The ultrasound done on 4/18/02 revealed a 38 week and five day fetus with an estimated fetal weight of 3382 grams. There was a normal amount of amniotic fluid present. A biophysical profile at that time was 8/8.

Her final prenatal visit was recorded on 5/9/02 at which time the patient was 39.6 weeks, had a blood pressure of 126/88, negative urine protein, and a cervical exam which was posterior and soft with no indication of cervical dilatation. Induction was scheduled for the A. M. of 5/10/02. I could not find documentation indicating the reason for the induction, and/or any documentation of a conversation explaining the indications for and risks of induction of labor with the patient. These deviations were below the accepted standard of care.

The patient was admitted Dubois Regional Medical Center on 5/9/02 for induction of labor (see orders for protocol for induction of labor using IV pitocin and routine labor/delivery). A verbal order was given by Dr. Kruszewski at 1200 on 5/10/02 to start pitocin per protocol.

According to the admission note by Dr. Kruszewski dated 5/10/02 at 7:40 a.m.:

"Prenatal course was unremarkable except blood pressure has been increasing slowly the past couple of weeks. Preeclampsia labs, BPP, and NST were done 4/18 and were all normal." "Monitor shows good FHT variability. Mild contractions q 1 -- 2 minutes." "Cx exam was performed and membranes ruptured during exam. Cx 3-4/75%/-3/Vertex."

According to the Dubois Regional Medical Center's Maternity Department Policy and Procedure Manual (hereafter "Hospital's Policy and Procedure"), Policy and Procedure, No. 76.1, entitled Active Management of Labor in Primipara:

"In patients admitted in spontaneous labor make a definitive diagnosis as soon as possible.

A. Diagnosis based on the following criteria:
   1. Contractions: At least 1 in 7 minutes.
   2. Show.
   3. Rupture of membranes.
   4. State of Cervix:
      a. If effacement at least 70%-80%
      b. Cervical dilation of 3 cm or greater.
      c. Contractions as above, then in labor."

These criteria support that this patient was in labor on admission.

According to Dr. Kruszewski's admission note, "Hook was used to rupture membranes further and large amount of clear fluid was obtained."

Dr. Kruszewski deviated from the Hospital's Policy and Procedures, P/PR-No.-79, entitled Protocol for Amniotomy which states:

"The artificial rupture of membranes may only be carried out by a physician. The fetal head must be fully engaged in the pelvis prior to amniotomy."

According to the progress record authored by Dr. Kruszewski on 5/10/02 at 9:30 p.m.:

"The patient was noted to be 8 to 9 cm/100%/minus 1-0/vertex.... FHT's have been good throughout."

This was the only progress note written by Dr. Kruszewski from the time of admission until delivery.

According to Dr. Kruszewski's Delivery Note on 5/11/02 at to 12:55 a.m.:

"Patient was complete approximately 10:00 p.m... She pushed well and vertex came down to plus 1 to plus 2 station. Baby had a sustained bradycardia and vacuum was applied. Delivery was accomplished in one to two minutes after vacuum applied. Baby was suctioned and NICU personnel were called for resuscitation. Baby was delivered from OA positioned with vacuum over a midline episiotomy. Birth time was 11:52 p.m... Placenta delivered intact at 11:54 p.m. A cord pH was 7.13."

In review of the Vacuum Assisted Delivery Sheet dated 5/11/02 at 12:50 a.m., the fetal station was noted to be +1-+2, consistent with a midpelvic delivery. There were 4 pulls recorded, 2 pop offs and a duration of cup application of 3 minutes. The pressure was not reduced between contractions.

According to progress record the patient was discharged at 5:00 p.m. on 5/11/02.

According to the nursing progress record:

The patient was admitted at the 0653.
An IV was started at 0700.
The patient's vital signs on admission were normal with a blood pressure of 110/76.
The nurse documents a cervical exam at 0725 of 3-4 centimeters/50%/minus three station.
The pelvic exam documented by Dr. Kruszewski in her note of 7:40 a.m. was noted to be 3-- 4 cm/75%/minus 3/vertex.
The nurse documents contractions from between two to six minutes apart.
She documents AROM large amount of clear fluid at 0725.
The patient was started on pitocin at 12:40 p.m. on 5/10/02. According to the Hospital's Policy and Procedure, P/PR No. 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

There was no indication for induction and or augmentation with pitocin. There was no notation by Dr. Kruszewski as to why the pitocin was started. She failed to discuss the risks of and indications for induction and or augmentation with the patient. She did not evaluate the baby for fetal size and failed to perform clinical pelvimetry. These deviations were below the accepted standard of care.

The pitocin was steadily increased to a maximum level of 28 milliunits per minute.
On 5/10/02 and 1500 the patient received an epidural anesthetic.

According to the nursing patient progress note dated 5/10/02:

5:30p.m. - Dr. Kruszewski was notified of coupling and tripling pattern with pitocin and of the average fetal heart rate variability. The nurse was instructed to continue gradual increase of pitocin per protocol.
8:30p.m. - Dr. Kruszewski was advised of the uterine contraction pattern with extended periods out of duration increased, and fetal heart rate variability after reviewing the prior 2 hours of the fetal heart rate tracing. The nurse received an order to continue increasing the pitocin. A late entry indicates that Dr. Kruszewski was informed of an increased temperature on the patient.

According to the nursing patient progress notes dated 5/11/02;

1:00 a.m. late entry narrative - Dr. Kruszewski in attendance assisting. Patient with pushing from 2212. Fetal heart rate baseline 150s with average long term variability onset of pushing. The epidural was discontinued by anesthesia.

The fetal heart tracing demonstrated variable deceleration pattern increasing with progressive pushing. Occasionally variable with late onset.

IV bolus 1000 and LR with 800 cc.

At 2244, 02 increased to 5 L per minute via nasal cannula at 2246 as nursing a measure.

At 2300 depth of variable decelerations reached a fetal heart rate level of 60s returned to baseline 130 – 140's after less than 1 minute. Dr. Kruszewski questioned re. patient resting through a few contractions. Instructed to proceed with pushing.

800 CC fluid bolus infused by 2312 and 02 at 10 L per minute.

As of 2330 variable decelerations to 58 – 72 bpm lasting 30 -- 80 seconds noted with UC.

Patient proceeding to push vertex to +2 station. Fetal heart rate return to normal parameters. Fetal heart rate with scalp stimulation by Dr. Kruszewski with variables.

2342 Fetal heart rate capture lost on external fetal monitor. Pitocin discontinued per nursing measure at 2343.

2344 Fetal heart rate audible 60 – 70s. Fetal scalp stimulation by Dr. Kruszewski.

2346 Fetal heart rate audible at 50bpm and dropping.

2347 Order received verbally for vacuum.

2349 Vacuum extractor applied by Dr. Kruszewski with continuous effort made until vacuum assisted the vaginal delivery a female infant over median episiotomy by Dr. Kruszewski.

2354 spontaneous vaginal delivery of placenta by Dr. Kruszewski.

In review of the fetal heart tracing and notations, I note:

The patient was having contractions with a notation on the tracing of "AROM large clear fluid with the patient at 3 – 4 cm/50%." (Tracing #55105)

As seen on fetal tracing number 55109 the patient was contracting almost every minute.

Beginning on 55133 the contraction baseline was elevated after up to 17 attempts to calibrate the external monitor to this point.

Pitocin was started at 2 milliunits per minute at approximately 1239.

The patient was noted to have hyperstimulation with bradycardia. The fetal heart rate was below 110 from 1502 through 1521 at which point the standard of care required placement of a scalp electrode, intrauterine pressure device, discontinuing the pitocin, and to notify Dr. Kruszewski. Not doing so was below the accepted standard of care.

The patient was noted to have a prolonged deceleration beginning at approximately 1536 through 1541 associated with uterine hyperstimulation requiring that the nurses place a scalp electrode, an intrauterine pressure device, discontinue the pitocin and notify Dr. Kruszewski. Not doing so was below the accepted standard of care. Shortly after this episode, the fetal heart variability was decreased requiring placement of a scalp electrode and testing for fetal well being. Not doing so was below the accepted standard of care.

At 1845, a pelvic exam revealed the cervix to be unchanged and the patient was noted to have at least seven contractions in 10 minutes.

At 1849, the patient was positioned in the knee chest position and the pitocin increased to 22 milliunits per minute. The fetal heart tracing was inadequate and uninterpretable from 1848 through 1914. The notation on the fetal strip was "UA INOP CARDIO INOP."

At 1855, the nurse notes on the tracing, "poor fetal and uterine toco capture while in knee chest against BB."

At 20:32, Dr. Kruszewski was notified by phone of the last two pelvic exams, pitocin level, the periods of hypertonic appearing contractions, fetal heart rate with average variability and IV fluid bolus at 2031. The pitocin was then increased to 26 milliunits/min.

The pitocin finally reached its maximum level of 28 mu/min at 2050.

The patient had an episode of fetal bradycardia beginning at 2057 associated with an increased contraction baseline and hyperstimulation with contractions less than a minute apart. The bradycardia terminated at 2116. The nurse documents on the fetal tracing "maternal heart rate". Dr. Kruszewski was not made aware of this finding. An internal fetal scalp electrode was not placed. These deviations were below the accepted standard of care. The only way to accurately determine the difference between the fetal and maternal heart rate was by placement of a scalp electrode or by ultrasound. According to the Hospital's Policy/Procedures, P/PR No. 61.3 entitled, Fetal Scalp Electrode:

"Application of Fetal Scalp Electrode by nursing personnel is permitted by order of the Physician after documented education, training and supervised practice." "In emergency situations, nursing may apply fetal scalp electrodes before notifying Physicians."

At 2120, the patient was having variable decelerations requiring placement of a scalp electrode. Not doing so was below the accepted standard of care.

Dr. Kruszewski performed a pelvic exam at 2123 and the cervix was found to be 8 to 9 cm and 100% effaced. A note by the nurse at that time revealed that the electronic fetal monitoring strip to present was reviewed by Dr. Kruszewski. A scalp lead was not placed during the pelvic exam. This was below the accepted standard of care.

The pitocin was decreased to 20 milliunits per minute at 2131.

The fetal heart rate variability was decreased from 2138 through 2158 associated with uterine hyperstimulation. Dr. Kruszewski failed to place a fetal scalp electrode and/or intrauterine pressure device. Not doing so was below the accepted standard of care.

At 2146 the pitocin was decreased to 18 milliunits per minute. The variability was still decreased.

At 2200, the nurse notes that the electronic fetal monitoring tracing was reviewed to present by Dr. Kruszewski. Dr. Kruszewski also performed a pelvic exam, and the patient was found to be completely dilated. The pitocin was decreased to 16 milliunits per minute.

The patient began pushing at approximately 2213.

The epidural was stopped at approximately 2226.

The fetal tracing was suboptimal beginning at 2230 with episodes of drop out and decelerations noted. Not placing a fetal scalp electrode was below the accepted standard of care.

The patient was having repetitive decelerations beginning at 2243. The IV fluid was increased at 2244 and oxygen was placed at 2246. These findings mandated placement of a scalp electrode, an intrauterine device, discontinuing the pitocin and taking the patient to cesarean section. Not doing so was below the accepted standard of care.

Beginning at 2250 the patient was noted to be hyperstimulated associated with multiple repetitive severe variable decelerations, with loss of variability, mandating discontinuing the pitocin, placement of a scalp electrode and intrauterine pressure device, and performing an emergency cesarean section. Not doing so was below the accepted standard of care. (According to the Hospital Policy and Procedure Manual, P/PR No. 61:2, entitled Fetal Monitoring, Nonreasurring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.
4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent or correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

The pitocin was continued, a scalp electrode was not placed, and the patient was not taken to cesarean section. These deviations were below the accepted standard of care.

The severe variable decelerations became more pronounced after 2310, associated with late recovery and total loss of variability consistent with hypoxia and asphyxia. (SEE P/PR No. 61.2 above under "ominous fetal heart rate pattern") Not stopping the pitocin and performing an emergency cesarean section was negligent and below the accepted standard of care.

At 2306, oxygen via face mask at 10 L per minute was started.

At 2311, intravenous fluids were increased.

The severe variable decelerations were repetitive, more severe and associated with loss of variability and late components.

At 2338, an episode of terminal bradycardia occurred requiring emergent delivery. Not doing so was below the accepted standard of care.

At 2340, the fetal heart rate was essentially lost.

The pitocin was discontinued at 2343 and the nurse notes that the fetal heart rate was audible at 60 – 70.

Again the nurse notes on the strip at 2346 that the fetal heart rate was audible at 50 beats per minute and dropping at which time an order was received for the vacuum extractor which was applied. A second RN was called to the room.

At 2348 the nurse notes on the strip that the vacuum was applied by Dr. Kruszewski.

At 2350 the nurse notes on the fetal tracing that she was unable to capture the fetal heart rate.

At 2350 the nurse notes that the NICU was notified to come stat upon delivery of the infant's head.

At 2351 the nurse notes delivery time, vacuum assisted vaginal delivery female infant over media lateral episiotomy.

Dr. Kruszewski took infant to warmer, NICU staff present.

According to the obstetric discharge summary, completed by Dr. Kruszewski, the discharge diagnosis was term pregnancy delivered. None of antenatal risk factors including any that could be added were checked off.

According to history and physical examination done by Sundar Chandrasekhar, M.D.;

"Mikayla Rhoades was born by a spontaneous vaginal delivery assisted with the vacuum at 11:42 p.m. 15/10/02. The baby was noted to have a fetal bradycardia during the second stage of labor and delivery was assisted by vacuum, as mentioned. Cord pH was noted to be 7.13; loose cord around the neck was noted. The baby was limp at birth with no heart rate or respirations. Apgar at 1 minute was 0, at 5 minutes was 3, at 10 minutes was 4, at 20 minutes was 5. Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds, after which the heart rate went up to over 100 per minute. The baby was then transferred right away to the NICU for further management. First gas in the NICU showed a pH of 6.60, a second gas done at 12:30 a.m. showed a pH of 6.90, CO2 of 49, PO2 of 1021 vent settings of 100% oxygen."

Excerpts from the physical exam revealed that the central nervous system examination shows anterior fontanel open, pupils were small but did not appear to react to light. The baby did not have any response to painful stimuli. Deep tendon reflexes were not elicitable.

The impression was "large for gestational age female term baby with perinatal depression."

The plan was to provide prophylactic phenobarbital to prevent seizures.

According to the Pediatric Discharge Summary by Dr. Richard Grout, M.D.:

"This patient was transferred to Children's Hospital because of birth asphyxia with Apgar scores at 0 at 1 minute, 3 at 5 minutes, 4 at 10 minutes, 5 at 20 minutes."

Excerpts from the physical examination revealed a birth weight of 4400 g. "The patient was noted to be minimally responsive to external stimuli with some withdrawal to noxious stimuli only. The patient had some tremors and was given to boluses of Phenobarbital 10mg/kg for a total of20 mg/kg. The patient was catheterized and there was a small urine output which was sent for urine analysis."

The transferred diagnosis was: "severe birth asphyxia, term birth."

Reason for transfer was: "need for supervisory care of the pediatric neurologist and in conjunction with the familial request for transfer."

Excerpts from the Children's Hospital of Pittsburgh inpatient discharge summary dated 6/28/02 by Carol Gilmour M.D. indicate that;

"She did have chest compressions for less than 30 seconds for low heart rate."

"Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace.

The baby was evaluated for sepsis.

We also had neurology evaluate her. Her EEG times two showed no baseline activity, just intermittent focal sharp waves. She had a CT scan times two that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had lost a spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of severe hypoxic ischemic encephalopathy.

Over the next several days there was no change in Mikayla exam. There continued to be fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with neonatology, neurology, social work in the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life-support. The etiology is suspected to be acute perinatal total asphyxia. -- This was discussed thoroughly with the parents so the family did continue support of this infant."

According to the FINAL AUTOPSY REPORT dated 5/15/02, the final autopsy diagnoses were:

"A five day old female with hypoxic ischemic encephalopathy",
Brain – "Acute ischemic encephalopathy, severe."
Edematous and congested lungs,
Biventricular hypertrophy of the heart,
Congested hepatomegaly,
Congested spleen,
Thymic depletion,
Hemorrhagic adrenal glands,
Congested kidneys,
Pericardial fluid,
Generalized pitting edema.

Special Procedures:
CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord;

1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE

Microscopic Neuropathology revealed – "sections show widespread, severe acute ischemic damage in neurons in nearly all areas of the brain with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

Summary/Discussion – "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ----"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

To a reasonable degree of medical certainty I have reached the following conclusions and opinions in addition to those are ready mentioned;

1. The induction of labor was not indicated and conducted below the accepted standard of care.

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only."

According to ACOG, the indications for induction are;

"Abruptio Placenta
Chorioamnionitis
Fetal demise
Pregnancy induced hypertension
Premature rupture of membranes
Post term pregnancy

Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension)

Fetal compromise (e.g., severe fetal growth restriction, isoimmunization) preeclampsia, eclampsia."[1]

"Labor also may be induced for logistical reasons, for example, risk of rapid labor, distance from hospital, or psychosocial indications."[2]

There was no indication for the induction. There is no documentation as to the indication for the induction.

The patient was not at risk for rapid labor and there were no logistical indications for labor induction.

The patient was never diagnosed with pregnancy induced hypertension or chronic hypertension. During the patient's last prenatal visit with Dr. Kruszewski, on 5/9/02, the patient's blood pressure was 126/88 and she had no protein in the urine. She had already had a negative workup for preeclampsia including blood work, an NST and a biophysical profile of 8/8. The last ultrasound performed on the patient was interpreted as normal. Even defense expert Dr. Sommer agreed that the pregnancy was "uncomplicated", noting that "preeclampsia was appropriately ruled out with normal lab studies, a normal biophysical profile, and an ultrasound that showed a baby that was slightly larger than average size." Dr. Sommer fails to note that the only way to accurately determine this was by noting the percentile weight for gestational age and that the fetal weight on ultrasound bordered on macrosomia or fetal weight >90%.

There was no medical indication for induction of labor.

According to ACOG, "assessment of gestational age and consideration of any potential risks to the mother or fetus are of paramount importance for appropriate evaluation and counseling before initiating cervical ripening or labor induction. The patient should be counseled regarding the indications for induction, the agents and methods of labor stimulation, and the possible need for repeat induction or cesarean delivery."[3]

Dr. Kruszewski never documented an indication for the induction in either the prenatal chart or hospital record. There is no documentation that Dr. Kruszewski ever discussed the reason for the induction with the patient. There is no documentation indicating that Dr. Kruszewski ever explained the risks associated with induction with Mrs. Rhoades and there was never a discussion about the possibility of a repeat induction or cesarean section with the patient. These deviations were below the accepted standard of care.

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[1] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.
[2] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

[3] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to ACOG, "Additional requirements for cervical ripening and induction of labor include cervical assessment, pelvic assessment, assessment of fetal size and presentation, and personnel familiar with the effects of uterine stimulants on the mother and fetus because uterine hyperstimulation may occur with induction of labor. Monitoring the fetal heart rate and uterine contractions is recommended as for any high risk patient in active labor. Although trained nursing personnel can monitor labor induction, a physician capable of performing a cesarean delivery should be readily available."[4]

There was nothing in the record to support that the maternal pelvis and fetal size were evaluated prior to induction. Dr. Kruszewski admitted that she never evaluated the baby's weight and thus failed to recognize that the baby was macrosomic as evidenced by a birth weight of approximately 4400 g. The nurses and Dr. Kruszewski were not familiar with the effects of uterine stimulants on the mother and fetus and failed to recognize and act on the hyperstimulation caused by the pitocin which resulted in severe periodic changes with loss of variability indicating asphyxia. They failed to monitor the patient appropriately by utilizing internal fetal monitoring with a scalp electrode and intrauterine pressure device. These deviations were below the accepted standard of care and lead to progressive and severe perinatal asphyxia.

2. The management of the induction, augmentation and labor were below the accepted standard of care;

A. Dr. Kruszewski failed to recognize that the patient was at risk for and had a labor abnormality. This was below the accepted standard of care:

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

[4] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to Williams Obstetrics, "Pelvic contraction and fetal malposition are common causes of uterine dysfunction. That moderate degrees of pelvic contraction and fetal malposition may cause hypotonic uterine dysfunction is of great clinical importance."[5]

The patient had no medical indications for induction. Ultrasound examinations during the pregnancy were consistent with a larger than normal baby and bordered on fetal macrosomia. On exam, the patient was noted to have an unengaged fetal head. In a primagravida patient this finding is associated with a poor prognosis for vaginal delivery and indicated cephalopelvic disproportion. Dr. Kruszewski admitted that she failed to evaluate the pelvis and fetal size. The baby's birth weight was approximately 4400 grams or nearly 9 pounds indicating fetal macrosomia which also placed the mother and fetus at risk for labor abnormalities that would not justify the aggressive pitocin induction and or augmentation.

The patient presented to the hospital on 5/10/02, for induction of labor in active labor with contractions at a frequency of 2-6 minutes apart. According to the nurses notes on admission the pelvic exam was 3-4cm/50%/-3 station. According To Dr. Kruszewski's exam the cervix was 3-4/75%/-3. According to the Hospital's Policy and Procedures, P/PR No. 76.1 entitled Active Management of Labor in Primipara, the diagnosis of labor is made as follows,

a. Diagnosis based on the following criteria:

1. Contractions: At least 1 in 7 minutes.
2. Show.
3. Rupture of membranes.
4. State of Cervix:
    a. If effacement at least 70%-80%
    b. Cervical dilation of 3 cm or greater.
    c. Contractions as above, then in labor."

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[6] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[7]

The patient presented to the hospital in the active phase of labor.

There is no notation as to why the pitocin was started. There is no notation that there was a discussion with the patient about the risks associated with induction and or augmentation of labor with pitocin, especially in light of the fact that the patient was already in active labor. These deviations were below the accepted standard of care.

The patient's membranes were ruptured by Dr. Kruszewski.

The patient was noted to be 3 to 4 cm at that time with an unengaged fetal head, and at 0740 the patient was having contractions almost every minute. From the time of admission until the pitocin was started at 12:39 p.m., the tocometer was readjusted and or zeroed on multiple occasions indicating the need for an intrauterine pressure device to accurately evaluate and

[5] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia, 1989, pg 343.
[6] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[7] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

monitor the contraction pattern prior to administering pitocin. Not doing so was below the accepted standard of care. The cervix was unchanged from the time of admission until the pitocin was started consistent with active phase arrest.

According to Williams Obstetrics, "Uterine dysfunction in any phase of cervical dilatation is characterized by lack of progress, for one of the prime characteristics of normal labor is its progression."[8] The patient had no cervical change for over four hours prior to starting pitocin.

According to Williams, "Uterine dysfunction is often a protection against some degree of pelvic contraction or abnormalities of fetal size or presentation. Fortunately, the uterus does not typically persist in spontaneous activity that would lead to rupture. Instead the usual forces of labor are replaced by hypotonic uterine dysfunction. Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[9]

Dr. Kruszewski failed to place an intrauterine pressure catheter and fetal scalp electrode. She failed to determine that the baby was macrosomic, that the patient was arrested in the active phase of labor, and failed to perform a cesarean section after two hours of labor with no cervical change. These deviations were below the accepted standard of care.

According to Williams Obstetrics, "There have been three significant advances in the treatment of uterine dysfunction:

(1) The realization that undue prolongation of labor may contribute to perinatal morbidity and mortality;

(2) The use of very dilute intravenous infusion of oxytocin in the treatment of certain types of uterine dysfunction; and

(3) The more frequent use of cesarean section to affect delivery rather than difficult midforceps delivery or if oxytocin fails or its use is inappropriate."[10]

B. Dr. Kruszewski and the nurses failed to recognize that this patient was arrested in the active phase in labor which was a contraindication to the use of intravenous pitocin. This was below the accepted standard of care.

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[8] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 341.

[9] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.

[10] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 342.

A summary of the patient's pelvic exams are as follows;

| TIME | DILATION | EFFACEMENT | STATION |
|---|---|---|---|
| 7:25 a.m. | 3-4cm | 50%-75% | -3 |
| 8:25 a.m. | 4cm | 60% | -3 |
| 9:30 a.m. | 4cm | 70% | -3 |
| 12:50 p.m. | 4cm | 70% | -2 |
| 3:40 p.m. | 4-5cm | 70% | -2 |
| 5:10 p.m. | 5cm | 75% | -2 |
| 6:50 p.m. | sve unchanged | | |
| 8:10 p.m. | 4-5cm | 80% | 0/-1 |
| 8:30 p.m. | 4-5cm | 80% | 0/-1 |
| 9:20 p.m | 8-9cm | 100% | 0/-1 |
| 10:00 p.m. | complete | | |

The chart indicates that the patient's cervical exam remained unchanged for approximately 12 hours.

The patient presented to the hospital actively contracting and was found to be 4 cm dilated on admission. The patient was re-examined over 4 hours later and her cervical exam was unchanged despite having contractions as often as 1 minute apart consistent with arrest in the active phase of labor. The standard treatment for arrest in the active phase of labor with evidence of cephalopelvic disproportion was and is a cesarean section. Not doing so was below the accepted standard of care.

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[11] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[12]

The patient presented to the hospital in the active phase of labor.

According to ACOG, arrest disorders constitute no cervical dilatation in a nullipara for more than two hours. This requires that the patient to have entered the active phase of labor to make a diagnosis.

Protraction Disorders:

1a. Multiparous - dilatation less than 1.5 centimeters per hour;
b. Multiparous - descent less than 2.0 centimeters per hour;

[11] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[12] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

2 a. Nulliparous - dilatation less than 1.2 centimeters per hour; and
b. Nulliparous - descent less than 1.0 centimeter per hour

Arrest disorders are defined as follows:

1a. Multiparous- No cervical dilatation for greater than two hours;
b. Multiparous - No descent of the presenting part for greater than one hour;

2a. Nulliparous - No cervical dilatation for greater than two hours;
b. Nulliparous - No descent of the presenting part for greater than one hour.[13]

According to ACOG, "It has been suggested that before the arrest disorder can be diagnosed in the first stage of labor, the following criteria should be met:

1. The latent phase is completed (*i.e.*, cervical dilatation is a minimum of 4 centimeters), and

2. A uterine contraction pattern exceeds 200 Montevideo Units for two hours without cervical change. "Assessment of powers during the active phase of the first stage of labor involves the investigation of uterine contractility. The minimal contraction pattern of 95 percent in spontaneous labor consists of three to five contractions in a ten minute window."[14] The patient was having in excess of 5 contractions in 10 minute windows.

"Several methods of quantifying uterine activity with internal monitors have been described."[15] "In a retrospective report an induction of labor with Oxytocin, 91% of women achieved at least 200 to 224 Montevideo Units and 40% achieved at least 300 Montevideo Units."[16] The only way to diagnose an active phase arrest associated with a hypotonic labor dysfunction was by placing an intrauterine pressure device.

According to Parer, with reference to the Tokodynamometer or external contraction monitor "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experience hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This

[13] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[14] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[15] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[16] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[17] An intrauterine pressure device was not placed by Dr. Kruszewski to assess the powers of labor. This was below the accepted standard of care.

At 0725, the cervical exam was 3-4 cm. Her cervical exam was unchanged at the time pitocin was started at 12:39 p.m., 4 1/2 hours later. If an intrauterine pressure device had been placed prior to starting pitocin and indicated that the contractions were adequate, a cesarean section would have been indicated and pitocin unnecessary.

Starting pitocin, while the patient was actively contracting, in active labor, with no cervical change for over 4 hours, without first placing an intrauterine pressure device to document contraction adequacy was below the accepted standard of care.

According to Williams Obstetrics, "failure of the cervix to dilate or of the presenting part to descend is cause for concern. Prolongation of either the first or second stage of labor may result in increased perinatal and maternal morbidity. Any delay in cervical dilatation during the first stage or prolongation of the second stage of labor should alert the obstetrician to possible danger."[18]

There was no indication for the pitocin augmentation.

C. Aggressive pitocin augmentation was not indicated and below the accepted standard of care.

The patient was arrested in the active phase of labor for up to 12 hours. According to Williams Obstetrics, "oxytocin is a powerful drug, and it has killed or maimed mothers due to rupture of the uterus and even more babies through hypoxia from markedly hypertonic uterine contractions."[19]

According to Williams, oxytocin stimulation is appropriate if the following criteria for pelvic adequacy are met;

1. The diagonal conjugate is normal,
2. The pelvic sidewalls are nearly parallel,
3. The issue spines are not prominent,
4. The sacrum is not flat,
5. The suprapubic angle is not narrow,
6. The occiput is known to be the presenting part,
7. The fetal head is engaged or descends through the pelvic inlet with fundle pressure. ( the patient presented with an unengaged, floating head, at -3 station)

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[17] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[18] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 341.
[19] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345.

If these criteria are not met, the alternatives are cesarean delivery or possibly oxytocin stimulation. If oxytocin is used, it is mandatory that the fetal heart rate and the contraction pattern frequency, intensity, duration, and timing in relation to fetal heart rate be observed closely."[20]

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"POLICY:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

Dr. Kruszewski failed to perform clinical pelvimetry on this patient who presented with a macrosomic infant, and an unengaged floating head indicating cephalopelvic disproportion. Dr. Kruszewski failed to place an intrauterine pressure device to document contraction adequacy, and to accurately monitor the contraction pattern. Dr. Kruszewski started the pitocin augmentation without precise knowledge of contraction adequacy and after the patient was arrested in the active phase of labor for over 4 hours with contractions as close as 1 minute apart. She aggressively augmented this patient without first discussing and documenting the indications for its use. These deviations were below the accepted standard of care.

According to Williams, "the arrest disorders are considered to be present when there is no cervical dilatation for two hours, when the deceleration phase is prolonged, or when there is failure of the presenting part to descend for greater than one hour or longer. Friedman (1978) maintains that approximately one half of these patients have "insurmountable obstruction" and recommends the judicious use of intravenous oxytocin but cautions that such efforts, while effective in dilating the cervix and ultimately resulting in vaginal delivery, may subject the fetus to substantial risks of hypoxic injury as well as birth trauma[21]."

According to Williams Obstetrics, "one characteristic of intravenous oxytocin is that when successful, it acts promptly, leading to noticeable progress with little delay. For any given rate of infusion the plasma level reaches a plateau after about 30 to 40 minutes as the rate of infusion and rate of destruction by oxytocinase achieve equilibrium. Therefore, the drug need not be used for an indefinite period of time to stimulate labor. It should be employed for no more than a few hours; if, by then, the cervix is not changed appreciably and if predictably easy vaginal

[20] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 344
[21] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 346

delivery is not imminent, cesarean delivery should be performed."[22] "Ready resort to cesarean section in cases where oxytocin fails or in which there are contraindications to its use has served to diminish perinatal mortality and morbidity appreciably."[23]

D. The patient was exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive pitocin augmentation, resulting in progressive hypoxia, asphyxia and permanent central nervous system damage. This was below the accepted standard of care.

According ACOG, "the goal of oxytocin administration is to effect uterine activity that is sufficient to produce cervical change and fetal descent while avoiding uterine hyperstimulation and fetal compromise. Minimally effective uterine activity has been defined as 3 contractions per 10 minutes averaging greater than 25 mmhg above baseline."[24] "Typically, a goal of a maximum of five contractions in a 10 minute period with resultant cervical change is considered adequate."[25]

According to Dr. Kruszewski's deposition testimony,

Question – "What do you consider to be significant hyperstimulation of the uterus?" (pg. 28)

Answer – "If the uterus is staying contracted for more than two or three minutes and not relaxing."

Question – "Did you have any concerns about the administration of oxytocin or pitocin causing uterine hyperstimulation during the labor?"(96)

Answer – "No."

Question – "Did you make any observations which would indicate that Mrs. Rhodes was suffering from uterine hyperstimulation at any time during her labor?"(96)

Answer – "No."

Question - "Can hyperstimulation cause fetal stress?"(96)

Answer – "Yes."

Question – "Would this discontinuance of oxytocin be an intrauterine resuscitation procedure that could mitigate a worrisome fetal heart rate patterns?"(97)

Answer – "Possibly."

Question – "Do you believe that the administration of pitocin over the course of Kim's labor caused any complications of her pregnancy?"(97)

Answer – "No."

According to the deposition testimony of Gloria Bennett (referencing 3:26 when the pitocin was decreased),

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[22] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345

[23] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345

[24] ACOG Technical Bulletin, Dystocia—, No.218, December 1995

[25] ACOG Technical Bulletin, Dystocia—, No.218, December 1995

Question – "Okay. Now, why did you reduce the pitocin at that point that you've just described?"(29)

Answer - "Just to see the fetal response to a pitocin decrease."

Question - "Why would you do that, I mean what medical reason would you have for reducing the pitocin and how would that affect the infant response?" (29)

Answer - "If the contractions are close together which at that point they were very close together." "It can be over stimulating the fetus."

Question - "And when you say it's over stimulating the fetus, what do you mean? (29-30)

Answer - "Just means that it's not giving the baby a chance to recover between contractions."

According to the Hospital's Policy and Procedures Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinues oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.

According to ACOG, hyperstimulation is defined as "a persistent pattern of more than five contractions in 10 minutes, contractions lasting 2 minutes or more, or contractions of normal duration occurring within 1 minute of each other."[26]

According to Williams Obstetrics, "Uterine contractions must be evaluated continually and oxytocin shut off immediately if contractions exceed 5 in a 10 minute period or last longer than 1 minute or if the fetal heart rate decelerates significantly."[27]

The pitocin was started at 12:39 p.m. on 5/10/02, and progressively increased, without an intrauterine pressure device, to a maximum level of 28 milliunits per minute resulting in unrecognized iatrogenic hyperstimulation causing severe periodic changes, loss of variability, terminal bradycardia, profound hypoxia, asphyxia, and irreversible brain damage. The aggressive use of pitocin and the failure to recognize the uterine hyperstimulation and the repetitive periodic changes were below the accepted standard of care.

There were multiple episodes of hyperstimulation on pitocin throughout the fetal tracing beginning as early as 1431. Because of the difficulty the nurses were having maintaining a tracing with the tokometer, the poor tracing quality, elevated baseline, and uterine

[26] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[27] Williams Obstetrics, 20th Edition, Cunningham et al., Dystocia—, 1997, pg 426.

hyperstimulation, placement of an intrauterine pressure device was mandatory. Not doing so was below the accepted standard of care.

According to Parer, with reference to the Tokodynamometer or external contraction monitor, "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experienced hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[28]

According to Williams, "Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[29]

The nurses and Dr. Kruszewski failed to recognize and act on the inadequate tracing of uterine contractions, uterine hypertonus, and failed to recognize the multiple episodes of uterine hyperstimulation. These deviations were below the accepted standard of care.

The nurse and Dr. Kruszewski failed to recognize and act on the repetitive severe fetal heart rate decelerations caused by the iatrogenic uterine hyperstimulation with pitocin. They failed to place an intrauterine pressure device and fetal scalp electrode to monitor fetal well-being and short term variability. They failed to realize that the repetitive severe decelerations associated with loss of variability signaled hypoxia, asphyxia and fetal compromise. They failed to discontinue the pitocin which was causing the hyperstimulation and the decelerations. Dr. Kruszewski failed to take this patient to cesarean section. These deviations were below the accepted standard of care and lead to the delivery of a profoundly asphyxiated and neurologically damaged infant.

According to ACOG, "if hyperstimulation with a non-reassuring fetal heart rate occurs, intravenous infusion of oxytocin should be decreased or discontinued to correct the pattern. Additional measures may include turning the woman on her side and administering oxygen or more intravenous fluid. If hyperstimulation persists, use of terbutaline or other tocolytics may be considered."[30]

According to the Hospital's Policy and Procedures Manual, No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.

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[28] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[29] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.

[30] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent, on correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

E. The nurses and Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability. This led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damage. These actions were below the accepted standard of care.

1. The nurses and Dr. Kruszewski were unfamiliar with the basic concepts and principles of fetal monitoring resulting in the unrecognized progressive iatrogenic fetal asphyxia.

Dr. Kruszewski admitted that she failed to review the entire fetal monitoring strip when she arrived at the hospital at 9:30 p.m. (deposition pg. 47). This was below the accepted standard of care.

Dr. Kruszewski demonstrated a lack of understanding of basic fetal monitoring as evidenced by her deposition testimony.

Question – "What do you mean when you say prolonged decelerations?" (pg. 25)

Answer – "Again, that varies from case to case. There is no strict definition of what a prolonged deceleration is."

According to a Parer, the definition of a prolonged deceleration is, "an abrupt decreased (defined as onset of deceleration to beginning of Nader of less than 30 seconds) in FHR from the baseline. The decrease in FHR below the baseline is at least 15 beats per minute, lasting (from baseline to baseline) at least 15 seconds and is greater than two minutes, but less than 10 minutes."[31]

Question – "What is a sustained bradycardia?" (pg. 49)

Answer – "That the heart rate went down below 100 beats per minute and stayed that way for more than two or three minutes."

According to Parer, "a bradycardia is considered to represent a decrease in heart rate below 110 beats per minute for 10 minutes or longer."[32]

Dr. Kruszewski also demonstrated a lack of understanding of the fetal scalp stimulation test by noting in her deposition (pg. 57),

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

When Gloria Bennett was asked about fetal scalp stimulation on page 42 of her deposition she responded,

Question - "What is fetal scalp stimulation?"

Answer - "Where you just rubbed the baby's head and watch how the heart rate responds."

Question - "Did the heart rate respond to that?"

Answer - "Yes, it would come up to baseline."

According to Parer, with reference to scalp stimulation, "in the case of suspected fetal acidosis the scalp is digitally stimulated during vaginal examination and a FHR monitor observed for acceleration of 15 seconds duration, peaking 15 beats per minute above the baseline FHR.[33]

2. The nurses and Dr. Kruszewski were unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia.

When Dr. Kruszewski was asked in her deposition, pg.49, whether or not the baby was asphyxiated she responded as follows,

Question – "Okay. Was the baby asphyxiated?" (pg. 50)

Answer – "No"

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[31] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg148.
[32] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg152.
[33] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 120

Question – "Do you know what the term asphyxiated means?" (50)
Answer – "Yes."
Question – "What does it mean to you, Doctor?"(50)
Answer – "Significant deprivation of oxygen causing metabolic abnormalities."
Question – "How did you determine the baby was not asphyxiated when it was delivered?"(51)
Answer – "By the cord pH."
Question – "You weren't able to make an observation?"(51)
Answer – "No."
Question - "And make that determination?"(51)
Answer – "No."
Question – "Is there any way that you could have determined whether or not the infant was experiencing asphyxia if she was prior to her delivery?"(66)
Answer – "No"
According to the Hospital Policy and Procedure, P/PR No. 76.1, entitled Active Management of labor in Primipara:
"Consider check scalp PH if suspicious of fetal distress."

Dr. Kruszewski was contradicted by the deposition testimony of Richard Grout, pg. 39, when he states,
Question – "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that as evidence of acidosis?"
Answer – "Correct."

This patient had a prolonged period of repetitive severe variable decelerations and fetal bradycardia with complete loss of short term variability. Dr. Kruszewski and the nurse failed to recognize the progressive fetal asphyxiation. Dr. Kruszewski failed to place an internal scalp electrode, failed to place an intrauterine pressure device, failed to stop the pitocin and failed to perform a cesarean section. These deviations were below the accepted standard of care.

According to Parer, "there is also general agreement that the fetus with absent FHR variability, a heart rate within or outside the normal range, and deep variable or late decelerations, is presumed to be asphyxiated, and expeditious delivery is indicated."[34]

According to Parer, "fetal asphyxia almost always occurs as a result of insufficient umbilical or insufficient uterine blood flow."[35] This can be seen with umbilical cord compression and with uterine hyperstimulation.

According to Parer, "In the presence of normal FHR variability, no matter what other FHR patterns may be present, the fetus is not suffering cerebral tissue asphyxia, because it has been able to successfully centralize the available oxygen and is thus is physiologically compensated. In the presence of excessive asphyxial stress, however, as evidenced by severe periodic changes or prolonged bradycardia, this compensation may break down, and the fetus

[34] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 201
[35] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg198.

may have progressive central tissue asphyxia (i.e., hypoxia in cerebral and myocardial tissues). In this case, it is theorized that fetal heart rate variability decreases and eventually is lost."[36]

According to Parer, "the presence of FHR variability indicates central (nervous system and or myocardial) normoxia, while its decrease in the presence of distress patterns indicates a decrease in the oxygenation of these organs."[37] A decrease in oxygenation leads to hypoxia, acidemia, and asphyxia.

According to ACOG, "the term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia, and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damage, including all of the following:

1. Profound metabolic or mixed acidemia (pH less than 7.00) on an umbilical cord arterial blood sample, if obtained.
2. Persistent Apgar scores of 0-3 for longer than five minutes.
3. Evidence of neonatal neurological sequelae (e.g., seizures, coma, hypotonia, and one or more of the following: cardiovascular, gastrointestinal, and the to logical, pulmonary, or renal system dysfunction)."[38]

According to the deposition testimony of Karen Constantino, she was called Stat close to midnight to the delivery room.

Question - "Did you perform a blood gas or did you extract the blood to submit to the lab for a blood gas test from the cord?"(7)

Answer - "We don't submit them to the lab. We run them and draw and them, it's a respiratory function."

Question - "So you do both testing and the obtaining of the blood sample to be tested?"(7)

Answer - "Right"

Question - "Did you do that in this case? (7)

Answer - "Yes I did."

Question - "How did you obtain the blood gas sample in this case?"(7)

Answer - "I used they -- we have pre-Heparinized syringes for drawing blood and just insert the needle in either the vein or the artery of the cord and draw sufficient amount to which each usually around 3 cc and then we put them in the blood gas machine which reads the values.

Question - "Do you keep a record of whether you put the needle in the vein or the artery?"(7)

Answer - "No, because sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed."

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[36] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 157.

[37] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 202.

[38] ACOG Committee Opinion, No. 197, February 1998.

Question - "OK. In this case would the chart show or would you have any record of where the sample actually came from?"

Answer - "No, it's just I would have marked it a cord gas."

According to the deposition of Richard Grout,

Question - "Dr. Chandrasrasekar also noted a cord pH of 7.13. What was the significance of that finding to you when you took over Mikayla's care?"(15)

Answer - "That indicates the infant had acidosis at the time of birth. The accuracy of that finding is difficult to assess sometimes because it's not always known whether that sample comes from the cord artery or the cord vein."

"Or it can be a mixture of the two together."

"And it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two."(16)

Question - "When you stated on the cord gas which I think was around midnight was taken, you indicated that was not reliable because you didn't know what vessel it came from?" (38)

Answer - "Correct"

Question - "And is that because of the person taking the sample, could you explain that a little more, I know you explained there were a vessel and an artery?"(38)

Answer - "I believe it has to do with the technique that's used to do it."

Question - "Do you know what technique was used here" (38)

Answer - "They still do it the same way. It is basically, the sample of the cord is isolated between two clamps, and a needle attached or syringe is inserted in the cord and they attempt to aspirate back blood and hopefully -- usually they try to go to the vein.

Question - "We have no evidence here, other than the fact there was the cord gas, we don't know whether they were in the vein or an artery, is that what you're saying?"(38)

Answer - "Correct, you don't know for absolute certainty which one."

Question - "So indeed it could be a valid test too?"(39)

Answer - "Well, its validity is, it certainly couldn't be any better than it was. I mean the best -- the sample coming from the vein with the blood going to the baby, and hopefully that would be the best that he could be."

Question - "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that is evidence of acidosis?(39)

Answer - "Correct."

According to the history and physical exam of Dr. Chandrasekhar, "the baby was limp at birth and with no heart rate or respirations. Apgar at one minute was 0/10, at five minutes was 3/10, at 10 minutes was 4/10 and at 20 minutes was 5/10." "Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds." The first gas in the NICU showed a pH of 6.60.

Dr. Grout admitted in his deposition that the cord pH obtained at delivery indicated fetal acidosis.

The baby's neurological exam was markedly abnormal and the baby was placed on prophylactic phenobarbital for seizures.

According to the discharge summary dictated by Dr. Richard Grout, the transferred diagnosis was, "severe birth asphyxia, term birth."

After evaluation at the Children's Hospital of Pittsburgh revealed no baseline brain activity, the baby was withdrawn from life support and died.

The final autopsy report indicated, "A five day old female with hypoxic encephalopathy (clinical)" and a brain with "acute ischemic encephalopathy, severe."

According to the Autopsy Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

In my opinion to a reasonable degree of medical certainty this baby was repetitively and progressively iatrogenically asphyxiated by the nursing staff and Dr. Kruszewski resulting in profound central nervous system destruction, and eventually the death of the baby.

3. The patient had multiple episodes of unrecognized iatrogenic asphyxial stress which required intervention by cesarean section. Not performing a cesarean section in this situation resulted in fetal asphyxia and permanent brain damage. This was below accepted standard of care.

The fetal monitor revealed episodes of prolonged decelerations, severe variable decelerations with and without late components, fetal bradycardia, and loss of variability.

In review of the fetal tracing the patient had a reassuring fetal tracing on admission which correlates highly with fetal well being.

The pitocin was started at approximately 12:39 p.m. after over 4 hours of no cervical change and active phase arrest. The patient was noted to have fetal bradycardia from 15:02 to 15:21 associated with uterine hyperstimulation. A scalp electrode and intrauterine pressure device should have been placed, the pitocin stopped, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

The tracing revealed a prolonged deceleration from 15:37 to 15:41 associated with uterine hyperstimulation. The variability was decreased after the prolonged deceleration mandating placement of a scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care. The hyperstimulation mandated placement of an intrauterine pressure device to accurately monitor the contraction pattern and the pitocin should have been discontinued. Not doing so was below the accepted standard of care. According to Dr. Kruszewski's deposition testimony,

Question - "what kind of things would you be looking for to determine whether intervention was an option during labor?" (pg. 25)

Answer – "prolonged decelerations or decelerations that were occurring very frequently with the mother remote from delivery, decreased in fetal heart rate variability." She defines

intervention as, "can be any number of things, it can be a C-section, it can be a vacuum assisted delivery." (pg. 24).

The nurse notes on the strip at 15:38, "SVE 4-5cm 70% -2.", "Dr. Kruszewski called in, report given of recent variable decels and pitocin changes." The pitocin should have been discontinued, and the patient taken to cesarean section for arrest in the active phase of labor. Not doing so was below the accepted standard of care.

The Toco revealed an increased baseline from 17:10 to 17:20, requiring the reference to be readjusted again. The nurse also noted on the fetal tracing that there were multiple maternal position changes making interpretation of the uterine contraction pattern even more difficult. Not placing an intrauterine pressure device was below the acceptable standard of care.

The nursing staff continued to increase the pitocin in the face of arrest in the active phase of labor associated with uterine hyperstimulation from 16:40 on. They did not inform Dr. Kruszewski that the patient was being iatrogenically hyperstimulated, they failed to stop the pitocin and to insist that Dr. Kruszewski come in to evaluate the patient. These deviations were below the accepted standard of care.

The hyperstimulation with pitocin continued and the nurse noted on the tracing that the patient was placed in the knee chest position at approximately 18:49. The tracing indicated at this point that the "UA INOP, CARDIO INOP". The fetal heart tracing from 18:50 to 19:11 was inadequate and unreliable. The nurse notes on the fetal tracing that, "poor fetal and uterine toco capture while pt in knee chest against BB." At this time the patient was hyperstimulated with contractions almost every minute. Dr. Kruszewski should have been notified, a fetal scalp electrode and intrauterine pressure device should have been placed, the pitocin should have been discontinued, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 20:08, the cervical exam was unchanged. The patient was arrested in the active phase of labor for over 12 hours, associated with uterine hyperstimulation. A cesarean section was indicated. Not performing one was below the accepted standard of care.

At 20:31, the nurse again documents a note indicating that "Dr. Kruszewski on phone aware of last 2 exams, Pit level, periods of hypertonic appearing FHR average variability, IV fluid bolus. The nurse should have insisted that Dr. Kruszewski come in to evaluate the patient and discontinue the pitocin. The nurse should have insisted that Dr. Kruszewski be present to manage the patient. She should have discontinued the pitocin augmentation because of the arrest in the active phase of labor and because of the uterine hyperstimulation. These deviations were below the accepted standard of care.

Instead, the nurse increased the pitocin to 26 mu/min. If Dr. Kruszewski failed to respond, the nurse should have involved the nursing supervisor, Chief of Obstetrics and or the Hospital Administrator. According to the Hospital Policy and Procedures, No. 82, entitled Physician Notification in Maternal/Fetal Distress:

"When patients demonstrate maternal or fetal distress, the attending Physician will be notified immediately and his specific orders carried out."

"The hospital Supervisor should be notified."

"In the event the attending Physician fails to respond, the Labor Room Nurse will notify the Manager or Supervisor. The Chief of Service may be notified for advice."

Other procedures noted are to "See Medical Staff Chain of command."

The nurse documents that Dr. Kruszewski was notified of the last 2 pelvic exams, periods of hypertonic appearing UC, fetal heart rate with average variability, and that an IV fluid bolus was given. The pelvic exam at that time was 4-5 cms. The patient's cervical exam was unchanged despite aggressive pitocin augmentation. A cesarean section was indicated. Not performing a cesarean section and proceeding with the aggressive pitocin augmentation was below the accepted standard of care and lead to iatrogenic hyperstimulation, severe periodic changes, loss of variability, end stage bradycardia and eventually profound and irreversible brain damage.

At 2057, the patient had an episode of bradycardia lasting approximately 16 minutes associated with hyperstimulation, and an increased contraction baseline requiring placement of a scalp electrode, intrauterine pressure device, and discontinuing the pitocin. Not doing so was below the accepted standard of care. Although the nurse notes on the strip that the fetal heart rate was consistent with "maternal" heart rate, the only way to differentiate maternal from fetal heart rate was by placement of a scalp electrode.

The nurse failed to make Dr. Kruszewski aware of the fetal bradycardia, abnormal uterine activity pattern, uterine hyperstimulation, and increased baseline tone. She failed to insist that Dr. Kruszewski evaluate the patient. She failed to place a scalp electrode and intrauterine pressure device. She failed to discontinue the pitocin. These deviations were below the accepted standard of care.

At around 2120, the fetal strip revealed variable decelerations.

At 2131 the pitocin was decreased to 20mu and maternal position was changed.

The variability was decreased to absent from 2138 and through 2200. The nurse notes the EFM tracing "to present" reviewed by Dr. Kruszewski. At that time a pelvic exam was done by Dr. Kruszewski and the pitocin was decreased to 16mu.

The patient began pushing at approximately 2213. The patient had an abnormal uterine activity pattern. The strip revealed areas of drop out and difficulty monitoring the contraction pattern with multiple recalibrations of the UA reference mandating placement of a fetal scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care.

The fetal heart tracing demonstrates that the patient was having decelerations at approximately 22:37.

In reference to the fetal tracing at 10:54 (22:54), Nurse Bennett states in her deposition,
Question – "Did the decelerations at this point concern you in any manner?"(36-37).
Answer - "I'd like to see the patient delivered."

The fetal tracing from 22:40 forward was suboptimal with areas of drop out, severe periodic changes and loss of variability.

There are multiple references by the nurses regarding difficulty tracing the fetal heart rate during labor. According to the deposition testimony of Gloria Bennett when asked about the variable decelerations at 1037,

Question - "You lost the heart rate on the monitor?"(34)

Answer - "Right, when they're doing this, baby's usually moving to get off the cord so you don't always keep capture the whole way through."

With reference to a variable at 1039,

Question – "Ok. And how long would that have lasted?"(35)

Answer – "That's indeterminate because of inadequate capture."

When referring to a variable at 1052 she states,

Answer - "At 52, there was shown a returning to baseline of 120's but there is not an accurate measure of whether it was maternal heart rate were capturing or fetal, so I can't determine that."(36-37)

Answer – "54, same scenario, 90s -- returning from the 90s after inadequate capture."(36-37)

Answer - "When the mother is pushing to, they're often in the position, where they're bumping the monitor she can't keep in the fetal heart rate all in the entire time."(36-37)

When referring to a deceleration at 2331 she states,

Answer - "At which time capture was lost for seconds, and when it recaptured was 120's."(40)

According to the deposition testimony of Sherry Kizina,

When asked about a variable deceleration at approximate 8:45 a.m. (on page 88 of the transcript),

Answer – "that's not clear; it's not captured the whole way."

According to Parer, with reference to the external heart monitor, "although this device is simple to apply and can be used before rupture of the membranes, it sometimes is unreliable during labor because of maternal and fetal movement. A greater disadvantage is that it may not always give a valid indication of beat to beat variability, because the Doppler signal is broad and slurred, and the machine is not always able to select accurately and consistently a point on this slurred curve to represent the exact time of a cardiac event. Hence, an artificial short term variability can be portrayed by the apparatus. Long term variability, however may be displayed reasonably accurately."[39] According to Parer, with reference to a fetal scalp electrode, "this mode gives the most valid FHR tracing because of the discreteness of the signal; therefore, it best depicts beat to beat variability."[40]

An IV fluid bolus was given at 2244; oxygen was started at 2247 via nasal cannula. A scalp electrode and intrauterine pressure catheter were mandatory in this situation. Not utilizing these modalities was below the accepted standard of care.

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[39] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 103

[40] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 102.

At and after 2250 the patient was hyperstimulated, was having repetitive severe periodic changes and loss of variability consistent with fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care

At 2306, 02 via facemask was applied at 10 L per minute, the patient had an abnormal uterine activity pattern and was having decelerations which were more severe associated with loss of variability signaling fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 2312 an IV fluid bolus was given and continued.

From 2310 forward the patient continued to have an abnormal uterine activity pattern, with severe periodic changes now with late components and loss of variability signaling fetal asphyxia and central nervous system compromise. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

Dr. Kruszewski stated in her deposition testimony (pg. 23) that "fetal stress can be some heart rate decelerations, changes in the variability of a heart rate pattern."

Question – "what do you consider to be non-reassuring fetal monitoring tracing?"(pg.28).

Answer – "frequent decelerations, decelerations with each contraction or almost every contraction that don't respond spontaneously to the end of the contraction, significant decrease in fetal heart rate variability." Allowing the patient to continue to labor in the face of progressive repetitive severe variable decelerations with loss of variability, resulted in fetal asphyxia and central nervous system damage. This was below the accepted standard of care.

According to Parer, severe variable decelerations are described as,

"A. Below 60 beats per minute and

B. Longer than 60 seconds in duration."[41]

Other practitioners use the "rule of 60s" as a guideline.

"When severe variable decelerations are present, vigorous efforts should be made to abolish them, because it is likely that even the normally grown fetus with normal placental function eventually will decompensate, although usually not before 30 minutes."[42]

According to Parer, "during severe variable decelerations the heart rate pattern must be observed for an intermittent reduction in FHR variability during and following the variable deceleration. Should this begin to occur and still abolition of the decelerations can not be achieved by the means outlined above (resuscitation maneuvers), then delivery is recommended. Delivery is recommended before the total loss of variability because this may signify asphyxial decompensation, and indeed must be present to do so unless asphyxia can be ruled out by ancillary methods."[43]

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[41] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[42] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[43] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

"Severe variable decelerations in the presence of frequent uterine activity may become confluent and form a prolonged deceleration, and eventually a bradycardia. Therefore in the presence of persistent severe variable decelerations it is prudent to attempt to maintain uterine contractions more than two minutes apart."[44] At 2330, the tracing revealed multiple severe variable decelerations with loss of variability associated with uterine hyperstimulation consistent with fetal asphyxia and central nervous system damage. This pattern finally terminated in severe bradycardia at 2338. The fetal tracing at this point was not traceable and unreliable.

The nurse notes that the pitocin was discontinued at 2343 and that the fetal heart rate was audible from 60 to 70. Emergent delivery was mandatory.

Dr. Kruszewski admits in her deposition that,

Question - "What can happen in a situation where the heart rate is that low and stays down?"(49)

Answer - "The baby's deprived of oxygen."

Question - "What happened in this case?"

Answer - "The baby was acidotic."

If Dr. Kruszewski contends that the startup time for her cesarean section was excessive, then this knowledge should have been applied to the management of the asphyxial stress due to the severe periodic changes by earlier delivery. Not doing so was below the accepted standard of care.

It is my opinion that the progressive, repetitive, severe variable decelerations with total loss of variability associated with uterine hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, rendering mode of delivery at this point irrelevant.

The nurse notes on the fetal tracing that the heart rate was audible at 50 beats per minute and dropping.

At 2346, the orders are received for vacuum. A second RN was called to the room.

According to the notation on the fetal tracing;

The vacuum was applied by Dr. Kruszewski at 2348 and at 2350 nurses are unable to capture the fetal heart rate.

At 2351, the time of delivery, the NICU was notifying to come stat upon delivery of the infant. The baby was delivered by Dr. Kruszewski.

On page 49 of her deposition when asked about her recollections of labor and delivery Dr. Kruszewski notes, "she was complete about 10 p.m. and started to push, and the progress of pushing was going relatively well, and then towards the end, just before the baby delivered, she began having decels, that didn't respond to scalp stimulation and other interventions, and the baby was crowning at that time so I asked for a vacuum to facilitate the delivery. Dr. Kruszewski's deposition testimony was contradicted by the fetal tracing and her own deposition testimony. The fetal tracing revealed multiple repetitive severe variable decelerations with loss of variability and bradycardia for up to one hour prior to delivery of Mikayla. The baby was not crowning but was noted to be at the +1 to +2 station at the time of the vacuum application. Dr. Kruszewski in her deposition (pg. 57) states,

[44] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised.

Severe repetitive periodic changes were present as early as 2237 which became more severe and atypical until they resulted in the end stage bradycardia documented by the nurse prior to delivery. A scalp electrode was not placed to evaluate variability and fetal well being. An intrauterine pressure device was not placed in light of the uterine hyperstimulation and difficulty maintaining the external toco. The pitocin was not discontinued when the iatrogenic pitocin augmentation resulted in repetitive severe periodic changes terminating in fetal bradycardia. A cesarean section was not performed when the severe periodic changes became repetitive and resulted in loss of variability. These deviations were below the accepted standard of care.

When Dr. Kruszewski was asked whether there is a time when bradycardia becomes significant in whether the child will be delivered healthy, she answered "not that I'm aware of."(pg. 55)

In review of the report of Dr. Sommers, there were numerous inaccuracies and omissions:

She notes that the baby was transferred to Children's Hospital of Pittsburgh and that "over the next few days her condition deteriorated." According to the inpatient discharge summary authored by Carol Gilmour on 6/28/02, "Neurology's impression was that of a severe hypoxic ischemic encephalopathy." "Over the next several days there was no change in Mikayla's exam".

Dr. Sommers notes that, "An autopsy was performed and the clinical diagnosis was acute total asphyxia of unknown etiology and subsequent perinatal hypoxic/ischemic encephalopathy."

According to the Final Autopsy Report: The final autopsy diagnosis was "a five day old female with hypoxic encephalopathy (clinical)."

According to the Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

Dr. Sommers did not address the lack of an indication for the induction, the failure to discuss the reason for and risks associated with induction and or augmentation with the patient, the fact that the patient had evidence of fetal macrosomia, cephalopelvic disproportion, and that

the Mrs. Rhoades was not examined by Dr. Kruszewski for fetal size or clinical pelvimetry prior to the induction and or augmentation.

Dr. Sommers failed to question the lack of documentation indicating the reason for the pitocin augmentation. She did not address the management of this patient who was arrested in the active phase of labor for up to 12 hours. She did not question why the pitocin augmentation was started after 4 hours of no cervical change and why the patient was not taken to cesarean section after 2 hours with no cervical change.

Dr. Sommers did not note that the nurses and Dr. Kruszewski failed to recognize and properly manage the prolonged episodes of uterine hyperstimulation.

Dr. Sommers failed to question why an intrauterine pressure device wasn't placed after the nurses were having difficulty maintaining the external tracing, after the multiple attempts at recalibration by the nurses were noted, after the baseline tone was increased and because of the uterine hyperstimulation.

Dr. Sommers did not address the inability of the nurses and Dr. Kruszewski to recognize asphyxial stress and to appropriately manage it. Dr. Sommers failed to question why a fetal scalp electrode was not placed with fetal bradycardia, prolonged decelerations, with extensive fetal dropout (while in knee chest), with decreased variability, and with repetitive decelerations.

Dr. Sommers failed to address why the pitocin was continued and the patient not taken to Cesarean section despite the recurrent severe periodic changes, uterine hyperstimulation, and the ominous fetal heart pattern with loss of variability indicating fetal asphyxia.

Nurse Comport's report contained numerous inaccuracies:

She notes that "an ultrasound done on 4/13/02, just 22 days prior to delivery, revealed a fetus at 3383 grams or 7#7oz confirming an average sized infant." She than goes on to mention that "the hospital staff did not make a determination of fetal weight either clinically or sonographically. However, this is refuted by the fact that ultrasound assessment had just been recently done revealing a normal sized infant."

The ultrasound examination was done more than 3 weeks prior to delivery and was not done "recently." Nurse Comport fails to substantiate how she concluded that the baby was "average size" since there was no percentile weight for gestational age given in the ultrasound report. Using standard tables, the percentile weight for gestational age approached the 90$^{th}$ percentile. What actually did happen was that Dr. Kruszewski failed to evaluate the fetal weight and pelvis on admission, failed to recognize that this baby was macrosomic, and failed to realize that an unengaged fetal head at -3 station indicated cephalopelvic disproportion. These deviations were below the accepted standard of care.

Nurse Comport opines that "a second issue addressed is the lack of appropriate nursing, assessments and responsiveness to the fetal heart rate changes." As illustrated in my report, the nurses were unfamiliar with the basic concepts of fetal monitoring, and principles of labor and delivery. They failed to recognize that this patient was arrested in the active phase of labor. They failed to insist that an intrauterine pressure device was placed after numerous attempts at recalibration, after abnormal uterine activity patterns were noted, and because of the iatrogenic

uterine hyperstimulation with pitocin (see P/PR No. 61.2). They failed to place or have Dr. Kruszewski place a fetal scalp electrode when the tracing revealed dropout, prolonged decelerations, bradycardia, repetitive decelerations and loss of variability (see P/PR No. 61.3). They failed to discontinue pitocin with the presence of nonreasurring and or ominous fetal heart rate patterns and when abnormal uterine activity patterns were present as per the Hospital's Policy and Procedures, P/PR No. 61.2.

Nurse Comport than goes on to note that, "Criticism has been raised that the pitocin was only decreased and not discontinued, but this is an appropriate course of action. You want to decrease the pitocin to decrease the contraction frequency, which in turn facilitates more oxygenated blood to the fetus." Even more of a reason to discontinue the pitocin optimizing blood flow and oxygenation to the baby. Nurse Comport failed to review the Hospital's Policy and Procedures P/PR, No. 61.2, which states that the procedure indicated for nonreasurring, ominous and abnormal uterine activity patterns is to "Discontinue oxytocin if in use."

She than mentions that "However, you also want to expedite the delivery especially if there are any signs of a change in the fetal heart rate pattern such as variable deceleration." Another way to expedite delivery, without exposing the baby to the asphyxial stress caused by variable decelerations, is by performing a Cesarean Section. Not doing so was below the accepted standard of care.

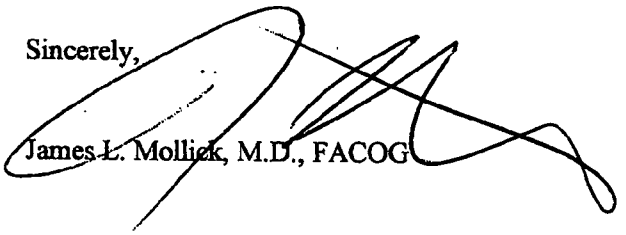
Nurse Comport finally goes on to note that, "During the second stage or the time the patient was pushing there were times when the fetal heart rate pattern was concerning. This is a relatively common occurrence with pushing as the uteroplacental blood flow is diminished during the pushing effort." Nurse Comport admits that there were times that the fetal heart rate pattern was concerning but fails question why a fetal scalp electrode was not placed, why the pitocin was not discontinued, and why the nurses did not insist that Dr. Kruszewski stop the pitocin augmentation and take this patient to cesarean section.

Nurse Comport recognizes that uteroplacental blood flow is diminished during the pushing effort. She failed to recognize that, in this case, the aggressive pitocin augmentation with uterine hyperstimulation and pushing resulted in decreased blood flow resulting in repetitive severe variable decelerations associated with loss of variability indicated hypoxia and asphyxia. The nurses did not stop the pitocin. They did not recognize that Mrs Rhoades was hyperstimulated and was having decelerations requiring placement of a fetal scalp electrode, intrauterine pressure device, discontinuing the pitocin and insisting that Dr. Kruszewski take this patient to cesarean section. These deviations were below the accepted standard of care.

If the nurses had truly recognized the significance of the fetal tracing, the nurses could have followed Hospital Policy and Procedure P/PR No. 82, entitled Physician Notification in Maternal/Fetal Distress. They chose not to. They did not recognize and act on the progressive iatrogenic fetal asphyxia caused by the aggressive pitocin augmentation and uterine hyperstimulation.

I reserve the right to amend this report if and when any further information becomes available to me.

Sincerely,



James L. Mollick, M.D., FACOG

April 6, 2004

Dr. Frederick A. Gonzales
88 North Mountain Drive
Dobbs Ferry, NY 10522

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424

RE: RHOADES ET AL VS. KRUSZEWSKI ET AL.
CASE NO. 03-1268-CD

Dear Mr. Ging,

In response to your request that I evaluate the records in the case of *Rhoades vs. Kruszewski, et al.*, and determine whether or not Dr. Kruszewski and the DuBois Regional Medical Center used the proper standard of care, and exercised the degree of care and skill ordinarily used by specialists in the field of obstetrics and gynecology, practicing in a community medical center as described in the information which you provided me., I have prepared this report.

I have reviewed the information which you provided me, which includes the following: The Complaint, the Amended Complaint, the Answer and Affirmative Defenses of Defendant Kruszewski, the depositions of Dr. Kruszewski, Desiree Smith, Shawn Welsh, Sherri Kizina, Tina Newell, Karen Consentino, Gloria Bennett, Richard Grout, M.D., the charts from Dr. Kruszewski's office, the DuBois Regional Medical Center, Children's Hospital of Pittsburgh and the autopsy report performed on the infant Mikayla.

I have reviewed these records in the same manner as I would if I were treating a patient, or consulting for another physician, and base the opinions which are provided herein on my knowledge, experience, and judgment as a medical doctor specializing in obstetrics and gynecology.

Kim Rhoades came under the care of Mary C. Kruszewski,, D.O., who held herself out as a specialist in obstetrics and gynecology, on November 1, 2001, at which time Dr. Kruszewski indicated that the infant had a gestational age of 12.5 weeks. Mrs. Rhoades had an unremarkable

pregnancy, and was admitted to the DuBois Regional Medical Center on May 10, 2002, for spontaneous vaginal birth delivery, Pitocin assisted, of an infant estimated to have a gestational age of 39.6 weeks. During the pregnancy Mrs. Rhoades' weight increased from 123 pounds to 170 pounds.

The sonogram performed at the DuBois Regional Medical Center on April 18, 2002 suggested a single intrauterine fetus in a cephalic presentation and longitudinal lie with fetal movement and cardiac activity at a heart rate of 128 beats per minute. All other findings of the sonogram were normal, and the expected fetal weight at the time was 3382 grams or 7 pounds, 7 ounces.

Mrs. Rhoades presented herself for delivery at the DuBois Regional Medical Center shortly after 7:14 a.m., and experienced the first deceleration at approximately 8:45 a.m. Beginning at 3:35 p.m., variable decelerations became progressively more frequent, and progressively more erratic, as labor progressed. Pitocin was not discontinued until 11:45 p.m.

It appears from the depositions of the delivery room nurses that fetal heart rate variability and decelerations were noted, and that Dr. Kruszewski was made aware of the decelerations on at least two different occasions prior to arriving at the hospital at approximately 9:20 p.m.

At 10:48 p.m. the fetal heart rate dropped to 85, and audible fetal heart rates were recorded at 11:45 p.m. as low as 50 beats per minute. At 11:49 p.m. vacuum was applied, consisting of four pulls and two pop offs, and the infant was delivered over a midline epesiotomy at 11:52 p.m.

Observations made by the neonatal physician and attending nurses indicate that Mikayla had a fetal heart rate deceleration during the second stage of labor and suffered from severe birth asphyxia with apgar scores of 0 at one minute, 3 at five minutes, 4 at ten minutes, and 5 at twenty minutes. The baby was noted to have a fetal bradycardia during the second stage of labor and delivery was assisted by vacuum. Cord pH was noted to be 7.13, and a loose cord around the neck was noted by the neonatal physician attending Mikayla. The mother was not on any medications during the pregnancy and had no abnormalities during the pregnancy.

At birth Mikayla was limp, with no heart rate or respirations. Chest compressions were provided after which the heart rate went up over 100 per minute.

Mikayla was transferred to Children's Hospital of Pittsburgh with a discharge diagnosis of severe birth asphyxia and large for gestational age. She was dosed with phenobarbital for seizure prophylaxis prior to being transferred to Children's Hospital of Pittsburgh. At +12 hours of life the

baby had chin and diaphragm quivering suspicious for seizure activity which was treated with phenobarbital, bilateral ankle clonus, no spontaneous movements, inconsistent grimace to suctioning and ineffective spontaneous respiration with low total volume.

Over the next several days, Mikayla was noted to have further deterioration with no spontaneous breathing over the ventilator, fixed pupils, diffuse hypotonia and spontaneous clonus of all extremities. The EEG showed a complete background suppression with two short epileptiform episodes originating from the left hemi-cortex.

On May 14, 2002 in face of a poor prognosis for meaningful recovery the family consented to removal of respiratory support and Mikayla Rhoades died at 4:31 p.m. An autopsy was performed, and the principal diagnosis was full term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic/ischemic encephalopathy.

This is a summary of the medical records, regarding the care and treatment of the mother and infant.

Having reviewed the information described above, there are a number of significant failures on the part of both the hospital staff and the physician which I believe led to Mikayla's death.

Initially I observed that there was no estimated fetal weight on the date of delivery, either clinically or sonographically. There is no mention of informed consent or any discussion with the parents regarding options for delivery of a macrosomic baby. In my opinion the failure to evaluate fetal weight and to properly counsel a patient when she has a macrosomic baby regarding an induction of labor is a departure from good and excepted standards of medical care. It is my opinion based upon a review of the facts of this case that if the patient had been properly advised, and if the patient had opted for a cesarean section the baby's birth asphyxia could have been avoided.

Induction of labor, once commenced, progressed very slowly. Fetal bradycardia was noted in the hospital record at 3:37 p.m., however despite the fact that the bradycardia occurred pitocin was not discontinued, and no precautions which should have been taken as a result of the bradycardia such as changing of position, or administering oxygen were taken. A scalp pH was not performed, due to the judgment of the physician and/or the inability to perform scalp pH at the Medical Center. Failure to discontinue pitocin, and to take precautions in light of the noted fetal bradycardia is a departure from good and accepted standards of medical care. Likewise, the inability to perform a scalp pH at the Medical Center and/or the physician's failure to perform a scalp pH constitutes a departure from good and accepted standards of medical care.

At approximately 10:46 p.m. severe and progressive variable decelerations occurred. These decelerations were noted by the nurse, and oxygen was being administered. Pitocin, however was not discontinued, and the failure to discontinue the use of pitocin at that point in time constituted a departure from good and accepted standards of medical care. It is my opinion that the baby should have been delivered by cesarean section at the point where the severe and progressive variable decelerations were occurring and observable on the FHM strip and that the failure to delivery by cesarean section represented a deviation from good and accepted medical care. Had the baby been delivered by cesarean section at this time, I believe that the severe birth asphyxia would not have occurred.

The decelerations continued and became progressively severe. Pitocin was finally discontinued at 11:43 p.m. A scalp pH was never performed. Failure to properly evaluate the fetus by performing a scalp pH or other diagnostic procedure is a departure from good and accepted standards of medical care. If the physician was unable to perform a scalp pH or other diagnostic procedure at the regional medical facility, the failure of the medical facility to have the ability to perform a scalp pH or other diagnostic procedure in situations such as the situation described in the medical chart is a departure from good and accepted standards of medical care.

Mikayla was delivered by vacuum extraction. There were four pulls and two pop offs. The pressure from the vacuum was not reduced between uterine contractions. This is an inappropriate use of vacuum extraction and represents a departure from good and accepted standards of medical care.

As a result of the failure of the physician and hospital personnel to use good and accepted standards of medical care a severely asphyxiated baby was born with Apgars of 0, 3, 4, 5, at one, five, ten and twenty minutes. The cord pH was 7.13 with a base excess of -13 which represents metabolic acidosis. Mikayla suffered seizures, temporal bleeding and swelling. These findings are all consistent with birth asphyxia and a traumatic delivery. In reviewing Dr. Kruszewski's deposition it became obvious to me that she was unfamiliar with protocols and procedures for dealing with a distressed infant during labor and delivery. It was obvious to me from reading Dr. Kruszewski's deposition and the depositions of the nurses that they were unprepared to deal with fetal distress, which led to the birth asphyxia.

While it appeared that Dr. Kruszewski was aware of intrauterine resuscitation procedures, she did not employ any intrauterine resuscitation procedures despite the fact that they were clinically indicated at the latest stages of labor and during the delivery.

Dr. Kruszewski was unaware that the infant was suffering from asphyxia, and did not have

a diagnosis for her condition at the time she was born other than that she was stressed. Perhaps the most demonstrative evidence that the physician lacked the skills and abilities to deliver Mikayla safely was her deposition testimony that she delivered a "viable female infant". Despite this post-delivery diagnosis, Dr. Kruszewski indicated that she did not know if Mikayla had a heartbeat at birth, of if she was breathing at birth.

In my opinion, the conduct of the nurses and Dr. Kruszewski who attended Kim and Mikayla Rhoades was a departure from good and accepted standards of medical care, and I give these opinions with a reasonable degree of medical certainty.

Sincerely,

Frederick A. Gonzales, M.D.

# NEONATAL ENCEPHALOPATHY AND CEREBRAL PALSY

## DEFINING THE PATHOGENESIS AND PATHOPHYSIOLOGY

The American College of Obstetricians and Gynecologists

*Women's Health Care Physicians*

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

# CHAPTER 8

# CRITERIA REQUIRED TO DEFINE AN ACUTE INTRAPARTUM HYPOXIC EVENT AS SUFFICIENT TO CAUSE CEREBRAL PALSY

Careful analysis of data compiled over the past 25 years demonstrates that intrapartum complications are less common causes of cerebral palsy than previously thought. Clinical epidemiologic studies indicate that in most cases the events leading to cerebral palsy occur as a result of multifactorial and unpreventable reasons either during fetal development or in the newborn after delivery (1–8).

See box for a description of the criteria required to define an acute intrapartum hypoxic event as sufficient to cause cerebral palsy. This box is a modification and update of the International Cerebral Palsy Task Force Consensus Statement, *A template for defining a causal relation between acute intrapartum events and cerebral palsy*, published in the British Medical Journal in 1999 (9).

Part 1.1 of the criteria presents four essential criteria that are necessary before an intrapartum hypoxic event can be considered as a cause of cerebral palsy. If any 1 of the 4 essential criteria is not met, this provides strong evidence that intrapartum hypoxia was not the cause of cerebral palsy. When all four essential criteria outlined are met, it is then important to determine whether the hypoxia is attributable to chronic or intermittent hypoxia of long standing duration of days or weeks or whether acute hypoxia has occurred during labor in a previously healthy fetus.

Part 1.2 of the criteria presents a set of five criteria that collectively suggest an intrapartum timing. With the exception of the first criteria of an acute hypoxic sentinel event occurring immediately before or during labor, all four other criteria described are weakly associated with acute intrapartum hypoxia. It is not necessary for all five of these criteria to be present to establish the relationship between acute intrapartum hypoxia and cerebral palsy. Accordingly, contrary evidence such as a reassuring fetal heart pattern, a normal Apgar score of 7 or greater at 5 minutes, or an early magnetic resonance imaging (MRI) study inconsistent with a recent global hypoxic or ischemic event excludes an injurious event during labor.

The use of these criteria will help to evaluate the probability that the pathology causing the cerebral palsy occurred during labor. For additional information on these criteria, see preceding sections in Chapters 1–7.

**Criteria to Define an Acute Intrapartum Hypoxic Event as Sufficient to Cause Cerebral Palsy**

1.1: Essential criteria (must meet all four)

1. Evidence of a metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery (pH <7 and base deficit ≥12 mmol/L)
2. Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation
3. Cerebral palsy of the spastic quadriplegic or dyskinetic type*
4. Exclusion of other identifiable etiologies, such as trauma, coagulation disorders, infectious conditions, or genetic disorders

1.2: Criteria that collectively suggest an intrapartum timing (within close proximity to labor and delivery, eg, 0–48 hours) but are nonspecific to asphyxial insults

1. A sentinel (signal) hypoxic event occurring immediately before or during labor
2. A sudden and sustained fetal bradycardia or the absence of fetal heart rate variability in the presence of persistent, late, or variable decelerations, usually after a hypoxic sentinel event when the pattern was previously normal
3. Apgar scores of 0–3 beyond 5 minutes
4. Onset of multisystem involvement within 72 hours of birth
5. Early imaging study showing evidence of acute nonfocal cerebral abnormality

*Spastic quadriplegia and, less commonly, dyskinetic cerebral palsy are the only types of cerebral palsy associated with acute hypoxic intrapartum events. Spastic quadriplegia is not specific to intrapartum hypoxia. Hemiparetic cerebral palsy, hemiplegic cerebral palsy, spastic diplegia, and ataxia are unlikely to result from acute intrapartum hypoxia (Nelson KB, Grether JK. Potentially asphyxiating conditions and spastic cerebral palsy in infants of normal birth weight. Am J Obstet Gynecol 1998;179:507–13.).

Modified from MacLennan A. A template for defining a causal relation between acute intrapartum events and cerebral palsy: international consensus statement. BMJ 1999;319:1054–9.

## Part 1.1: Essential criteria (must meet all four)

1. Evidence of a metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery (pH <7 and base deficit of ≥12 mmol/L)

It has been demonstrated that a realistic pH threshold for significant pathologic fetal acidemia (ie, a pH associated with adverse neonatal sequelae) is less than 7 (10–13). The metabolic component (ie, base deficit and bicarbonate) is the most important variable associated with subsequent neonatal morbidity in newborns with an umbilical artery pH of less than 7 (14). A base deficit of 12 mmol/L or greater is a reasonable cutoff criterion (15). Metabolic acidemia at birth must be present to establish that a potentially damaging intrapartum hypoxic event is a cause of cerebral palsy. The presence of metabolic acidemia does not define the timing of the onset of the hypoxic event. It is important to remember that even when this pH threshold of less than 7 is used to define significant acidemia, most newborns in this category will be neurologically normal with no apparent morbidity (16, 17).

2. Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation

Neonatal encephalopathy is a clinically defined syndrome of disturbed neurologic function in the earliest days of life in the near-term and term infant. If an intrapartum insult is severe enough to result in ischemic cerebral injury, abnormalities will be noted in the neurologic examination within 24 hours after birth. The examination is characterized by abnormalities in 1) cortical function (lethargy, stupor, coma with or without seizures), 2) brainstem function (ie, pupillary and cranial nerve abnormalities), 3) tone (hypotonia), and 4) reflexes (absent, hyporeflexia) (18, 19). Outcome is related to the maximum grade of severity (18). Thus, for infants with mild encephalopathy (stage 1), outcome is invariably favorable; moderate encephalopathy (stage 2) is associated with an abnormal outcome in approximately 20–25% of cases; severe encephalopathy (stage 3) is associated with a poor outcome in all cases (19).

Many cases of severe neonatal encephalopathy are not associated with intrapartum hypoxia (3, 4, 7, 20). The incidence of neonatal enceph-

alopathy attributed to intrapartum hypoxia, in the absence of any other preconceptional or antepartum abnormalities, is estimated to be approximately 1.6 per 10,000 infants.

3. Cerebral palsy of the spastic quadriplegic or dyskinetic type

Spastic quadriplegia and, less commonly, dyskinetic cerebral palsy are the only types of cerebral palsy associated with acute hypoxic intrapartum events (21, 22). Although spastic quadriplegia is the most common subtype of cerebral palsy associated with acute hypoxic intrapartum events, it is not specific to intrapartum hypoxia (22). Unilateral brain lesions are not the result of birth asphyxia; studies relating birth complications to neurologic outcome indicate that hemiparetic cerebral palsy is not a result of known intrapartum asphyxial complications (23, 24). Neither hemiplegic cerebral palsy, spastic diplegia, nor ataxia have been associated with acute intrapartum hypoxia (24). Any progressive neurologic disability is by definition not cerebral palsy and is not associated with acute hypoxic intrapartum events.

There is increasing information concerning another set of risk factors predisposing to fetal and neonatal strokes and thereby to hemiparetic cerebral palsy or, if bilateral, to spastic quadriparetic cerebral palsy (25–27). Such perinatal strokes commonly involve the middle cerebral artery, and many are related to inherited thrombophilias (of which the most common is the factor V Leiden mutation) (28), acquired disorders including antiphospholipid antibodies (29), combinations of these, or with environmental triggers (30).

Thromboembolic disease of the mother can be associated with obstetric complications and may be accompanied by placental thrombosis (31). Embolization from the placenta into the fetal circulation is a probable intermediary event (32).

4. Exclusion of other identifiable etiologies, such as trauma, coagulation disorders, infectious conditions, or genetic disorders

A large proportion of cerebral palsy cases are associated with maternal and antenatal factors, such as preterm birth, intrauterine growth restriction, intrauterine infection, maternal or fetal coagulation disorders, multiple pregnancy, antepartum hemorrhage, breech presentation, and chromosomal or congenital abnormalities (1, 2, 6, 24, 33). These causes must be considered and excluded before concluding intrapartum hypoxia is the cause of cerebral palsy.

Infections and inflammations along with thromboses and coagulopathies are recognized as being associated with white-matter damage and cerebral palsy. Correlates of fetal infection include elevated fetal cytokines in both amniotic fluid and fetal blood. Research in animals and humans has shown an association between inflammatory markers and periventricular leukomalacia and neonatal encephalopathy (34–38).

Coagulation disorders such as antithrombin-III deficiency, abnormalities of protein C or protein S, prothrombin genetic deficiencies, and the factor V Leiden mutation, can lead to stroke (31, 39–41). Also, occlusion of either arterial supply or venous return can cause permanent focal damage. Such damage may rarely be secondary to trauma in pregnancy, especially if in conjunction with an existing coagulation disorder. Early imaging studies may be very useful in identifying and evaluating a specific etiology (42–48).

Numerous genetic and metabolic disorders can present clinically as neonatal encephalopathy; however, although there are many possible genetic causes, in most infants with neonatal encephalopathy, the condition does not result from an identifiable genetic cause, and diagnosis in the perinatal period is unlikely unless there is heightened clinical suspicion based on specific findings or family history. The practitioner should attempt to identify such disorders by taking a family history, performing a thorough examination of the infant for dysmorphic features consistent with a genetic etiology, and ordering appropriate laboratory studies if warranted.

unusual pregnancy intervals (<3 months or >3 years) to be statistically significant with 95% confidence intervals that did not cross one (5). Specific gestational age data were not given.

A multivariate analysis of 164 cases and 400 controls evaluated the role of preconceptional, antepartum, and intrapartum factors in neonatal encephalopathy (1). The strongest antepartum risk factor for neonatal encephalopathy was fetal growth restriction. There are, however, many different causes of fetal growth restriction, and each may differ in its capacity to cause or predispose a fetus to neonatal encephalopathy. The risk for neonatal encephalopathy also increased with each advancing week of gestation after 38 weeks. Several sociodemographic characteristics were significant risk factors for neonatal encephalopathy. Maternal seizures, maternal thyroid disease, bleeding in pregnancy, an excess of congenital anomalies, and markers of prenatal and perinatal infection were also associated with neonatal encephalopathy, supporting the idea of multiple causal pathways leading to neonatal encephalopathy and cerebral palsy (1). Of significance, however, was that 70% of cases of neonatal encephalopathy were probably caused by events arising before the onset of labor. Infants with neonatal encephalopathy experienced a more adverse antepartum course than controls, and intrapartum hypoxia less frequently was the sole cause of neonatal encephalopathy.

### Conclusions

- There are numerous periconceptional and antenatal antecedents for both neonatal encephalopathy and cerebral palsy.
- Most known conditions associated with either neonatal encephalopathy or cerebral palsy are related to abnormal antepartum conditions rarely amenable to intervention by the health care provider.

## Fetal Heart Rate Monitoring

### *Physiologic Basis*

Alterations in blood flow and oxygen content of the maternal, uteroplacental, or umbilical circulations can result in fetal hypoxia. Certain fetal heart rate patterns indicate possible mechanisms for decreased fetal oxygenation.

Uteroplacental insufficiency can result if the maternal blood flow or blood oxygen content are diminished. Uterine contractions produce intermittent diminution of blood flow to the intervillous space where oxygen exchange occurs (6). If this intermittent interruption of flow exceeds a critical level, the fetal heart rate responds specifically with a pattern of late deceleration. Late deceleration begins as a vagal reflex; when fetal oxygenation is sufficiently impaired to produce fetal metabolic acidosis from anaerobic glycolysis, direct myocardial depression occurs (7). When the late deceleration is of the reflex type, the fetal heart rate tracing characteristically has good variability and fetal reactivity, but as the fetus develops metabolic acidosis, the fetal heart rate loses its variability. When the fetal pH is less than 7.20, the fetal heart rate reactivity, either spontaneous or evoked, may disappear (8, 9). If uteroplacental oxygen transfer is acutely and substantially impaired, the resulting fetal heart rate pattern is a prolonged deceleration. Clinical events associated with acute uteroplacental insufficiency are uterine rupture, maternal cardiovascular collapse, total placental abruption, and tetanic uterine contractions. Similarly, with total cord occlusion, a prolonged deceleration will develop.

When the umbilical cord is compressed, a fetal heart rate pattern of variable deceleration develops (10). This is characterized by rapid onset and resolution and bears no specific relation to the time during contractions that the deceleration begins. Usually, the cord compression is mild and of no consequence. There may be a transient elevation of the fetal $P_{CO_2}$ (partial pressure of carbon dioxide), but significant hypoxia usually does not develop. If cord compression is prolonged, significant fetal hypoxia can occur. When this happens, the return to baseline becomes gradual, the duration of the deceleration may increase, and frequently, the fetal heart rate variability will decrease and the baseline fetal heart rate may increase.

### *Antepartum Fetal Monitoring and Neonatal Encephalopathy*

Because of the difficulties with long-term follow up, very few studies have looked at the relationship between antepartum fetal testing and long-term neurologic outcome. Several randomized prospective trials using weekly nonstress test surveillance have shown no benefit (11–14). The rest of the literature on nonstress tests involves nonrandomized, usually retrospective reviews. The only prospective, randomized trial of antepartum fetal evaluation that showed benefit involved instructing women in fetal movement counts and showed a decreased occurrence of fetal death but no impact on long-term neurologic outcomes (15).

In 1983, an Australian study showed that among 72 patients with a nonreactive positive spontaneous contraction stress test result, there was a 28% perinatal mortality rate; of the 52 infants that survived the neonatal period, 45 were assessed and 27% were found to have a neurologic handicap (16). A retrospective study using biophysical profile as the primary means of surveillance reported the incidence of cerebral palsy was 1.33 per 1,000 in the group with biophysical profile and 4.74 per 1,000 in those patients not monitored with biophysical profile testing (17).

There is evidence that abnormal test results are found more frequently in patients with abnormal neurologic outcome. However, the predictive value of antenatal testing remains poor because of the high frequency of abnormal test results in patients with normal outcome.

### *Intrapartum Fetal Monitoring and Neonatal Encephalopathy*

Before the 1970s, the only widely available clinical techniques used to evaluate the intrapartum condition of the fetus were the appearance of amniotic fluid and auscultated fetal bradycardia. An analysis of the National Collaborative Perinatal Project data concluded auscultatory fetal heart rate monitoring was of little value (18). With the advent of intrapartum electronic fetal heart rate monitoring, a number of early nonrandomized, mainly historically controlled and mostly retrospective studies suggested a benefit to intrapartum fetal heart rate monitoring, primarily for high-risk patients (19–26). Many believed intrapartum fetal heart rate monitoring would prove beneficial in decreasing the incidence of cerebral palsy and mental retardation (27). Specifically, there were fewer cases of intrapartum and neonatal death in patients who had intrapartum fetal heart rate monitoring, and some studies showed fewer low Apgar scores, as well as less need for resuscitation.

In the late 1970s and early 1980s, a number of prospectively randomized trials compared intrapartum fetal heart rate monitoring with careful auscultation, usually with one-on-one nursing. These trials failed to show any benefit of electronic fetal monitoring with respect to fetal or neonatal death, Apgar scores, fetal pH, need for resuscitation, or neonatal intensive care unit admissions (28-33). Some studies showed increased cesarean delivery rates in patients who had intrapartum electronic fetal heart rate monitoring, which led to criticism of fetal heart rate monitoring from a cost–benefit standpoint and controversy over the value of the technique (34, 35).

The only benefit seen for intrapartum fetal heart rate monitoring in the randomized trials was a decreased incidence of neonatal seizures in the Dublin trial (36). When all the studies were subjected to a meta-analysis, it appeared neonatal seizures were indeed fewer among patients who had intrapartum fetal heart rate monitoring (37, 38). Long-term follow-up studies, however, failed to show any decrease in abnormal neurologic outcome between those who had electronic monitoring and those who did not (37). No prospective randomized trials have compared either intrapartum fetal heart rate monitoring or intermittent auscultation with no monitoring.

The correlation of intrapartum fetal heart rate patterns with outcome is problematic. Even if intrapartum fetal heart rate patterns were predictive of all bad outcome from hypoxia, there would be no value unless the patterns gave sufficient warning to allow the clinician to intervene

and take appropriate action to prevent the bad outcome. If, however, abnormal patterns did give warning in sufficient time to prevent a bad outcome, there would be no correlation with outcome. Fetuses who are severely asphyxiated during the intrapartum period will have abnormal fetal heart rate patterns (39). However, most patients with nonreassuring fetal heart rate patterns give birth to neonates with normal Apgar scores (40). Abnormal electronic fetal heart patterns are poor predictors of subsequent development of cerebral palsy (41).

The use of fetal scalp blood sampling for patients with nonreassuring patterns has been shown to be associated with decreased need for operative intervention (29). However, fetal scalp blood sampling use has decreased as fetal scalp stimulation and vibroacoustic stimulation have proved to be easier ways to assure a normal fetal pH when evoked accelerations occur (8, 42).

The U.S. Food and Drug Administration has approved labeling for the use of fetal pulse oximetry for patients with nonreassuring fetal heart rate patterns. A large randomized clinical trial of fetal pulse oximetry showed a decrease in cesarean delivery for nonreassuring fetal heart rate patterns but a corresponding increase in cesarean delivery for dystocia. Neonatal outcomes were similar in the fetal pulse oximetry group when compared with a group with nonreassuring patterns managed without fetal pulse oximetry (43). Further studies are needed before this technique can be considered standard practice.

The incidence of cerebral palsy has remained essentially unchanged despite the common use of intrapartum fetal heart rate monitoring in both high- and low-risk patients. This should not be surprising inasmuch as previous beliefs regarding the dominant contribution of intrapartum hypoxia to subsequent neurologic abnormalities are unfounded (44–46).

### *Current Role of Intrapartum Electronic Fetal Heart Rate Monitoring*

Before randomized controlled trials, 135,000 patients in nonrandomized trials of either continuous electronic monitoring or nonintensive fetal monitoring by auscultation were compared. The intrapartum fetal death rate in the electronically monitored group was 0.54 per 1,000 compared with 1.76 per 1,000 in the nonintensively auscultated group. This resulted in a fetal death ratio of 3.26, favoring electronic intrapartum fetal monitoring ($P = <0.05$) (47). In randomized controlled trials comparing electronic monitoring to intermittent auscultation, the auscultation group had an intensive protocol that consisted of a one-on-one nurse listening every 15 minutes in the first stage of labor and every 5 minutes in the second stage of labor. The intrapartum fetal death rate in both groups was comparable to the intrapartum fetal death rate in the nonrandomized electronically monitored group (28–31). Thus, it would appear that intensive intrapartum fetal monitoring by either auscultation or continuous electronic monitoring is better than nonintensive auscultation for the prevention of intrapartum fetal death. Although the use of fetal heart rate monitoring has led to a decrease in intrapartum fetal deaths, the incidence of cerebral palsy has not changed since its introduction.

The specific issue of the value of electronic fetal monitoring as a predictor of cerebral palsy has been addressed (41). No association has been determined between the highest or lowest fetal heart rate and the risk of cerebral palsy. The two findings associated with the development of cerebral palsy were repetitive late decelerations of the fetal heart rate and a decrease in beat-to-beat variability. These findings were uncommon in infants weighing more than 2,500 g. Also, these monitor findings had a very high false-positive rate for predicting cerebral palsy.

The National Institute of Child Health and Human Development consensus report stated a normal fetal heart tracing consisting of a normal baseline rate, moderate fetal heart rate variability, presence of accelerations, and absence of decelerations is extremely predictive of a normally oxygenated fetus. The report also said patterns predictive of current or impending asphyxia placing the fetus at risk for neurologic damage include

recurrent late or severe variable decelerations or substantial bradycardia, with absent fetal heart rate variability.

For intrapartum asphyxia to develop in a fetus that was previously normal at the start of labor, some major, or sentinel event must occur. If the fetus is undergoing continuous electronic fetal heart rate monitoring, the sentinel event should result in either an abnormal tracing with either a prolonged deceleration, repetitive late decelerations, and/or repetitive severe variable decelerations and decreased fetal heart rate variability. In the circumstance of a woman who presents in labor with an abnormal fetal heart rate that was present for an unknown period, and demonstrating one or all of the previous patterns, the fetus may have already experienced damage and rapid delivery may not improve the outcome.

### Conclusions

- Specific fetal heart rate patterns are associated with uteroplacental insufficiency and umbilical cord compression. Acute profound hypoxia from any cause results in a prolonged deceleration. Neonatal encephalopathy may result from severe fetal hypoxia from any cause.
- No randomized controlled trials have shown that any form of antenatal testing will decrease the incidence of cerebral palsy.
- Fetal movement counting may decrease antenatal death rates.
- Intrapartum electronic fetal heart rate monitoring is associated with fewer cases of neonatal seizures than dedicated fetal heart rate auscultation.
- Intrapartum fetal heart rate monitoring is not associated with a decrease in cerebral palsy when compared with patients with dedicated fetal heart auscultation.
- Abnormal fetal heart patterns have an extraordinarily high false-positive rate of predicting the development of cerebral palsy.

## Neonatal Neurologic Outcome Following Acute Catastrophic Intrapartum Asphyxia: The Effect of Time from Diagnosis to Delivery

Animal data show that the duration and degree of fetal hypoxia are related to the occurrence and extent of brain damage. The data in humans, however, are not as clear because the situation in humans does not allow experimental manipulation to determine the different factors involved. In humans, information is extrapolated from actual cases of umbilical cord prolapse, abruptio placenta, shoulder dystocia, maternal cardiac arrest, and catastrophic uterine rupture. A multitude of clinical factors surrounding these conditions affect the neurologic outcome of the fetus. Included are the degree and duration of cord compression (complete versus variable), the degree and duration of placental separation, the effectiveness and duration of maternal cardiopulmonary resuscitation, and the fetal condition before the event (a normal fetus versus one compromised by preexisting uteroplacental insufficiency or intermittent cord occlusion). Fetal outcome also will likely be affected by the length of time between actual occurrence of the event, diagnosis, and the ability to effect termination of the insult.

The pattern of neurologic injury following acute catastrophic hypoxic–ischemic insult can involve the thalami and basal ganglia predominantly and may be different from the common pattern following chronic insult in the term newborn that involves predominantly the cerebral cortex and the subcortical white matter (48, 49). This pattern was found to be highly predictive of poor outcome and corresponds closely to experimental models of acute total perinatal asphyxia (50). In a review of infants hospitalized in an infant special care unit, 85 developed neonatal seizures. Eleven of those infants had a gestational age beyond 37 weeks at delivery and had experienced persistent prolonged decelerations without recovery just before delivery (49). Radiologic and clinical findings showed a consistent pattern of injury in the subcortical brain nuclei with complete or relative sparing of the

# Executive Summary

The American College of Obstetricians and Gynecologists (ACOG) convened a Task Force on Neonatal Encephalopathy and Cerebral Palsy to collate and review the best scientific data available on the topic and to publish these findings. The American Academy of Pediatrics collaborated with ACOG on the Task Force and is a co-author of the final report. This executive summary covers important information and is intended to complement, not substitute, the full report.

Neonatal encephalopathy and its subset of hypoxic–ischemic encephalopathy (HIE) are conditions defined in and described for term and near-term infants. Neonatal encephalopathy is defined clinically on the basis of a constellation of findings to include a combination of abnormal consciousness, tone and reflexes, feeding, respiration, or seizures and can result from myriad conditions. Neonatal encephalopathy may or may not result in permanent neurologic impairment. It can be stated with certainty, however, that the pathway from an intrapartum hypoxic–ischemic injury to subsequent cerebral palsy must progress through neonatal encephalopathy.

In contrast, cerebral palsy is a chronic disability of central nervous system origin characterized by aberrant control of movement and posture, appearing early in life and not as a result of progressive neurologic disease. Research supports that spastic quadriplegia, especially with an associated movement disorder, is the only type of cerebral palsy associated with an acute interruption of blood supply. Purely dyskinetic or ataxic cerebral palsy, especially where there is an associated learning difficulty, commonly has a genetic origin and is not caused by intrapartum or peripartum asphyxia. Similarly, absent cerebral palsy, neither epilepsy, mental retardation, nor attention-deficit hyperactivity disorder are caused by birth asphyxia.

Historically, the factors used to define perinatal asphyxia, such as meconium-stained amniotic fluid and Apgar scores, were not specific to the disease process leading to neurologic damage. For instance, Nelson and associates have shown that use of nonreassuring fetal heart rate patterns to predict subsequent cerebral palsy had a 99% false-positive rate. Use of such nonspecific markers for perinatal asphyxia identifies a large number of individuals as being exposed to inappropriately diagnosed "perinatal asphyxia." Thus, it is not surprising that removing exposure to such nonspecific markers has failed to change the risk for the disease.

Epidemiologic studies have shown that only 19% of cases of neonatal encephalopathy met what were very nonstringent criteria for intrapartum

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## EDUCATION

ALBRIGHT COLLEGE
Reading, Pa — Graduated: 1982

Bachelor of Science (Magna Cum Laude)... Major: Biology

TEMPLE UNIVERSITY SCHOOL OF MEDICINE — Graduated: 1986
Philadelphia, PA

Doctor of Medicine

## PROFESSIONAL EXPERIENCE

TEMPLE UNIVERSITY HOSPITAL
Philadelphia, PA

OB/GYN Resident — 1986 to 1990

Academic Chief Resident — 1989 to 1990

## CERTIFICATIONS

Laser Certification-Temple University Hospital — 1990
Clinical Instructor-Temple University Hospital
Laser Course

American Board of Obstetrics and Gynecology — 1992

Diplomate National Board of Medical Examiners

AMA Physicians Recognition Award — 11/1/90 to Present

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## EXTENDED EDUCATION

| | |
|---|---|
| Advances in Maternal-Fetal Medicine<br>Vail, Colorado | 1987 |
| Ultrasonography (Dr. Hobbins)<br>Yale University | 1988 |
| Advances in Maternal-Fetal Medicine<br>Vail, Colorado | 1990 |
| American College of Obstretrics and Gynecology<br>Annual Meeting<br>San Francisco, California | 1990 |
| Vaginal Surgery "A Panorama"<br>Temple University | 1991 |
| Hysteroscopy- Master's Course<br>San Francisco, California | 1992 |
| Laparoscopy - "The Easy Way"<br>Orlando, Florida | 1992 |
| Hysteroscopy/LEEP Seminar<br>Wyoming, Wisconsin | 1991 |
| Laparascopic Hysterectomy ( Dr. Reich)<br>Kingston, Pennsylvania | 1991 |
| Osler Institute Review Course<br>Nashville, Tennessee | 1992 |

## AWARDS AND HONORS

| | |
|---|---|
| Who's Who's<br>Among outstanding business executives | 1996 |
| Resident of the Year<br>Awarded by Ortho Pharmaceuticals | 1990 |
| Berlex Education Award<br>For Academic Excellence | 1989 |
| Chief Resident Recorder<br>Awarded by Syntex Pharmaceuticals for<br>1990 ACOG meeting, San Francisco, California | 1990 |
| Ortho Pharmaceutical Resident's Day Bowl<br>Third Place | 1990 |

JAMES L. MOLLICK, M.D.

MANUSCRIPTS IN PREPARATION

Incidence of Actinomycosis Associated with IUD use

Follow-Up Treatment/Response of IUD Related Actinomycosis Infection

Case Report: Meckel's Gruber Syndrome

Retrospective Study: The Biophysical Profile as a Method of Antenatal Surveillance in Premature Rupture of Membranes

PROFESSIONAL MEMBERSHIPS

1. American Medical Association
2. Pennsylvania Medical Society
3. Montgomery County Medical Society
4. Fellow of the American College of Obstetrics and Gynecology
5. The Society of Laparoendoscopic Surgeons
6. Society of Gynecological Laparoscopists.
7. The Cincinnatus Society

SPEAKING ENGAGEMENTS

| | |
|---|---|
| Women During the Reproductive Years<br>Sacred Heart Hospital | 1992 |
| Diabetes/Sexuality<br>Sacred Heart Hospital<br>OB/GYN Department | 1992 |
| Women's Issues<br>Business Women's Association of Montgomery County | 1992 |
| Genital Cancer<br>Sacred Heart Hospital | 1991 |
| Women's Health Issues<br>Montgomery Hospital | 1999 to 2001 |
| Montgomery County Bar Association<br>Topic - The expert witness | 2004 |
| Pennsylvania Bar Institute<br>Topic - Birth Trauma<br>Pittsburgh and Philadelphia | 2004 |

James L. Mollick, M.D.

## HOSPITAL COMMITTEES

Suburban General Hospital
Norristown, PA
- Surgical Audit Committee
- Quality Assurance Committee

Montgomery Hospital
Norristown, PA
- Tissue (Invasive Procedure) Committee 2000 to 2004
- Quality Assurance Committee 2004 to Present

Sacred Heart Hospital
Norristown, Pa.
- Credentials Committee
- JOAH Review Coordinator
- Ethics Committee

## Special Committees:

Independence Blue Cross Cesarean Section advisory committee 1996

## Appointments:

Assistant Chairman- Dept. OB/GYN
Montgomery Hospital 1999 to Present

## PERSONAL DATA

Date of Birth: 12-01-59
PA Medical License Number: MD-039900-E
DEA Number: BM-1354442

## REFERENCES

Personal and professional references will be furnished upon request.

Curriculum Vitae

Frederick Andrew Gonzalez
88 North Mountain Drive
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(718)-334-5366 work

Date of Birth 2/23/1951

Place of Birth: San Juan, Puerto Rico

Citizenship: USA

Languages: Fluent in English and Spanish. Knowledgeable in French.

EDUCATION

| | |
|---|---|
| 1965 - 1968 | High School Diploma, The Lawrenceville School Lawrenceville, New Jersey |
| 1968 - 1972 | Bachelor of Arts, major in biology,cum laude Boston University, Boston, Mass. |
| 1972 - 1976 | Columbia University College of Physicians & Surgeons, New York, NY |

Postdoctoral Training

| | |
|---|---|
| 1980 - 1983 | Fellowship in Maternal-Fetal Medicine Harbor-UCLA Medical Center Torrance, California |
| 1976 - 1980 | Residency in Obstetrics and Gynecology Downstate Medical Center State University of New York Brooklyn, New York |

Certification:

| | |
|---|---|
| 1983 | American Board of Obstetrics and Gynecology Certification in Obstetrics and Gynecology |
| 1985 | American Board of Obstetrics and Gynecology Certification in Maternal and Fetal Medicne |

Licensure:

| | |
|---|---|
| 1977 | Diplomate National Board of Medical Examiners Certificate |
| 1977 | Doctor of Medicine License: New York 131268 |

1980 Doctor of Medicine License: California G41540

Honors:

1972 Cum laude, Bachelor of Arts, Boston University

Academic Appointments:

1976-1980 Clinical Instructor, Downstate Medical Center

1982-1983 Adjunct Assistant Professor UCLA

1983-1984 Assistant Professor New York Medical College

1984 - 3/30/1999 Assistant Clinical Professor, Columbia University College of Physicians & Surgeons

4/1/1999 - present Assistant Clinical Professor, Mt. Sinai School of M

Hospital Appointments:

1983-1984 Westchester County Medical Center, Valhalla, NY

1984 - 3/30/1999 Columbia Presbyterian Medical Center, N.Y., N.Y.

1992 - 3/30/1999 St. Johns Riverside Hospital, Yonkers, NY

1998 - 3/30/1999 Yonkers General Hospital, Yonkers, NY

1993 - 3/30/1999 Community Hospital at Dobbs Ferry, Dobbs Ferry, NY

4/1/1999 - present Elmhurst Hospital Center, Elmhurst, NY

Misc.

12/1999 - present Chief of Obstetrics, Elmhurst Hospital Center

1985-2000 President Frederick A. Gonzalez, MD, PC private practice group

1988 - 1992 Consultant Maternal Fetal Medicine for Allen Pavilion, Columbia Presbyterian Medical Center

1987 - 1992 Director of OB/GYN-Ambulatory Care Network Corporation, Columbia Presbyterian Medical Center

1984 - 1987 Director of Perinatal Clinics and the Antenatal Testing Center, Columbia Presbyterian Medical Center

Professional Societies:

| | |
|---|---|
| 1976 - 1985 | Junior Fellow American College of Obstetricians and Gynecologist |
| 1986 - present | Fellow of the American College of Obstetricia |
| 1976 - present | American Medical Association |
| 1980 - present | Society for Maternal and Fetal Medicine |
| 1983 - present | American Institute of Ultrasound in Medicine |
| 1985 - present | New York Academy of Medicine |
| 1985 - 1990 | American Society of Psychoprophylaxis in Obstetrics |
| 1997 - 1999 | Westchester County Medical Society |
| 1999 - present | Queens Obstetrical Society |

Continuing Education:

| | |
|---|---|
| 1998 | Controversies in Obstetrics and Gynecology N.Y.,N.Y. |
| 1998 | Clinical Ultrasound, Vail, Colorado |
| 1997 | Basic Risk Management, sponsored by MLMIC, New York, NY |
| 1996 | Masters Symposium on Ultrasound in Obstetrics and Gynecology, Institute for Advanced Medical Education, New York, NY |
| 1995 | Second Florida Winter Perinatal Symposium, Sarasota Memorial Hospital, Florida |
| 1995 | Gynecology in the 90's: Improving Outcomes, American Medical Association,, Squaw Valley, CA |
| 1994 | Training in Infection Control, CPMC, New York, NY |
| 1994 | Clinical Innovations in OB/GYN Ultrasound, American Institute of Ultrasound in Medicine, New York, NY |
| 1993 | Gynecologic Endoscopy, American Association of Gynecologic Laparoscopists, San Francisco, CA |
| 1993 | Operative Laparoscopy and Endoscopic Laser, CPMC, New York, NY |
| 1993 | Laparoscopic Surgery, Westchester Academy of Medicine, Purchase, NY |

1990 Hysteroscopy and Pelviscopy, ACOG Postgraduate Course New York, NY

1990 International Symposium on Intrapartum Surveillance, Nottingham, England

1989 29th Annual Postgraduate Course, Columbia University College of Physicians and Surgeons, New York, New York

1989 Hysteroscopy, Laparoscopy; and Laser Surgery in Gynecology, Virginia Beach, VA, New York Academy of Medicine, New York, NY

1987 27th Annual Postgraduate Course, Columbia University College of P&S, New York, NY

1987 Society of Perinatal Obstetricians, Orlando, Florida

1986 26th Annual Postgraduate Course, Columbia University College of P&S, New York, NY

1986 18th Annual Greater New York March of Dimes

1986 Society of Perinatal Obstetricians, San Antonio, Texas

1985 17th Annual Greater New York March of Dimes

1985 Symposium on Computer Applications in Medical Care

1985 Symposium on Infections in Obstetrics, New York Academy of Medicine

1985 Symposium on Genetics, Mount Sinai Medical Center, New York, NY

1984 Symposium on Ultrasound in Medicine, Mount Sinai Medical Center, New York, NY

1983 23rd Annual Review Course in Obstetrics and Gynecology

1983 Symposium in Obstetrics and Gynecology, New York Medical College, Valhalla, NY

1983 Programming in BASIC, UCLA, Los Angeles, California

1982 Programming in BNMP, UCLA, Los Angeles California

1982 Biostatistics, Department of Biomathematics

1982 Society for Gynecologic Investigation Meeting

1982 Society for Perinatal Obstetricians Meeting, San Antonio, Texas

1981 District VIII A. C. O. G. Meeting, San Diego, California

1981 Topics in Maternal-Fetal Medicine, Aspen, Colorado

1981 Society for Gynecologic Investigation Meeting, St. Louis, MO

1980 Symposium on Perinatal Medicine, Palm Springs, California

1980 Symposium on Adolescent Sexuality, New York, New York

1979 Statistical Package for the Social Sciences

1979 Symposium on Hypertensive Diseases in Pregnancy, Downstate Medical Center Brooklyn, New York

1979 A. C. O. G. National Convention, New York, New York

1979 International Symposium on Gynecologic Endocrinology and Infertility Downstate Medical Center, Brooklyn, New York

1978 A.C.O.G. District 11 Meeting, New York, New York

1978 Symposium on Gynecologic Oncology, Downstate Medical Center Brooklyn, New York

1978 Therapeutic Touch, New York University, New York, New York

1976 Hypnosis, Psychiatric Institute of New York, New York, NY

PRESENTATIONS

I . "Clinical Experience with the 42 week Safe Date Projection in Pregnancies with Poor Dates," A. C. O. G. District VIII Meeting, San Diego, California, 198 1.

2. "Sex Differences in Rabbit PNMT Activity: An explanation for the female advantage, "Poster session Abstract #169, Society for Gynecologic Investigation Meeting, Dallas, Texas, 1982.

3. Panel Discussion March of Dimes Symposium on Prevention of Prematurity, 1984, N.Y.

4. "Computerization of the Antenatal Testing Center at Columbia Presbyterian Medical Center," Sympoosium on Computer Applications in Medical Care, Baltimore, MD, November, 1985.

5. "Genetic Amniocentesis with Continuous Ultrasound Monitoring Abstract #81, Society of Perinatal Obstetricians Meeting, January, 1986.

6. "Factors Influencing Correlation of Continuous tissue pH values and Fetal Scalp pH Samples" Abstract #1 12, Society of Perinatal Obstetricians Meeting, January, 1986.

7. "Use of a Continuous Tissue pH Probe in Labor Patients" Abstract #55, Society of Perinatal Obstetricians Meeting, February, 1987.

8. "Biophysical Profile Scoring as Nonstress test Backup" Abstract #1 14, Society of Perinatal Obstetricians Meeting, February, 1987.

9. "Online Obstetrical Record" First World Symposium on Computers in the Care of the Mother, Fetus, and Newborn" Vienna, Austria, March, 1987.

10. "Computerization of the Antenatal Testing Center at Columbia Presbyterian Medical Center" International Confederation of Midwives Meeting, The Hagus, Netherlands, August 1987.

11. "Development and Implementation of a Computerized Obstetrical Record in a High Risk Obstetrical Clinic" 12th Annual Symposium on Computer Applications in Medical Care, Washington, D.C., November, 1988.

12. "Clinical Experience with the Continuous Tissue pH probe," International Symposium on Intrapartum Surveillance, Nottingham, England, 10/90.

LECTURES

11/89 Labor Physiology, Maternal-Fetal Physiology Course, Columbia University School of Nursing, New York, N.Y.

10/89 Antepartum/Intrapartum Monitoring, 28th Annual Postgraduate Course, Columbia University College of P&S, New York, N.Y.

9/89 Antepartum Fetal Evaluation, Grand Rounds, Palisades Hospital, New Jersey.

10/88 Antepartum/Intrapartum Monitoring, 28th Annual Postgraduate Course, Columbia University College of P&S, New York, N.Y.

5/88 Fetal Development, Presbyterian Hospital, New York, N.Y.

3/88 Rh Disease, Neonatal Fellow's, Baby's Hospital, New York, N.Y.

10/87 Antepartum/Intrapartum Monitoring, 27th Annual Postgraduate Course, Columbia University College of P&S, New York, N.Y.

7/87 Rh Disease, Neonatal Fellows, Baby's Hospital, New York, N.Y.

4/87 Hypertensive Disorders in Pregnancy, Staten Island Hospital, New York.

12/86 Prevention and Treatment of Prematurity, Stamford Hospital, Connecticut

11/86 Comparing Safety and Risk Issues for VBAC, Westchester ASPO Conference, VBAC: Taking the Responsibility.

11/86 Antenatal Testing Annual Postgraduate Review Course Columbia College of P&S, N.Y.

10/86 Hypertensive Disease in Pregnancy, Columbia Presbyterian Medical Center, N.Y.

1985 Ultrasound Symposium Regional Perinatal Center.

1985 Antepartum Fetal Evaluation, Symposium Regional Perinatal Center

1985 Electronic Fetal Monitoring, Columbia Presbyterian Medical Center, N.Y.

1985 Antenatal Testing, CPMC, Neonatal lectures

1985 Electronic Fetal Monitoring, CPMC, Resident Lectures

1985 Biophysical Profile, CPMC, Department of Ultrasound

2/82 Obstetrical Emergencies, Pace University, Family Primary Care Program

1/84 Antepartum Fetal Evaluation, Symposium Regional Perinatal Center

1984 Drugs in Pregnancy, Phelps Hospital, New York

1984 Drugs in Pregnancy, Misericordia Hospital, New York

1984 Biophysical Profile, United Hospital, New York

1984 Biophysical Profile, Lincoln Hospital, Grand Rounds, Bronx, New York

1984 Diabetes in Pregnancy, Nyack Hospital, Nyack, N.Y.

1984 Vaginal Birth after Cesarean, Arden Hills Hospital, Goshen, N.Y.

1984 Management of Post-dates Pregnancy- Phelps Medical Center, Tarrytown, N.Y.

1984 Management of Rh-sensitization, Westchester County Medical Center, Grand Rounds, Valhalla, N.Y.

1984 Nephrotic Syndrome in Pregnancy, Westchester County Medical Center, Grand Rounds, Valhalla, N.Y.

1984 Drugs in Pregnancy, Lincoln Hospital, Bronx, N.Y.
1984 Drugs in Pregnancy, Westchester County Medical Center

Grants

1. "Prostaglandin in Hypertensive Disorders in Pregnancy," New York Medical College approved but not funded.

2. "Non-Invasive Prediction of Fetal Lung Maturity, with John E. Buster, NIH IROIHDI6045-01 reviewed by Human Embryology and Development SS, approved but not funded.

3. Catecholamine physiology in mother, fetus, and newborn, with Calvin J. Hobel and James Padbury NIH HD 1 175 3 -04 reviewed by Human Embryology and Development S S, approved but not funded.

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1. Gonzalez, F.A., Waxman, M., "Ectopic Pregnancy: A Prospective Study," Diagnostic Gynecology and Obstetrics, 2:101-109, Summer, 1981.

2. Gonzalez, F.A., Waxman, M., "Ectopic Pregnancy: A Prospective study of 501 consecutive patients, "Diagnostic Gynecology and Obstetrics, 3:181-186, Fall 198 1.

3. Padbury, J., Hobel, C., Gonzalez, F.A., Fisher, D., Autogenesis and Sex Differences in Rabbit Fetal Adrenal Zenylethanolamine N-Methyl transferase", Biology of the Neonate 205-210, 1983.

4. Worthen, N., Gonzalez, F.A., "The Ultrasonographic Solution of Uterus Subsptus," Obstetrics and Gynecology 34S-38S, 1984.

5. Gonzalez, F.A., Lakshmannan, J., Hoath, S., Fisher, D. "Epidermal Growth Factor Response to 17-b estradiol stimulation in the mature mouse uterus", Acta Endocrinologic 105:425-428, 1984.

6. Gonzalez, F.A., "Ultrasound," Journal of Nurse Midwifery 29, #6 NovemberDecember, 1984.

7. Gonzalez, F.A., Buster, J., "Fetal Gender Affects Internal Prolactive Levels" J. Rep. Med. 32)1):21-24, 1987.

8. Gonzalez, F.A., Lee, R. S., Fox, H.E., "Computerization of Antenatal Testing Center at Columbia Presbyterian Medical Center.

9. Antenatal Proceedings Ninth Annual Symposium on Computer Applications in Medical Care, p. 135-137, 1985. #8 also quoted in Hess, D. Respiratory Care, Vol. 3 1, #9, September, 1986.

10. Gonzalez, F.A., Fox, H.E., "Online Obstetrical Record," Perinat.Med. 15:12 (Supplement 1) 1987.

11. Gonzalez, F.A., Fox, H.E. "Computerization of the Antenatal Testing Center at Columbia Presbyterian Medical Center", International Conference of Midwives, August, 1987.

12. Gonzalez, F.A., Fox, H.E. "Development and Implementation of a Computerized Obstetrical Record in a High Risk Obstetrical Clinic" Proceedings 12th Annual Symposium on Computer Applications in Medical Care, p.713-716, 1988.

13. Gonzalez, F.A., Fox, H.E. "The Development and Implementation of a Computerized Online Obstetrical Record," Br. J. Obstetrics.Gynecology, Vol 96/1 1, November 1989, p1323-1327.

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I . Gonzalez, F.A., "Epidemiology of Prematurity," Book Review Journal of Nurse Midwifery, Vol 25, #2 March-April, 1980.

2. Gonzalez, F. A., "Fetal and Maternal Medicine," Book Review Journal of Nurse Midwifery, Vol 27, #1 January-February 1982.

3. Gonzalez, F.A., "Drugs During Pregnancy: Clinical Perspectives "Book Review.

4. Gonzalez, F. A., "Nueva Vida (new Life) Media Review Journal of Nurse-Midwifery vol 27 no 3 May/June 1982.

5. Gonzalez,F.A., "Parto por Cesarea (Cesarean Birth) Media Review, Journal of NurseMidwifery vol 27 no 3 May/June 1982.

6. Gonzalez, F.A., "Obstetric and Perinatal Immunology" Book Review, Journal of NurseMidwifery vol 28 no 5 Sept/Oct 1983

7. Gonzalez, F.A., "Obstetrics and Gynecology Annual 1982" Book Review, Journal

8. Gonzalez, F. A., "Placental Transfusion: A Clinical and Physiological Study" Book Review Journal of Nurse-Midwifery 130 no 5 Sept/Oct 1985

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Gonzalez, F.A., "Traveling During Pregnancy: Some Precautions Needed" The Big Apple Parents Paper Vol. 3, No. 2, pi 5, November, 1987.

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May 11, 2004

Robert P. Ging, Jr. Esquire
2095 Humbert Road
Confluence, PA 15424-2371

# Vocational/Economic Analysis of Earning Capacity Of Decedent, Mikayla Rhoades

## Introduction

Portions of the case file on the above stated plaintiff were given to this evaluator by your office. My assignment was to evaluate the earnings loss of the decedent and/or her estate, and to provide an economic projection of the results of my findings. Case records for review included the following documents: Amended Complaint signed 10/14/03; Resume of Kim Rhoades; Resume of Rich Rhoades; Income summary sheet for Kim and Rich Rhoades; Children's Hospital of Pittsburgh Inpatient Discharge Summary dated 5/14/02; Children's Hospital of Pittsburgh Final Autopsy Report.

## Vital Statistics:

| | |
|---|---|
| Plaintiff: | Mikayla Rhoades |
| DOB: | 5/10/02 |
| DOD: | 5/14/02 |
| Age at Death: | 4 days old |
| Time Elapsed: | 96 weeks; or @ 1.85 years |
| Pre-Death Life Expectancy*: | 79.92 years |
| Pre-Death Worklife Expectancy**: | 34 |
| Estimated Beginning Earning Capacity: (Based on age 22 College Grad. with $30,347 starting salary in 2002 dollars)*** | $76,175 |
| Wage Growth****: | 4.76% |
| Interest Rate (Discount Rate) | 5.54% (as of 5/10/04, U.S Treasury) |

* U.S. National Center for Health Statistics. Vital Statistics of the United States. Department of Health & Human Services. Also see "Statistical Abstract of the United States" and "Determining Economic Damages" (reference cited below).
** "Median Years to Retirement and Worklife Expectancy for the Civilian U.S. Population," Tamorah Hunt, Joyce Pickersgill, and Herbert Rutemiller, *Journal of Forensic Economics*, Vol. X, no, 2, Summer, 1997. Also see, "Determining Economic Damages," Gerald D. Martin and Ted Vavoulis, James Publishing Incorporated, Costa Mesa, CA., 6/02. U.S. Census Bureau, Current Population Survey p20-538.
*** See "Determining Economic Damages," Gerald Martin, James Publishing Incorporated, Table 40.

## ASSIGNMENT INFORMATION

This wage earning capacity evaluation on Mikayla Rhoades, deceased child, was requested by Attorney Robert Ging, Jr... The report follows the discounting to present value method require by MCARE reforms, and deducts for personal maintenance as allowed or required by Pennsylvania law.

## BACKGROUND INFORMATION

Mikayla was born on 5/10/02 to Dennis and Kimberly Rhoades. Both parents are college graduates[1] and make a middle class living in professional level work. They have had combined incomes of approximately $50,000 a year for full time work.

Unfortunately, Mikayla, due to alleged medical malpractice, died 4 days after her birth.

## OVERVIEW OF PROBABLE EARNING CAPACITY

Studies have found that the educational attainment, work ethic, and earnings of the parents have a positive influence on the child. In fact, the child of parents who have both graduated from college has a high probability of doing so also. Typically, in the U.S., it may be said, the higher the education, the higher the earnings. Hence, Mikayla probably would have enjoyed the earning capacity of a college graduate.

## HER PROBABLE AVERAGE EARNINGS:

Based upon Mikayla's probable educational attainment, given in part to the educational attainment of her parents and the increasing level of education for the average American, she could have had, for example, an average yearly wage of approximately $29,985 (the sum of the means for Political Science/Government and English Major Graduates in 2003 dollars)[2]. Furthermore, as was noted above, the average female college graduate in what would have been her age cohort earned $30,347 in 2002. Naturally, there are many majors that she could have chosen, and each would have a different starting salary offer level. However, these two examples are very close in earning capacity and hence representative of what she could have earned as a college graduate in the last couple of years dollars.

Therefore, it is assumed that Mikayla could have had, but for the wrongful death, a first year annual average earnings of $76,175 (in 2024 dollars). Multiplying that average yearly wage for the 34 years of her worklife expectancy, with a 4.76% growth factor compounded annually, and discounted back to present value with a 5.54% interest rate, we see that she could have earned total non-discounted wages of $6,177,403, but $1,414,265 when discounted to present value.

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1 Hence, she had a 70% probability of being a college graduate also. See, "Determining Economic Damages," 321.3.

2 Fall 2003 *Salary Survey*, National Association of Colleges and Employers, $28,786 for English Majors and $31,163 for Political Science/Government Major graduates.

**BENEFITS:**
The average college graduate worker receives fringe benefits as part of their compensation. The average percentage of wage paid in benefits is 27.1%[3]. Mikayla could have earned $1,414,265 in discounted wages. Therefore, she could have earned benefits with a discounted value of $383,266.

**PERSONAL MAINTENANCE (PM) CONSUMPTION**
It is common practice to deduct an amount that the decedent would have spent to maintain her own life, at a level commensurate with her station in life, in order to determine the amount of loss to her estate. The amount varies depending on marital status, the number of children she might have had, and her earnings. For example, as a single woman she would have consumed almost all of her income. However, as a married woman it would have dropped to approximately 30%. With each child, her personal consumption percentage rate would have lessened while the child was a dependent. Finally, it would go back to 30% when she and her husband would have been "empty nesters."

It is difficult to state with absolute certainty what her PM consumption would have been at any given time. Therefore, based within the known parameters, it is assumed that she would have had an overall yearly consumption rate of approximately 30%.

Therefore, with a personal consumption rate of approximately 30%[4] , she would have consumed approximately $424,280 leaving approximately $989,985 for her estate.

William Houston Reed

William Houston Reed, Ph.D.
Vocational Expert

3 See, Determining Economic Damages, Gerald Martin, Ford Publishing Inc.
4 See, "Determining Economic Damages," Gerald Martin, Ford Publishing, Inc.

# The Credentials
# of

# William Houston Reed, Ph.D.

Specializing In:
Economic & Vocational Evaluations

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## CREDENTIALS

TABLE OF CONTENTS


| Subject | Page |
|---|---|
| Summary of Formal Education, Experience and Certifications | 1 |
| Continuing Education | 3 |
| Book & Papers Published &/or Presented | 13 |
| Teaching Experiences | 14 |
| Honors | 17 |
| Resume | 18 |
| Curriculum Vitae | 20 |
| Thesis and Dissertation Titles | 23 |
| Description of Certification | 24 |

**William Houston Reed, Ph.D.**
Board Certified Economist & Registered Vocational Expert

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## EDUCATIONAL, CERTIFICATION & WORK SUMMARY:

### ECONOMICS & STATISTICS:

**Post-Doctoral University Courses in Economics:**

- Course Entitled: **"Calculating Vocational Loss, Economic Damages and Present Value,"** 1 Graduate credit, **Texas Wesleyan School of Law (Fort Worth, TX) and Our Lady of the Lake University** (BADM 8142, Forensic Economics) **(San Antonio, TX)**

- Course Entitle: **"Economics for the Vocational Rehabilitation Professional,"** 3 credit Graduate Course, **University of Nevada (UNLV),** Division of Continuing Education, Course No. 720E, Section 380,. Las Vegas, Nevada.

- Course Entitled; **"The Economics of Personal Injury Evaluation,"** 1 Graduate credit, **Marylhurst University (Oregon),** Course No. EC560.

- Course Entitled: **"Time Value of Money: Determining a Future Earnings Growth Rate, Discount Rate, and Other Elements of Evaluation,"** 1 Graduate credit, **University of North Alabama**, Office of Continuing Education.

- Course Entitled: **"Essential Statistics Revisited: A Primer Addressing Core Concepts and Procedures Demanded of the Practicing Vocational Expert,"** 3 contact hours of continuing education credits, **Louisiana State University** Medical Center (LSUMC).

**Post-Doctoral Conference/ Workshops in Economics/Vocational/Disability Training:**

- 22 National Conferences with more than 90 workshops

**Doctoral University Courses in Statistics:**

- Course Entitled: **"Methods of Research,"** University of Pittsburgh.
- Course Entitled: **"Educational Inquiry,"** University of Pittsburgh.
- Course Entitled: **"Statistical Analysis,"** University of Pittsburgh.

**Graduate and Undergraduate Courses in Economics & Statistics:**

- Course Entitled: **"Macro Economics,"** Point Park College.
- Course Entitled: **"Micro Economics,"** Point Park College.
- Course Entitled: **"Managerial Economics,"** Point Park College.
- Course Entitled: **"Research Methodology,"** University of Pittsburgh.

**DISABILITY & REHABILITATION:**

**Post-Doctoral University Course in Rehabilitation:**

- Post Graduate Course Entitled: **"Practical Psychiatry for Legal Professionals," Harvard Medical School**, Department of Continuing Education, Course No. 92F503.

**Doctoral Courses in Disability & Rehabilitation:**

- **"Introduction to Rehabilitation,"** Books read included: ***The Role of The Rehabilitation Services Administration in Serving the Disabled Poor***, Kershaw; Borow, ***Man in a World at Work***; McGowan and Porter, ***An Introduction to the Vocational Rehabilitation Process***; W. L. Slocum, ***Occupational Careers***; Sussman, ***Sociology and Rehabilitation***; Malikin and Rusalem, ***Vocational Rehabilitation of the Disabled***; Szasy; Murthard and Solomone, ***The Roles and Functions of the Rehabilitation Counselor***; Goldin and Perry, ***Dependency and Its Implications for Rehabilitation***; Roth and Eddy, ***Rehabilitation for the Unwanted.***

- **"Counseling Theory,"** Readings included: Slovenko, ***Psychiatry and Law.***

- **"Individual Counseling,"** Readings included: Hogan, ***Clinical Supervision***.

**VOCATIONAL ANALYSIS:**

**Graduate Courses in Vocational Analysis:**

- **Methods of Work Supervision**
- **Organization and Coordination of Vocational Education**

## UNIVERSITY AND COLLEGE DEGREES:

**Ph.D.**, Specializing in: **Rehabilitation Counseling & Consulting; Statistical Analysis & Research Methodology**, Division of Specialized Professional Development, University of Pittsburgh, Degree granted December, 1977.

**M.Ed., Vocational Education (Distributive),** University of Pittsburgh, Degree granted August, 1971

**B.S., Business Administration**, Point Park College, **Minor concentration in Economics**, Degree granted May, 1969

**A.S., Business Administration**, Point Park College, **Minor concentration in Accounting**, Degree granted May, 1968

QPA in Majors: Doctor's - 3.90; Master's - 3.31

## BOARD CERTIFICATION:

Certified Rehabilitation **Economist**, No. 9004, 1989-present, by the American Rehabilitation Economics Association.

## WORK EXPERIENCE SUMMARY:

In: Economic Evaluations; Vocational Evaluations; Rehabilitation Consulting; Disability Consulting; Occupational Placement; Employment Counseling; and Vocational School Guidance Counseling.

Includes: 33 years of professional career experience, including 25 years of testimonial experience in thousands of disability hearings, and 20 years of experience in thousands of economic/vocational evaluations in Personal Injury, Employment Law, Wrongful Death, Wrongful Discharge, Medical Malpractice, Workers Compensation and Product Liability trials regarding disability, employability, earnings, benefits, household services, rehabilitation, Life Care costs, discounting to present value, and deductions for personal maintenance.

## CONTINUING EDUCATION IN ECONOMICS, VOCATIONAL EVALUATION, REHABILITATION, AND DISABILITY ISSUES

May, 2003

American Rehabilitation Economics Association (AREA), Annual Spring Conference, Fort Worth, TX., **Sessions Attended, Pre-Conference**,: **"Calculating Vocational Loss, Economic Damages and Present Value,"** This was a **Graduate Course in Economics, 1 Graduate Credit** (BADM 8142, Forensic Economics) was earned from Our Lady of the Lake University, Fort Worth, TX. Presented by Lawrence Deneen, Ph.D., Certified Life Care Planner and Certified Earnings Analyst in full time vocational-economic analysis practice; and, Mary Barros-Bailey, MA, CRC, ABVE-F (Past President of AREA), is a Fellow of the American Board of Vocational Experts, a Certified Disability Management Specialist, Certified Life Care Planner, Certified Rehabilitation Counselor, Registered Forensic Vocational Expert, and holds a National Counselor Certificate; Gerald Martin, Ph.D. (Currently vice-president at large of the National Association of Forensic Economists), former university professor in Economics at Fresno, CA., and private practice forensic economist for 30 years, is the author of "Determining Economic Damages, now in its 16th revision; and, Herbert Burkman, Ph.D., an economist with 29 years of college/university teaching experience who is currently researching and teaching the utilization of principles from economics and finance for forensic vocational and economic applications; and, **Sessions Attended, Main-Conference**: **"Best of the 'Bad' Testimony: Strategies and Techniques No Expert Should Ever Use – and Why,"** This workshop was designed to provide experts with information on flawed approaches, methodologies and techniques used by some that have become increasingly discredited given the current litigation environment. Presented by Allyn Needham, Ph.D., Registered Forensic Economist in private practice and Adjunct Professor of Economics at Weatherford College and Texas Christian University; and, Gerald Martin, Ph.D., (Currently vice-president at large of the National Association of Forensic Economists), former university professor in Economics at Fresno, CA., and private practice forensic economist for 30 years, is the author of "Determining Economic Damages, now in its 16th revision; and, **"Victims Compensation Fund: Frameworks and Methods for Appraising Economic Loss,"** This workshop described how the Victims Compensation Fund is approaching the issue of determining economic loss, the basis for formulations of economic loss (including qualitative data) and the role of economists in the process. Presented by Deborah E. Greenspan, J.D., (*Magna cum laude* from The University of Michigan Law School in 1981) Attorney at Law, Deputy Special Master, 9/11 Victims Compensation Fund; and, **"Issues in Calculating Work Life Expectancy: Quantitative vs. Qualitative Data,"** This workshop was designed to define how work life expectancy is calculated and debated the relative weight that should be ascribed to qualitative (information from injured parties, their families and expert knowledge) and quantitative data (work life tables) in a forensic setting. Presented by Joseph Agrusa, MS, Board Certified Rehabilitation Economist, Board

Certified Case Manager, Board Certified Vocational Evaluator, Board Certified Rehabilitation Counselor, and recognized & utilized by the US Department of Justice as a Life Care Planning Expert; Allyn Needham, Ph.D., Registered Forensic Economist in private practice and Adjunct Professor of Economics at Weatherford College and Texas Christian University; Shannon Shipp, Ph.D., Certified Earnings Analyst, forensic economist in private practice and Associate Professor of Marketing at the J.J. Neeley School of Business at Texas Christian University; and, Michael Nieswiadomy, Ph.D. (In Economics from Texas A&M University, 1983), is Professor of Economics at the University of North Texas, past president of the Dallas Economists' Club; and, **"How to Prepare for Trial – What Works and What Doesn't: Perspectives from Inside and Outside the Tent,"** The purpose of this workshop was to increase the testifying skills of the expert by describing certain observed presentation techniques and the jurors perceptions of those presentation techniques. Presented by: The Honorable Robert C. Jenevein served as Judge of the County Court at Law No. 3 in Dallas, TX and is now an attorney in private practice in Dallas, TX; Michael Payma, J.D, (Texas Wesleyan University School of Law, a Trial Attorney specializing in medical negligence, personal injury and product liability; Kevin Marshall, Ph.D., J.D., Attorney and Testifying Economic Expert, (Bachelor or Arts, *cum laude*, Phi Beta Kappa, with major in Economics from Knox College, 1982; and, Emory University, School of Law in Atlanta, Georgia, 1985); Thomas E. Loraine, J.D., St. Louis University, 1971, Attorney-at-Law in private practice, former Assistant U.S. Attorney for the Eastern District of Missouri; Charles H. Steen, Ph.D., J.D., Bachelor or Science in Economics with distinction from George Mason University in 1986, Masters of Arts in Economics in 1988, Juris Doctor in 1991, and Doctor of Philosophy in Economics in 1993, all from the University of Virginia and is a practicing attorney and Adjunct Professor in Economics at Southern Methodist University, Dallas, TX.; and, **Developing Demonstrative Exhibits and Evidence for Trial Presentation: Is There any 'Power' in a PowerPoint Presentation? or, Old Wine in New Bottles?"**, The workshop explained how to develop reports that can transform into powerful trial exhibits for the best "teaching" technique. Presented by Eric H. Nelson, President of Trial Logistics, Inc., a nationwide trial support company, which has been involved in nationally high profile cases such as the *Firestone/Bridgestone Case;* and, **"Catching Evasions, Ploys and Subterfuge in the Reports of Life Care Planners and Vocational Experts: Refining and Extending the 'Red Flags' Concept to Vocational Plans"** This workshop focused on how to identify inappropriate foundations in vocational evaluations and life care plans. Presented by Penelope Caragonne, Ph.D., who has an international practice, is an Adjunct Faculty Member, Graduate Certificate Program in Forensic Economics, University of Missouri-St. Louis, and is Vice-President of External Affairs for the American Rehabilitation Economics Association; Betty Killette Mitchell, R.N., M.A., CLCP, CCM, is a 1974 graduate of Georgia State University School of Nursing, a Registered Nurse, Certified Life Care Planner (CLCP), and Certified Case Manager (CCM), for 12 years she owned and managed Rehabilitation Management Corporation, a comprehensive national case management consulting company and is currently Commissioner for Rehabilitation Nursing of Life Care Planning with the Commission for

Health Care Certification (CHCC), and is a member of the Case Management Society of America, The National Association of Rehabilitation Professionals in the Private Sector and The American Association of Legal Nurse Consultants; David B. Stein, Ph.D., CRC, CDMS, a practicing vocational expert and President of the American Board of Vocational Experts; Jan Lowe, M.S., CRC, CCM, CIRS, ABVE, has been a vocational rehabilitation consultant for 27 years; and, **"Post-Litigation Activities and the Development of Special Needs Trusts: When the Rubber Really Hits the Road,"** This workshop was designed to provide forensic experts with the scope and range of 'real-life' post-litigation issues when civil litigation is completed. Presented by Donald E. Weeks, Associate, American Society of Pension Actuaries, Chairman, Structured Annuities, Inc., and President, Pension Planning Associates; Gregory S. Love, J.D. and B.B.A. (Accounting) Texas Tech University, Attorney-at-Law and Guardian ad Litem; Ronald R. Cresswell, Attorney-at-Law, former Tax Attorney, Office of Chief Counsel, Internal Revenue Service, former Attorney-Advisor to Judge Sterrett, U.S. Tax Court, Washington, D.C., former Adjunct Professor, Southern Methodist University School of Law, former Chairman, Probate, Trusts and Estates Section, Dallas Bar Association, currently Fellow, American College of Trust and Estate Counsel and board certified in Estate Planning and Probate Law by the Texas Board of Legal Specialization; Kathy A. Christoffel, Senior Trust Officer, Vice President, Wells Fargo Trust; and, **"The 'McCroskey' Program: How to Use It and Not Abuse It,"** This workshop provided key concepts and operational features of a software program that is being developed as a comprehensive transferable skills/job market analysis/economic calculations tool. Cynthia P. Grimley, MS, CRC, CCM, DABVE, a Diplomate and current Secretary of the American Board of Vocational Experts, and Editor of The Vocational Expert, has a forensic consulting and expert services private practice; Jan Lowe, M.S., CRC, CCM, CIRS, ABVE, has been a vocational rehabilitation consultant for 27 years and has worked closely on a number of MVQS related projects with Dr. McCroskey; and, **"Cases Involving Serious Harm to Multiple Family Members,"** The workshop discussed economic, vocational, life care and legal issues arising from such cases. Presented by Tom Ireland, Ph.D. RFE, Professor earned his Ph.D. in Economics from the University of Virginia, and currently is the Director of the Graduate Certificate Program in Forensic Economics at the University of Missouri-St. Louis and has a forensic economics private practice; Everett G. Dillman, Ph.D., is a retired Full Professor from the University of Texas at El Paso, he received his MBA at the University of New Mexico and his Ph.D. in Management and Statistics at the University of Texas at Austin, and is considered one of the premiere economic expert consultants in the USA because of his extensive teaching, publishing and consulting activities.

May, 2002

American Rehabilitation Economics Association (AREA), Annual Spring Conference, Reno, NV. Sessions Attended: **"Use of Statistical Tools in a Forensic Context,"** Presented by Lindette L. Mayer, Ph.D., a licensed and board certified professional counselor and forensic consultant. Dr. Mayer is a former co-Editor of *The Journal of Forensic Vocational*

*Analysis* and a member of the Board of Directors, American Board of Vocational Evaluators. Publications include labor market studies and statistical studies of wage and disability status, as well as validation studies of outcome measures; and, **"Applied Inferential & Non-Inferential Statistics: Valid Use in a Forensic Context,"**, Presented by J. Herbert Burkman, Ph.D., an Economist with 25 years fo experience in economic and statistical analysis, and 29 years of college teaching experience in graduate business programs, and special interest in the utilization of principle from economics and finance for forensic vocational and economic applications; and, **"Providing Testimony in a Dauber/Kumho Context: The Seven Deadly Sins of Expert Witnesses,"** Presented by Carrie McCrea Hanlon, Esq., Law Offices of Pyatt & Silvestri, Lyndall M. Lambert, Esq., Holland & Knight, LLP, and Mark J. Mills, M.D., J.D., Forensic Sciences Medical Group. Attorney Hanlon attended law school at California Western School of Law in San Diego and was the recipient of the Faculty Award for Outstanding Contribution to the Law School and American Jurisprudence Awards in Civil Procedure and Labor Law. Attorney Lambert is a partner with the international law firm of Holland & Knight in Miami, Florida and specializes in alternative dispute resolution, litigation related to aviation accidents, personal injury and wrongful death, and product liability. Dr. Mills is a principal at Forensic Sciences Medical Group, in Washington DC. and is Clinical Professor, Department of Psychiatry, New York Medical College, St. Vincent's Hospital. He currently serves as Clinical Professor, Department of Psychiatry at Georgetown University School of Medicine, Washington, DC. Dr. Mills is board certified in Psychiatry and Forensic Psychiatry. He received his Doctor of Jurisprudence from Harvard Law School in 1970 and his M.D. form Stanford University School of Medicine in 1975; and, **"Understanding the O*NET: Possibilities & Limitations"** Presented by Mary Barros-Bailey, M.A., FVE. Ms. Barros-Bailey is a bilingual rehabilitation counselor and vocational expert who is the AREA representative on the inter-organizational O*NET Task Force that is advising the US Department of Labor and the Social Security Administration on disability-related issues for changes to the O*NET; and, **"What Information Should be Provided by a Vocational Specialist to a Same-Side Economist? - and Vice-Versa?"** Presented by G. Michael Graham, Ed.D. and Barry Ben-Zion, Ph.D. Dr. Graham obtained his doctorate form Nova Southwestern University with a specialty in Brain Injury/Learning Disabilities. He has a private forensic practice and is currently President of the American Board of Vocational Experts. Dr. Ben-Zion was a Professor of Economics in the School of Business & Economics, Sonoma State University from 1969 to 2000. He has had a private forensic practice for many years.; and, **"Understanding the MCPI: List of Terms & Definitions of Categories / The Appropriate Use & Application of the MCPI in a Litigation Context"** Presented by Allyn Needham, Ph.D., CEA, Keith Sofka, ATP; and Anthony H. Riccardi, MBA. Dr. Needham is a partner at Shipp, Needham & Durham, L.L.C. He worked for more than 20 years in the banking, insurance and finance industries before joining the forensic practice group. His is a Past President of the Southwestern Society of Economists. Mr. Sofka is a rehabilitation technologist and a principal in the firm of Caragonne & Associates, Inc., and has researched for the past 2 years, with the

Bureau of Labor Statistics staff, the appropriate use and application of the Medical Consumer Price Index (MCPI). Mr. Riccardi hold 2 Masters degrees in Business Administration and Arts/Economics. He teaches economics to bankers through the American Institute of Banking and has been an Associate/Adjunct Professor at Empire State College and State University of New York at Albany. He has been a consulting economist and forensic expert witness for more than 20 years; and, **"Surviving a Daubert Challenge: A Survey of Attorneys"** Presented by Dr. Allyn Needham (see above for his credentials); and, **"Annuities: Their Role and Use in a Litigation Context"** Presented by Anthony H. Riccardi, MBA (see above for his credentials) and Thomas R. Ireland, Ph.D. Dr. Ireland earned his Ph.D. form the University of Virginia. He has published 10 books and more than 75 articles. Professor Ireland teaches courses in micro economics, public finance, law and economics, organizational theory, and forensic economics. He is currently Director of the Graduate Certificate Program in Forensic Economics at the University of Missouri-St. Louis.

May, 2001

American Rehabilitation Economics Association (AREA), Annual Spring Conference, Reno, NV. Sessions Attended: **"Psychological Factors & Their Impact on Earning Capacity,"** Presented by David Orlowski, MS, CRC, CRE, CPC, President of Vocational Economic Services, Inc., former President of the American Rehabilitation Economics Association, Doctoral Candidate in Counseling., and; **"Disability Data Panel,"** The presentation addressed the relative merits of using CPS or SIPP data for determining earnings and work experience of disabled workers. Presented by: James D. Rodgers, Ph.D. (panel chair), Professor Emeritus of Economics at Penn State University, prior to his retirement from Penn State in 1999, he taught a variety of graduate and undergraduate courses in Economics, including upper-division undergraduate courses in Forensic Economics and the Economics of Accident Law. He is President of the National Association of Forensic Economics. He has published a number of articles in major professional journals in economics, including the *American Economic Review*. He co-author of a 1998 book on expert economic testimony. He has been an economic consultant in private practice sine 1976; David Gibson, MBA, CPA, Chief Operating Officer for Vocational Economics, Inc., and develops new statistical and demographic data for use in economic databases; Robert Male, Ph.D., Past Chair of the Human Studies Department and Assistant Vice-President for Academic Affairs at Marylhurst University in Oregon, Past President of the American Rehabilitation Economics Association, Founder and current Editor of AREA's journal *The Earnings Analyst*, Board Member and Vice-President of the American Academy of Economic and Financial Experts, At-Large Vice-President and Board Member of the National Association of Forensic Economics, Advisory Board Member of the American Board of Disability Analysts; Lindette Mayer, Ph.D., Held various faculty positions at Indiana, Purdue, and West Virginia Universities, Licensed and board certified professional counselor, past Co-Editor of *The Journal of Forensic Vocational Analysis*; Gary Skoog, Ph.D., degreed in Economics, faculty positions at Universities of Minnesota, Wisconsin, Chicago, and DePaul. Founding member of the National Association of

Forensic Economists. He is a member of the Econometric Society, the American Economic Association, the American Statistical Association, the Institute of Mathematical Statistics, the Royal Statistical Society (London), the American Academy of Economic and Financial Experts, and, the National Association of Business Economists., and; **"Face-Off: Issues of Worklife Expectancy, Methodologies of Developing Useable Data & the U.S. Bureau of the Census,"** A.M. Gamboa, Jr., Ph.D., MBA, received his doctorate from Ohio State University, specializing in vocational counseling, and completed post-doctoral study in vocational rehabilitation and the economics of disability at the University of Cincinnati, the University of Louisville, Purdue University and the University of Chicago where he also received his MBA. He has worked for 25 years within the field of disability as a vocational counselor, researcher, university professor, vocational expert witness consultant with the Social Security Administration, and as a vocational economic analyst. He has authored and co-authored numerous publications dealing with the economics of disability. Gary Skoog, Ph.D., degreed in Economics, faculty positions at Universities of Minnesota, Wisconsin, Chicago, and DePaul. Founding member of the National Association of Forensic Economists. He is a member of the Econometric Society, the American Economic Association, the American Statistical Association, the Institute of Mathematical Statistics, the Royal Statistical Society (London), the American Academy of Economic and Financial Experts, and, the National Association of Business Economists James Ciecka, Ph.F., Ph.D., received his Ph.D. from Purdue University in 1970. He is Professor of Economics at DePaul University. He has published refereed papers, comments, and monographs on a variety of topics. He is a co-author of worklife expectancy tables using the Increment-Decrement Model and the Markov Process Model. He referees for various journals, including: *Journal of Economics; Journal of Forensic Economics; Journal of Legal Economics; Litigation Economics Digest; Economic Inquiry; and, Review of Social Economy.*; David Gibson, MBA, CPA, Chief Operating Officer for Vocational Economics, Inc., and develops new statistical and demographic data for use in economic databases; Ronald Missun, Ph.D., received his doctorate from the University of Illinois. He has teaching experience at Illinois Wesleyan University and the University of Illinois. He is a member of the National Association of Forensic Economics and has presented papers to the Midwestern Economic Association, the Cincinnati Bar Association Tort and Insurance Committee and the 1999 Annual Convention of the Ohio Academy of Trial Lawyers. His current research effort focuses on the economic impact of occupational disability and employment issues for displaced workers.; James Rodgers, Economics at Penn State University, prior to his retirement from Penn State in 1999, he taught a variety of graduate and undergraduate courses in Economics, including upper-division undergraduate courses in Forensic Economics and the Economics of Accident Law. He is President of the National Association of Forensic Economics. He has published a number of articles in major professional journals in economics, including the *American Economic Review*. He co-authored a 1998 book on expert economic testimony. He has been an economic consultant in private practice sine 1976.

May, 2000

American Rehabilitation Economics Association (AREA), Spring Conference, Reno, NV. Sessions Attended: **"A Perspective on Life and Worklife Expectancies"**, Presented by Everett Dillman, Ph.D., who has been a Forensic Economics practitioner and educator for 35 years. He has served on the Board of Directors of the National Association of Forensic Economics and on the Steering Committee for Forensic Rehabilitation of the National Association of Rehabilitation Professionals in the Private Sector; **"Estimating the Value of Social Security as a Fringe Benefit",** presented by Jim Rogers, Ph.D., A private practitioner and Professor Emeritus of Economics at Penn State University. Dr. Rodgers received his Ph.D. in economics from the University of Virginia in 1970. Prior to his retirement from Penn State in 1999, he taught graduate courses in forensic economics and the economics of accident law. He is President-Elect of the National Association of Forensic Economics.; **"Issues in Assessing Personal Consumption and Maintenance in Wrongful Death Actions."**, Presented by Thomas Ireland, Ph.D., Professor in the Department of Economics, University of Missouri-St. Louis, a Private Practitioner in Forensic Economics, Associate Editor of the Journal of Forensic Economics, on the board of editors for the Journal of Legal Economics, President of the American Academy of Economic and Financial Experts, At-Large Board Member of The American Rehabilitation Economics Association (AREA); **"Disability and The New Worklife Expectancy Tables: A Critical Analysis"**, Presented by David Toppino, M.A. (Ph.D. Student), a Private Practitioner who is board certified as a certified Earnings Analyst, and has published many articles and presented numerous workshops and seminars to vocational experts, economists, and health care professionals. Mr. Toppino is a Past President of the American Rehabilitation Economics Association, and co-authored a primer entitled "The ABC'S of Rehabilitation Economics."

March, 1998

The Louisiana State University Medical Center (LSUMC), ABVE Pre-Conference Workshop, Spring, New Orleans, LA. Workshop Title: **"Essential Statistics Revisited: A Primer Addressing Core Concepts and Procedures Demanded of the Practicing Vocational Expert"**, Presented by Douglas C. Strohmer, Ph.D. LSUMC Head of Department, Department of Rehabilitation Counseling; Lindette L. Mayer, Ph.D., Stephen J. Leierer, Ph.D., LSUMC; Michael J. Millington, Ph.D., LSUMC; Craig Feldbaum, Ph.D., Clinical Professor, Rehabilitation Counseling at LSUMC; Director of the LUSMC Vocational Assessment and Counseling Clinic. The objective of the workshop was to reacquaint vocational and rehabilitation experts with the critical statistical and psychometric underpinnings of our field and to equip experts with the tools to address the issues raised in the *Daubert* decision and to answer statistically-oriented cross examination in a way the edifies the jury. Earned 3 contact hours of continuing education credits from The Louisiana State University Medical Center (LSUMC).

March, 1998

The American Board of Vocational Experts (ABVE), Spring Conference, New Orleans, LA. Sessions Attended: **"Vocational Impact Analysis After Trauma"**, Presented by Craig Feldbaum, Ph.D., Clinical

Professor, Rehabilitation Counseling at LSUMC; Director of the LUSMC Vocational Assessment and Counseling Clinic. Dr. Feldbaum addressed convergent approaches to documenting the underlying empirical bases of forensic opinions; **"Computer Technology and Life Care Planning: A Database Management Tool"**, Randall L. Thomas, Ph.D., board certified as a Vocational Expert, and, as a Rehabilitation Psychologist in private practice in Madison, MS. Dr. Thomas shared his development of a software package that assists in the planning and case management of life care plans; **"Vocational Evaluations and Cultural Differences"** Panel Discussion led by Ronald Peterson, Ph.D., Francis A. Thomas, Ph.D., and Craig Feldbaum, Ph.D.; **"Chronic Pain, The Injured Worker, Use of Psychopharmacological, Medical, and Other Interventions, and the Functional Implications of Return to Work"** Panel Discussion led by Harry Gould, M.D., Ph.D.; James H. Diaz, M.D., DrPH, MPA, LSUMC Multidisciplinary Pain Clinic; Charles Genovese Jr., in private practice in Independence, LA.; **"Occupational Functioning in Individuals with Chronic Pain"**, Presented by James H. Diaz, M.D., DrPh, MHA, Professor and Acting Chair of LSUMC Department of Public Health and Preventative Medicine. Dr. Diaz addressed the management of chronic pain and its vocational sequella from his perspective as an Anesthesiologist and active member of the LAUMC Multidisciplinary Pain Clinic. He delineated the pharmaceutical and other interventional modalities used to attempt to restore functional capacity in patients with chronic pain.

March, 1997

The American Board of Vocational Experts (ABVE), Spring Conference, Las Vegas, NV. Sessions Attended: **"Traumatic Brain Injury: Beyond Diagnosis"**, Presented by Robert Schalock, Ph.D., Chair, Psychology Department, Hastings College; Faculty Member, Boston College, Boston, MA.; Author of more than 120 texts and articles; National Past President, American Association on Mental Retardation. Dr. Schalock addressed the treatment and out-come expectation of TBI patients, including ongoing treatment, life-care planning, and employability; **"The Quality of Life Approach to Forensic Rehabilitation"**, Presented by John M. Williams, D.Ed., Forensic Rehabilitation Expert in private practice, in Coral Springs, FL., and Author of several texts and numerous articles on forensic rehabilitation. Dr. Williams presented an approach methodology and rationale for use of quality of life as a measure of pain and suffering as opposed to pleasure of life lost as a measure of hedonic damages. He discussed the advantages of measuring the quality of life as a way of demonstrating a scientific basis of forensic rehabilitation opinion that meets the Dauber standard; **"The Daubert Standard and Its Interaction with the Federal Rules of Civil Procedure and Evidence"**, Presented by Craig Feldbaum, Ph.D., Clinical Professor, Department of Rehabilitation Counseling, Louisiana State University Medical Center; Director, LSUMC Vocational Assessment and Counseling. Dr. Feldbaum presented an advanced multimedia update on the Daubert standard from its inception; **"The World Wide Web as a Vocational Expert Resource Tool"**, Presented by Michelle Warn, M.S., and Sandra Whitteker, M.S., both with the Interwork Institute at San Diego State University. Ms. Warn and

Whitteker demonstrated how to conduct searches on the Web for academic and professional research to assist in evaluations.

April, 1997

American Rehabilitation Economics Association (AREA), Spring Conference, San Diego, CA. Sessions Attended: **"Ethics in the Courtroom: How to Avoid the Compromising of Your Integrity"**, Presented by David Orlowski, M.S., President, American Rehabilitation Economics Association; **"How to Critique the Opposing Expert's Work - A Seven Step Process"**, presented by Kristy Farnsworth, Ph.D., A private practitioner, she is a Certified Rehabilitation Counselor, and Vocational Expert. She also holds an advanced certificate as a Life Care Planner from the University of Florida. Dr. Farnsworth has been a trainer for the Utah State Bar and Utah State Legal Services Program. She has written numerous articles and co-written several books. She presented a method of critique that has a high degree of scientific validity and assists in objective conclusions; **"Current Controversies Among Forensic Economists: Worklife Expectancy, et. al."**, Presented by Gerald Martin, Ph.D., Professor Emeritus of Finance, California State University at Fresno, Private Practitioner in Forensic Economics, a Certified Earnings Analyst (AREA), Author of Determining Economic Damages. Dr. Martin discussed the various approaches to forensic/rehab economics that can be taken; **"Surfing in Southern California: Internet Resources and Demonstration of Access"**, Presented by G. Michael Graham, Ph.D., a Private Practitioner who is board certified as a Vocational Expert and Certified Earnings Analyst, and has published many articles and presented numerous workshops and seminars to lawyers, judges, vocational experts, economists, health care professionals and claims supervisors. Dr. Graham gave a live/interactive demonstration of how to get on the internet and to find professionally relevant data and information for our evaluations; **"Panel Discussion: Functional Capacity Evaluations in the Court Room: The Views of an Attorney, Physician, and Vocational Rehabilitationist"**.

October, 1994

**"The Economics of Personal Injury Evaluation"**, instructed by Professors Michael Butler and Regina Thomas (University of North Alabama), both have private practices in forensic economics. Dr. Butler is President of the American Academy of Economic and Financial Experts and is the Editor of the Journal of Legal Economics. This advanced graduate course provided 1 graduate school credit (EC560) through Marylhurst College (Oregon). The **Course Outline covered: Time Value of Money (Compound interest; non-annual periods; present value of an uneven stream; compound annuities; and present value of an annuity), Determining a Future Earnings Growth Rate (Compound growth rates; and linear regression estimates), Discount Rate (Economic theory of interest rates; real vs. nominal rates; long-term rates vs. short-term rates; and use of a portfolio to fund an award), Other Elements of Evaluation (Age earnings adjustments; fringe benefits; retirement age; LPE method).** Held during the Fall Conference of the American Rehabilitation Economics Association in Sonoma Valley, CA.

October, 1994 — American Rehabilitation Economics Association (AREA), Fall Conference in Sonoma Valley, CA., Sessions Attended: **"Vocational/Economic Interface in Civil Litigation**, Presented by Dr. Barry Ben-Zion, Committee Chairman, Registered Forensic Experts (AREA), and Dr. Robert Male, President of AREA, and Chair of Human Studies and V.P. of Academic Affairs at Marylhurst College. Both have private forensic practices; **"Forensic Parameters of Worklife/Household Service Estimates"** Presented by Dr. Jerald Udinsky, author and private forensic practitioner, and David Toppino, author, forensic practitioner and past president of AREA; **"The Economics of Life Care Planning"**, Presented by David Orlowski, V.P. Internal Affairs (AREA) and forensic private practitioner.

March, 1994 — **"Vocational Evaluation: Testing and Its Implications for the VE,"** Presented by: Dr. Thomas Modahl, Forensic Psychologist in Private Practice, Professor of Psychology at University of Wisconsin-Stout and author of several articles and books on testing, **Seminar Topic: The Critical Vocational Behavior Model, various methods used to determine whether a client is employable, and legal ramifications of testing using norms and statistics in interpretations,** at the **American Board of Vocational Experts** Spring Conference in Tempe/Scottsdale, Arizona.

November, 1993 — **"Vocational and Economic Issues Seminar"**, Presented by: Dr. Everett Dillman, Forensic Economic Consultant, At Large Board Member of the National Association of Forensic Economics, Retired Professor of Business Administration at the **University of Texas** at El Paso, Author or numerous books, articles and computer software programs on those topics; and Dr. Tim Field, a Rehabilitation Consultant, Publisher, and Author of numerous books, articles and computer software programs on vocational and rehabilitation issues, **Seminar Topics: Transferable Work Skills; Vocational & Economic Resources; Estimating Lost Employment; Estimating Lost Earning Capacity; Estimating Future Lost Earnings; and Calculating Economic Damages**. El Paso, Texas.

March, 1993 — **"Forensic Rehabilitation Economics", University of North Alabama,** Office of Continuing Education, presented by Dr. Michael W. Butler, Professor of Economics, President Elect of the American Academy of Economic and Financial Experts, Board Member of the American Rehabilitation Economics Association, Editor of the Journal of Legal Economics. **Seminar Topics Attended: Discount Rates; Wage Forecasts; Life Expectancy; Worklife Expectancy; Real Interest Rates vs. Nominal Rate; Demand for Loanable Funds Theory; Preferred Habitat Theory; and The LPE Method of Worklife Expectancy;** Las Vegas Nevada.

March, 1993 — **American Rehabilitation Economics Association, Annual Symposium**, Las Vegas, Nevada. **Sample of Topics Attended: "Valuing Household Services: The New Cornell Study"** by David Orlowski, CRE, (Certified in Rehabilitation Economics); **"Current Trends Among Traditional Forensic Economists" by** Dr. Michael Butler, Professor of Economics, North Alabama University, President-

Elect of the American Academy of Economic and Financial Experts, Editor of the Journal of Legal Economics; and **"Mobile Vocational Assessment: A Practical Technique"** by Dr. Edward Hester, Industrial Psychologist and President of Hester Evaluations, Inc.; **"The Economic Consequences of Abuse"** by Dr. Robert Male, Adjunct Professor, Portland State University, CRE, President of American Vocational Economics Association and Executive Board Member of American Rehabilitation Economics Association.

April, 1993 — **American Academy of Economic and Financial Experts 5th Annual Meeting**, Las Vegas, Nevada, Joint Session with American Rehabilitation Economics Association, Topic "Communication & Cooperation", facilitated by Dr. Clarence G. Ray, Professor of Economics, University of Nevada, President of the American Academy of Economic and Financial Experts.

October, 1992 — **"Practical Psychiatry for Legal Professionals"**, 92F503, Post Graduate Course, **Harvard Medical School**, Department of Continuing Education, Taught by 27 nationally recognized Psychiatrists and Psychologists, many of whom also held J.D. degrees from law schools, who were professors at Harvard Medical School and Massachusetts General Hospital, Department of Psychiatry, Boston, Massachusetts. Three day Seminar Topics Attended: The Mental Health System: Diagnostic and Treatment Standards; Personality Disorders; Obsessive Compulsive Disorder; Schizophrenia; Crisis Intervention and Civil Commitment; Child Abuse; Mood Disorders; Panic and Anxiety; Psychotherapy; Pain Disorder; Alcohol Abuse; Substance Abuse; The Battered Woman's Syndrome; Head Injuries and Seizure Disorders; Psychological and Neuropsychological Testing; Psychology and Psychobiology of Traumatic Stress; Factitious Disorders; and a special seminar and case discussions on Occupational Stress Disorder.

April & June 1992 — **"Economics for the Vocational Rehabilitation Professional"**, **University of Nevada (UNLV)**, included the following **Topics: "Lost Earning Capacity at Time of Death/Injury" and, "Consumer Price Index: construction and Composition" and, "Issues in Selecting Proper Discount Rate" and, "Valuation of Household Services" and, "Individual Consumption Allowance" and, "Adjusting Awards for Income Taxes" and, "Construction and Use of Electronic Spreadsheets" and, "When the Injured Party Owns a Business"**, by Dr. Terrence M. Clauretie, Professor of Economics (UNLV) and Consulting Forensic Economist; and **"Time Value of Money Fundamentals: Part I and Part II"** by Dr. Robert E. Chatfield, Chairman of the Department of Finance (UNLV), and Consulting Forensic Economist; and **"Using Applied Statistics: Part I and Part II" and, "Issues of Productivity"** by Dr. Thomas Carroll, Professor of Economics(UNLV) and Author of books on Econometrics; and, **"Valuation of Pensions in Divorce Cases"** by Dr. E. William Johnson, Chairman, Division of Business, Shepherd State College, and **"Lost Earning Capacity at Time of Death/Injury"** by Dr. Robert Male, Adjunct Professor, Portland State University, and **"Forum: Analysis and**

**Discussion of Selected Publications" (Topics included The Total Offset Method, The Direct Offset Method, Inflation, Productivity, etc.)** panel/student discussion lead by Dr. Jerry Lynch, Professor of Economics, Purdue University, Dr. Clauretie, Dr.Chatfield, Dr. Carroll, Dr. Johnson, Dr. Male, Dr. Anthony Gamboa, Chief Executive Officer, Vocational Economics, Inc., course through the Division of Continuing Education, Course No. 720E, Section 380, 3 credit Graduate Course. Las Vegas, Nevada.

June, 1992 — **American Vocational Economics Association, Annual Conference**, Las Vegas, Nevada, **Sample of Papers Heard and Discussed: "Methodological Issues: Wage Growth and Interest Rates"** by Dr. Frank Lawlis and Dr. Robert Male; and, **"Translating Damages into Monetary Awards: Some Thoughts on the Total Offset Method"** by Dr. T. Nick Fenger, Dr. Donald R. Vogenthaler and Dr. Richard L. Gibson; and **"Power to Earn and Worklife Expectancy: Foundations of Vocational Economic Loss"**, by Drs. Gibson, Vogenthaler and Fenger, and **"Ordinary and Reverse Tax Effect in Personal Injury and Wrongful Death Cases"** by Drs. Robert J. Alberts, Terrence M. Clauretie and Mel Jameson; and **"A Proposal for the Utilization of Ultimate Worklife Expectancies in Earning Capacity Evaluations"** by Dr. William Houston Reed.

Nov., 1991 — **American Rehabilitation Economics Association, Annual Symposium, Sample of Topics: "Trends in Forensic Vocational Rehabilitation"** by Dr. Tim Fields, Vocational Expert and Publisher; **"Trends in Forensic Economics"** by **Dr. Melvin Fredlund, Former Assistant Professor & Professorial Lecturer in Economics at Wayne State University**, Detroit, Michigan; California State University, Hayward, California; and Golden Gate University, San Francisco, California, and Consulting Forensic Economist,; **"Psychiatric Evidence, Disability and Rehabilitation Economics"** by Dr. Sidney Bolter, M.D.; Hon. Edward Steinman; and Dr. Robert Metcalf, Past President of the American Rehabilitation Economics Association; **"Rehabilitation Economics in Soft Tissue Injury Cases"** by Attorney David Berglund, Economist Robert Johnson; and David Toppino, current President of the American Rehabilitation Economics Association, who collaborated on behalf of a plaintiff's soft tissue case that resulted in a $3 million plus award.

March, 1988 — **American Board of Vocational Experts, Annual Conference**, St. Petersburg, Florida, **Sample of Topics Attended: "Determining Diminished Earning Capacity of Young Children: A Case History from Referral to Court"** by Dr. Bart Hultine, currently Executive Board Member of the American Board of Vocational Experts and former Executive Board Member of the American Rehabilitation Economics Association; **"Ergonomics Quantification of Physical Capacity for Vocational Experts"** by Richard Timming, M.D.; **"Abuse and Misuse of Computer Generated Dictionary of Occupational Titles Data Bases by Vocational Experts"** by David Rollins; **"Earning Capacity: Using Authoritative Resources"**, by Richard Strauss and James Watson; and **"Transferable Skills: A Dichotomy in Practice"** by Don Vander Vegt.

December, 1987 **The 4th National Conference of Expert Witnesses, Litigation Consultants & Attorneys,** Sponsored by the National Forensic Center & the National Forensic Foundation, Atlanta, Georgia, **Sample of Topics Attended: "Vocational Rehabilitation/Forensic Economics Workshop - Assessing Capacity to Perform Work & Earn Money"** by Dr. Anthony M. Gamboa, Jr., Professor of Psychology at the University of Louisville and President Vocational Economics, Inc.; **"Experts' Reports Under a Microscope: A Critical Analysis"** by Professor Oliver C. Schroeder, Jr., Director Emeritus of the Law Medicine Center, Case Western University, Past President of the American Academy of Forensic Sciences and the Forensic Sciences Foundation, Member of Panel of Advisors of the National Forensic Center; **"Vocational Rehabilitation/Forensic Economics Workshop - Life Care Planning"** by Dr. Paul M. Deutsch, President of Paul M. Deutsch & Associates, Inc., author of many books and articles, including A Guide to Rehabilitation and Rehabilitation Testimony.

March, 1987 **American Board of Vocational Experts, Annual Conference**, Cancun, Mexico, **Sample of Topics Attended: "Naturalistic Job Analysis: Proof of Loss of Earnings Capacity for Non-Working Women"** by Dr. Paul Lees-Haley; **"The Vocational Expert in Child Injury Cases"** by Dr. Richard E. Lawrence; **"Cost Analysis in Marriage Dissolutionment"** by Dr. Joyce Puckett; **"Disability Management Program"** by Kenneth Ogren and Mike Dreiling; and **"Trial Simulation Software"** by Dr. Everett Dillman.

## PUBLISHED BOOK:

March, 1998 — **The ABCs of Rehabilitation Economics**, Co-Authored by David C. Toppino, M.A.; William Houston Reed, Ph.D.; and, Joseph Agrusa, M.S., "The Professional Reader Series", Volume 2, Number 4, 1998, published by Elliott & Fitzpatrick, Inc.

## PAPERS WRITTEN and/or PRESENTED:

May, 2001 — **"Determining Earning Capacity Mitigation"**, William Houston Reed, Ph.D.; Lindette L. Mayer, Ph.D.; David Toppino, MA, MS (economics), Dr. Reed presented sections on the proper use of the Veterans' Disability Schedule and the Social Security Disability Model in Personal Injury, Workers Compensation and/or Wrongful death cases, AREA, Annual Spring Conference, Reno, NV.

March, 1994 — **"A Primer on Vocational Economics"**, Panel Member Presented sections on Worklife Expectancy estimates and Household Services assessment and calculation in earning capacity evaluations, **presented by Dr. William Houston Reed**, Joint Session of American Rehabilitation Economics Association and American Board of Vocational Experts, Annual Spring Conference, Tempe/Scottsdale, Arizona.

June, 1992 — **"A Proposal for the Utilization of Ultimate Worklife Estimates in Earning Capacity Evaluations", written by Dr. William Houston Reed**, American Vocational Economics Association, Annual Conference, Las Vegas, Nevada.

Nov, 1991 — **"How to Integrate Vocational Rehabilitation Expertise and Economic Calculation Methodology to Produce Comprehensive Earning Capacity Evaluations", written by Dr. William Houston Reed**, American Rehabilitation Economics Association, Annual Symposium.

March, 1987 **"The Current Technological Tools of the Vocational Expert Trade",written by Dr. William Houston Reed**, American Board of Vocational Experts, Annual Conference, Cancun, Mexico.

## TEACHING EXPERIENCES:

**Mock Social Security Disability Hearings:**

After every mock hearing that Dr. Reed participates in as a Vocational Expert he gives instruction in the form of constructive criticisms and teaches proper hypothetical questioning techniques to elicit informative testimony about vocational disability issues.

February, 2003 — **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law Judge Bukes attended by law student representatives. Dr. Reed was the Vocational Expert on the cases. 2 hours.

February, 2002 — **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law Judge Bukes attended by law student representatives: Tamara Broadus, Matt Gisler, Chrissie Cianflone and Hagen Starz. Dr. Reed was the Vocational Expert on the cases. 2 hours.

October, 2001 — **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law Judge Hatfield and attended by law student representatives: Norm Sawyer, Jason Miller, Bob Reufle (Claimant Actor), Kirsten Erickson, Jessica Ellel, and Shirley Ratner (Claimant Actor). Dr. Reed was the Vocational Expert on the cases. 2 hours.

February, 2001 — **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law Judge Hatfield attended by law student representatives: Tony, Nat and George Digman (Claimant Actor). Dr. Reed was the Vocational Expert on the case. 1 hour.

September, 2000 — **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law Judge Harner and attended by law student representatives: Ben Buckles, Brian Bluth, Wendy Zeltzer and Sandy Miller. Dr. Reed was the Vocational Expert on the cases. 2 hours.

February, 2000 — **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law

Judge Smith and attended by law student representatives: Steve, Hyun, Tonya, and Joe. 2 hours.

September, 1999 **"Mock Social Security Disability Hearing"**, with the **University of Pittsburgh, School of Law, Health Law Clinic**, held at the Office of Hearings and Appeals, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. The hearing was conducted by Administrative Law Judge Bukes and presented by law student representatives: Kelly, Eunice, Jennifer and Eleanor. 2 hours.

February, 1999 **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic**, arranged by Ms. Stella L. Smetanka, Clinical Associate Professor of Law. Hearing conducted by Administrative Law Judge Smith and attended by law student representatives: Stephen Cotter, Michael Hennen, Susan Stitt, and Romin Currier. 2 hours.

February, 1998 **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic**, arranged by Ms. Stella L. Smetanka and Karen Engro, Assistant Clinical Professors of Law. Hearing conducted by Administrative Law Judge Bergstrom and attended by law student representatives. 2 hours.

October, 1997 **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic**, arranged by Ms. Stella L. Smetanka and Karen Engro, Assistant Clinical Professors of Law. Hearing conducted by Administrative Law Judge Michael Colligan and attended by law student representatives Emeka Amanze, Carole Tino, Chris Hildebrandt, Vanessa Wallace. 2 hours.

February, 1997 **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic**, arranged by Ms. Stella L. Smetanka and Karen Engro, Assistant Clinical Professors of Law. Hearing conducted by Administrative Law Judge Bergstrom and attended by law student representatives. 2 hours.

September, 1996 **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic**, arranged by Ms. Stella L. Smetanka and Karen Engro, Assistant Clinical Professors of Law. Hearing conducted by Administrative Law Judge and attended by law student representatives. 2 hours.

November, 1995 **"Mock Civil Litigation - Medical Malpractice Trial"**, at the **University of Pittsburgh, School of Law, Health Law Clinic,** arranged by Ms. Stella L. Smetanka and Karen Engro, Assistant Clinical Professors of Law. Trial conducted by Allegheny County Court of Common Pleas Judge, 4 law students for the defense and 2 for the plaintiff. Dr. Reed enacted the part of a testifying doctor regarding the malpractice of a certified nurse midwife. Several days of preparation and pre-trial conference teaching and two days of testimony.

October, 1995 — **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic**, arranged by Ms. Stella L. Smetanka and Karen Engro, Assistant Clinical Professors of Law. Hearing conducted by Administrative Law Judge Alma DeLeone, law student representatives Paula and J. Jones. Dr. Reed was the Vocational Expert on the case. After the mock hearing Dr. Reed and Judge Harner gave constructive criticisms and taught proper techniques. 2 hours.

February, 1995 — **"Mock Social Security Disability Hearing"**, at the **University of Pittsburgh, School of Law, Health Law Clinic,** arranged by Ms. Stella L. Smetanka, Assistant Clinical Professor of Law. Hearing conducted by Administrative Law Judge Alma DeLeone, law student representatives David Hart and Angela Popp. 2 hours.

March, 1993 — **"Intermediate Rehabilitation Economics"**, Earning Capacity Institute, **Dr. Reed was Faculty Instructor and taught the following topics: Traditional vs. Ultimate Worklife Expectancy Estimates for Earning Capacity Evaluations; Benefits: Total Compensation Percentage vs. Percentage of Wage Paid in Benefits**, for 10 practicing professionals in Las Vegas, Nevada.

January, 1993 — **"Introduction to Rehabilitation Economics"**, Earning Capacity Institute, **Dr. Reed was Faculty Instructor and taught the following topics: Resources for Life Expectancy; Worklife Expectancy; Wage Forecasts; Discount Rates; Interest Rates; Transferable Work Skills; and Alternative Work;** for 20 practicing professionals, Chicago, Illinois.

October, 1986 — **"The Vital Role of the Vocational Expert Witness"**, Allegheny County Bar Association, Social Security Disability Law, Bridge-The-Gap Seminar Series for Social Security Attorneys/Practitioners, Other Members/Presenters included: Administrative Law Judge in Charge of Pittsburgh Office, Philip Lawton Moore: United States Magistrate for the Western District of Pennsylvania, Ila Jean Sensenich; Medical Advisor, Dr. Alan J. Barnett and Social Security Attorney Cynthia Berger.

January, 1984 — **"How to Utilize Vocational Expert Testimony"**, Allegheny County Bar Association, Social Security Practitioners Group, Lecture Presentation. Dr. Reed taught attorney practitioners how to effectively integrate medical opinion and claimant testimony to create meaningful hypothetical questions that address the vocational disability issues.

## HONORS

By: **The Library of Congress**, National Referral Center, Science and Technology Division, **Listed as a Vocational Expert and a national resource with specialized knowledge.**

**The Library of Congress**, National Distinguished Service Registry; Counseling and Development; **Listed as a Distinguished Counseling Professional** in recognition of contributions to the field of counseling.

**The Department of Health and Human Services, Social Security Administration**, Office of Hearings and Appeals, **adjudged a qualified Vocational Expert Witness** to testify at disability hearings.

**The United States of America, Railroad Retirement Board**, Bureau of Hearings and Appeals, **adjudged a qualified Vocational Expert Witness** to testify at disability hearings.

**American Rehabilitation Economics Association**, Professional Advisory Board Member, Vice-President and Editor of Publications, 1988 — May, 1993.

**The American Board of Vocational Experts**, Professional Advisory Board Member, 1987-88.

**The Commonwealth of Pennsylvania, Governor's Board of Pardons**, Letter of Commendation from Commissioner of Correction for exemplary performance and deportment when presenting pleas for clemency as a Pardons Case Representative before Lt. Governor.

**The University of Pittsburgh, School of Education**, Departments of: Counselor Education; Special Education and Rehabilitation; and Educational Administration each offered full graduate status in their respective doctoral programs.

**Point Park College**, Board of Trustees Member, June, 1984 to June, 1987.

**RESUME**

William Houston Reed, Ph.D., CRE

10/83 to present **REHABILITATION ECONOMIST; VOCATIONAL EXPERT; DISABILITY CONSULTANT** **PRIVATE PRACTICE**

Provide evaluations and, if necessary, testimony regarding the injured and/or disabled. Through law firms, provide vocational evaluation of pre-injury skills, transferable skills, areas of possible employment with probable wages, and economic calculations of future wage loss or gain, and perhaps costs of rehabilitation and life care. As a "friend of the court" impartial Vocational Expert Witness have provided testimony in thousands of disability hearings at the Social Security Administration's Office of Hearings and Appeals.

11/81 to 10/83 **OCCUPATIONAL PLACEMENT SPECIALIST/ REHABILITATION CONSULTANT** **NATLSCO REHABILITATION MANAGEMENT, INC.**

As Certified Rehabilitation Counselor, provided medical and vocational rehabilitation case management for disabled workers. Goal was to rehabilitate disabled workers to their optimal post-injury level. Accomplished by using: planning, research, counseling, management, guidance and job placement skills. Tasks included: presentation and interpretation of job characteristics to physicians to aid their determination of residual functional capacities (RFC), or work restrictions; identification of jobs within the workers RFC; interpretation of the workers abilities and disabilities to employers to aid identification of possible jobs for injured workers; determination of vocational training and career change options by gathering and analyzing forecast information from *Occupational Outlook Handbook*, Bureau of Employment Security data, private industry sources, etc.; determination of earnings, number employed, projected openings, etc.; and by conducting job searches and placement of injured workers in new jobs.

3/79 to 11/81 **VOCATIONAL CONSULTANT/EXPERT WITNESS** **U.S. GOVERNMENT**

Contracted with the Federal Government to provide Vocational Expert Witness testimony for the Social Security Administration's Office of Hearings and Appeals. Reviewed medical, employment and judicial records to determine the level of residual functional capacity (RFC) of claimant and transferable skills, if any, to another job. Used Dictionary of Occupational Titles, other source materials and personal knowledge to provide employment data.

9/73 to 3/79 **VOCATIONAL SCHOOL GUIDANCE COUNSELOR** **SCI, Pittsburgh**

Conducted professional interviews to advise and counsel pupils on school adjustment and career plans, especially as applies to disadvantaged populations; provided professional counseling services to aid students in personality and social adjustments; administered, scored and interpreted aptitude, intelligence and personality tests; established and maintained effective working relationships with pupils and other members of the staff, outside agencies and the general public. Designed and implemented procedures for program evaluations. Counseled students involved in: Adult Basic Education, Vocational Courses, General Educational Development,

Community College of Allegheny County and the University of Pittsburgh. I was Certified in Elementary and Secondary Guidance Counseling. Before retiring from State service, became Acting Vocational/Academic Education Director.

11/71 to 9/73 **VOCATIONAL EDUCATION PROGRAM SPECIALIST** **SCI, Pittsburgh**

Prepared proposals, budgets and reports required by Federal, state and private funding sources. Contacted various governmental agencies and researched source documents to determine which trades were to be in demand in the future for this geographic area; developed an educational/vocational philosophy that complimented the unique setting of an institution; stimulated participation of business organizations, labor unions and civic groups to aid program; provided job leads for graduated students and established relations for further training in the community; conducted statistical studies to determine success of the program; direct supervision of seven (7) instructors and ninety to one hundred and fifty (90-150) students.

3/71 to 11/71 **DISTRIBUTIVE EDUCATION ADVISOR** **SCI, Pittsburgh**

Responsible for program development for disadvantaged population who would have special problems in attaining economic and social development. My employment status changed from independent services contractor to state civil service employee. Additional duties included development of a social training segment to supplement the vocational programs; established education as a treatment tool equal with other rehabilitative programs. Supervised staff of five (5) workers.

2/70 to 3/71 **VOCATIONAL COORDINATOR** **SCI, Pittsburgh**

Created vocational training programs; coordinated efforts of all other institutional training sources (industrial plant, work crew foremen, etc.); established community public relations to extent that business organizations and labor unions participated in development of programs by donating time, materials, and money.

10/69 to 1/70 **SUBSTITUTE TEACHER** **PITTSBURGH PUBLIC SCHOOLS**

Provided initial teaching and educational management experience. The constant variety of classes and schools was invaluable training for future roles as teacher, supervisor, counselor, and administrator.

2/69 to 10/69 **EMPLOYMENT COUNSELOR** **AMERICAN BUSINESS CENTER**

Had responsibilities for creating job orders from business community and placement of job seekers. Became familiar with organizational structures and procedures: hiring processes; pay ranges; fringe benefits; advancement structure; job duties/responsibilities and executive decision-making rationale. Serviced needs of clients that ranged from unskilled high school "dropouts" to college graduate corporate executives.

## CURRICULUM VITAE

**Bachelor's Degree Courses** in Business Administration in part included:
A minor concentration in **economics including; Macro Economics, Micro Economics and Managerial Economics.**

**Master's Degree Courses** in Vocational Distributive Education in part included:
**Methods of Work Supervision; Organization and Coordination of Vocational Education; Methods of Adult Training; and Research Methodology**.

**Doctor's Degree Courses** in Specialized Professional Development
**Rehabilitation, Counseling, Statistical Analysis, Research Methodology, Special**

**Education Issues and Social Systems and the Disabled,** and contained the following courses:

**INTRODUCTION TO REHABILITATION** — A lecture oriented course which used readings to stimulate class discussion.

Readings included: A. S. Desimone, *The Role of The Rehabilitation Services Administration in Serving the Disabled Poor*; Kershaw, *Government Against Poverty: Report of the National Advisory Committee on Civil Disorder*; Borow, *Man in a World at Work*; McGowan and Porter, *An Introduction to the Vocational Rehabilitation Process*; W. L. Slocum, *Occupational Careers*; Sussman, *Sociology and Rehabilitation*; Malikin and Rusalem, *Vocational Rehabilitation of the Disabled*; Szasy, "The Myth of Mental Illness:," *American Psychologist*, Vol. 15, 113-118; Murthard and Solomone, *The Roles and Functions of the Rehabilitation Counselor*; Goldin and Perry, *Dependency and Its Implications for Rehabilitation*; Roth and Eddy, *Rehabilitation for the Unwanted.*

**SURVEY OF SPECIAL EDUCATION AND REHABILITATION** — A lecture and seminar course.

Readings included: Stevens, *Taxonomy in Special Education for Children with Body Disorders*; Kirk, *Educating Exceptional Children*; Hodgson, "Special Education — Facts and Attitudes." *Exceptional Children*, 30, 196-201; Willover, "Special Education: Organization and Administration" *Exceptional Children*, 36, 591-594.

**ADMINISTRATION OF SPECIAL EDUCATION** — Designed to give students experiences as administrators through the use of reality based simulator and training materials.

Readings included: Stevens, Sterrett and Woods, *Development of a Reality-Based Simulator for In-service Training of Special Education Leadership Personnel in Intermediate Units in Pennsylvania.*

**COUNSELING THEORY** — Areas of concentration: History; Current Trends; Future Trends; and Integration and Recommendations.

Readings included: Slovenko, *Psychiatry and Law.*

**GROUP SUPERVISION OF INDIVIDUAL COUNSELING** — 3 segments: faculty supervised group participation of individual counselor-client tape recorded counseling sessions; a triadic supervision model and development and implementation of a pre-practicum experience for Master's students. Readings included: Robert Goldhammer, *Clinical Supervision.*

**SUPERVISION THEORY** — Group oriented and designed to aid individuals with development of their personal Theory of Supervision.

Readings included: Hogan, *Issues and Approaches in Supervision*; Delaney, *A Behavior Model for the Practicum Supervision of Counselor Candidates*; Hoegh, *Understanding the Motivation of Counselors and Supervisors in Checking Barriers of Dependency*; Hogan, *Clinical Supervision.*

**PERSONALITY THEORY** — Major theme was "Individual v. Collective" Readings included: E. Fromm, *Sigmund Freud's Mission*; E. A. Bennet, *What Jung Really Said*; Sherman, *On the Psychology of Women*; Freud, *New Introductory Lectures on Psychoanalysis*; Sullivan, *The Interpersonal Theory of Psychiatry.*

**GROUP COUNSELING** — Consisted of 3 segments: group theory; class participatory Bion groups and acting as group leader for Transactional Analysis.

Readings included: Parloff, *Analytic Group Psychotherapy*; Gazda, *Innovations to Group Psychotherapy*; Bion, *Experiences in Groups and Other Papers*; Bowen, *Differentiation of Self in One's Family*; Berne, *Principle of Group Treatment*; Yalom, *The Theory and Practicum of Group Psychotherapy.*

**STATISTICS** — Methods of Research, and Educational Inquiry.

**INDIVIDUAL SUPERVISION OF PRACTICUM SUPERVISION** — Supervision of the individual counseling sessions of 2 Master's students.

**FIELD SUPERVISION PRACTICUM** — Supervision of a Master's student practicum.

**SUPERVISION OF INDIVIDUAL COUNSELING** — Continuation of supervision of one Master's student who elected to continue counseling after her practicum had ended.

**INDEPENDENT STUDY** — 2 Segments: Educational Planning and Implementation of a Planning System.

Readings included: Star, *The Structure of Human Decisions*; Cleland and King, *Systems Analysis and Project Management; Program Evaluation and Review Technique.*

**SOCIAL SYSTEM** — 3 Segments: Study of program development while involved in the program; manipulation of the program and realization of one's effect on the system from within.

Readings included: Loomis, *Social Systems*; Lasswell, *Pre-View of Policy Sciences*; Schein, *Process Consultation*; Bechard, *Organizational Development: Strategies and Models*; Bennis, *Organizational Development: Its Nature, Origins and Prospects.*

**SOCIAL SYSTEMS** — A workshop designed to aid class members in developing their "mapping" of the social system that they chose to study.

**SOCIAL SYSTEMS** — A symposium. Readings included: Berger & Luckmann, *The Social Construction of Reality*; Arendt, *The Human Condition*; Bernstein, *Praxis and Action*.

## THESIS AND DISSERTATION TITLES

### MASTER'S THESIS:

"A Survey of Students, Teachers and Employers Regarding the Effectiveness of Vocational Distributive Education in Pittsburgh Public Schools."

### DOCTORAL DISSERTATION:

"The Differential Effect of a Vocational Training Program and a Group Therapy Program on the Frequency of Misconduct of Inmates in a State Correctional Institution."

## DESCRIPTION OF CERTIFICATION

**Certified in Rehabilitation Economics** (CRE), No. 9004, **American Rehabilitation Economics Association.**

**Standards:** Certification in Rehabilitation Economics required a graduate degree in related field of study; certification from another nationally recognized professional organization in Economics or Rehabilitation or Vocational Evaluation; at least 3 years of professional work experience in the field of Forensic economics; transcript(s) of graduate degree(s); 3 letters of recommendations from professionals who know your work; two Forensic work products illustrating competency in rehabilitation economics; and at least 15 hours of continuing professional education annually.

**Essential Performance Areas:** The work products must include analysis of: Transferable skills; past and future wage loss (gain); loss of household services; life care expenses; and discounting to present value. The applicant also had to make an oral defense of the work products before the certification board.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| | ) | NO. 03-1268 CD |
| Plaintiffs, | ) | JURY TRIAL DEMANDED |
| vs. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that the Motions of Defendant Dr. Kruszewski in the above-referenced matter was served by Regular Mail at State College, Pennsylvania, this 19th day of June, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

MOTION TO REQUEST ACCOMMODATIONS WITH RESPECT TO ORDER OF COURT DATED JUNE 14, 2006

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.


COUNSEL:
Robert P. Ging, Jr., Esquire
Victor H. Pribanic, Esquire
John W. Blasko, Esquire

Counsel of Record for This Party:

David R. Johnson, Esquire
PA I.D. #26409

Thomas B. Anderson, Esquire
PA I.D. #79990

THOMSON, RHODES & COWIE, P.C.
Firm #720
1010 Two Chatham Center
Pittsburgh, PA 15219

(412) 232-3400



FILED NO CC
m/ 11:18 BC
JUN 22 2006

William A. Shaw
Prothonotary/Clerk of Courts

MOTION TO REQUEST ACCOMMODATIONS WITH RESPECT TO ORDER OF COURT DATED JUNE 14, 2006

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and requests that the court approve certain accommodations to this defendant with regard to the order of court dated June 14, 2006 for the reasons set forth below:

1. This defendant received an order of court dated June 14, 2006 scheduling a settlement conference in the above matter for July 14, 2006.

2. Undersigned counsel had previously planned to be on vacation between July 13, 2006 and July 17, 2006 for a trip to Illinois. Additionally, the PMSLIC claims representative for this defendant, Stephanie Chelius, will be away on vacation during the week of the conference.

3. Undersigned counsel can provide an attorney to attend the settlement conference who will be fully apprised of all relevant issues and who will have the same ability to participate in settlement discussions as undersigned counsel.

4. Additionally, an alternative PMSLIC representative possessing whatever settlement authority Ms. Chelius would have (if any) can be made available by telephone at the time of the conference.

5. For the above reasons, this defendant respectfully requests that the court enter an order permitting attendance of substitute counsel at the settlement conference and permitting the PMSLIC representative to be available by telephone.

WHEREFORE, defendant respectfully requests that the court enter the attached order.

Respectfully submitted,

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

**CERTIFICATION OF SERVICE**

I hereby certify that a true and correct copy of the within MOTION TO REQUEST ACCOMMODATIONS WITH RESPECT TO ORDER OF COURT DATED JUNE 14, 2006 has been served upon the following counsel of record and same placed in the U.S. Mails on this 20th day of June, 2006:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424

Victor H. Pribanic, Esquire
Pribanic & Pribanic
1735 Lincoln Way
White Oak, PA 15131

John W. Blasko, Esquire
McQuaide Blasko Schwartz Fleming & Faulkner, Inc.
811 University Drive
State College, PA 16801

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| | ) | No. 03-1268 CD |
| Plaintiffs, | ) | |
| vs. | ) | |
| MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

ORDER OF COURT

AND NOW, this _____ day of _____, 2006, it is hereby ordered that the court's previous order of June 14, 2006 is supplemented as follows:

1. Substitute counsel may appear for David R. Johnson.

2. A representative of PMSLIC Insurance Company (the insurer for DRMC) shall be available by telephone.

BY THE COURT:

_____J.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

v.

MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

CASE NO.: 03-1268-CD

**MOTION TO MODIFY JUNE 16, 2006 ORDER OF COURT**

Filed on behalf of Plaintiffs: Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades

Counsel of Record for this Party:

Victor H. Pribanic
Pa. I.D. No.: 30785

PRIBANIC & PRIBANIC, L.L.C.
1735 Lincoln Way
White Oak, PA 15131

(412) 672-5444

**JURY TRIAL DEMANDED**

FILED 2cc Atty Pribanic
m 11:18 BY
JUN 26 2006
William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| | ) | CASE NO.: 03-1268-CD |
| Plaintiffs, | ) | |
| v. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**MOTION TO MODIFY JUNE 16, 2006 ORDER OF COURT**

AND NOW, come the Plaintiffs, Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades, by and through their counsel, Victor H. Pribanic and the law firm of Pribanic & Pribanic, L.L.C., and Robert P. Ging, Jr., and file the within Motion to Modify June 16, 2006 Order of Court, and in support thereof aver as follows:

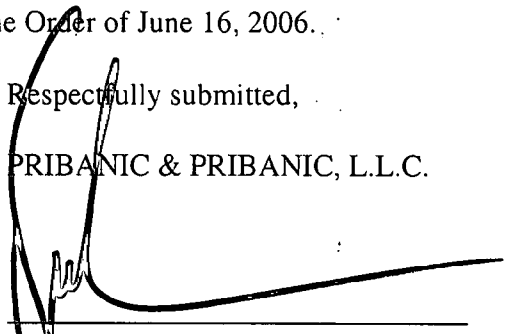
1. The Plaintiffs are in receipt of this Court's Order of June 16, 2006, a copy of which is attached.

2. The Plaintiffs do not intend to call and will not utilize the testimony of Frederick Gonzales, M.D. at the trial of this matter in any fashion.

WHEREFORE, Plaintiffs respectfully request that the Court enter an Order excluding Frederick Gonzales, M.D. from the application of the Order of June 16, 2006.

Respectfully submitted,

PRIBANIC & PRIBANIC, L.L.C.

By: 

Victor H. Pribanic
1735 Lincoln Way
White Oak, PA 15131
(412) 672-5444

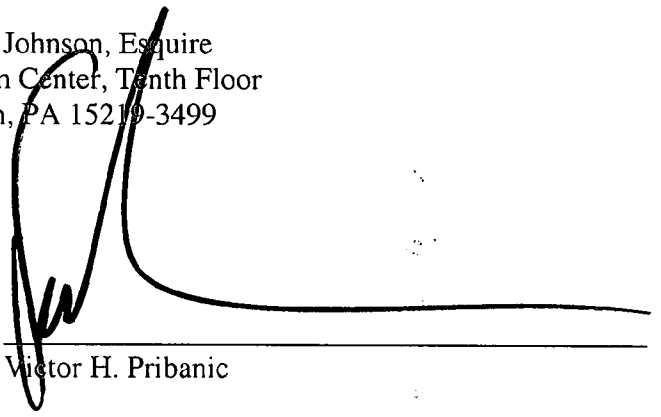
Counsel for Plaintiffs, Dennis R. and Kimberly Rhoades, individually and as personal representatives of the Estate of Mikayla Rhoades

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing has been served via first class United States mail, postage prepaid, this 23rd day of June, 2006, upon the following:

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499



Victor H. Pribanic

6114

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

DENNIS R. and KIMBERLY RHOADES *
individually and as personal representatives *
of the ESTATE OF MIKAYLA RHOADES, *
Plaintiffs *
vs. * NO. 03-1268-CD
MARY C. KRUSZEWSKI, D.O. and *
DuBOIS REGIONAL MEDICAL CENTER, *
Defendants *

I hereby certify this to be a true and attested copy of the original statement filed in this case

JUN 19 2006

Attest.

Prothonotary/
Clerk of Courts

**ORDER**

NOW, this 16th day of June, 2006, it is hereby ORDERED:

1. That Defendant, Mary C. Kruszewski, D.O. shall produce within thirty (30) days the following:

a) The percentage of the income of Dr. O. Richard Depp, III and Dr. William W. Fox which involves medical-legal cases relating to the delivery of a child and post-delivery care for the period from 2003 to date.

b) The amount of the fees paid to Dr. O. Richard Depp, III and Dr. William W. Fox for appearing and testifying in this case.

c) Any relationships of Dr. O. Richard Depp, III and Dr. William W. Fox with defense counsel and his firm.

d) Any relationship between Dr. Mary Kruszewski and Dr. O. Richard Depp, III and Dr. William W. Fox.

e) The number of medical malpractice cases in which Dr. O. Richard Depp, III and Dr. William W. Fox have reviewed and testified at trial or deposition for defense counsel and his firm, for the period from 2003 to date.

f) The percentage of medical malpractice cases which Dr. O. Richard Depp, III and Dr. William W. Fox have reviewed for other defense law firms, and/or medical malpractice insurance carriers.

g) The percentage of all cases reviewed by Dr. O. Richard Depp, III and Dr. William W. Fox on behalf of Plaintiffs and/or Plaintiff law firms compared to the percentage of cases reviewed on behalf of Defendant healthcare providers and/or their attorneys.

2. Copies of any and all articles authored, in whole or in part, by either Dr. O. Richard Depp, III or Dr. William W. Fox, on the subject of medical malpractice over the last three years.

3. The Plaintiffs, Dennis and Kimberly Rhoades, shall provide within thirty (30) days all the same type of information required to be produced by the Defendant, Mary Kruszewski, D.O. under Paragraph 1 a, b, c, d, f and g of this Order, for their experts, James Mollick, M.D., Frederick Gonzales, M.D. and William H. Reed.

4. In the event there is a failure to comply with this Order, the Court upon motion may consider appropriate jury instructions on same or other sanctions.

BY THE COURT,

/s/ Fredric J Ammerman

FREDRIC J. AMMERMAN
President Judge

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | CIVIL DIVISION |
| Plaintiffs, | ) | CASE NO.: 03-1268-CD |
| v. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**ORDER OF COURT**

AND NOW, to-wit, this ____ day of _____, 2006, it is hereby ORDERED that the Plaintiffs need not comply with the terms of this Court's Order of June 16, 2006, in respect to Frederick Gonzales, M.D. Frederick Gonzales, M.D. may not be used as a witness by the Plaintiffs in this matter.

BY THE COURT:

_____, J.

CA

IN THE COURT OF COMMON PLEAS

OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

FILED
0/11:42cm
JUN 26 2006
William A. Shaw
Prothonotary

cc Attys: Johnson Blasko Pribanic G.ng

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES | : | |
| -vs- | : | No. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DUBOIS REGIONAL MEDICAL CENTER | : | |

O R D E R

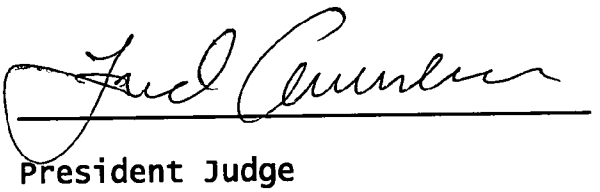
NOW, this 23rd day of June, 2006, in consideration of the Motion to Request Accommodations with Respect to Order of Court dated June 14, 2006, filed on behalf of DuBois Regional Medical Center, it is the ORDER of this Court as follows:

1. Substitute counsel may appear for David R. Johnson, Esquire. Substitute counsel will be fully apprised of all relevant issues, and will have the same ability to participate in settlement discussions as Attorney Johnson;

2. An alternate PMSLIC claims representative may appear for the insurance company. The claims representative will appear at the settlement conference in

person. The request for a PMSLIC representative to be available only by telephone is denied.

BY THE COURT,



President Judge

DATE 6-26-06

____ You are responsible for serving all appropriate parties.

__X__ The Prothonotay's office has provided service to the following parties:

____ Plaintiff(s) __X__ Plaintiff(s) Attorney ____ Other

____ Defendant(s) __X__ Defendant(s) Attorney

____ Special Instructions:

FILED

JUN 26 2006

William A. Shaw
Prothonotary

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | * | |
| vs. | * | NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., DuBOIS REGIONAL MEDICAL CENTER, Defendants | * | |

**ORDER**

NOW, this 22nd day of June, 2006, the Court being in receipt of a letter from Defendant's counsel, John W. Blasko, Esquire, requesting Dr. Kruszewski be excused from attending the scheduled settlement conference on July 14, 2006, due to the fact she has given absolute written consent/authority to her insurance carrier to settle the matter. In light of this information, it is the ORDER of this Court that Mary C. Kruszewski, D.O. is excused from attending the said scheduled settlement conference on July 14, 2006.

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge

FILED
01:24 BL
JUN 26 2006

William A. Shaw
Prothonotary/Clerk of Courts

1CC Attys:
R.Ging
V. Pribanic
J. Blasko
D. Johnson

FILED

JUN 26 2006

William A. Shaw
Prothonotary/Clerk of Courts

DATE: 6/26/06

____ You are responsible for serving all appropriate parties.

__X__ The Prothonotay's office has provided service to the following parties:

____ Plaintiff(s) __X__ Plaintiff(s) Attorney ____ Other

____ Defendant(s) __X__ Defendant(s) Attorney

____ Special Instructions:

CA

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

**MEDICAL PROFESSIONAL LIABILITY ACTION**

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**MOTION IN LIMINE TO PRECLUDE TESTIMONY OF THE DEFENDANT'S EXPERTS DR. WILLIAM W. FOX, AND DR. RICHARD DEPP, WHICH CONTRADICTS THE PATHOLOGIST AND NEUROPATHOLOGIST WHO CONDUCTED THE AUTOPSY REPORT**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

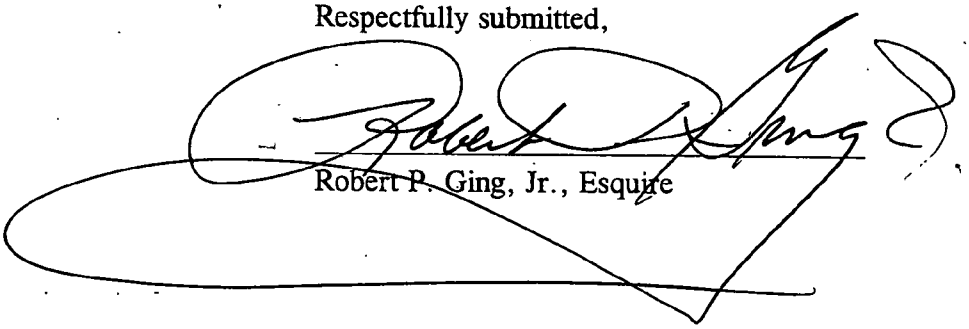
VICTOR H. PRIBANIC, ESQUIRE
SUPREME CT. No. 30785
1735 Lincoln Way
White Oak, PA 15131
(412) 672-558

FILED NO CC
m/11:24 BL
JUL 06 2006
William A. Shaw
Prothonotary/Clerk of Courts

# NOTICE TO PLEAD

Please take notice that the attached pleading may require a response to be made by you, so as to protect your rights. Please file a responsive pleading in the time and manner provided by law.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**MOTION IN LIMINE TO PRECLUDE TESTIMONY OF THE DEFENDANT'S EXPERTS, DR. WILLIAM W. FOX, AND DR. RICHARD DEPP, WHICH CONTRADICTS THE PATHOLOGIST AND NEUROPATHOLOGIST WHO CONDUCTED THE AUTOPSY REPORT.**

AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and set forth the following Motion in Limine to Preclude the Testimony of Dr. William W. Fox and Dr. Richard Depp.

1. Defendant has identified William W. Fox, a pediatrician and Richard Depp, an Ob/Gyn as individuals who may testify as experts on her behalf in the above captioned case. A copy of the reports of Drs. Fox and Depp are attached hereto, as Exhibits 1 and 2.

2. Both Dr. Fox and Dr. Depp conclude that Mikayla Rhoades was born critically ill and "appeared" to be in septic shock. Dr. Depp opined that the infant's death was inconsistent with hypoxia, arising in labor, and more consistent with infection and its consequences.

3. Neither Dr. Depp nor Dr. Fox, according to the curriculum vitaes provided by the Defendant's counsel, are qualified as a pathologist or neuropathologist by training or speciality. A copy of the curriculum vitae of Drs. Depp and Fox are attached as Exhibits 3 and 4.

4. The trial depositions of Dr. Ranganathan, M.D., a pediatric pathologist, and Dr. Ronald L. Hamilton, M.D., a neuropathologist were taken in the above captioned case. Dr. Ranganathan and Dr. Hamilton were the attending pathologists who performed the autopsy.

5. Dr. Hamilton testified, consistent with the autopsy report, that he performed both gross and microscopic neuropathology testing on the deceased infant. His microscopic neuropathological examination showed severe acute ischemic damage in neurons in nearly all areas of the brain and nearly all areas of the cerebral cortex. His final diagnosis was acute ischemic encepalopathy severe.

6. Dr. Ranganathan testified, consistent with the autopsy report, that he performed the autopsy procedure, and that based upon that procedure he concluded, as the attending pathologist, that the most significant finding was severe hypoxic encepalopathy most likely due to perinatal asphyxia. He also found congestion of the organs with hypoxic changes in the cardiac muscle, in the liver, and in other organs.

7. Dr. Ranganathan specifically found that there were no significant infections or congenital anomalies noted at autopsy.

8. Dr. Ranganathan found that the cause of death was acute ischemic and hypoxic encepalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor.

9. Dr. Ranganathan found that there was no evidence of chorioamnionitis in the placenta.

Dr. Ranganathan also found that the neurology impression of Dr. Hamilton was severe perinatal total asphyxia.

10. Despite the findings of the two attending pathologists, Dr. Fox steps outside of his specialty, and in his report suggests that the baby appeared to be in septic shock. This hypothesis in Dr. Fox's report requires him to render opinions outside of his speciality as a pediatrician and clearly contradictory to the testimony of the attending pathologist and neuropathologist.

11. Dr. Fox hypothesizes that there is no other explanation in Mikayla's case for her condition except for sepsis, again contradicting the findings of the attending pathologist and neuropathologist, and rendering opinions outside of his area of specialization..

12. Dr. Depp likewise steps out of his area of specialization, as an OB/GYN, and despite admitting in his report (page 5) that there is no evidence of chorioamnionitis, and his agreement that the autopsy indicates a full term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic ischemic encepalopathy (page 6) opines that Mikayla was "not severely asphyxiated" (page 7, paragraph 8), and that corioamneonitus and associated fetal infection were the likely causes of the infant's neonatal condition.

13. Dr. Ranganathan specifically testified that there was no evidence of virus or infection in the infant based upon the autopsy.

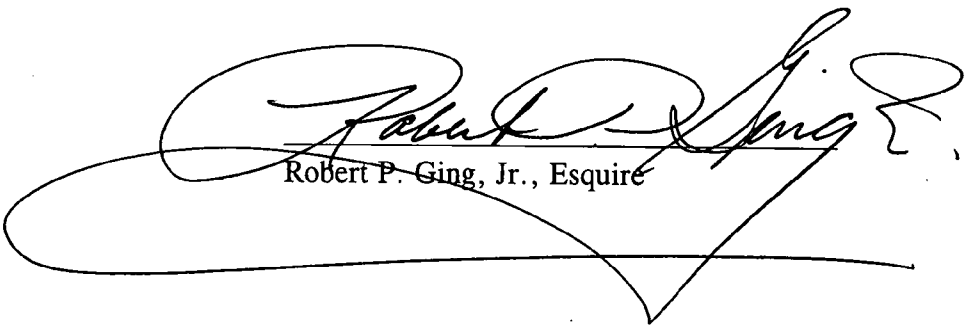
14. Section 512 of the M-Care Statute, 40 P.S. §1303.512( c)(2) prohibits a person from being competent or offering an expert medical opinion in a medical professional liability action unless that individual practices in the same sub-speciality or a sub-speciality which has a substantially similar standard of care for a specific care at issue. Although sub-section ( c)(2) addresses standard of care, sub-section (b) indicates that an expert testifying on a medical matter

including causation must meet that qualification.

15. Neither Dr. Depp nor Dr. Fox are pathologists, nor do their curriculum vitaes indicate that they are trained as pathologists, and thus under the M-Care Act they would be precluded from offering opinions contrary to those of the pathologist and neuropathologist as set forth in the autopsy report.

WHEREFORE, this Honorable Court is requested to enter the attached Order.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

# EXHIBIT 1

MAR 2 0 2006

March 7, 2006

Mr. John Blasko, Esquire
McQuaide, Blasko
811 University Drive
State College, Pennsylvania 16801-6699

Re: Rhoades vs. Kruszewski, et al

Dear Mr. Blasko:

I have reviewed records on the case of Rhoades vs. Dr. Kruszewski, et al. These include the following:

1. Duboise Regional Medical Center Records 5/10/02 to 5/11/02 of the mother;
2. DRMC records, 5/10/02 to 5/11/02, the baby;
3. Records from Children's Hospital of Pittsburgh, 5/11/02 to 5/14/02;
4. Autopsy reports on the infant.

The baby was born on 5/10/02 from a 34-year-old mother, gravida 1 para 0. It was a term gestation. The mother's blood pressure had been increasing over 2-3 weeks. There was an increase in temperature noted on three occasions in the mother. These were 99°, 100°, and 98.9°. Preeclamptic maternal labs, the biophysical profile, and non-stress test were all reported to be normal. On 4/18/02 the mother was Group B Strep negative. The maternal monitor showed good fetal heart tone variability. A clinical exam was performed and the membranes ruptured during the exam. Cervix was noted to be 3-4 cm dilated, and then futher rupture of the membranes produced a large amount of clear fluid. This is a note from 7:40 a.m. At 9:30 a.m., a note reveals the labor was progressing slowly. The fetal heart tones have been good throughout. The epidural was working well. The cervix was 8-9 cm dilated, and the infant was being monitored and they anticipated a vaginal delivery. On 5/10/02 at 12:55 a.m. the patient was completely dilated at 10 cm. in vertex position. During labor the baby sustained a bradycardia and vacuum was applied. Delivery was accomplished in 1-2 minutes after the vacuum was applied. A midline episiotomy was performed. The baby was limp, and the NICU personnel were called for resuscitation. Birth time was 11:52 p.m. The placenta was delivered at 11:54 p.m. Cord pH was 7.13. The initial Apgars were 0 at one min., 3 at

five min, 4 at 10 min., and 5 at 20 min. The infant was suctioned and stimulated and given chest compression at less than 30 seconds, after which the heart rate increased to greater than 100 per min. A second gas at 00:20 on 5/11 showed a pH of 6.9, $pCO_2$ of 49, $pO_2$ of 102, bicarbonate of 8.2, base deficit –27. CBC at that time showed a white blood count of 32,000 with a platelet count of 185,000. There were 5% bands, and the hemoglobin was 16. The baby's weight was 4.4 kg. Blood pressure was 67/32. The baby was noted to have nasal flaring and pursing of the lips. At 00:25 the baby had a pH of 6.6 with a $pCO_2$ of 95 and a $pO_2$ of 73. At 00:30 a.m., pH of 6.9 with a $pCO_2$ of 49, $pO_2$ of 102, base deficit –27. By 1:30 a.m. pH was 7.3 with a $pCO_2$ of 23, $pO_2$ of 197, bicarb of 11, base deficit –14; and at 1:55 a.m., the pH was 7.34, $pCO_2$ 24, $pO_2$ 94, base deficit –11. The baby was noted to have some tremors and was treated with Phenobarbital — 10/kg x2. The infant was cultured, placed on a ventilator at 24/4 with a rate of 60 in 50%. A nursing progress note at 1:20 a.m. shows $O_2$ sats of 96%. The baby was on the vent and was noted to be on 30% oxygen with sats in the 97-98% range. Blood pressure was 68/39. Throughout the rest of the early morning, the blood pressure was noted to be 73/41, $O_2$ sats 97%. The baby had been weaned down to 18/4 on the ventilator with a rate of 45; and, subsequently, by approximately 4:30 a.m. was weaned to 16/4 with a rate of 40 in 25% oxygen. Subsequently the infant was transferred to Children's Hospital of Pittsburgh, and there a white count was noted to be 42,200 with 13% bands. Platelet count was 193,000 on this occasion, and antibiotics were on board. Again, at Children's Hospital of Pittsburgh on 5/11/02, the baby was extubated at 8:30 p.m. and initially did well with good $O_2$ sats, but at 23:00 on the 11$^{th}$ began having desats to the high 80's, and at 23:30 had a major desat that required bag-mask ventilation. The infant was reintubated with a 3.5 endotracheal tube. The baby remained on Phenobarbital, and there was no seizure activity noted. On the 13$^{th}$, a repeat complete blood count showed a white blood count of 37,000 with 7% bands. The baby was cultured for HSV. It should be noted that at Dubois Hospital an AST was 403 and an ALT was 272, both of which were elevated. A creatinine was 1.1, calcium was normal; but subsequently by the 13$^{th}$, calcium decreased to 7.5 and liver function tests improved slightly to an AST of 281 and ALT of 221. The platelet count continued to drop to 124,000, and the baby had a fever of 39.3. There was a CT scan done x2 that showed a slight increase in density of the cortex, small temporal bleeds, and minimal soft tissue swelling.

**Summary**

This baby was born critically ill and appeared to be in septic shock with a white blood count initially of 32,000, which subsequently increased to 42,000 with up to 13% band count. This is indicative of an acute infection, and this acute infection was responsible for the shock and clinical deterioration of this infant. This septic process was occurring intrauterinely and at least 24 hours prior to the baby's delivery. The mother was noted to have fever; and the baby, after delivery, was noted to have fever. This baby clearly had problems related to sepsis. I am not concerned that the neonatal blood cultures were negative, as up to 50% of neonatal blood cultures are negative in acute sepsis such as this infant experienced. After antibiotic treatment was instituted, the white count continued to decrease over the next 2-3 days and liver function enzymes, which were initially elevated (indicative of sepsis), decreased subsequently. The placenta does

not have to show chorioamnionitis in order to have a major cytokine reaction and shock in a neonate such as this baby. It only takes sepsis from a few bacteria to produce the kind of shock this baby experienced. There is no other explanation in this baby's case for white counts as high as 42,000. Resuscitation alone would not have produced a white count in that range. I, therefore, feel that all the care administered to this infant was within the standards of medical care at both Dubois Medical Center and at the University of Pittsburgh Medical Center.

I hold these opinions to be within a reasonable degree of medical certainty as based on 33 years of experience in the Newborn Intensive Care Unit at The Children's Hospital of Philadelphia. I reserve the right to amend this report at any time.

Sincerely,

William W. Fox, M.D.
Professor of Pediatrics
University of Pennsylvania School of Medicine

WWF:er

# EXHIBIT 2

*Richard Depp, MD*
*1280 Club House Road*
*Gladwyne, PA 19025*
*610 527 6294*

John W. Blasko
McQuaide and Blasko
811 University Drive
State College, PA 16801-6699

**Re: Rhoades vs. Kruszewski**

Dear Mr. Blasko

I am doubly board certified in both Obstetrics & Gynecology and as a subspecialist in Maternal Fetal Medicine. I have had extensive experience in obstetrics and maternal fetal medicine, having managed and directed several large obstetric services over more than 30 years of clinical practice. I have founded and managed a large maternal-fetal medicine fellowship program and directed a large Obstetric clinical service at Northwestern University directing both MFM and Obstetrics. I have visited, lectured and consulted at numerous hospitals in my career and am aware of the standard of care.

I have served as the chair of the department of Obstetrics and Gynecology at Jefferson Medical College through 1997. I currently do not practice, but am actively involved in weekly teaching of residents and students and academic pursuits including clinical research, I continues to manage a weekly FHR conference for residents and attending physicians as I have done for many years. I have led several national Fetal Monitoring courses for the ACOG. I also continue to lecture attending physicians at Postgraduate courses.

I have been elected by my peers to several significant leadership positions in my specialty and continue to be involved in developing educational programs as well as strategies to improve the quality of care provided to patients on a national basis

I have had an opportunity to review the above case in which your firm represents the hospital and its nurses I would like to summarize my opinions at this time. As of this date I have had the opportunity to review the following:

**LEGAL PAPERS:**
Plaintiff Complaint

**MEDICAL RECORDS:**
Prenatal Records from office of Dr. Kruszewski
Maternal Admission to Dubois Regional Medical Center
FHR Records
Newborn records at Dubois Regional Medical Center
Newborn records at Childrens Hospital of Pittsburgh
Autopsy report including placenta

DEPOSITIONS:

Dennis R. Rhoades
Gloria Bennett, RN
Mary C Kruszewski, D.O. (Defendant OB)
Richard Grout, MD (Neonatology)

EXPERT OPINIONS:

Frederick A Gonzales, MD - Plaintif OB expert
James Mollick, MD

RELEVANT LITERATURE:

1. National Institute of Child Health and Human Development Research Planning workshop. **Electronic fetal heart rate monitoring: Research guidelines for interpretation.** Am. J. Obstet. Gynecol. 1997; 177: 1385-90
2. National Institute of Child Health and Human Development Research Planning Workshop. **Electronic fetal heart rate monitoring: Research guidelines for interpretation.** JOGN Nursing 26: 635-640 1997.(same as 1a, but in nursing journal)

OVERVIEW:

Ms. Kim Rhoades at the time of her initial presentation was a 33 year old gravida 1 who was 5 foot 6 inches and weighed 123 pounds. Her LMP was 8.3.01 and her EDC was 5.10.01 (3.4.02 by ultrasound at 13 plus weeks gestation. Other than two borderline blood pressures (the last on 5.9.02) with no associated significant proteinuria, the pregnancy was relatively uncomplicated, within the limitations of prenatal evaluation with limited ability to assess fetal condition. Preeclamptic labs, BPP and NST were done 4.18.02 and were normal. GBS culture was also negative.

Ms. Rhoades was scheduled for induction on the morning of May 10, 2002. Upon admission the FHR was thought to show "good FHT variability and mild contractions every 1-2 minutes. The initial cervical examination was 3-4 / 75% / -3 vertex. Artificial rupture of membranes released "large amount o f clear fluid". The admitting clinician, Dr. Kruzewski appropriately recommended augmentation of labor if necessary, anticipating a vaginal delivery.

Of interest there was a progressive rise in maternal temperature to the last recording of 100.1 at 8pm several hours before delivery and an associated rise in maternal pulse. Serial maternal pulse rates over the last several hours and recorded on the FHR strip reflect significant maternal tachycardia. In the absence of terbutaline or maternal heart disease, a change in maternal pulse of the magnitude observed from the time of admission to the time of delivery, especially when taken in the context of the relative rise in maternal temperature is highly suspicious of chorioamnionitis which would place the fetus at risk for infection or sepsis and / or fetal inflammatory response syndrome. The latter would account for why the FHR pattern observed over the last hour is consistent with the observed cord pH of 7.13 and base deficit of -13, but not consistent with the first umbilical blood gas of 6.60 which was observed at approximately 35-36 minutes of life following placement on a ventilator. Greater specifics of labor are presented below.

Newborn laboratory evaluation at Dubois Regional Medical Center revealed a significantly elevated newborn WBC count with 5% bands, 36% segs and 185,000 platelets.

Later findings at Children's Hospital of Pittsburgh are also of interest. Infectious disease was number 3 of 5 of initial assessment and plans by Beverly Brozanski. She made note of a further elevation of the WBC to 42.2 with 55 polys, 13 bands.

In view of the surprising appearance of the fetus at birth with a pH of only 7.13 which correlates well with the observed FHR pattern, it is likely that there is an independent process which accounts for the inability of the fetus to transition to newborn condition in the first hour and the associated drop in pH. Continuous FHR does not screen for fetal infection, but instead is limited to screening for varying degrees of cord compression and uteroplacental insufficiency.

Infection / sepsis / and / or fetal inflammatory response would be a good independent candidate to explain the newborn transitioning difficulty and the laboratory findings. Infection / sepsis / FIRs can present a clinical picture identical to that of severe metabolic acidosis including the Apgar scores (which conflict with the observed cord blood gases) and such a difficulty in transitioning. The maternal findings of a rising maternal temperature and increasing pulse rate to frank tachycardia are clearly supportive of such a cause. Negative cultures would not eliminate that consideration because of sensitivity limitations of cultures.

**LMP:** 8.3.01 **EDC:** 5.10.01 **DELIVERY DATE:**
**US EDD 1:** 5.4.02 by ultrasound at 13 plus weeks

**PRENATAL CARE:**
**First Visit:** November 1, 2001 at 12.5 weeks
**At Risk Factors:**
AFP refused
**Biophysical Testing:**
4.18.02 BPP 8 of 8; with normal fluid and EFW 3382 gms.
**Diabetes Screening:** 126 at 1 hour
**GBS Screen:** Negative on 4.18.02

**ADMISSION of May 10, 2002 at – 40 wks gestation to Dubois Regional Medical Center**

0653: Admission
97.4; Pulse 70; Fundal height 39 cm.
0714 97.4 / P=70
0725: Artificial rupture of membranes

1145: Order for pitocin protocol
1240: 2 mU pitocin
1300: Recorded time of onset of labor
1535: 4-5 / 70 /-2 8 mU pitocin
1710: 5 / 75 / -2 14 mU pitocin
1850 Unchanged

1900 99.1 / P = 111
2000 100.1 / P = 104
2030: Late Entry: Dr. Kruszewski informed of patient's increased temperature. Bolus of LR given.

2010: 4-5 / 80 / 0 to -1 24 mU
2030 4-5 / 80-90 / 0 to -1 24 mU
2120 Dr. Kruszewski arrives at hospital
2130: Kruszewski Note: 8-9 / 100 / -1 to 0 vertex; Anticipate vaginal delivery

2159: Recorded time of complete dilation 16 mU

**2212 forward:** See late entry at 0100
2225 Epidural infusion stopped for more effective pushing; variable decelerations
2244: IV fluid bolus (Note: Fluid replacement)
2246: Oxygen increased
2300 Variable deceleration continue
2342: FHR capture lost on EFM
2347: Vacuum ordered
2349: Vacuum applied with continuous effort
2352: Female infant - limp and NICU staff called for resuscitation
Cord blood pH 7.13 and BD -13.

**MAY 11, 2002**

**12:55A Delivery Note:** ..... complete approximately 10:00 pm....came down to +1 / +2 station. Baby had a sustained bradycardia and vacuum was applied.. Delivery was accomplished in 1-2 minutes after vacuum applied.

Baby was delivered from LOA position; Birth time was 11:52 pm...Cord pH was 7.13Baby was limp and NICU personnel were called for resuscitation.

***0100: Late Entry:*** *Dr. Kruszewski in attendance assisting patient with pushing from 2212. FHR baseline 150s with average LTV at onset of pushing.*
*2330: Variable decels to 58-72 bpm, lasting 30-80 sec.....push verte4x to +2 station.*
*FHR returned to normal parameter; FHR with scalp stim by Dr. K with variables.*
*2342: FHR capture lost on EFM;* ***Pitocin d/c'd*** *per nursing measures at 2343*
*2344: FHR audible 60s-70s; Fetal scalp stim by Dr. K.*
*2346; FHR audible 50 bpm*
*2347: Order received for vacuum*
***2349: Vacuum extractor applied by Dr. K....to delivery***

PLACENTAL PATHOLOGY:

Mature placenta with mild subchorionic and intervillous fibrin deposition, and areas of calcification.

Trivascular umbilical cord with **partial velamentous insertion**

Amnion nodosum, with focal squamous metaplasia, as may be seen in cases of **oligohydramnios.** No evidence of acute chorioamnionitis or funisitis.

NEWBORN:

**Delivery at** **2349**
**Birthweight:** 4420 gms; HC 38; AC 36 cm; L: 54.5
**Nuchal Cord?** Loose loop around neck (Ped records)

| APGAR | 1 Minute | 5 Minutes | 10 minute | 20 minutes |
|---|---|---|---|---|
| Heart Rate | | 2 | 2 | 2 |
| Respirations | | | | |
| Muscle Tone | | | | |
| Reflex Irritabil. | | | | 1 |
| Color | 0 | 1 | 2 | 2 |
| TOTAL | 0 | 3 | 4 | 5 |

**RESUSCITATION**
- 1103: Ped arrived in Delivery room to infant being vigorously stimulated by Dr. K; no spontaneous respirations
- Chest compression for less than 30 seconds for low heart rate of 60 bpm for less than 30 seconds, after which ...up to over 100 bpm
- Intubated within 1 minute of birth due to respiratory depression w 3.5 ET - (see Neon Admission Data sheet)
- Transferred right away to NICU
- Later transferred to Children's Hospital of Pittsburgh

**Early Newborn Gases**

| | FiO2 | pH | pCO2 | pO2 | HCO3 | BE | |
|---|---|---|---|---|---|---|---|
| CORD GASES | | | | | | | |
| • Arterial | @2349 | 7.13 | 50 | 31 | 16 | -13 | |
| • Venous | | | | | | | |
| NEWBORN | | | | | | | |
| 0025 | To vent. | 6.60 | 95 | 73 | 8.6 | ? | |
| 0030 | | 6.90 | 49 | 102 | 8.2 | -27 | |
| 0130 | | 7.30 | 23 | 197 | 11 | -14 | |
| | | | | | | | |

LATER COURSE:

Baby Mikayla was subsequently transferred to Children's Hospital of Pittsburgh and died later on May 14 2002 at 4:31 pm. Reference to WBC results is mentioned above.

An autopsy was performed - the principal diagnosis being - full term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic ischemic encephalopathy.

MY OPINIONS:

**My opinions are presented below linked to allegations by plaintiff:**

***1. No Estimated fetal weight - clinically or sonographically***

Estimation of the fetal weight is not required and in fact is largely inaccurate. See also below.

***2. No mention of informed consent or discussion regarding options for delivery of macrosomic baby.***

The newborn weighed 4420 grams and was Large for Gestational age. By current ACOG guidelines macrosomia is above 4500 gms and may even be greater than 5000 gms for a non-IDM newborn. Importantly if ultrasound were used to estimate fetal weight, the range would be 900 gms on each side of the actual weight. Even if the ultrasound were to identify the actual weight there would be no way for the Ob to know it was correct and furthermore there is no reason to electively offer a cesarean delivery at an estimated weight of 4420 gms.

***3. Fetal bradycardia at 3:37 pm - pitocin not discontinued and no precautions were taken as a result of the bradycardia.***

There is considerable doubt that there was a fetal bradycardia at this time interval. There is considerable likelihood that the heart rate recorded following this time was maternal in origin. Even if fetal, the variability is sufficient to provide reassurance that the fetal acid base status was well within normal limits.

***4. A scalp pH was not performed / unable to be performed***

There is no requirement to perform scalp pH relating to the presence of variability described above or alternatively that the heart rate referred to is maternal in origin. Very few hospitals offer access to scalp capillary blood pH determinations.

***5. Severe and progressive variable decelerations at 10:46 pm and pitocin was not discontinued until 11:43 pm.***

Variable decelerations are noted at 10:46. They are only moderate to moderately severe. Severe variables are generally below 70 bpm in excess of 60 seconds each repeatedly.

Variable decelerations are very common in the second stage. In general as long as the variability between the decelerations is normal, it is assumed there is no significant metabolic acidosis.

At the end the variables are less than 70 bmp for 30-40 seconds and variability is maintained at a baseline rate in the 150 plus range with accelerations above that baseline rate.

Importantly the FHR is consistent with the cord pH of 7.13 with a base deficit of only -13. Both are generally acknowledged to be insufficient to account for a strictly hypoxic etiology for the subsequent course.

***6. Oxytocin Usage***

*Oxytocin use was appropriate and indicated. Labor disorders have criteria and have prognostic significance. However the presence of a disorder is not synonymous with an indication to proceed to cesarean once an interval is achieved. A significant number of patients with labor disorders will deliver vaginally.*

***7. Vacuum pressure between pulls was not reduced between contractions***

Vacuum delivery was appropriately performed in a reasonable time interval. There are no consequences of the vacuum delivery. There is no evidence that can be reliably attributable to trauma in excess of what is commonly encountered in the labor and delivery process.

***8. Severely asphyxiated baby was born with Apgars of 0, 3, 4, and 5 at 1, 5, 10 and 20 minutes. The cord pH was 7.13 with a base excess of -13, which represents metabolic acidosis.***

The newborn was not "severely asphyxiated". The Cord pH was only 7.13 and the Base deficit only -13, both values with 2 standard deviations of normal and well above the values required to cause CP, much less more severe - death.

***9. Causation***

As mentioned above, chorioamnionitis and associated fetal infection or sepsis and / or fetal inflammatory response syndrome is a likely consideration in view of the poor matching of the cord blood with the subsequent newborn course, but good match with the FHR findings observed. There is supportive evidence in terms of maternal temperature and pulse changes as well as rising WBC, polys / segs as well as bands in the newborn first at Dubois Regional Medical Center and later at Childrens Hospital of Pittsburgh.

**SUMMARY:**

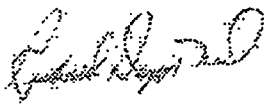
In summary, Dr. Mary Kruszewski and nurses who were involved in the management of Ms. Rhoades were not negligent and did not breach the standard. Their conduct did not increase the risk of harm to the mother or the fetus. There is a high likelihood that infection / sepsis and /or the fetal inflammatory response is responsible for the difficulty

the newborn had in transitioning, despite a relatively common cord pH of 7.13 and base deficit of only -13. Neither is consistent with hypoxia arising in labor as the cause, but is more consistent with infection and its consequences. A negative culture of the newborn would not rule this out because of the sensitivity limitations of blood culture under the circumstances of the case.

My opinions are expressed to a reasonable degree of medical certainty, after considering the complex totality of the specifics of this case. I base my opinions on my expertise and extensive reading and clinical experience in the specialty of Obstetrics and Gynecology and the subspecialty of Maternal Fetal Medicine. I reserve the right to modify or supplement my opinions as additional information and detail becomes available.

Please let me know if there is a need for clarification or additional information.

Best regards,



Richard Depp, M.D.

# EXHIBIT 3

MAR 2 3 2006

Depp Roles – Academic / Clinical

8 April 2005

I have served as the founder and Chief of Maternal Fetal Medicine and Chief of Obstetrics at **Northwestern University** in Chicago (1975-1987) and subsequently as Chairman of Obstetrics and Gynecology at **Jefferson Medical College** in Philadelphia (1987-1998) and as Chair Emeritus thereafter. I have had extensive clinical experience in Obstetrics and Maternal Fetal Medicine and have founded and directed a subspecialty fellowship program in Maternal Fetal Medicine at Northwestern University Medical School for 12 years. I am currently a Professor in the department of Obstetrics and Gynecology of **Drexel University College of Medicine.**

I have not practiced clinical medicine since mid-2000, but remain active in clinical research, lecturing extensively to attendings on a national level, residents and students and have run a significant Continuing Medical Education program. I continue to run a **Fetal Heart Rate Monitoring conference** on a weekly basis for residents and attendings; difficult and controversial FHR Strips are presented to me for discussion and ultimate resolution. I have received a 5 of 5 evaluation for these conferences for the last several years.

I have extensive experience in clinical research, which I continue to do and have been the principal investigator for a Maternal Fetal Medicine Clinical Research Center for the **National Institute of Child Health and Human Development** (NICHD). I am currently a co-Principal investigator on a number of clinical trials with our MFMU – multi-center grant, funded by the (NICHD). I was a member of a select number of leaders in the field to assist in the development of a **Fetal Heart Rate Consensus Document** by the NICHD published by J.T. Parer and Ted Quilligan in the AJOG and the JOGN.

I have submitted two major grant applications in 2005; awards will not be announced until the summer of 2005.

I served as the President of the Association of Professors of Gynecology and Obstetrics (1997) and as Chairman of the Association of Professors of Gynecology and Obstetrics Medical Education Foundation (until 2003).

I have been appointed as the first ever Executive Director of the Society of Maternal Fetal Medicine (2003-) - the clinical education and research promotion organization for more than 1700 Maternal Fetal Medicine subspecialists in the United States.

I was the founder (January, 2005) and first President of the **Maternal Fetal Medicine Foundation** - a not for profit organization whose mission is to transition emerging clinical technologies into clinical application in a responsible manner. This organization is currently involved in a very large project to address quality review issues involving prenatal diagnosis on a national level. I am also one of 5 board members of this new organization

I served as one of a select number of leaders in the field invited to serve as a contributor to the **Neonatal Encephalopathy and Cerebral Palsy Monograph**, which has been endorsed by multiple specialty and subspecialty organizations in the United States as well as internationally.

I edited two volumes of a large clinical textbook in "Gynecology and Obstetrics" until 2004 and continue to review clinical papers for a number of the major journals in the field.

# CURRICULUM VITAE
## O. Richard Depp, III, M.D.

ADDRESS: Department of Obstetrics and Gynecology
Drexel University College of Medicine
245 N. 15th Street, 16th Floor, Mail Stop 495
Philadelphia, Pennsylvania 19102
215-762-1503 (Debra)

MARRIED: Kathleen Ann Kuhlman, M.D., March 7, 1981

EDUCATION: Tulane University, New Orleans, Louisiana, 1956-1959, B.S., Zoology
Tulane University Medical School, New Orleans, Louisiana, 1959-1963, - M.D.

POSTGRADUATE EDUCATION:

**Internship**: Mixed Medicine and Obstetrics and Gynecology, Charity Hospital, (Tulane) New Orleans, Louisiana, 1963-1964

**Residency**: Obstetrics and Gynecology, Southern Baptist Hospital (Tulane affiliated), New Orleans, Louisiana, 1964-1967

**Senior Research Fellow**: Reproductive Medicine, Department of Obstetrics and Gynecology, University of Washington School of Medicine Seattle, Washington, July 1967-October 1968

Program for Chiefs of Clinical Services, Executive Programs in Health Policy and Management, School of Public Health, Harvard University, Boston, Massachusetts, January 1980

APGO-Wyeth-Ayerst Executive Education Program for University Chairmen, February 1992, St. Davids, Pennsylvania, July 1992, Boston, Massachusetts

APGO-Wyeth-Ayerst Advanced Leadership Development Program: Negotiating Skills and Managed Care, July 1995, Boston Massachusetts

LICENSURE:

Louisiana, 1963
Washington, 1969
Pennsylvania, 1971-
Illinois, 1975-88

SOCIAL SECURITY NUMBER: 437-56-0651
AMA MED. EDUC. NUMBER: 021-01-63-021-1

BOARD CERTIFICATION:

American Board of Obstetrics and Gynecology
Part I, 1967
Part II, 1969
Division of Maternal-Fetal Medicine, American Board of Obstetrics & Gynecology
Part I, June 1975
Part II, November 1975
**Recertified 1994**

ACADEMIC APPOINTMENTS:

**Drexel University College of Medicine**
1. Professor, Department of Obstetrics & Gynecology, 2001-

**Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania**
1. Professor, Department of Obstetrics and Gynecology, 1987-
2. Chairman, Department of Obstetrics and Gynecology, 1987-97
3. Chairman Emeritus 1997-

**Northwestern University Medical School, Chicago, Illinois**
1. Professor, Dept Ob-Gyn 1981-1987
2. Associate Professor, Department of Obstetrics and Gynecology, 1975-1981
3. Head, Section on Maternal-Fetal Medicine, 1975-1987

**University of Pittsburgh**
1. Assistant Professor, Department of Obstetrics and Gynecology, and Pediatrics, 1971-1975

**University of Washington, Seattle, Washington**
1. Assistant Professor, Department of Obstetrics and Gynecology, 1970-1971
2. Instructor, Department of Obstetrics and Gynecology, 1968-1970

HOSPITAL APPOINTMENTS:

**Thomas Jefferson University Hospital**
Chief of Service, Department of Obstetrics and Gynecology, 1987-97;

**Northwestern Memorial Hospital / Prentice Women's Hospital-Chicago, Illinois**
1. Attending Staff, 1975-1987;
2. Director, Division of Obstetrics, 1975-1987

**Magee Women's Hospital, Univ. of Pittsburgh**
1. Attending Staff, 1972-1975;
2. Director, Fetal-Maternal Intensive Care Unit, 1972-1975

**Harborview Medical Center (King County Hospital) of the University of Washington, Seattle, Washington**
1. Chief, Department of Obstetrics and Gynecology, 1969-1971

PROFESSIONAL ASSOCIATIONS:

Fellow, The American College of Obstetricians and Gynecologists
Member, Association of Professors of Gynecology and Obstetrics
Member, Society of Maternal Fetal Medicine (formerly SPO)
(Founding Member)
Member, Society for Gynecologic Investigation
Member, American Gynecological and Obstetrical Society
Member, The Central Association of Obstetricians and Gynecologists (Through 1989)
Fellow, Chicago Gynecological Society (thru 1987)
Member, National Perinatal Association (thru 1987)
Member, Illinois Association of Maternal-Child Health
Member, Obstetrical Society of Philadelphia (1987-
District III Representative, Standing Committee Chairs

LEADERSHIP ROLES:

**American Board of Obstetrics & Gynecology**

1. Examiner for Oral Ob-Gyn Boards

**Association of Professors of Obstetrics and Gynecology**

1. Member, APGO Council 1994-98;
2. Member, APGO Budget Committee 1994-1998;
3. **President, 1997-98;**
4. Co-Director APGO Wyeth Executive Education Program for Department Chairs 1990-1994;
5. Program Chairman for APGO-Wyeth Ayerst Executive Education Program 1994-
6. Member, Advisory Committee Wyeth Ayerst Executive Education Program, 1991-

**Assoc. Professors of Gynecology and Obstetrics Medical Education Foundation**

1. Member, Board of Trustees, 1994-
2. Secretary-Treasurer, 1992-99
3. **President, 2000-2003 (March)**

**American College of Obstetrics and Gynecology**

1. Member, Committee to Reduce Cesarean Deliveries, 1997-99.
2. Member, Committee on Obstetric Practice, 1998-
1. Member Committee on Perinatal Brain Damage 2000-
2. Liaison to American Academy Pediatrics, 1998-
3. Vice-Chair – Committee on Obstetrical Practice 2000-

**Society of Maternal Fetal Medicine**

1. Founding Member
2. **Executive Vice President (Jan 2003 -**

**National Institute of Child Health Human Development**

1. See Grants
2. NICHD Research Workshop on Intrapartum Electronic Monitoring, Participant, Moderator and Discussion Leader, Bethesda, Maryland, May 14-15, 1995

**Maternal Fetal Medicine Foundation**

1. Founder
2. **President, 2005-**

**Council University Chairs of Obstetrics and Gynecology, (CUCOG):**

1. Founding Member
2. Program Director, 1994-2000
3. Member, Health Care Financing Committee

**Obstetrical Society of Philadelphia,**

1. Member of Council 1991-1995

**Accreditation Council for Graduate Medical Education**

1. Panel for Accreditation Appeals in Obstetrics and Gynecology 1999-

**Keystone Health Plan East**

1. Member, Ob. Advisory Panel, Keystone Health Plan East, 1994- 1998

**American Association for Maternal and Neonatal Health**

AAMANEH (1987-93) Member, Board of Directors,
Member, Chicago Maternal and Child Health Advisory Committee
Member, Subcommittee on Maternal and Perinatal Morbidity and Mortality, Chicago Maternal and Child Health, Advisory Committee
Member, Perinatal Advisory Board, National Foundation-March of Dimes, Chicago
Member, Perinatal Survey Committee, National Foundation-March of Dimes, White Plains
Member, Perinatal Advisory Committee, Dept. of Public Health, State of Illinois

PROFESSIONAL APPOINTMENTS:

THOMAS JEFFERSON UNIVERSITY

1. **Chairman**, Department of Obstetrics and Gynecology 1987-1997; (Chair Emeritus 1997-;
2. Member, Executive Council, 1987-1997;
3. Member, Executive Committee 1987-1997;
4. Member, Committee on Ethics, 1988- ;
5. Member, Comm. on Faculty Appointment, 1988-1995;
6. Chairman, Committee on Committees, 1991-1992;
7. Member, Practice Plan Advisory Committee, 1988-1997;
8. Member, Practice Plan Steering Committee, 1988-1997;
9. Member, Clinical Practice Plan Claims Committee, 1993;
10. Co-Chairman, Physician Practice Management Information System, 1993-1997;
11. Member, Clinical Advisory Committee for the Family Nurse Practitioner Program, 1995- ;
12. Member, Board of Directors, Jeff Care, Inc., 1994- ;
13. Member, Jefferson Faculty Foundation Reorganization Ad-hoc Committee, 1997

NORTHWESTERN UNIVERSITY (1975-1987)

1. **Director Division of Obstetrics**
2. **Section Head Maternal Fetal Medicine (Founder)**
3. Member, Board of Directors, Foundation for Reproductive Research and Education;
4. Member, Board of Directors; Member, Finance Committee, Northwestern Medical Faculty Foundation;
5. Executive Director, Northwestern Perinatal Center, McGaw Medical Center of Northwestern University;
6. **Chairman, Executive Committee, Northwestern Perinatal Center, McGaw Medical Center of Northwestern University;**
7. **Director, Maternal-Fetal Medicine Fellowship Training Program, Department of Obstetrics and Gynecology, 1975-1987;**
8. Member, Executive Committee;
9. Member, Committee on Clinical Privileges;
10. Member, Clinical Practice Review Committee;
11. Member, Quality Assurance Committee, Prentice Women's Hospital and Maternity Center of Northwestern Memorial Hospital;
12. Member, Research Committee, Northwestern Memorial Hospital;
13. Member, Residency Education Committee;
14. Member, Appointment and Promotions Committee; Obstetrics and Gynecology, Northwestern Univ. Medical School 1975-1987;
15. Member, Practice Committee, Department of Obstetrics and Gynecology, Northwestern Medical Faculty Foundation

DREXEL UNIVERSITY COLLEGE OF MEDICINE

1. Revenue Cycle Committee (2003-2004)
2. Resident Committee (2001 -
3. Co-Chair of IT Committee ( 2003-2004)

**HONORS:**

1. Phi Eta Sigma, Honorary Premedical Society, Tulane University Medical School, Founding Member;
2. Alpha Epsilon Delta, Honorary Premedical Society, Tulane University Medical School;
3. Society Prize for Most Outstanding Paper, Society of Perinatal Obstetricians, January 29, 1983, San Antonio, Texas
4. **Good Housekeeping, One of Top 110** Outstanding Ob-Gyn's in the United States, September, 1988 issue
5. **Honorary President**, "Standards in Gestosis Consensus Conference" Rome, Italy, May 22-26, 1991
6. **William Heath Byford Award for Outstanding Northwestern University Alumnus in Obstetrics and Gynecology, 1991-1992**
7. **The Best Doctors in America,** Directory of Experts, Woodward and White, Inc., 1994-1995
8. **The Best Doctors in America**: Northeast Region, Woodward and White, Inc., 1996-1997
9. **Good Housekeeping**, The Best Doctors for Women, August, 1997 issue

**MAJOR RESEARCH SUPPORT:**

1. Efficacy of Antenatal Steroids in Reducing Neonatal Respiratory Distress Syndrome, Principal Investigator, NICHD Grant, 1977-1983, **$850,000**.

2. Diabetes in Pregnancy Center, Co-Principal Investigator, NICHD Center Grant, 1978-1982 **$2.5 million**;

3. Clinical Trial of Hexaprenaline vs. Ritodrine, Principal Investigator, Byk-Gulden Corporation, 1979-1981, **$100,000**

4. Multicenter Preterm Birth Prevention Trial, Principal Investigator, March of Dimes Birth Defects Foundation, 1982-1987, **$410,000;**

5. Multicenter Network of Maternal-Fetal Medicine Units, Principal Investigator, NICHD Grant, 9/1/87 to 8/31/91, **$953,835.**

6. Ethnic Differences in Life Style, Psychological Factors, and Medical Care During Pregnancy, NICHD, 1986, estimated budget to be approximately **$375,000** over three years, Co-Principal Investigator

**EDITORIAL/REVIEW ACTIVITIES:**

1. **Associate Editor**, Volume II & III, Gynecology and Obstetrics, Harper & Row, Hagerstown, Maryland, 1979-
2. **Editorial Board**, Fetal Medicine, Karger Publishers, Inc.
3. **Peer Reviewer for**:
   American Journal of Obstetrics & Gynecology;
   Obstetrics & Gynecology;
   Journal of the American Medical Association;
   International Journal of Gynecology and Obstetrics;
   Journal of Reproductive Medicine

**TELEVISION:**

1. First Ob-Gyn Grand Rounds Program, Lifetime Medical Television, May 21, 1989
2. Permanent Host, Lifetime Medical Television: Ob-Gyn Update 1991-1993 (52 Productions)

**RD/ April 2005**

# BIBLIOGRAPHY


1. Depp, R. and Russell, H. H.: Intra-arterial transfusion and treatment of septic shock. Tulane Univ. Med. Bull., 1964.

2. Cleary, R. E., Depp, R. and Pion, R. J.: Relation of C19 steroid sulfates in cord plasma to maternal urinary estriol. Am. J. Obstet. Gynecol., 106:534-539, 1970.

3. Johnson, W. L., Depp, R. and Hunter, C.A., Jr.: Comparison of spontaneous, oxytocin-stimulated, and hypertonic saline-induced labor by different methods of record analysis. Am. J. Obstet. Gynecol., 107:268-273, 1970.

4. Depp, R., Kind, A. C., Kirby, W. M. M. and Johnson, W. L.: Transplacental passage of methicillin and dicloxacillin into the fetus and amniotic fluid. Am. J. Obstet. Gynecol., 107:1054-1057, 1970.

5. Depp, R., Cox, D. W., Pion, R. J., Conrad, S. H. and Heinrichs, W. L.: Inhibition of the pregnenolone Δ5-3ß-hydroxy-steroid dehydrogenase-Δ5-4 isomerase systems of human placenta and corpus luteum of pregnancy. Gynecol. Invest., 4:106-120, 1973.

6. Hyman, C. J., Depp, R., Pakravan, P., Stinson, D. A. and Allen, A. C.: Pneumothorax complicating amniocentesis. Obstet. Gynecol., 41:43, 1973.

7. Pakravan, P., Kenny, F. M., Depp, R. and Allen, A. C.: Familial congenital absence of adrenal glands; evaluation of glucocorticoid, mineralocorticoid, and estrogen metabolism in the perinatal period. J. Pediatr., 84:74-78, 1974.

8. Sciarra, J. J., Tagatz, G. E., Notation, A. D. and Depp, R.: Estriol and estetrol in amniotic fluid. Am. J. Obstet. Gynecol., 118:626-641, 1974.

9. Depp, R.: The high-risk pregnancy: The puzzle of postmaturity. Contemp. OB/GYN, 3:109, 1974.

10. Abouleish, E. and Depp, R.: Acupuncture in obstetrics. Anesth. Analg. 54:83-88, 1975.

11. Freeman, R. K., Depp, R., Huddleston, J. D. and Spellacy, W.: Symposium: The enigma of prolonged pregnancy. Contemp. OB/GYN, 7:116, 1976.

12. Depp, R., Davidson, E. C., Jr., Freeman, R. K. and Sabbagha, R. E.: Symposium: Bleeding in the third trimester. Contemp. OB/GYN, 7:157, 1976.

13. Sabbagha, R. E. and Depp, R.: Sonar: A tool for the detection of fetal congenital anomalies. Clin. Obstet. Gynecol., 20:279-283, 1977.

14. Tamura, R. K., Sabbagha, R. E. and Depp, R.: Diagnosis of intrauterine growth retardation. Clin. Obstet. Gynecol., 20:309-313, 1977.

15. Depp, R.: How ultrasound is utilized by the perinatologist. Clin. Obstet. Gynecol., 20:315-323, 1977.

16. Giesler, C. V., Buehler, J. H. and Depp, R.: Alpha1-antitrypsin deficiency: Severe obstructive lung disease and pregnancy. Obstet. Gynecol., 49:31-34, 1977.

17. Sabbagha, R. E., Depp, R., Grasse, D. and Kipper, I.: Ultrasound diagnosis of occipitothoracic meningocele at 22 weeks' gestation. Am. J. Obstet. Gynecol., 131:113-114, 1978.

18. Sabbagha, R. E., Hughey, M. and Depp, R.: Growth adjusted sonographic age. Obstet. Gynecol., 51:383-386, 1978.

19. Wennberg, R. P., Depp, R. and Heinrichs, W. L.: Indications for early exchange transfusion in patients with erythroblastosis fetalis. J. Pediatr., 92:789-792, 1978.

20. Painter, M. J., Depp, R. and O'Donoghue, P. E.: Fetal heart rate patterns and development in the first year of life. Am. J. Obstet. Gynecol., 132:271-277, 1978.

21. Escarcena, L., McKinney, R. D. and Depp, R.: Fetal baseline heart rate variability estimation: I. Comparison of clinical and stochastic quantification techniques. Am. J. Obstet. Gynecol., 135:615-620, 1979.

22. Ellis, R., Berger, G., Keith, L., Depp, R. and Hatcher, R.: The Northwestern University multihospital twin study: II. Mortality of first versus second twins. Acta Genet. Med. Gemellol., 28:347-352, 1979.

23. Ogata, E. S., Sabbagha, R. E., Metzger, B. E., Phelps, R. L., Depp, R. and Freinkel, N.: Serial ultrasonography to assess evolving fetal macrosomia. Studies in 23 pregnant diabetic women. JAMA, 243:2405-2408, 1980.

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25. Depp, R.: Present status of the assessment of fetal maturity. Semin. Perinatol., 4:229-248, 1980.

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27. Keith, L., Ellis, R., Berger, G. S. and Depp, R.: The Northwestern University multihospital twin study. I. A description of 588 twin pregnancies and associated pregnancy loss, 1971 to 1975. Am. J. Obstet. Gynecol., 138:781-789, 1980.

28. Barglow, P., Hatcher, R., Wolston, J., Phelps, R., Burns, W. and Depp, R.: Psychiatric risk factors in the pregnant diabetic patient. Am. J. Obstet. Gynecol., 140:46-52, 1981.

29. Collaborative group on antenatal steroid therapy: Effect of antenatal dexamethasone administration on the prevention of respiration distress syndrome. Am. J. Obstet. Gynecol., 141:276-287, 1981.

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35. Depp, R., Sabbagha, R. E., Brown, J. T., Tamura, R. K. and Reedy, N. J.: Fetal surgery for hydrocephalus: Successful in utero ventriculoamniotic shunt for Dandy-Walker Syndrome. Obstet. Gynecol., 61:710-714, 1983.

36. Thurnau, G. R., Dyer, A., Depp, O. R. and Martin, A. O.: The development of a profile scoring system for early identification and severity assessment of pregnancy-induced hypertension. Am. J. Obstet. Gynecol., 146:406-416, 1983.

37. Collaborative Group on Antenatal Steroid Therapy: Effects of antenatal dexamethasone administration in the infant: Long-term follow-up. J. Pediatr., 104:259-267, 1984.

38. Reedy, N. J., Alonso, B. K., Bozzelli, J. E. and Depp, R.: Maternal-fetal transport. A nurse team. JOGN Nursing, 13:91-100, 1984.

39. Socol, M. L., Sing, E. and Depp, O. R.: The tap test: A rapid indicator of fetal pulmonary maturity. Am. J. Obstet. Gynecol., 148:445-450, 1984.

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44. Reedy, N. J., Ford, K. L. and Depp, R.: Intrauterine fetal surgery: A nursing challenge. JOGN Nursing, 13:291-295, 1984.

45. Morrison, J. C., Korones, S. B., Curet, L. B., Zachman, R. D., Poole, W. K., Rao, A. V., Bauer, C. R., Rigatto, H., Depp, R., and The Collaborative Group on Antenatal Steroid Therapy: Influence of infant gender on respiratory distress syndrome occurring after maternal treatment with dexamethasone. J. Perinatol., 5:2-5, 1985.

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47. Sabbagha, R. E., Sheikh, Z., Tamura, R. K., Dal Compo, S., Simpson, J. L., Depp, R. and Gerbie, A. L.: Predictive value, sensitivity, and specificity of ultrasonic targeted imaging for fetal anomalies in gravid women at high risk for birth defects. Am. J. Obstet. Gynecol., 152:822-827, 1985.

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51. Socol, M. L., Sabbagha, R. E., Elias, S., Tamura, R. K., Simpson, J. L., Dooley, S. L., and Depp, R.: Prenatal diagnosis of congenital muscular dystrophy producing arthrogryposis. N. Engl. J. Med., 313:1230, 1985.

52. Tamura, R. K., Sabbagha, R. E., Depp, R., Dooley, S. L., and Socol, M. L.: Diabetic Macrosomia: Accuracy of Third Trimester Ultrasound. Obstet. Gynecol., 67:824-832, 1986.

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mellitus: A syndrome with phenotypic and genotypic heterogeneity. Horm. Metabol. Res., 18:427-430, 1986.

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57. Kuhlman, K. A. and Depp, R.: Acoustic stimulation testing. Obstet. Gynecol. Clin. N. A., 15:1-17, 1988.

**58. Painter, M. J. Scott, M., Hirsch, R.P., O'Donoghue, P., and Depp, R.: Fetal heart rate patterns during labor: Neurologic and cognitive development at six to nine years of age. Am. J. Obstet. Gynecol. 159:854-858, 1988**

59. Socol, M. L., Cohen, L., Depp, R., Dooley, S. L. and Tamura, R. K.: Apgar scores and umbilical cord arterial pH in the breech neonate. Int. J. Gynecol. Obstet., 27:37-43, 1988.

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61. Depp, O. R., Keith, L. G., and Sciarra, J. J.: The Northwestern University Twin Study. VII: The mode of delivery in twin pregnancy North American considerations. Acta Genet. Med. Gemellol., 37:11-18, 1988.

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69. Depp R, Zichella L, Rippman ET: Standards in gestosis — Consensus conference, May 25-26, 1991. Int. J Gynecol Obstet 42:281-289, 1993.

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72. Sibai BM, Gordon T, Thom E, Caritis SN, Rocco L, Klebanoff M, McNellis D, Romero R, Paul RH, Depp R, Witter F, Rosen M: Risk factors for preeclampsia in healthy nulliparous women: A prospective multicenter study. Am J Obstet Gynecol, 172: 642-8, 1995

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2. Depp, R.: Steroid therapy in the prevention of respiratory distress syndrome, in Rathi, M. L. (ed.), Perinatal Medicine, London, 1978, Perganan Press Ltd., p. 75.

3. Hobart, J. M. and Depp, R.: Prolonged pregnancy, in Sciarra, J. J. (ed.), Depp, R. (assoc. ed.), Gynecology and Obstetrics, Hagerstown, Md., 1979, Harper & Row, Vol. III, Chapter 64, pp. 1-8.

4. Depp, O. R. and Dooley, S.: Monitorizacion fetal intraparto, in Aladjem, S. y Vidyasagar, D. (eds.), Atlas de Perinatologia, Barcelona, 1980, Salvat Editores, S. A., Capitulo 7, pp. 173-187.

5. Depp, R.: Dynamics of fetal growth, in Sabbagha, R. E. (ed.), Diagnostic Ultrasound, Hagerstown, Md., Harper & Row, 1980, pp. 111.

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7. Berger, G. S., Keith, L. G., Ellis, R. and Depp, R.: The Northwestern University multiple twin study. III. Obstetric characteristics and outcome, in Twin Biology and Multiple Pregnancy, New York, N. Y., 1981, Alan R. Liss, Inc., pp. 207-215.

8. Depp, R., Clinical evaluation of fetal status, in Danforth, D. N. (ed.), Obstetrics and Gynecology, Fourth Edition, Hagerstown, Md., 1982, Harper & Row, Chapter 11, pp. 802-835.

9. Depp, O. R. and Dooley, S.: Fetal monitoring, in Aladjem, S. and Vidyasagar, D. (eds.), Atlas of Perinatology, Philadelphia, 1982, W. B. Saunders Company, Chapter 7, p. 173.

10. Depp, R.: Care of the high-risk mother, in Sciarra, J. J. (ed.) and Depp, R. (assoc. ed.), Gynecology and Obstetrics, Philadelphia, 1985, Harper & Row, Vol. III, Chapter 1, pp. 1-34.

11. Depp, R.: Clinical evaluation of fetal status, in Danforth, D. N. and Scott, J. R. (eds.), Obstetrics and Gynecology, Philadelphia, 1986, J. B. Lippincott Company, Chapter 41, pp. 770-803.

12. Depp, R.: Cesarean delivery and other surgical procedures, in Gabbe SG, Niebyl JR, Simpson JL (eds), Obstetrics Normal and Problem Pregnancies, New York, Churchill Livingstone, Chapter 20, pp 635-693, 1991.

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15. Silber, C. and Depp R: Analgesia and Anesthesia for Forceps Delivery, in Bonica JJ, McDonald JS (eds), Principles and Practice of Obstetric Analgesia and Anesthesia, Second Edition, Baltimore, 1995, Williams & Wilkins Chapter 27, pp. 918-935.

16. Depp R and Kuhlman K: Intensive Care of the Fetus and Neonate, in Spitzer A. (Ed) Identification and Management of the Fetus at Risk for Acidosis Mosby Yearbook Publishing, Philadelphia Chapter 9, pp. 105-122.

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18. Depp, Richard Cesarean Delivery, in Gabbe S., , Niebyl JR, Simpson JL (Ed), New York, Churchill Livingstone, 2001.

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**THE OB/GYN RESIDENT**, SLACK Incorporated, Thorofare, New Jersey, 1992-1993

- Editorial, January/February 1992
- Disability Insurance, March/April 1992
- Malpractice, May/June 1992
- Hospital Privileges, July/August 1992
- Starting Salaries, September/October 1992
- Interviewing, November/December 1992
- Academic Medicine, January/February 1993
- Guidelines for Moonlighting, March/April 1993

- Have You Considered Becoming a Locum Tenens?, May/June 1993
- Is Group Practice for You? July/August 1993
- Infectious Diseases: Don't Let Down Your Guard, September/October 1993
- Constructing a CV, November/December 1993

## ABSTRACTS

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1. Tamura RK, Sabbagha RE, Vaisrub N, Depp R: Preterm fetuses with premature labor or rupture of membranes show diminished growth. Dallas, Texas, March 1982.

2. Thurnau GR, Tamura RK, Sabbagha R, Depp OR III: Estimated fetal weight (EFW) formula, based on real-time ultrasound measurements of fetuses less than 34 weeks' gestation. Dallas, Texas, March 1982.

3. Socol ML, Sing E, Depp OR: The tap test as an indicator of fetal pulmonary maturity. Washington, D. C., March 1983.

4. Dooley S, Tamura R, Depp R, Socol M, Vaisrub N: Ultrasound in diabetics with timed pregnancies: Early expression of accelerated fetal somatic growth. San Francisco, California, March 1984.

5. Cheesman KL, Graham A, Depp OR, Chatterton RT Jr. Changes in total and free steroid concentrations in amniotic fluid at the onset of term and preterm labor. Phoenix, Arizona, March 1985.

6. Graham ADM, Cheesman KL, Depp OR, Chatterton RT: Association of term, but not pre-term, labor with an increase in the ratio of estradiol to progesterone in amniotic fluid. Atlanta, Georgia, March 1987.

7. Dooley S, Silver R, Tamura R, Depp R: Diminished Wharton's jelly (WJ) and decreased amniotic fluid (AFV) in prolonged gestation: Relation to intrapartum FHR variable decelerations. Atlanta, Georgia, March 1987.

8. Silver R, Pachman L, Jacobitz J, Andersen R, Depp R: Immunogenetic evaluation of recurrent preterm delivery. Atlanta, Georgia, March 1987.

9. Kuhlman, KA, Burns K, Depp R Longitudinal study of fetal habituation to external vibroacoustic stimulation using a semiquantitative neurobehavioral scoring system. Baltimore, Maryland, March 1988.

10. Sibai B, Caritis S, Phillips E, Klebanoff M, Paul R, Witter F, Depp R, et al.: Safety of low-dose aspirin in healthy nulliparous women: A double-blind placebo-controlled trial. Toronto, Canada, March 1993.

### Society of Perinatal Obstetricians (SPO)

1. Tamura RK, Sabbagha RE, Depp R, Dal Compo S, Dooley SL, Socol ML: Fetal sex determination by real time ultrasound in the third trimester. San Antonio, Texas, February 1982.

2. Thurnau GR, Tamura RK, Sabbagha R, Depp OR m, Dyer A, Larkin R, Lee T, Laughlin C: Estimated fetal weight (EFW) formula, based on real-time ultrasound measurements of fetuses less than 34 weeks' gestation. San Antonio, Texas,

February 1982.

3. Graham A, Depp R, Dooley SL, Socol ML: Neonatal outcome in severely acidotic infants. San Antonio, Texas, January 1983.

4. Socol ML, Sing E, Depp OR: The tap test: A rapid indicator of fetal pulmonary maturity. San Antonio, Texas, February 1984.

5. Tamura RK, Sabbagha RE, Dooley SL, Socol ML, Vaisrub N, Depp R: Real-time ultrasound estimations of weight in fetuses of diabetic gravidas. San Antonio, Texas, February 1984.

6. Dooley SL, Depp R, Socol ML, Tamura RK, Vaisrub N: Urinary estriols in diabetic pregnancy: A reappraisal using fetal heart rate testing as the standard of fetal well-being. San Antonio, Texas, February 1984.

7. Pesavento DJ, Dooley SL, Socol ML, Tamura RK, Depp R: Meconium below the vocal cords at delivery: correlation with intrapartum events. Las Vegas, Nevada, January 1985.

8. Kuhlman KA, Hidvegi D, Tamura RK, Depp R: Is amniotic fluid material in the central circulation of peripartum patients pathologic? Las Vegas, Nevada, January 1985.

9. Socol M, Cohen L, Dooley S, Tamura R, Depp R: Apgar scores and umbilical cord arterial pH in the breech neonate Las Vegas, Nevada, January 1985.

10. Painter MJ, Scott M, Depp R Neurological and developmental follow-up of children at six to nine years relative to intrapartum fetal heart rate patterns. Las Vegas, Nevada, January 1985.

11. Kuhlman KA, Depp R, Burns K, Sabbagha RE: Real-time ultrasonographic imaging of fetal response decrement to external acoustic stimulation. San Antonio, Texas, January 1986.

12. Tamura RK, Sabbagha RE, Depp R, Dooley SL, Socol ML: Diabetic Macrosomia Accuracy of third trimester ultrasound. San Antonio, Texas, January 1986.

13. Silver RK, Dooley SD, Tamura RK, Depp R: The impact of diminished umbilical cord Wharton's jelly and decreased amniotic fluid in prolonged pregnancy. Orlando, Florida, February 1987.

14. Kuhlman KA, Depp R: Acoustic tests in fetuses with non-reactive nonstress tests. Orlando, Florida, February 5-7, 1987.

15. MacGregor SN, Silver RK, McKnight T, Depp R: Conservative management of severe preeclampsia: A reappraisal. New Orleans, Louisiana, January 1989.

16. Fischer RL, Kuhlman KA, Wapner RJ, Depp R: Doppler evaluation of the umbilical and uterine-arcuate arteries in the postdate pregnancy. New Orleans, Louisiana, February, 1989.

17. Kuhlman KA, Depp R, Kaufmann M: "Dose Response" relationship between stimulus duration (SD) and FHR patterns with external low frequency acoustic stimulation (AS) in the near term fetus. Houston, Texas, January 27, 1990.

18. Sibai B, Caritis S, Phillips E, Klebanoff M, McNellis D, Rocco L, and the NICHD MFM Network. Prevention of preeclampsia: Low-dose aspirin in nulliparous women: A double-blind, placebo-controlled trial. San Francisco, California, February 8, 1993.

**Central Association of Obstetrics and Gynecology (CAOG)**

1. Depp R, Boehm JJ, Nosek JA, Dooley SL, Hobart JM: Antenatal corticosteroids to prevent neonatal respiratory distress syndrome: Risk versus benefit considerations. White Sulphur Springs, Virginia, September 1979.

2. Barglow P, Hatcher R, Walston J, Phelps R, Burns W, Depp R: Psychiatric risk factors in the pregnant diabetic. Minneapolis, Minnesota, September 1980.

**Other**

1. Detwiler JS, Depp OR: The fetal heart rate: An example of quantitative analysis of point process irregularity. 27th ACEMB, Philadelphia, Pennsylvania, October 1974.

2. Keith L, Hatcher R, Ellis RF, Berger GS, Depp R: Differential mortality rates between first and second twins. International Workshop on the "At Risk" Infant, Tel Aviv, Israel, July 1979.

3. Freinkel N, Metzger BE, Ogata ES, Sabbagha RE, Phelps RL, Depp R, Boehm JJ, Hellerstrom C, Lewis NJ, Johnson R, Lake W, Dudek RW: More concerning pregnancy as a "tissue culture" experience. 10th Congress of the International Diabetes Federation, Vienna, Austria, September 1979.

4. McKinney RD, Escarcena LE, Depp R: The evaluation of heart rate variations on the human fetus using spectral analysis techniques. In proceedings Eighth Northeast Bioengineering Conference, Massachusetts Institute of Technology, Boston, Massachusetts, March 1980, pp 188-191.

5. Sabbagha RE, Tamura RK, Vaisrub N, Depp R: Fetuses born preterm after spontaneous labor or rupture of membranes show diminished growth. American Institute of Ultrasound in Medicine, Annual Meeting, Denver, Colorado, 1982.

6. Tamura RK, Sabbagha RE, Depp R, Vaisrub N, Dooley SL, Socol ML: Fetuses born preterm after spontaneous labor or rupture of membranes show diminished growth. American Gynecologic and Obstetric Society, Annual Meeting, Phoenix, Arizona, September 1983.

7. Socol ML, Dooley SL, Tamura RK, Depp R: Perinatal outcome following prior delivery in the late second or early third trimester. Chicago Gynecological Society, Chicago, Illinois, March 1984.

8. Dooley SL, Tamura RK, Sabbagha RE, Depp R, Socol ML, Vaisrub N, Ober C: Ultrasound in timed pregnancies: Early expression of accelerated fetal somatic growth in diabetic versus control subjects. The American Gynecological and Obstetrical Society, Annual Meeting, Hot Springs, Virginia, September, 1984.

9. Keith L, Wittman R, Depp R, Lopez-Zeno J, Socol M: The Northwestern University Twin Study V: Comparative outcome of Twins A and B: Apgar scores and pH. International Workshop on Twin Pregnancies, Toulouse, France, September 25-27, 1985.

10. Wittman R, Keith L, Method M, Depp R: The Northwestern University Multi hospital twin study: VI. Factors relating to low Apgar scores in twin delivery. International Workshop on Twin Pregnancies, Toulouse, France, September 25-27, 1985.

11. Green OC, Winter RJ, Depp R, Dooley S, Boehm J, Ogata ES, Phelps R, Metzger BE, Freinkel N: Fuel-mediated teratogenesis: Prospective correlations between anthropometric development in childhood and antepartum maternal metabolism. Association of American Physicians, January 1987.

12. Sibai B, Gordon T, Phillips E, McNellis D, Caritis S, Romero R, Rocco L, Klebanoff M, Paul R, Depp R, et al.: Risk factors for preeclampsia in healthy nulliparous women: A prospective multicenter study. American College of Obstetricians and Gynecologists, May 1, 1993.

13. Goodwin TM, Paul R, Silver H, Valenzuela G, Depp R, Knuppel R, Renfroe Y, Creasy R, Creasy G, Lane R, and the Antocin study group. Dose Ranging Study of the Oxytocin Antagonist Antocin™ (Atosiban) and Comparison to Ritodrine. Poster presentation at the Annual Meeting of the American College of Obstetricians and Gynecologists, presented May 9, 1994, Orlando, Florida.

14. Bennett IM, Depp R, Perussia B: Differentiation of human natural killer cells from lineage negative umbilical cord blood progenitors. Poster presentation at the 9th International Congress of Immunology Meeting, Presented July 27, 1995, San Francisco, CA

**RD April 2005**

# EXHIBIT 4

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE
Curriculum Vitae

Date: March 2005

William W. Fox, M.D.

Home Address: 411 Penn Valley Road
Narberth, PA 19072

Office Address: Division of Neonatology
The Children's Hospital of Philadelphia
34th Street & Civic Center Boulevard
Philadelphia, PA 19104

Education:

| | | |
|---|---|---|
| 1958-62 | B.S. | Duke University, Durham, NC |
| 1962-66 | M.D. | Duke University Medical School, Durham, NC |

Postgraduate Training and Fellowship Appointments:

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|---|---|
| 1966-67 | Internal Medicine Internship, Presbyterian University Hospital, University of Pittsburgh, Pittsburgh, PA |
| 1969-70 | Internal Medicine Residency, Hospital of the University of Pennsylvania, Philadelphia, PA |
| 1970-72 | Pediatric Residency, The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1972-73 | Pulmonary Neonatology Fellowship, Department of Pediatrics McGill University School of Medicine and Montreal's Children's Hospital, Montreal, Canada |

Military Service:

| | |
|---|---|
| 1967-69 | Teaching in Bolivia Medical School, Co-Director of Tuberculosis Control Program, Peace Corps — U.S. Public Health Service, Bolivia, South America |

Faculty Appointments:

| | |
|---|---|
| 1973-74 | Associate in Pediatrics, Department of Pediatrics University of Pennsylvania School of Medicine |
| 1974-79 | Assistant Professor of Pediatrics, Department of Pediatrics The Children's Hospital of Philadelphia University of Pennsylvania School of Medicine |
| 1979-85 | Associate Professor of Pediatrics, Department of Pediatrics The Children's Hospital of Philadelphia University of Pennsylvania School of Medicine |

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|---|---|
| 1985- | Professor of Pediatrics, Department of Pediatrics<br>The Children's Hospital of Philadelphia<br>University of Pennsylvania School of Medicine |

Hospital and Administrative Appointments:

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|---|---|
| 1973- | Staff Neonatologist<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1973- | Staff Neonatologist<br>The Hospital of the University of Pennsylvania, Philadelphia, PA |
| 1974-82 | Director, Pulmonary Function Laboratory<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1977- | Senior Physician<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1978-94 | Medical Director, Infant Intensive Care Unit<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1982-pres/ | Director, Infant Breathing Disorder Center<br>The Children's Hospital of Philadelphia, Philadelphia, PA |
| 1982-85 | Attending Neonatologist, Lankenau Hospital, Philadelphia, PA |
| 1986-90 | Attending Neonatologist, Frankford Hospital, Philadelphia, PA |
| 1989-91 | Attending Neonatologist, Jeanes Hospital, Philadelphia, PA |
| 1982-pres. | Director, CHOP GCRC Scatterbed Research Nurse Program |

Specialty Certification:

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|---|---|
| 1974 | Diplomate of the American Board of Pediatrics |
| 1975 | Diplomate of the American Subspecialty Board of Neonatal/Perinatal Medicine |

Licensure:

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|---|---|
| 1966 | North Carolina |
| 1973 | Pennsylvania |

Awards Honors, and Membership in Honorary Societies:

| | |
|---|---|
| 1964 | Davison Fellowship<br>Duke University Medical School, Durham, NC |
| 1976 | Elected to "The Best Doctors in America" |
| 1994 | Elected to "The Best Doctors in America" |
| 1997 | Elected to "The Best Doctors in the Northeast" |
| 1998 | Elected to "The Best Doctors in America" |
| 1998 | CHOP Teaching Honor Roll |
| 1999 | CHOP Teaching Honor Roll |
| 2000 | CHOP Teaching Honor Roll |
| 2002 | CHOP Teaching Honor Roll |

| | |
|---|---|
| 2002 | Elected to "The Best Doctors in America" |
| 2003 | Elected to "The Best Doctors in America" |
| 2003 | CHOP Teaching Honor Roll |
| 2004 | Quality and Safety Award for the Clinical Practices of the University of Pennsylvania |
| 2004 | Elected to "The Best Doctors in America" |
| 2004 | Top Doctors, Philadelphia Magazine, Philadelphia, PA |
| 2004 | CHOP Teaching Honor Roll |

Membership in Professional and Scientific Societies:

National Societies:

Society for Pediatric Research
American Pediatric Society
American Lung Association
Fellow of the American Academy of Pediatrics
Southern Society for Pediatric Research

Local Societies:

Philadelphia Perinatal Society

Editorial Positions:

1982 Editor, Monograph Series on Sudden Infant Death Syndrome

Scientific Reviewer for Journals:

Pediatrics
Journal of Pediatrics
Critical Care Medicine
Pediatric Research
Developmental Pharmacology and Therapeutics
Pediatric Pulmonology

Scientific Reviewer for Grants:

March of Dimes
Thrasher Foundation
National Institutes of Health

Academic Committees at the University of Pennsylvania and Affiliated Hospitals:

| | |
|---|---|
| 1989- | Member, Fellowship Committee<br>The Children's Hospital of Philadelphia |
| 1991- | Founder and Co-director, Research Poster Day<br>The Children's Hospital of Philadelphia |

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|---|---|
| 1995- | Member, Advisory Board, Clinical Research Center<br>The Children's Hospital of Philadelphia |
| 2002- | Founder and Co-director<br>Resident's International Fellowship Program<br>The Children's Hospital of Philadelphia |

Major Teaching and Clinical Responsibilities at the University of Pennsylvania:

| | |
|---|---|
| 1. | Attending Physician, Infant Intensive Care Unit, 4 months/year<br>The Children's Hospital of Philadelphia |
| 2. | Attending Physician, Infant Intensive Care Unit, 5 months/year<br>Hospital of the University of Pennsylvania |
| 3. | Pediatrics 200 Lecturer, throughout the year |
| 4. | Physiology 201 Lecturer, once/year |
| 5. | Ob-Gyn 307 Lecturer, throughout the year |
| 6. | Neonatal Fellowship Program Participant, throughout the year |
| 7. | Lecturer, Wilderness Medicine Course<br>University of Pennsylvania School of Medicine |

**Lectures by Invitation:**

| | |
|---|---|
| February 1997 | "Liquid Ventilation" — University of Pennsylvania School of Veterinary Medicine, Philadelphia, Pennsylvania |
| March 1997 | "Liquid Ventilation" — Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| June 1997 | "Mechanical Ventilation of the Neonate"<br>"Advances in Neonatal Care/Liquid Ventilation"<br>"Pulmonary Function Evaluation"<br>Neonatology Symposium, Cochabamba Bolivia |
| June 1997 | "Mechanical Ventilation of the Neonate"<br>National Medical School of Bolivia, La Paz, Bolivia |
| October 1997 | "Liquid Ventilation in the Surgical Neonate"<br>Surgical Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| November 1997 | "Mechanical Ventilation of the Neonate"<br>1) "PPHN in the Neonate"<br>2) "Liquid Ventilation of the Neonate"<br>3) "Nitric Oxide in the Neonate"<br>International Symposium, Concepción, Chile |

| | |
|---|---|
| 1995- | Member, Advisory Board, Clinical Research Center<br>The Children's Hospital of Philadelphia |
| 2002- | Founder and Co-director<br>Resident's International Fellowship Program<br>The Children's Hospital of Philadelphia |

Major Teaching and Clinical Responsibilities at the University of Pennsylvania:

| | |
|---|---|
| 1. | Attending Physician, Infant Intensive Care Unit, 4 months/year<br>The Children's Hospital of Philadelphia |
| 2. | Attending Physician, Infant Intensive Care Unit, 5 months/year<br>Hospital of the University of Pennsylvania |
| 3. | Pediatrics 200 Lecturer, throughout the year |
| 4. | Physiology 201 Lecturer, once/year |
| 5. | Ob-Gyn 307 Lecturer, throughout the year |
| 6. | Neonatal Fellowship Program Participant, throughout the year |
| 7. | Lecturer, Wilderness Medicine Course<br>University of Pennsylvania School of Medicine |

**Lectures by Invitation:**

| | |
|---|---|
| February 1997 | "Liquid Ventilation" — University of Pennsylvania School of Veterinary Medicine, Philadelphia, Pennsylvania |
| March 1997 | "Liquid Ventilation" — Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| June 1997 | "Mechanical Ventilation of the Neonate"<br>"Advances in Neonatal Care/Liquid Ventilation"<br>"Pulmonary Function Evaluation"<br>Neonatology Symposium, Cochabamba Bolivia |
| June 1997 | "Mechanical Ventilation of the Neonate"<br>National Medical School of Bolivia, La Paz, Bolivia |
| October 1997 | "Liquid Ventilation in the Surgical Neonate"<br>Surgical Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| November 1997 | "Mechanical Ventilation of the Neonate"<br>1) "PPHN in the Neonate"<br>2) "Liquid Ventilation of the Neonate"<br>3) "Nitric Oxide in the Neonate"<br>International Symposium, Concepción, Chile |

**Lectures by Invitation:** ***(continued)***

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|---|---|
| November 1997 | "Advances in Mechanical Ventilation of the Neonate"<br>Neonatal Grand Rounds, St. Christopher's Hospital for Children, Philadelphia, Pennsylvania |
| April 1998 | "International Medicine" — Grand Rounds<br>The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania. |
| October 1998 | "Liquid Ventilation"<br>"Persistent Pulmonary Hypertension of the Newborn"<br>"Mechanical Ventilation of the Neonate"<br>"Respiratory Failure in the Neonate"<br>"High Frequency Ventilation and Cases"<br>Philadelphia-Salzburg Seminars<br>Sponsored by The American Austrian Foundation<br>Salzburg, Austria |
| March 10, 1999 | "An Update of Liquid Ventilation"<br>Philadelphia Perinatal Society, Phila., Pennsylvania |
| June, 1999 | "New Advances in Mechanical Ventilation of the Neonate"<br>"Liquid Ventilation and Respiratory Failure"<br>Cochabamba Medical School, Cochabamba Bolivia |
| June 1999 | "Neonatal Respiratory Distress Syndrome"<br>"Mechanical Ventilation of the Neonate"<br>La Paz Medical School, La Paz Bolivia |
| March 16, 2000 | "Liquid Ventilation for the Next Milennium"<br>Surgical Grand Rounds, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania |
| November, 2000 | "Travel Electives in South America" — International Group, University of Pennsylvania School of Medicine |
| April, 2001 | "High Altitude Pulmonary Edema"<br>Wilderness Medicine Course, International Group<br>University of Pennsylvania School of Medicine |
| April, 2002 | "High Altitude Pulmonary Edema"<br>Wilderness Medicine Course, International Group<br>University of Pennsylvania School of Medicine |
| January 24, 2003 | "Ventilating the Very Low Birthweight Infant: When, How, Why?"<br>A Day with the Newborn Seminar<br>St. Christopher's Hospital, Philadelphia, PA |

**Lectures by Invitation:** ***(continued)***

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|---|---|
| April, 2003 | "High Altitude Pulmonary Edema"<br>Wilderness Medicine Course, International Group<br>University of Pennsylvania School of Medicine |
| July 2003 | "Early Continuous Positive Airway Pressure"<br>La Paz Medical School, La Paz Bolivia |
| July 2003 | "Neonatal Mechanical Ventilation"<br>Cochabamba Medical School, Cochabamba Bolivia |

Bibliography:

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Weis CM, Cox CA, Fox WW: Oxygen Therapy in the Neonate. In Spitzer A, editor. Intensive Care of the Fetus and Neonate. St. Louis, MO: Mosby, published 2004.

Books:

Keck CW, and Fox WW: The Bolivian Ministry of Public Health Corps Tuberculosis Control Program in the Yungas Area of Bolivia, La Paz Press, 1969.

Polin RA and Fox WW, editors: The Newborn (Volume I and II). Pediatric Clinics of North America. W.B. Saunders Company, Philadelphia, 1986.

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Polin RA and Fox WW, editors: Fetal and Neonatal Physiology. W.B. Saunders Company, Philadelphia, 1992.

Polin RA and Fox WW, editors. Fetal and Neonatal Physiology, 2nd Edition. W.B. Saunders Company, Philadelphia, PA, 1998.

Polin RA and Fox WW, Abman S, editors. Fetal and Neonatal Physiology, 3rd Edition. W.B. Saunders Company, Philadelphia, PA, Oct. 2003.

Principal Investigator of Grants:

Neonatal Pulmonary Research, sponsored by Ohmeda Medical
December 2002 to July 2004 — $3,600.

NIH-CRC Neonatal Scatterbed Nurse Program
July 2000 to June 2005 — $175,000/year x 5 years.

A Collaborative Clinical Trial on High Frequency Jet Ventilation in Premature Infants,
National Institutes of Health, $820,000, 1984-1990.

Burroughs-Wellcome Co., Beta-Casomorphin Study. $30,000/2 years, 1989-1991

Glaxo Inc., Effects of Albuterol on Pulmonary Mechanics in Infants with Bronchopulmonary Dysplasia, $15,000, 1987-1989

Parker B. Francis Foundation, Fellowship Training Grant, $50,000/year, 1978-1983

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ORDER**

AND NOW, to wit, this _____ day of _____, 2006 upon Motion of the Plaintiffs, it appearing that neither Dr. Depp nor Dr. Fox practice in the specialty of pathology, it further appearing that neither Dr. Fox nor Dr. Depp are trained as pathologists, it is hereby Ordered that Dr. Depp and Dr. Fox are precluded on testifying contrary to the opinions and findings of the pathologist and neuropathologist in the autopsy report.

BY THE COURT

_____

Judge

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Motion in Limine to Preclude Testimony of the Defendant's Experts Dr. William W. Fox, and Dr. Richard Depp, Which Contradict the Pathologist and Neuropathologist who Conducted the Autopsy Report was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail

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State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: July 5, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

**MOTION IN LIMINE TO PRECLUDE REFERENCE TO CIRCUMSTANCES SURROUNDING VACUUM EXTRACTION DELIVERY**

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.

Counsel of Record for This Party:

David R. Johnson, Esquire
PA I.D. #26409

Brad R. Korinski, Esquire
PA I.D. #86831

THOMSON, RHODES & COWIE, P.C.
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FILED NO CC
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JUL 10 2006

William A. Shaw
Prothonotary/Clerk of Courts

MOTION IN LIMINE TO PRECLUDE REFERENCE
TO CIRCUMSTANCES OF VACUUM EXTRACTION DELIVERY

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and files the following motion in limine.

## I. INTRODUCTION

1. The purpose of this motion in limine is to preclude plaintiffs from making prejudicial, irrelevant and immaterial references at trial which comment upon the circumstances of the vacuum assisted extraction delivery of plaintiffs' decedent on May 10, 2002. Although mentioned generally in the amended complaint, the fact that plaintiffs' decedent was delivered through a vacuum assisted method does not comprise any aspect of the liability allegations plead against this defendant, DRMC. Moreover, plaintiffs have not offered any expert opinion to advance a theory that the type of delivery method employed resulted in any injury or increased risk of harm to the decedent. In fact, Dr. James Mollick, plaintiffs' ob/gyn expert, has concluded the use of vacuum extraction to be of no impact whatsoever upon the health of Mikayla Rhoades.

2. Without the support of expert testimony as to its causative relevance, the fact that decedent was delivered with the assistance of a vacuum device is irrelevant to the issues to be decided in this case. However, even if relevant, the facts surrounding the vacuum extraction, as plead in the complaint and as testified to by witnesses in this case, are of such a prejudicial nature that their admission into evidence may confuse and mislead the jury, causing it to render a verdict in a professional liability case based upon a liability theory neither plead nor supported by expert testimony.

3. The pertinent facts are plead in ¶ 25 of the amended complaint, which concern the emergency measures undertaken by the defendants in response to the sudden onset of fetal distress experienced by the decedent. In this regard, plaintiffs have averred the following.

> "The infant Mikayla was ultimately born by vaginal delivery with vacuum assistance and the performance of an episiotomy on Kimberly Rhoades. The vacuum assistance consisted of four pulls, and two pop offs during the attempt to deliver. Efforts to commence vacuum extraction were delayed due to the fact that all of the parts necessary to operate the vacuum extraction device were not available in the delivery

room at the time of the delivery. The pressure of the vacuum extraction was not reduced during uterine contraction."

4. This defendant believes that plaintiffs will to introduce facts surrounding such averments for the purpose of: (a) suggesting culpability based on these events (notwithstanding the absence of expert testimony linking these facts in any way to causation); and (b) improperly inflaming the emotions of the jury solely for the purpose of prejudicing this defendant and the healthcare professionals with whom it is associated. These inherently prejudicial misleading matters have absolutely no place in this professional liability case and any reference to them should be precluded from argument to the jury for the reasons that: (1) facts relating to the vacuum extraction do not constitute any aspect of the liability theories plead against this defendant, and are thus irrelevant; (2) plaintiff has submitted no expert opinion that, even if the above averments are assumed to be true, any circumstances surrounding the vacuum extraction resulted in any negligent conduct or caused harm to the decedent or plaintiffs; and (3) the prejudicial nature of such allegations to the defendants vastly outweighs any scant relevance which the circumstances of the vacuum extraction delivery may otherwise possess.

## II. LEGAL ARGUMENT

### A. Evidence or Testimony Concerning the Vacuum Extraction Is Irrelevant to the Liability Theories Plead Against this Defendant

5. The fundamental consideration in determining the admissibility of evidence is whether the proferred evidence is relevant to facts sought to be proved at trial. Evidence is relevant if it tends to make a fact at issue more or less probable. Gregg v. Fisher, 377 Pa. 445, 105 A.2d 105 (1954); Martin v. Soblotney, 502 Pa. 418, 466 A.2d 1022 (1983).

6. Relevance has two aspects: materiality and probative value. "It must be determined first, if the inference sought to be raised by the evidence bears upon a matter at issue in the case and, second, whether the evidence renders the desired inference more probably true than if the evidence had not been presented. Commonwealth v. Stewart, 461 Pa. 274, 336 A.2d 282, 284 (1975).

7. The relevant issues herein are framed by the nature of this case as a professional liability action. To sustain such a case, a plaintiff must establish the following elements: (1) a duty owed to a

patient; (2) the breach of that duty by a healthcare provider; (3) that the breach stands as a proximate cause of the injury alleged; and (4) that the damages sought arose from the injury. Rauch v. Mike-Mayer, 783 A.2d 815 (Pa. Super. 2001).

8. Plaintiffs have not alleged any negligence claim against this defendant for performance of the vacuum extraction. To the contrary, the liability averments lodged against DRMC solely concern the conduct of its nursing staff in: (1) not discontinuing the administration of pitocin after becoming aware of fetal distress; (2) not properly notifying Dr. Kruszewski; and (3) not taking appropriate action in response to the fetal distress. (See, amended complaint ¶ 33). Indeed, at p. 32 of his report, plaintiffs' expert, Dr. Mollick, characterizes the mode of delivery (i.e., the vacuum extraction) as "irrelevant."

9. Therefore, the circumstances surrounding the vacuum extraction are irrelevant to those elements of plaintiffs' cause of action which must be proved at trial. Further buttressing the irrelevancy of this information is the fact that, despite contending that Dr. Kruszewski is liable for negligence in the vacuum extraction (See, amended complaint ¶ 32), these allegations are not supported by the requisite expert testimony to establish either the breach of the standard of care or causation. Thus, for all of the above reasons, such allegations should be excluded for their lack of relevance pursuant to Rule of Evidence 402.

B. Evidence or Testimony Concerning the Vacuum Extraction Should Be Excluded Pursuant to Rule of Evidence 403 Because It is Inherently Prejudicial and Misleading

10. Particularly in light of the fact that it does not form the basis of any liability allegation against this defendant, in the factual context of this professional liability action, there is perhaps no more inflammatory or prejudicial picture that can be painted for a jury than that, at the last minute, the healthcare providers could not locate necessary equipment and that, when used, the vacuum device "popped off" from head of the newborn. Introduction of such matters encourage the jury to render a liability verdict against this defendant on allegations that have not been plead or supported by expert reports. Moreover, such evidence would be extraordinarily misleading because, by all accounts, these events were immaterial to what occurred.

11. Rule of Evidence 403 provides that relevant evidence may be excluded if its probative value is outweighed by the danger of unfair prejudice, confusion of the issues or potential for misleading the jury. Prejudicial evidence is that which has the undue tendency to suggest to the jury a decision on an improper basis, far removed from the particular facts of the case. Mahan v. Am-Guard, 841 A.2d 1052 (Pa. Super. 2004). If the weight of the evidence is very slight (as is the case herein), even a small risk of unfair prejudice or waste of time will justify its exclusion. Commonwealth v. Klick, 272 Pa. Super. 61, 414 A.2d 669 (1972).

12. Here, any possible relevance presented by the allegations made by plaintiff in relation to the vacuum extraction delivery pale in comparison to the latent prejudicial effect which certainly will arise if such information is permitted to be offered to the jury. Without any expert testimony/opinion to support its materiality, introduction of this information may cause the jury to render a verdict based upon its emotions and or reasons and factors far divorced from the matters at issue as framed by the pleadings and expert reports.

13. The potential prejudice of plaintiffs' allegations to this defendant is extraordinary. The evidentiary weight of such allegations is extremely light, if at all extant. Accordingly, plaintiff should be estopped from offering any argument, testimony or evidence to the jury pertaining to the vacuum extraction delivery pursuant to Rule of Evidence 403.

C. Any Allegations Concerning the Vacuum Extraction Delivery Lack the Support of Expert Testimony and Should Be Excluded on This Basis

14. This is a professional liability case in which plaintiffs contend that the alleged negligent conduct of the defendants in providing healthcare resulted in harm.

15. In medical malpractice cases, litigants are required to produce expert testimony in order to establish the elements of negligence. Brillman v. Saylor, 761 A.2d 1208 (Pa. Super. 2000). It is incumbent upon a plaintiff to produce an expert opinion, to a reasonable degree of medical certainty, that the given defendant deviated from the standard of care and that the deviation stands as the proximate cause of plaintiff's injury. Grandelli v. Methodist Hospital, 777 A.2d 1138 (Pa. Super. 2001).

16. Additionally, in medical malpractice actions, plaintiffs are precluded from offering expert testimony at trial which is at variance with the theories of liability advanced against a defendant in the pleadings; such conduct constitutes an impermissible amendment of the cause of action beyond the statute of limitations. Reynolds v. Thomas Jefferson University Hospital, 676 A.2d 1205, 1209 (1996).

17. The expert reports submitted by plaintiffs in this litigation do not specially opine that the use of vacuum extraction (or any delay in the vacuum extraction being performed) was inappropriate, that it constituted a breach in the standard of care or that the breach caused harm to the decedent.

18. Indeed, Dr. Mollick, plaintiffs' ob/gyn expert, in the midst of his report reviewing the care provided to Mikayla Rhoades offered the following opinion - actually discounting the idea that the vacuum extraction caused any untoward consequences to the decedent.

> "It is my opinion that progressive, repetitive, severely variable decelerations with total loss of variability associated with hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, rendering mode of delivery at this point irrelevant."

See, Mollick Report, p. 32 of 36.

> "Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised."

See, Mollick Report, p. 32 of 36.

19. Moreover, at no point do any of plaintiffs' experts opine that the standard of care required the delivery suite to be stocked with a vacuum extractor or that the failure to have certain equipment on hand harmed the decedent.

20. Under Pennsylvania law, experts are limited to the four corners of their expert reports and are precluded from testifying at trial inconsistent with or beyond the scope of their reports. Pa. R.C.P. 4003.5.

21. Because plaintiffs will be unable to offer any expert opinion at trial that the vacuum extraction delivery or any of the circumstances surrounding it caused any harm to the decedent, such

matters are completely irrelevant to the cause of action being litigated by plaintiffs, as they cannot form the basis for any recovery by plaintiffs against these defendants.

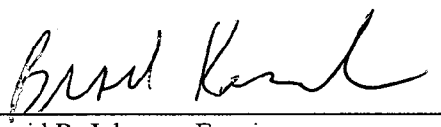
## III. CONCLUSION

22. For all of the reasons stated above, plaintiffs cannot be permitted to offer any testimony, evidence or argument to the jury pertaining to the vacuum extraction delivery of the decedent, since such matters are irrelevant, inflammatory and prejudicial, legally incongruous to the claims alleged and without the support of any expert opinion whatsoever as to their materiality. Allowing plaintiffs to introduce such matters to the jury constitutes reversible error.

WHEREFORE, DuBois Regional Medical Center, one of the defendants, respectfully requests that this Honorable Court grant its motion in limine and preclude plaintiff from making any argument to the jury, whether by the evidence, testimony or via counsel, concerning, in any way, the circumstances surrounding the vacuum extraction delivery of the decedent on May 10, 2002.

Respectfully Submitted,

THOMSON, RHODES & COWIE, P.C.



David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center,
one of the defendants.

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within document has been served upon the following counsel of record and same placed in the U.S. Mails on this 7th day of July, 2006:

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Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | |
|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | CIVIL DIVISION |
| | No. 03-1268 CD |
| Plaintiffs, | Issue No. |
| Vs. | |
| MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER, | |
| Defendants. | |

ORDER OF COURT

AND NOW, to wit, on this _____ day of _____, 2006, upon consideration of the motion in to preclude reference to circumstances surrounding the vacuum extraction delivery of the decedent, it is hereby ORDERED, ADJUDGED and DECREED that said motion is GRANTED.

Plaintiffs are prohibited from introducing any evidence or testimony at trial, via witnesses, counsel or otherwise, concerning the circumstances surrounding the vacuum extraction delivery of the decedent, and plaintiffs expert witnesses may not offer any opinion concerning different with or addition to that which is already contained with their reports attached to plaintiffs' pre-trial statement.

_____J.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

**MOTION IN LIMINE TO PROHIBIT PLAINTIFFS FROM PURSUING LIABILITY THEORIES AT TRIAL WHICH HAVE NOT BEEN IN THEIR AMENDED COMPLAINT**

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.

Counsel of Record for This Party:

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PA I.D. #26409

Brad R. Korinski, Esquire
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FILED NO CC
JUL 10 2006
William A. Shaw
Prothonotary/Clerk of Courts

MOTION IN LIMINE TO PROHIBIT PLAINTIFFS FROM PURSUING LIABIILTY THEORIES AT TRIAL WHICH HAVE NOT BEEN PLEAD IN THEIR AMENDED COMPLAINT

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and files the following motion in limine.

1. The purpose of this motion in limine is two-fold: (1) to clarify the liability theories which plaintiffs may advance at trial against DRMC per those averments specified in the Amended Complaint; and (2) to preclude the testimony of plaintiffs' experts James Mollick, M.D. and Dianne Moore, Ph.D., R.N., in that reports from both experts contain opinions critical of DRMC and its nursing staff which are not otherwise plead in the amended complaint.

2. As this Court is aware, this case pertains to medical treatment provided to mother-plaintiff at DRMC by the defendant physician and other healthcare personnel pursuant to her pregnancy. Due to complications unrelated to the professional negligence of any of the individuals or entities therein involved, mother-plaintiff's fetus unexpectedly experienced severe problems which resulted in the death of the fetus on May 11, 2002.

3. The operative pleading in this case is plaintiffs' amended complaint filed on October 14, 2003. (Attached hereto as exhibit "A").

4. The liability theories averred by plaintiffs against DRMC are contained within ¶ 33 of the amended complaint. The totality of ¶ 33 is reproduced below.

> "[DRMC] was negligent in that:
>
> (a) The failure of the staff of [DRMC] to discontinue administration of pitocin when they became aware of severe and progressive variable decelerations was a departure from good and accepted standards of medical care.

(b) The failure of the staff of [DRMC] to make Dr. Kruszewski aware of the severe and progressive variable declerations was a departure from good and accepted standards of medical care.

(c) The failure of the staff of [DRMC] to take any action when the fetal distress became apparent was a departure from good and acceptable standards of medical care."

5. Despite the specific allegations contained within the second amended complaint, the plaintiffs' liability expert witnesses address a myriad of theories which are not plead. The report of James Mollick, M.D. (ob/gyn expert) and the report of Dianne Moore, Ph.D., R.N. (nursing expert) are attached hereto as exhibits "B" and "C," respectively.

## I. THE OPINIONS EXPRESSED IN THE REPORT OF DR. MOLLICK GO BEYOND THE ALLEGATIONS OF THE AMENDED COMPLAINT

6. The following theories are raised by Dr. Mollick as criticisms of DRMC and its nursing staff, but nowhere in the amended complaints are such bases of liability plead - indeed, in submitting Dr. Mollick's report, plaintiffs have surreptitiously and improperly sought to amend their complaint.

(a) "The induction of labor was not indicated and conducted below the accepted standard." (See exhibit "B," p. 10).

(b) "There was nothing in the record to support that the maternal pelvis and fetal size were evaluated prior to induction ... They [the nurses and Dr. Kruszewski] failed to monitor the patient appropriately by utilizing internal fetal monitoring with a scalp electrode and intrauterine pressure device." (See exhibit "B," p. 12).

(c) "Dr. Kruszewski and the nurses failed to recognize that this patient was arrested in the active phase of labor which was a contraindication to the use of intravenous pitocin." (See exhibit "B," p. 14).

(d) "Aggressive pitocin augmentation was not indicated and below the accepted standard of care." (See exhibit "B," p. 17).

(e) "The patient was exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive pitocin augmentation ..." (See exhibit "B," p. 19).

(f) "The aggressive use of pitocin and the failure to recognize the uterine hyperstimulation and the repetitive periodic changes were below the standard of care." (See exhibit "B," p. 20).

(g) "Because of the difficulty the nurses were having maintaining a tracing with the tokometer, the poor tracing quality, elevated baseline and uterine hyperstimulation, placement of an intrauterine pressure device was mandatory. Not doing so was below the accepted standard of care." (See exhibit "B," p. 21).

(h) "The nurses ... failed to recognize and act on the inadequate tracing of uterine contractions, uterine hypertonus, and failed to recognize the multiple episodes of uterine hyperstimulation. These deviations were below the accepted standard of care." (See exhibit "B," p. 21).

(i) "They [the nurses] ... failed to place an intrauterine pressure device and fetal scalp electrode to monitor fetal well-being and short term viability." (See exhibit "B," p. 21).

(j) "The nurses ... were unfamiliar with the basic concepts and principles of fetal monitoring resulting in the unrecognized progressive iatrogenic fetal asphyxia." (See exhibit "B," p. 22).

(k) "The nurses ... were unfamiliar with the patho-physiology and clinical presentation of fetal asphyxia." (See exhibit "B," p. 23).

(l) "In my opinion ... this baby was repetitively and progressively iatrogenically asphyxiated by the nursing staff ... resulting in profound central nervous system destruction, and eventually the death of the baby." (See exhibit "B," p. 27).

(m) "She [the nurse] failed to place a scalp electrode and intrauterine pressure device ... These deviations were below the accepted standard of care." (See exhibit "B," p. 29).

(n). The report is replete with allegations that the nurses failed to follow purportedly applicable hospital policies and procedures. (See exhibit "B," pp. 34-35).

A. Negligence in Failing to Follow Hospital Policies

7. Plaintiffs' amended complaint does not assert a cause of action against DRMC for negligence based upon a failure of the nurses to follow hospital policies and procedures, nor does it allege that the hospital negligently failed to enforce such policies. (See, pp. 1 and 2 of this motion, supra.).

8. However, plaintiffs' expert report of Dr. Mollick contains numerous opinions and observations that the nursing staff breached the standard of care by not following specific hospital policies. For example, Dr. Mollick comments as follows:

> "Beginning at 2250 the patient was noted to be hyperstimulated associated with multiple repetitive severe variable decelerations, with loss of variability, mandating discontinuing the pitocin, placement of a scalp electrode and intrauterine pressure device, and performing an emergency c-section. Not doing so was below the accepted standard of

> care. According to the Hospital Policy and Procedure Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns ...."

See exhibit "B," p. 7; See also, p. 8, p. 21 and pp. 34-35 (addressing P/PR 61.2 entitled "Ominous Fetal Heart Rate Pattern); p. 10 and p. 18 (addressing P/PR 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor); p. 28 and p. 35 (addressing P/PR 82 entitled Physician Notification in Maternal/Fetal Distress).

9. The amended complaint never alleges any negligence by the nursing staff for failure to adhere to or follow the policies and procedures enacted by DRMC. Thus, plaintiffs must be precluded at trial from presenting any evidence, testimony or argument to the effect that the nursing staff was negligent based on its failure to follow hospital policies and procedures.

B. Negligence in Initiating Induction of Labor

10. Plaintiffs' amended complaint does not assert a cause of action against the nursing staff for negligence based on the initial decision to undertake induction of labor (via intravenous administration of pitocin). See, pp. 1 and 2 of this motion, supra.). Rather, the amended complaint contends that, as to the nurses, **the pitocin should have been discontinued** at the signs of progress variable decelerations and fetal distress. The gravaman of plaintiffs' cause of action, based upon the allegations in the complaint, is that pitocin should have been **stopped**, not that it should never have been initiated or continued up to the point where they allege fetal distress became apparent.

11. However, plaintiffs' expert report asserts that the nurses breached the standard of care by **initiating** pitocin to augment mother-plaintiff's labor. Specifically, Dr. Mollick has offered the following opinions:

> "Aggressive pitocin augmentation was not indicated and below the accepted standard of care." (See, exhibit "B," p. 17).

See also, p. 10 ("induction of labor not indicated and below accepted standard"); p. 14 (opinion that pitocin should not have been used since patient was arrested and in active stage of labor); p. 19 (allegation that pitocin augmentation caused iatrogenic uterine hyperstimulation); p. 20 (use of pitocin alleged to be below the standard of care).

12. Plaintiffs must be precluded at trial from presenting any evidence or testimony to the effect that the nurses were negligent based on the initiation or continuation of pitocin augmentation beyond that period of time plead in the amended complaint. That is, plaintiffs must be confined at trial to pursuing the liability theory that the nurses were negligent for the administration of pitocin only "when they became aware of severe and progressive variable declerations," as set forth in the amended complaint.

C. Negligence in Failing to Document Aspects of Mother-Plaintiff's Care

13. Plaintiffs' amended complaint does not assert a cause of action against DRMC for the negligence of its nurses to properly document within the medical records the care and treatment of mother-plaintiff or other pertinent vital signs or test results. (See, pp. 1 and 2 of this motion, supra.).

14. Yet, at p. 12 of the report, plaintiffs' expert, Dr. Mollick, appears to criticize the nursing staff for failing to have documentation of the maternal fetal and pelvis size prior to initiating pitocin augmentation. (See, exhibit "B," p. 12). Although not specifically alleged, there is language at various portions of Dr. Mollick's report that can be construed to further criticize DRMC for some alleged lack of documentation. See also, p. 2 and p. 13 (noting lack of written indications for induction of labor).

15. Since plaintiffs did not premise a cause of action upon the adequacy of the nursing staff's documentation, plaintiffs must be precluded from presenting evidence, testimony or argument to the effect that the nurses were negligent based upon items that they did not include in the medical records.

D. Negligence in Failing to Monitor the Condition of Mother-Plaintiff and Her Fetus, Including Through the Use of Scalp Electrodes and/or an Intrauterine Pressure Device

16. The amended complaint does not allege a cause of action against the nurses for negligence based upon any alleged failure to appropriately monitor the mother-plaintiff or fetus. Indeed, the converse is true. All the allegations lodged against DRMC are premised upon the specific assertion that its nurses became aware of the onset of the fetal distress, but failed to either: (a) stop the pitocin; (b) notify Dr. Kruszewski of the fetal distress; or (c) undertake action in response to the fetal distress. (See, pp. 1 and 2 of this motion, supra.).

17. Thus, the issue plead in the amended complaint is the failure to recognize the significance of the information obtained as a result of monitoring, not the failure to employ a certain type of monitoring and/or doing the monitoring in a negligent fashion.

18. In contrast, Dr. Mollick repeatedly alleges that the nursing staff breached the standard of care by not using scalp electrodes or intrauterine pressure devices. For example, Dr. Mollick opines that:

> "An IV fluid was given at 2244; oxygen was started at 2247 via nasal cannula. A scalp electrode and intrauterine pressure catheter were mandatory in this situation. Not utilizing these modalities was below the accepted standard of care." (See, exhibit "B," p. 18).

See also, pp. 12, 20, 21 and 29 (containing criticisms of the nursing staff for failing to use appropriate monitoring devices); pp. 22-23 ("nurses were unfamiliar with the basic concepts and principles of fetal monitoring ...").

19. Additionally, and in complete contradiction to the averments of the complaint, Dr. Mollick also opines that the nursing failed to recognize episodes of uterine hyperstimulation - a condition which, Dr. Mollick claims, if recognized, would have led to appropriate treatment being provided to mother-plaintiff. See, exhibit "B," p. 21.

See also, pp. 20 (failure to recognize uterine hyperstimulation is deemed to fall below standard of care).

20. Plaintiffs must be precluded at trial from presenting evidence, testimony or argument to the effect that the nursing staff was negligent based on the allegation of any failure to apply the correct type of monitoring devices, specifically scalp electrodes or intrauterine pressure catheter devices, and/or any allegation that the nursing staff failed to appropriately monitor either mother-plaintiff or the fetus.

## II. THE OPINIONS EXPRESSED IN THE REPORT OF DR. MOLLICK GO BEYOND THE ALLEGATIONS OF THE AMENDED COMPLAINT

21. As is the case with the opinions expressed by Dr. Mollick, supra., several of the criticisms made against DRMC and its nursing staff by Nurse Moore in her report also bear no relation to the pleadings; thus Nurse Moore's report constitutes an improper attempt to supplement the amended complaint subsequent to the closure of the pleadings.

22. Nurse Moore's report is attached to this motion as exhibit "C." Her report diverges from the allegations of the amended complaint in the following particular areas, all of which will be specifically addressed in the below paragraphs:

(a) Criticism of the pre-natal care provided to mother-plaintiff. See, exhibit "C," p. 1

(b) Criticism of the initial labor examination performed at the hospital on May 10, 2002, and the alleged lack of documentation of findings made during that examination. See, exhibit "C," p. 1.

(c) Criticism of the nursing staff for failing to consider the possibility of a pro-lapsed cord. See, exhibit "C," p. 1.

(d) Criticism of the nursing staff for failing to properly monitor the condition of the fetus (including via application of an internal monitoring device). See, exhibit "C," pp. 1-3.

(e) Criticism of the nursing staff for failing to follow hospital policies and procedures. See, exhibit "C," p. 3.

A. Negligence for Failing to Provide Appropriate Pre-Natal Care and Counseling Prior to May 10, 2002

23. The allegations made against DRMC and its nursing staff concern conduct which occurred after mother-plaintiff arrived at the hospital on May 10, 2002. All of the allegations of negligence in the amended complaint concern events which occurred on that date.

24. Yet, in her report, Nurse Moore levels criticisms against DRMC for treatment of mother-plaintiff provided prior to May 10, 2002.

> "... She had a total of 13 prenatal visits which showed adequate fetal growth and movement, normal NST's, ultrasounds and BPP. Mrs. Rhoades developed edema of her hands, feet and face as well as a rise in her blood pressure along with a 47 lb weight gain. PIH laboratory work was ordered along with an ultrasound and NST and BPP, they were reported as normal but there is no evidence in the pre-natal notes of any further care, teaching or advice. Since she is an 'elderly primipara' there is a higher incidence of pre-eclampsia to be concerned about." See, exhibit "C," p. 1.

25. Because the allegations in the amended complaint solely concern events which occurred during mother-plaintiff's treatment on May 10, 2002, plaintiffs should be barred from offering any opinions, testimony or evidence that DRMC and its nursing staff were negligent in any manner for treatment provided to mother-plaintiff and the fetus prior to May 10, 2002.

B. Negligence Pertaining to the Initial Examination on May 10, 2002 and Any Allegation of Improper Documentation by the Nursing Staff

26. The allegations of the amended complaint against DRMC are strictly confined to those events which occurred subsequent to the nursing staff allegedly becoming aware that the fetus was in a distressed state. (See, pp. 1 and 2 of this motion, supra.).

27. Nonetheless, takes specific issue with the performance and documentation of the initial labor examination conducted upon mother-plaintiff.

> "... There is a late ultrasound with an EFW of 3500 grams which translates to an slightly larger than average size baby of approximately 7 pounds 11.5 ounces but no follow up clinically either prior to labor or when she was admitted to the hospital in labor. The labor examination does not include an evaluation of fetal size, engagement of the head or position, all of which are important in a primpara especially when the vaginal examination shows a - 3 station and the plan is induction/augmentation of labor." (See, exhibit "C," p. 1).

28. Nurse Moore also finds fault with the nursing staff for not reporting "on a concern for a prolapsed cord which is a strong possibility with a - 3 station. (See, exhibit "C," p. 1).

29. Any criticisms pertaining to the initial labor examination, nursing documentation of the results of that examination and/or any events occurring prior to the nurses' allegedly becoming aware to the child's fetal distress do not have any basis in the amended complaint. As such, plaintiffs must be precluded from offering any testimony, evidence or argument at trial as to any alleged deficiency with either the initial labor examination, the nursing documentation or any circumstances surrounding same.

C. Negligence as to the Monitoring of the Condition of Mother-Plaintiff and Her Fetus

30. This is the same issue as is discussed in paragraphs 16-20 of this motion, supra., involving similar allegations/opinions contained within the report of Dr. Mollick. As with Dr. Mollick, Nurse

Moore opines that the nurses should have undertaken the monitoring of mother-plaintiff and the fetus through different modalities (namely through placement of an internal fetal monitor).

31. Again, there is no averment in the amended complaint that the nursing staff failed to become aware of the condition of the fetus because of a lack of monitoring; to the contrary, the thrust of the liability claims against DRMC involve allegations of what the nursing staff should have done after it became aware of the fetal distress being then experienced.

32. Yet, on page 3 of her report, Nurse Moore opines that a "safer course of action would have been to use an internal fetal monitor to get a true picture of the fetal and uterine response ..." (See, exhibit "C," p. 3).

33. Plaintiffs must be precluded at trial from presenting evidence, testimony or argument to the effect that the nursing staff was negligent based on the allegation of any failure to apply the correct type of monitoring devices, specifically scalp electrodes or intrauterine pressure catheter devices, and/or any allegation that the nursing staff failed to appropriately monitor either mother-plaintiff or the fetus.

D. Negligence Based Upon Allegations of Failing to Follow Hospital Policies and Procedures

34. The amended complaint does not allege that the nursing staff was negligent because it failed to follow internal hospital policies and procedures. (See, pp. 1 and 2 of this motion, supra.).

35. However, in her report, Nurse Moore opines that the nursing staff should have followed the applicable hospital policies to notify Dr. Kruszewski of the condition of the mother-plaintiff and the fetus. It thus appears that Nurse Moore premises a portion of her standard of care opinion against the nursing staff upon their alleged running afoul of DRMC policies and procedures.

36. The amended complaint never alleges any negligence by the nursing staff for failure to adhere to or follow the policies and procedures enacted by DRMC. Thus, plaintiffs must be precluded at trial from presenting any evidence, testimony or argument to the effect that the nursing staff was negligent based on its failure to follow hospital policies and procedures.

## III. PENNSYLVANIA LAW PROHIBITS PLAINTFFS FROM PURSUING LEGAL THEORIES AT TRIAL WHICH HAVE NOT BEEN PLEAD

37. A complaint must not only give the defendant notice of what the plaintiff's claim is and the grounds upon which it rests, but it must also formulate the issues by summarizing the facts essential to support the claim. Baker, et al. v. Rangos, 324 A.2d 498 (Pa. Super. 1974). This holding follows upon the general principle that Pennsylvania is a fact pleading state, which, as set forth in Pa. R.C.P. 1019(a), requires specificity in all pleadings.

38. A plaintiff is barred from filing a complaint which avers a one cause of action and, then, be permitted, on the eve of trial, to prove a different cause of action which has not been plead. Smith v. County of Allegheny, 155 A.2d 615, 616 (Pa. 1959). The purpose behind this prohibitory rule is that, if a plaintiff were permitted to proceed upon a cause of action not otherwise plead, this would permit the filing of a new cause of action beyond the statute of limitations. *See* Junk v. East End Fire Dept., 396 A.2d 1296, 1277 (Pa. 1978); Laursen v. General Hospital of Monroe County, 431 A.2d 237 (Pa. 1981); Reynolds v. Thomas Jefferson University Hospital, 676 A.2d 1205 (Pa. Super. 1996), appeal denied, 700 A.2d 442 (Pa. 1996).

39. A new cause of action arises if the amendment proposes a different theory or a different kind of negligence than the one previously raised or if the operative facts supporting the claim are changed. Junk v. East End Fire Dept., 396 A.2d 1269, 1277 (Pa. 1978). As the Supreme Court in Junk instructed:

> "A cause of action in negligence has been defined as the negligent act or acts which occasioned the injury for which relief is sought. Cox v. Wilkes Barre Railway Corp., 6 A.2d 538, 539 (Pa. 1939) ... A new cause of action does not exist if plaintiff's amendment merely adds to or amplifies the original complaint or if the original complaint states a cause of action showing that the plaintiff has a legal right to recover what is claimed in the subsequent complaint. Wilson v. Howard Johnson Restaurant, 219 A.2d 676 (Pa. 1966) ... A new cause of action does arise, however, if the amendment proposes a different theory or a different kind of negligence than the one previously raised or if the operative facts supporting the claim are changed. ..." Junk, 396 A.2d at 1277.

40. In Reynolds v. Thomas Jefferson University Hospital, 676 A.2d 1205 (Pa. Super. 1996), the Superior Court applied the "new cause of action" definition supplied by Junk, supra., to preclude a plaintiff's expert from alleging that the agents of the hospital were negligent in failing to refer a patient to a specialist, when the complaint only contained allegations that the agents were liable for the conduct in the placement and removal of an endotracheal tube. Reynolds stands for the proposition that plaintiffs can only advance at trial theories that have first been averred in the pleadings. If any material variance exists between the pleadings and trial theories, the holding of Reynolds concluded that the plaintiffs are actually attempting to assert a "new cause of action" that should be barred by the expiry of the statute of limitations. Id., 676 A.2d 1212.

41. Here, the statute of limitation has long since passed for all claims related to the birth and death of Mikayla Rhoades.

## IV. CONCLUSION

42. Pursuant to Pennsylvania law, plaintiffs are estopped from advancing at trial (through the testimony of experts and the like) theories of recovery which have not been contained within the pleadings. Therefore, Dr. Mollick should be precluded from testifying as to issues involving: (1) negligence of the nurses in failing to follow hospital policies; (2) negligence of the nurses in inducing labor through pitocin augmentation; (3) negligence of the nursing staff in allegedly failing to make appropriate documentation of care and treatment; (4) negligence of the nursing staff in failing to properly monitor the condition of mother-plaintiff and the fetus.

43. Additionally, Dr. Mollick should be precluded from expressing any opinions critical of the nursing staff for failing to follow the nursing standard of care for the reason that he is not a nurse and does not possess any reasonable pretense of knowledge (from either his training or experience) to offer an opinion upon this topic.

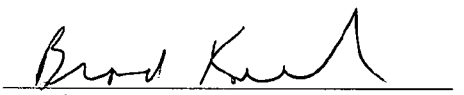
44. For the same reason that Dr. Mollick's expert testimony must be confined to those theories of liability plead in the amended complaint, Nurse Moore must also be precluded from offering

opinion on the following matters: (1) negligence of DRMC/the nursing staff for failing to provide appropriate care and treatment for any time prior to May 10, 2002; (2) negligence of the nursing staff pertaining to the initial labor examination on May 10, 2002 and any alleged lack of documentation of treatment during the course of mother-plaintiff's care; (3) negligence based upon any claim that the nurses failed to appropriately monitor mother-plaintiff and the fetus; and (4) negligence of the nurses in failing to follow hospital policies and procedures.

45. Accordingly, plaintiffs should be barred and precluded from presenting at trial any evidence, testimony or argument, by either an attorney or witness, on any matters which are outside of those allegation plead against DRMC and its nursing as found in paragraph 33 of the amended complaint.

Respectfully Submitted,

THOMSON, RHODES & COWIE, P.C.



David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center,
one of the defendants.

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within document has been served upon the following counsel of record and same placed in the U.S. Mails on this _____ day of _____, 2006:

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David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | |
|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | CIVIL DIVISION<br>No. 03-1268 CD |
| Plaintiffs, | Issue No. |
| Vs. | |
| MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER, | |
| Defendants. | |

ORDER OF COURT

AND NOW, to wit, on this _____ day of _____, 2006, upon consideration of the motion in limine to prohibit plaintiffs from pursuing liability theories at trial which have not been plead in the amended complaint, it is hereby ORDERED, ADJUDGED and DECREED that said motion is GRANTED.

Plaintiffs are prohibited from introducing any evidence or testimony that DuBois Regional Medical Center and/or any members of its nursing staff breached the standard of care toward the plaintiffs by: (1) failing to follow hospital policies; (2) negligently inducing labor through pitocin augmentation; (3) failing to make appropriate documentation of care and treatment; (4) failing to properly monitor the condition of mother-plaintiff and the fetus; (5) failing to provide appropriate care and treatment for any time prior to May 10, 2002; and (6) negligence pertaining to the initial labor examination on May 10, 2002.

In all other respects, the testimony of plaintiffs' expert witnesses as to liability will be confined to those allegations plead against DuBois Regional Medical Center set forth in paragraph 33 of the amended complaint.

_____J.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**AMENDED COMPLAINT**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

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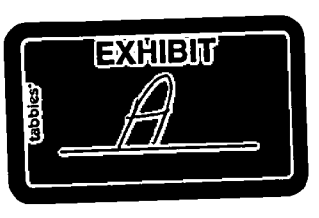


IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

David S. Meholick, Court Administrator
Clearfield County Courthouse
Clearfield, PA 16830
(814) 765-2641, Ext. 5982

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY D. RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**AMENDED COMPLAINT**

AND NOW come the Plaintiffs Dennis R. and Kimberly D. Rhoades, individually, and as personal representatives of the Estate of Mikayla Rhoades, and set forth the following Amended Complaint in support of their cause of action.

1. The Plaintiffs Dennis R. and Kimberly D. Rhoades are adults, residents of the Commonwealth and reside at R.D. #2, Brookville, Pennsylvania. Plaintiffs were the parents and natural guardians of Mikayla Rhoades, at all times material hereto. Dennis R. and Kimberly D. Rhoades were appointed the personal representatives of the Estate of Mikayla Rhoades by the Register of Wills of Jefferson County on July 7, 2003.

2. Defendant Mary Kruszewski is an individual and at all times material hereto was believed to be a duly licensed and practicing physician specializing in obstetrics and gynecology having an address of 90 Beaver Drive, DuBois, Pennsylvania 15801.

3. The Defendant DuBois Regional Medical Center is a Pennsylvania corporation having an address of 100 Hospital Avenue, DuBois, Pennsylvania 15801. At all times material hereto DuBois Regional Medical Center provided the facilities, staff, and privileges to Dr. Kruszewski, and, acting through its agents, servants, and employees participated in the delivery of the Plaintiffs' decedent, and in the acts set forth herein.

**JURISDICTION**

4. Jurisdiction of this Court is conferred by 42 Pa.C.S. §931 granting the Courts of Common Pleas original jurisdiction over actions and proceedings, including actions and proceedings at law. This is an action in trespass, a survival action, and a wrongful death action.

**VENUE**

5. Venue is in the Court of Common Pleas of Clearfield County, in that the Defendants maintain their respective places of business in Clearfield County, Pennsylvania, and in that the cause of action arose or took place in Clearfield County, Pennsylvania.

**FACTS**

6. The Plaintiffs Dennis and Kimberly Rhoades, husband and wife, sought the

professional medical assistance of Mary Kruszewski, D.O. on or about June 22, 2001.

7. Subsequent to the initial establishment of a physician/patient relationship with Dr. Kruszewski, Kimberly Rhoades became pregnant and Dr. Kruszewski agreed to perform gynecological and obstetric services including but not limited to monitoring and supervising her pregnancy, and delivery of her child at the DuBois Regional Medical Center.

8. The DuBois Regional Medical Center provided staff privileges to Dr. Kruszewski, and provided the facility, staff, and equipment for the monitoring and delivery of the Plaintiffs' infant Mikayla.

9. At all times material hereto Dr. Kruszewski held herself out as being a specialist in the field of obstetrics and gynecology.

10. At all times material hereto the DuBois Regional Medical Center held itself out to be a medical facility having the staff and equipment necessary to provide monitoring and delivery services to the Plaintiffs for the birth of their child.

11. Throughout the course of her pregnancy and up to and including the time of delivery the Plaintiff Kimberly Rhoades was under the care and treatment of Dr. Kruszewski, and services necessary to monitor maternal health and fetal development were provided by Dr. Kruszewski and the DuBois Regional Medical Center.

12. On or about April 18, 2002 Kimberly Rhoades commenced a course of weekly visits to Dr. Kruszewski, for the monitoring and supervision of her pregnancy. During that time Kimberly Rhoades expressed concerns about the size of the baby to Dr. Kruszenski on several occasions.

13. On May 9, 2002 Dr. Kruszewski directed Mrs. Rhoades to present herself at the

DuBois Regional Medical Center on May 10, 2002 for the purpose of inducing labor.

14. Mrs. Rhoades presented herself at the DuBois Regional Medical Center on May 10, 2002 at 7:00 a.m. There was no determination made of the condition of the mother or child before inducing of labor.

15. Mrs. Rhoades was admitted for induction of labor and delivery of her infant at the request and direction of Dr. Kruszewski. During the course of Mrs. Rhoades' admission the following principal and secondary procedures were performed by Dr. Kruszewski and/or agents, servants, or employees of the Medical Center: vacuum assisted vaginal delivery over midline episiotomy, repair of episiotomy, amniotonomy, pitocin augmentation of labor, and continuous administration of epidural anesthesia during labor.

16. At the time of the admission of Mrs. Rhoades to the Medical Center neither Dr. Kruszewski nor the DuBois Regional Medical Center had requested or required a determination of the fetal weight of the unborn infant either clinically or sonigraphically, although a sonogram had been performed on several occasions during Mrs. Rhoades' pregnancy.

17. At the time of the admission of Mrs. Rhoades to the Medical Center there was no effort made during the pre-admission procedure to obtain the informed consent of the parents regarding the following:

(a) vacuum assisted vaginal delivery over midline episiotomy

(b) repair of episiotomy

(c) amniotonomy

(d) administration of continuous epidural anesthesia during labor

(e) pitocin augmentation of labor and delivery of a large baby.

18. There was no discussion with either of the parents with respect to the nature of pitocin induced delivery or any material facts, risks, complications or alternatives to pitocin induced delivery of a large bodied infant, nor was there any discussion with the parents that a caesarean section delivery was an alternative.

19. The failure to evaluate fetal weight and to properly counsel a patient when she had a large baby, regarding the pitocin augmentation of labor and vacuum assisted vaginal delivery of the infant over a midline episiotomy and alternatives to this method of delivery, was a departure from good and accepted standards of medical care, and a battery.

20. Induction of labor by administration of pitocin at the DuBois Regional Medical Center commenced at 12:40 p.m. after Mrs. Rhoades' admission on May 10, 2002, however the labor progressed very slowly.

21. At 3:37 p.m. on May 10, 2002, monitors being used by nurses employed by and under the supervision and control of the DuBois Medical Center demonstrated a fetal bradycardia, which ultimately recovered, however administration of the drug pitocin to Mrs. Rhoades was never discontinued and no precautions were taken by the hospital employees upon the occurrence of the fetal bradycardia to avoid fetal distress. The failure to take any precaution to assure the health of the infant upon the occurrence of fetal bradycardia was a departure from good and accepted standards of medical care.

22. As the induction of labor continued severe and progressive variable decelerations, signs of fetal distress, were revealed by the monitors and noted by a hospital nurse employed by

and under the control and supervision of the DuBois Regional Medical Center. Administration of the drug pitocin was not discontinued at this time nor were any other steps to avoid further fetal distress, which was a departure from good and accepted standards of medical care.

23. As the induced labor continued at 10:46 p.m., decelerations continued and became progressively more severe. The decelerations were noted by an attending nurse. Failure to deliver the infant Mikayla at or prior to this time by caesarean section constituted negligence, willful and wanton conduct and reckless indifference to the rights of the infant and her parents.

24. Administration of the drug pitocin was discontinued at 11:42 p.m. on May 10, 2002.

25. The infant Mikayla was ultimately born by vaginal delivery with vacuum assistance and the performance of an episiotomy on Kimberly Rhoades. The vacuum assistance consisted of four pulls, and two pop offs during the attempt to deliver. Efforts to commence vacuum extraction were delayed due to the fact that all of the parts necessary to operate the vacuum extraction device were not available in the delivery room at the time of delivery. The pressure of the vacuum extraction was not reduced during uterine contractions.

26. The infant Mikayla was born at 11:52 p.m. on May 10, 2002, severely asphyxiated, and thereafter she suffered seizures, temporal bleeding, swelling and other affects of the asphyxiation.

27. Subsequent to the complications surrounding her delivery the infant Mikayla was transferred to Children's Hospital in Pittsburgh on May 11, 2002.

28. During the four days of her life, as a result of the asphyxia, the infant Mikayla suffered seizures, temporal bleeding, swelling and other affects of the asphyxia as more fully described in the records of Children's Hospital.

29. The infant Mikayla was treated at Children's Hospital of Pittsburgh from May 11, 2002 until May 14, 2002. On May 14, 2002, after discussions with neonatology, neurology, and social work divisions of Children's Hospital, and the parents, due to the infant Mikayla's condition and poor prognosis for meaningful recovery, life support was withdrawn. Mikayla died on May 14, 2002.

30. Dennis R. and Kimberly Rhoades were present during the delivery and personally witnessed the delivery and the incidents described herein which preceded the delivery and attended the infant during the four days of her life.

31. The negligence of the Defendants caused the birth asphyxia and death of the infant Mikayla.

32. Dr. Kruszewski was negligent in that:

(a) Dr. Kruszewski failed to evaluate fetal weight and properly counsel a patient with a macrosomic baby as to the potential risks of induced labor as opposed to other methods of delivery of a large baby;

(b) The use of vacuum extraction was inappropriate in this situation, and represented a departure from good and accepted standards of medical care.

(c) The failure of Dr. Kruszewski to order the discontinuance of the administration of pitocin when she became aware of severe and progressive variable decelerations was a departure from good and accepted standards of medical care.

(d) Dr. Kruszewski's failure to deliver the infant by caesarian section represented a deviation from good and accepted medical care.

(e) Dr. Kruszewski failed to have all equipment necessary for use of vacuum assisted delivery present in the delivery room.

(f) Dr. Kruszewski failed to obtain the informed consent of the parents regarding the delivery of a macrosomic baby.

33. The DuBois Regional Medical Center was negligent in that:

(a) the failure of the staff of the DuBois Regional Medical Center to discontinue administration of pitocin when they became aware of severe and progressive variable decelerations was a departure from good and accepted standards of medical care.

(b) the failure of the staff of the DuBois Regional Medical Center to make Dr. Kruszewski aware of the severe and progressive variable decelerations was a departure from good and accepted standards of medical care.

(c) the failure of the staff of the DuBois Regional Medical Center to take any action when the fetal distress became apparent was a departure from good and acceptable standards of medical care.

34. Dr. Kruszewski committed a battery on the Plaintiff Kimberly Rhoades in performing the procedures described herein by failing to obtain the informed consent of the Plaintiff Kimberly Rhoades for the procedures previously described, in connection with the vacuum assisted vaginal delivery over a midline episiotomy, and continuous administration of epidural anesthesia, surgical procedures within the meaning of the Health Care Services Malpractice Act, 40 P.S. §1303.504, and she breached her duty to provide sufficient material information necessary for a patient to determine whether to proceed with the surgical or operative procedure being performed. The battery was committed in the presence of the Plaintiffs, Dennis and Kimberly Rhoades.

35. Dr. Kruszewski failed to obtain the informed consent of the parents regarding the procedures she employed during the delivery of the infant Mikayla, and failed to provide them with sufficient material information necessary for them to determine whether to proceed with the

suggested operative procedures being performed.

36. The failure on the part of Dr. Kruszewski to obtain the informed consent of the parents to perform the surgical procedure set forth in the prior paragraphs as to the manner of delivery of the infant Mikayla caused the infant Mikayla to suffer severe birth asphyxia resulting in her death.

37. Dr. Kruszewski and the attending employees of the DuBois Regional Medical Center failed to possess and use the degree of skill and care ordinarily exercised or which would have been exercised by other physicians and delivery room employees, in similar circumstances.

38. The failure of Dr. Kruszewski and the hospital attendants to exercise a requisite degree of care and skill in the treatment and care of Kimberly Rhoades and the infant Mikayla was a direct and proximate cause of the asphyxia and infant death.

39. The failure to obtain the informed consent of the parents with respect to the procedure performed by Dr. Kruszewski and employees of the hospital, given the infant's condition, and to provide the parents with alternatives to surgical procedures performed on Mrs. Rhoades constituted an intentional tort, to wit, battery and resulted in severe birth asphyxia and death.

40. Dr. Kruszewski and the employees of the DuBois Regional Medical Center failed to exercise reasonable care, where the condition of the infant required prompt treatment, and prompt treatment was necessary based upon the condition of the mother and fetal distress of the infant, which failure resulted in the infant's birth asphyxia and death.

41. Dr. Kruszewski and the employees of the DuBois Regional Medical Center failed to recognize and treat the infant Mikayla's deteriorating condition in the face of obvious clinical signs and symptoms of fetal distress, which failure resulted in the birth asphyxia and eventual

death.

42. Dr. Kruszewski and the employees of the DuBois Regional Medical Center failed to act in a reasonable and diligent manner which resulted in the severe birth asphyxia and eventual death of the infant.

43. Dr. Kruszewski and the employees of the DuBois Regional Medical Center failed to diagnose the fetal distress of the infant, and respond in a timely manner, which resulted in severe birth asphyxia and eventual death.

44. Dr. Kruszewski and the employees of the DuBois Regional Medical Center allowed the infant to sustain asphyxia resulting in her ultimate death while under their care due to the negligent acts set forth herein.

45. As a direct and proximate cause of the negligence of Dr. Kruszewski and the employees of the DuBois Regional Medical Center the Plaintiffs individually on their own behalf, and as personal representatives of the decedent's estate, to the extent allowed under the law, claim compensatory and, if appropriate, punitive damages as follows:

(a) For the infant Mikayla's pain and suffering between the time she came under the care of Dr. Kruszewski until the time of her death.

(b) For economic loss including the infant's potential future earning power and other income.

(c) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life.

(d) for negligent infliction of emotional distress.

(e) For pecuniary losses suffered by the decedent's survivor by reason of her death, and reimbursement for medical bills, funeral expenses and other expenses incurred therewith and recoverable under the law.

(f) Such other damages as may be allowed under the Wrongful Death & Survival Acts and the laws of the Commonwealth of Pennsylvania.

(g) for damages arising out of the failure to obtain the Plaintiffs' informed consent.

## COUNT I -- FAILURE TO OBTAIN INFORMED CONSENT DENNIS R. AND KIMBERLY RHOADES VS. MARY C. KRUSZEWSKI, D.O.

46. Paragraphs 1 through 45 are incorporated herein by reference as if fully set forth.

47. Plaintiffs bring this action against Dr. Kruszewski, as an intentional tort, in that Dr. Kruszewski failed to obtain the informed consent of the Plaintiffs to perform the type of procedures which were performed on Mrs. Rhoades without fully advising her that Mikalya was a large baby, and of the potential complications arising from of the type of delivery conducted by the Defendants for a large baby and her mother.

48. As a direct and proximate cause of the failure of the Defendants to obtain the informed consent of the Plaintiffs, the Plaintiffs, individually, on their own behalf, and to the extent allowable under the law claim compensatory, and, if appropriate, punitive damages as follows:

(a) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life,

(b) For infliction of emotional distress.

(c) For economic damages arising out of the battery.

WHEREFORE, the Plaintiffs respectfully demand judgment in their favor for compensatory and punitive damages and against Dr. Mary C. Kruszewski in an amount in excess of the arbitration limits of Clearfield County including record costs and such interest as may be allowed by law.

**COUNT II -- FAILURE TO OBTAIN INFORMED CONSENT**
**DENNIS R. AND KIMBERLY RHOADES VS.**
**DuBOIS REGIONAL MEDICAL CENTER**

49. Paragraphs 1 through 45 are incorporated herein by reference as if fully set forth.

50. Plaintiffs bring this action against the DuBois Regional Medical Center, as an intentional tort, in that the Defendants, having accepted the responsibility to obtain the informed consent of Kimberly Rhoades to the procedures which were performed upon her, failed to obtain the informed consent of the Plaintiffs to perform the type of procedures which were performed on Mrs. Rhoades without fully advising her that Mikalya was a macrosomic baby, and of the potential complications arising from of the type of delivery conducted by the Defendants for a macrosomic baby and her mother.

51. As a direct and proximate cause of the failure of the Defendants to obtain the informed consent of the Plaintiffs, the Plaintiffs, individually, on their own behalf, and to the extent allowable under the law claim compensatory, and, if appropriate, punitive damages as follows:

(a) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life,

(b) For infliction of emotional distress.

(c) For economic damages arising out of the battery.

WHEREFORE, the Plaintiffs respectfully demand judgment in their favor for compensatory and punitive damages and against the DuBois Regional Medical Center in an amount in excess of the arbitration limits of Clearfield County including record costs and such interest as may be allowed by law.

## COUNT III -- WRONGFUL DEATH ACTION
## DENNIS R. AND KIMBERLY RHOADES, PERSONAL REPRESENTATIVES OF THE ESTATE OF MIKAYLA RHOADES VS. MARY C. KRUSZEWSKI, D.O.

52. Paragraphs 1 through 45 are incorporated herein by reference as if fully set forth.

53. The Plaintiffs bring this action under and by virtue of the laws of the Commonwealth, specifically they bring a wrongful death action pursuant to 42 Pa.C.S. §8301. The Plaintiffs are the parents and natural guardians of the decedent, and the personal representatives of the Estate of the decedent. The Plaintiffs are the only persons entitled by law to recover damages under the Wrongful Death Statute, and this action is brought in their behalf pursuant to Rule 2204 of the Pa. Rules of Civil Procedure.

54. As a direct and proximate cause of the negligence of Dr. Mary C. Kruszewski, the

Plaintiffs, to the extent allowable under the law claim compensatory, and if appropriate, punitive damages as follows:

(a) For the decedent's pain and suffering between the time of her birth and the time of her death,

(b) For economic loss, including the decedent's potential earning power,

(c) Any and all other financial losses suffered as a result of her untimely death,

(d) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life,

(e) For pecuniary losses suffered by the decedent's survivors by reason of her death, and reimbursement for medical bills, funeral expenses and other expenses incurred therewith and recoverable under law;

(f) All damages as may be allowed under the Wrongful Death Act and the laws of the Commonwealth of Pennsylvania.

WHEREFORE, the Plaintiffs respectfully demand judgment in their favor and against Dr. Mary C. Kruszewski in an amount in excess of the arbitration limits of Clearfield County including record costs and such interest as may be allowed by law.

## COUNT IV -- WRONGFUL DEATH ACTION
## DENNIS R. AND KIMBERLY RHOADES, PERSONAL REPRESENTATIVES OF THE ESTATE OF MIKAYLA RHOADES VS. DuBOIS REGIONAL MEDICAL CENTER

55. Paragraphs 1 through 45 are incorporated herein by reference as if fully set forth.

56. The Plaintiffs bring this action under and by virtue of the laws of the Commonwealth, specifically they bring a wrongful death action pursuant to 42 Pa.C.S. §8301. The Plaintiffs are the parents and natural guardians of the decedent, and the personal representatives of the Estate of the decedent. The Plaintiffs are the only persons entitled by law to recover damages under the Wrongful Death Statute, and this action is brought in their behalf pursuant to Rule 2204 of the Pennsylvania Rules of Civil Procedure.

57. As a direct and proximate cause of the negligence of the Defendants, the Plaintiffs, to the extent allowable under the law claim compensatory, and if appropriate, punitive damages as follows:

(a) For the decedent's pain and suffering between the time of her birth and the time of her death,

(b) For economic loss, including the decedent's potential earning power,

(c) Any and all other financial losses suffered as a result of her untimely death,

(d) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life,

(e) For pecuniary losses suffered by the decedent's survivors by reason of her death, and reimbursement for medical bills, funeral expenses and other expenses incurred therewith and recoverable under law;

(f) All damages as may be allowed under the Wrongful Death Act and the laws of the Commonwealth of Pennsylvania.

WHEREFORE, the Plaintiffs respectfully demand judgment in their favor and against the DuBois Regional Medical Center in an amount in excess of the arbitration limits of Clearfield

County including record costs and such interest as may be allowed by law.

## COUNT V – SURVIVAL ACTION
## DENNIS R. AND KIMBERLY RHOADES, PERSONAL REPRESENTATIVES OF THE ESTATE OF MIKAYLA RHOADES VS. MARY C. KRUSZEWSKI, D.O.

58. Paragraphs 1 through 45 are incorporated herein by reference as if fully set forth.

59. The Plaintiffs Dennis R. and Kimberly D. Rhoades are the personal representatives of the Estate of the decedent, and bring this action on behalf of the Estate of the decedent under and by virtue of the laws of the Commonwealth of Pennsylvania, 20 Pa. C.S. §3373 and 42 Pa.C.S. §8302 and claim such damages as may be allowed by law, and if appropriate, punitive damages including but not limited to the following:

(a) For the decedent's pain and suffering between the time of her birth, and the time of her death,

(b) For economic loss, including the decedent's potential earning power,

(c) Any and all other financial losses suffered as a result of her untimely death,

(d) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life,

(e) For pecuniary losses suffered by the decedent's survivors by reason of her death, and reimbursement for medical bills, funeral expenses and other expenses incurred therewith and recoverable under law;

(f) All damages as may be allowed under the Survival Act and the laws of the Commonwealth of Pennsylvania.

WHEREFORE, the Plaintiffs respectfully demand judgment in their favor and against Dr. Mary C. Kruszewski in an amount in excess of the arbitration limits of Clearfield County, including record costs and such interest as may be allowed by law.

**COUNT VI -- SURVIVAL ACTION**
**DENNIS R. AND KIMBERLY RHOADES VS.**
**DuBOIS REGIONAL MEDICAL CENTER**

60. The averments of Paragraphs 1 through 45 incorporated herein by reference as if fully set forth.

61. The Plaintiffs Dennis R. and Kimberly D. Rhoades are the personal representatives of the Estate of the decedent, and bring this action on behalf of the Estate of the decedent under and by virtue of the laws of the Commonwealth of Pennsylvania, 20 Pa. C.S. §3373 and 42 Pa.C.S. §8302 and claim such damages as may be allowed by law, and if appropriate, punitive damages including but not limited to the following:

(a) For the decedent's pain and suffering between the time of her birth, and the time of her death,

(b) For economic loss, including the decedent's potential earning power,

(c) Any and all other financial losses suffered as a result of her untimely death,

(d) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life,

(e) For pecuniary losses suffered by the decedent's survivors by reason of her death, and reimbursement for medical bills, funeral expenses and other expenses incurred therewith and recoverable under law;

(f) All damages as may be allowed under the Survival Act and the laws of the Commonwealth of Pennsylvania.

WHEREFORE, the Plaintiffs respectfully demand judgment in their favor and against the Defendants in an amount in excess of the arbitration limits of Clearfield County, including record costs and such interest as may be allowed by law.

## COUNT VII -- NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS DENNIS R. AND KIMBERLY RHOADES VS. MARY C. KRUSZEWSKI, D.O.

62. Paragraphs 1 through 45 are incorporated herein as if fully set forth.

63. As a direct and proximate cause of the negligence of Dr. Mary C. Kruszewski, the Plaintiffs lost their child and have, as a result thereof, suffered emotional distress. Both parents were present and witnessed this Defendant's negligence as set forth previously herein, and witnessed the effects of that negligence during the four days of their infant's life.

64. As a direct and proximate cause of the action of Dr. Mary C. Kruszewski, the Plaintiffs, and to the extent allowable under the law claim compensatory and if appropriate punitive damages as follows:

(a) For pain, suffering and inconvenience to the extent recoverable under the law,

and loss of enjoyment of life.

(b) For negligent infliction of emotional distress resulting from the loss of their child.

WHEREFORE, Plaintiffs, Dennis R. and Kimberly Rhoades respectfully demand judgment in their favor and against Dr. Mary C. Kruszewski in an amount in excess of the arbitration limits of Clearfield County including costs and interest.

## COUNT VIII -- NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS DENNIS R. AND KIMBERLY RHOADES VS. DuBOIS REGIONAL MEDICAL CENTER

65. Paragraphs 1 through 45 are incorporated herein as if fully set forth.

66. As a direct and proximate cause of the negligence of the DuBois Regional Medical Center, the Plaintiffs lost their child and have, as a result thereof, suffered emotional distress. Both parents were present and witnessed this Defendant's negligence as set forth previously herein, and witnessed the effects of that negligence during the four days of their infant's life.

67. As a direct and proximate cause of the action of the DuBois Regional Medical Center, the Plaintiffs, and to the extent allowable under the law claim compensatory and if appropriate punitive damages as follows:

(a) For pain, suffering and inconvenience to the extent recoverable under the law, and loss of enjoyment of life.

(b) For negligent infliction of emotional distress resulting from the loss of their child.

WHEREFORE, Plaintiffs, Dennis R. and Kimberly Rhoades respectfully demand judgment in their favor and against the DuBois Regional Medical Center in an amount in excess of the arbitration limits of Clearfield County including costs and interest.

**COUNT XI - NEGLIGENCE**
**DENNIS R. & KIMBERLY RHOADES IN THEIR OWN RIGHT VS. DR. KRUSZEWSKI**

68. The averments of Paragraphs 1 through 45 are incorporated herein as if fully set forth.

69. The negligence of Dr. Kruszewski in failing to counsel the Plaintiffs with respect to the availability of an elective procedure, specifically the delivery by a caesarean section injured Kimberly Rhoades to the extent that she had to endure an excruciating and prolonged delivery, which ultimately resulted in the birth of a child who had suffered asphyxia during the delivery process.

70. In addition to the prolonged and excruciating delivery, Kimberly Rhoades was required to undergo an episiotomy, and to undergo several treatments of epidural anesthesia, which could otherwise have been avoided had she been properly counseled, and made aware of the option of caesarean section delivery. As a result of the negligence of Dr. Kruszewski, in failing to properly counsel the Plaintiffs, and in failing to timely intervene when the fetal distress

of the infant became apparent, the Plaintiffs endured and suffered the birth of an injured child, and suffered through the four days of the infant's life, all of which could have been avoided but for the negligence of Dr. Kruszewski.

71. As a result of the negligence of Dr. Kruszewski the Plaintiffs were required to make a decision to terminate life support of the infant Mikayla.

72. As a direct and proximate result of the negligence of Dr. Mary C. Kruszewski the Plaintiffs, to the extent allowable under law claim compensatory, and if appropriate punitive damages as follows:

(a) For the pain and suffering caused by the prolonged delivery,

(b) For the pain and suffering resulting from the episiotomy performed by Dr. Kruszewski,

(c) For emotional distress suffered as a result of the loss of their infant daughter,

(d) For loss of consortium on the part of the husband Plaintiff.

WHEREFORE, the Plaintiffs respectfully demands judgment in their favor and against Dr. Kruszewski in an amount in excess of the arbitration limits of Clearfield County, including record costs and such interest as may be allowed by law.

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**VERIFICATION AFFIDAVIT**

I verify that the statements made herein are true and correct to the best of my knowledge, information and belief.

I understand that false statements herein are made subject to the penalties of 18 Pa. C.S., §4904, relating to unsworn falsifications to authorities.

Kimberly D. Bloodis

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Amended Complaint was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

DATED: October 14, 2003

Respectfully submitted,

Robert P. Ging, Jr., Esquire

PHONE (610) 279-6621

NORRISTOWN OB-GYN ASSOCIATES, P.C.
*WOMEN'S CENTER*
1437 MEDICAL ARTS BUILDING • SUITE 101
1437 DEKALB STREET
NORRISTOWN, PA 19401-3405

J. J. FITZGERALD, III, D.O.

J. L. MOLLICK, M.D.

February 15, 2005

Received DRJ

FEB 2 1 2005

Place ( ) Discussion ( )
Diary/Note ( )
Copy to Chart ( ) Copy Mailed ( )

Robert P. Ging
2095 Humbert Road
Confluence, PA 15424-2371

Re: Kim Rhoades

Dear Mr. Ging,

Thank you for allowing me to review the Rhoades case. I have reviewed the following medical records:

1. Amended Complaint,

2. Answer and New Matter to Plaintiffs' Amended Complaint filed on behalf of Mary C. Kruszewski, D.O.,

3. Answers and Objections to Interrogatories to Dr. Kruszewski and Request for Production of Documents,

4. Answers to interrogatories to the Dubois Regional Medical Center and request for production of documents,

5. Supplemental answers to interrogatories to the Dubois Regional Medical Center,

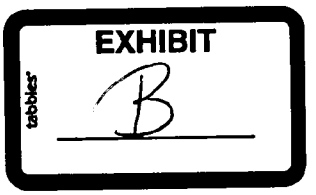
6. Amended answers to interrogatories to Dubois Regional Medical Center,

7. Objections and responses to interrogatories to the Dubois Regional Medical

8. Response to request for production of expert reports,

9. Medical records of Kimberly D. Rhoades (including prenatal records 2001-02), Mary C. Kruszewski D.O. and the Dubois Regional Medical Center (2002 admission),

10. Medical records of Mikayla Rhoades (birth to death 2002) including records of Sundar Chandrasekhar, M.D., Dubois Regional Medical Center (2002), Children's Hospital of Pittsburgh (2002) and the Final autopsy Report (2002),



11. Deposition's of Mary Kruszewski, D.O., Gloria Bennett, R.N., Tina Newell, R.N., Sheri Kizina, R.N., Suzanne McCullough, R.N., Shawn Welsh, R.N., Desiree Smith, R.N., Karen Consentino, Brian Yeskevich, M.D., Richard Grout, M.D.,

12. Expert Reports of Deborah Sommer, M.D., Diane Moore, PhD, RN, William Houston Reed, PhD, and Kimberly A. Comport RN.

After review of the records, depositions, an expert reports, I have reached the following opinions and conclusions to a reasonable degree of medical certainty:

Kim Rhoades was a 33-year-old white female G1P0000 with an LMP of 8/3/02, an EDC of 5/10/02 confirmed by a 13.5 week ultrasound done on 11/1/01. Prior to becoming pregnant she had a workup for infertility including hysterosalpingogram and semen analysis.

She was followed prenatally by Mary Kruszewski, D.O., and was seen for 13 prenatal visits. The patient was noted to have several elevated blood pressures during her pregnancy with negative workups.

The patient had several ultrasound examinations during her pregnancy. Dr. Kruszewski did not recognize that the reports failed to include a percentile weight for gestational age. The ultrasound done on 4/18/02 revealed a 38 week and five day fetus with an estimated fetal weight of 3382 grams. There was a normal amount of amniotic fluid present. A biophysical profile at that time was 8/8.

Her final prenatal visit was recorded on 5/9/02 at which time the patient was 39.6 weeks, had a blood pressure of 126/88, negative urine protein, and a cervical exam which was posterior and soft with no indication of cervical dilatation. Induction was scheduled for the A. M. of 5/10/02. I could not find documentation indicating the reason for the induction, and/or any documentation of a conversation explaining the indications for and risks of induction of labor with the patient. These deviations were below the accepted standard of care.

The patient was admitted Dubois Regional Medical Center on 5/9/02 for induction of labor (see orders for protocol for induction of labor using IV pitocin and routine labor/delivery). A verbal order was given by Dr. Kruszewski at 1200 on 5/10/02 to start pitocin per protocol.

According to the admission note by Dr. Kruszewski dated 5/10/02 at 7:40 a.m.:

"Prenatal course was unremarkable except blood pressure has been increasing slowly the past couple of weeks. Preeclampsia labs, BPP, and NST weré done 4/18 and were all normal." "Monitor shows good FHT variability. Mild contractions q 1 -- 2 minutes." "Cx exam was performed and membranes ruptured during exam. Cx 3-4/75%/-3/Vertex."

According to the Dubois Regional Medical Center's Maternity Department Policy and Procedure Manual (hereafter "Hospital's Policy and Procedure"), Policy and Procedure, No. 76.1, entitled Active Management of Labor in Primipara:

"In patients admitted in spontaneous labor make a definitive diagnosis as soon as possible.

A. Diagnosis based on the following criteria:
   1. Contractions: At least 1 in 7 minutes.
   2. Show.
   3. Rupture of membranes.
   4. State of Cervix:
      a. If effacement at least 70%-80%
      b. Cervical dilation of 3 cm or greater.
      c. Contractions as above, then in labor."

These criteria support that this patient was in labor on admission.

According to Dr. Kruszewski's admission note, "Hook was used to rupture membranes further and large amount of clear fluid was obtained."

Dr. Kruszewski deviated from the Hospital's Policy and Procedures, P/PR No. 79, entitled Protocol for Amniotomy which states:

"The artificial rupture of membranes may only be carried out by a physician. The fetal head must be fully engaged in the pelvis prior to amniotomy."

According to the progress record authored by Dr. Kruszewski on 5/10/02 at 9:30 p.m.:

"The patient was noted to be 8 to 9 cm/100%/minus 1-0/vertex.... FHT's have been good throughout."

This was the only progress note written by Dr. Kruszewski from the time of admission until delivery.

According to Dr. Kruszewski's Delivery Note on 5/11/02 at to 12:55 a.m.:

"Patient was complete approximately 10:00 p.m... She pushed well and vertex came down to plus 1 to plus 2 station. Baby had a sustained bradycardia and vacuum was applied. Delivery was accomplished in one to two minutes after vacuum applied. Baby was suctioned and NICU personnel were called for resuscitation. Baby was delivered from OA positioned with vacuum over a midline episiotomy. Birth time was 11:52 p.m... Placenta delivered intact at 11:54 p.m. A cord pH was 7.13."

In review of the Vacuum Assisted Delivery Sheet dated 5/11/02 at 12:50 a.m., the fetal station was noted to be +1-+2, consistent with a midpelvic delivery. There were 4 pulls recorded, 2 pop offs and a duration of cup application of 3 minutes. The pressure was not reduced between contractions.

According to progress record the patient was discharged at 5:00 p.m. on 5/11/02.

According to the nursing progress record:

The patient was admitted at the 0653.
An IV was started at 0700.
The patient's vital signs on admission were normal with a blood pressure of 110/76.
The nurse documents a cervical exam at 0725 of 3-4 centimeters/50%/minus three station.
The pelvic exam documented by Dr. Kruszewski in her note of 7:40 a.m. was noted to be 3-- 4 cm/75%/minus 3/vertex.
The nurse documents contractions from between two to six minutes apart.
She documents AROM large amount of clear fluid at 0725.
The patient was started on pitocin at 12:40 p.m. on 5/10/02. According to the Hospital's Policy and Procedure, P/PR No. 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

There was no indication for induction and or augmentation with pitocin. There was no notation by Dr. Kruszewski as to why the pitocin was started. She failed to discuss the risks of and indications for induction and or augmentation with the patient. She did not evaluate the baby for fetal size and failed to perform clinical pelvimetry. These deviations were below the accepted standard of care.

The pitocin was steadily increased to a maximum level of 28 milliunits per minute.
On 5/10/02 and 1500 the patient received an epidural anesthetic.

According to the nursing patient progress note dated 5/10/02:

5:30p.m. - Dr. Kruszewski was notified of coupling and tripling pattern with pitocin and of the average fetal heart rate variability. The nurse was instructed to continue gradual increase of pitocin per protocol.
8:30p.m. - Dr. Kruszewski was advised of the uterine contraction pattern with extended periods out of duration increased, and fetal heart rate variability after reviewing the prior 2 hours of the fetal heart rate tracing. The nurse received an order to continue increasing the pitocin. A late entry indicates that Dr. Kruszewski was informed of an increased temperature on the patient.

According to the nursing patient progress notes dated 5/11/02;

1:00 a.m. late entry narrative - Dr. Kruszewski in attendance assisting. Patient with pushing from 2212. Fetal heart rate baseline 150s with average long term variability onset of pushing. The epidural was discontinued by anesthesia.

The fetal heart tracing demonstrated variable deceleration pattern increasing with progressive pushing. Occasionally variable with late onset.

IV bolus 1000 and LR with 800 cc.

At 2244, 02 increased to 5 L per minute via nasal cannula at 2246 as nursing a measure.

At 2300 depth of variable decelerations reached a fetal heart rate level of 60s returned to baseline 130 – 140's after less than 1 minute. Dr. Kruszewski questioned re. patient resting through a few contractions. Instructed to proceed with pushing.

800 CC fluid bolus infused by 2312 and 02 at 10 L per minute.

As of 2330 variable decelerations to 58 -- 72 bpm lasting 30 -- 80 seconds noted with UC.

Patient proceeding to push vertex to +2 station. Fetal heart rate return to normal parameters. Fetal heart rate with scalp stimulation by Dr. Kruszewski with variables.

2342 Fetal heart rate capture lost on external fetal monitor. Pitocin discontinued per nursing measure at 2343.

2344 Fetal heart rate audible 60 – 70s. Fetal scalp stimulation by Dr. Kruszewski.

2346 Fetal heart rate audible at 50bpm and dropping.

2347 Order received verbally for vacuum.

2349 Vacuum extractor applied by Dr. Kruszewski with continuous effort made until vacuum assisted the vaginal delivery a female infant over median episiotomy by Dr. Kruszewski.

2354 spontaneous vaginal delivery of placenta by Dr. Kruszewski.

In review of the fetal heart tracing and notations, I note:

The patient was having contractions with a notation on the tracing of "AROM large clear fluid with the patient at 3 -- 4 cm/50%." (Tracing #55105)

As seen on fetal tracing number 55109 the patient was contracting almost every minute.

Beginning on 55133 the contraction baseline was elevated after up to 17 attempts to calibrate the external monitor to this point.

Pitocin was started at 2 milliunits per minute at approximately 1239.

The patient was noted to have hyperstimulation with bradycardia. The fetal heart rate was below 110 from 1502 through 1521 at which point the standard of care required placement of a scalp electrode, intrauterine pressure device, discontinuing the pitocin, and to notify Dr. Kruszewski. Not doing so was below the accepted standard of care.

The patient was noted to have a prolonged deceleration beginning at approximately 1536 through 1541 associated with uterine hyperstimulation requiring that the nurses place a scalp electrode, an intrauterine pressure device, discontinue the pitocin and notify Dr. Kruszewski. Not doing so was below the accepted standard of care. Shortly after this episode, the fetal heart variability was decreased requiring placement of a scalp electrode and testing for fetal well being. Not doing so was below the accepted standard of care.

At 1845, a pelvic exam revealed the cervix to be unchanged and the patient was noted to have at least seven contractions in 10 minutes.

At 1849, the patient was positioned in the knee chest position and the pitocin increased to 22 milliunits per minute. The fetal heart tracing was inadequate and uninterpretable from 1848 through 1914. The notation on the fetal strip was "UA INOP CARDIO INOP."

At 1855, the nurse notes on the tracing, "poor fetal and uterine toco capture while in knee chest against BB."

At 20:32, Dr. Kruszewski was notified by phone of the last two pelvic exams, pitocin level, the periods of hypertonic appearing contractions, fetal heart rate with average variability and IV fluid bolus at 2031. The pitocin was then increased to 26 milliunits/min.

The pitocin finally reached its maximum level of 28 mu/min at 2050.

The patient had an episode of fetal bradycardia beginning at 2057 associated with an increased contraction baseline and hyperstimulation with contractions less than a minute apart. The bradycardia terminated at 2116. The nurse documents on the fetal tracing "maternal heart rate". Dr. Kruszewski was not made aware of this finding. An internal fetal scalp electrode was not placed. These deviations were below the accepted standard of care. The only way to accurately determine the difference between the fetal and maternal heart rate was by placement of a scalp electrode or by ultrasound. According to the Hospital's Policy/Procedures, P/PR No. 61.3 entitled, Fetal Scalp Electrode:

"Application of Fetal Scalp Electrode by nursing personnel is permitted by order of the Physician after documented education, training and supervised practice." "In emergency situations, nursing may apply fetal scalp electrodes before notifying Physicians."

At 2120, the patient was having variable decelerations requiring placement of a scalp electrode. Not doing so was below the accepted standard of care.

Dr. Kruszewski performed a pelvic exam at 2123 and the cervix was found to be 8 to 9 cm and 100% effaced. A note by the nurse at that time revealed that the electronic fetal monitoring strip to present was reviewed by Dr. Kruszewski. A scalp lead was not placed during the pelvic exam. This was below the accepted standard of care.

The pitocin was decreased to 20 milliunits per minute at 2131.

The fetal heart rate variability was decreased from 2138 through 2158 associated with uterine hyperstimulation. Dr. Kruszewski failed to place a fetal scalp electrode and/or intrauterine pressure device. Not doing so was below the accepted standard of care.

At 2146 the pitocin was decreased to 18 milliunits per minute. The variability was still decreased.

At 2200, the nurse notes that the electronic fetal monitoring tracing was reviewed to present by Dr. Kruszewski. Dr. Kruszewski also performed a pelvic exam, and the patient was found to be completely dilated. The pitocin was decreased to 16 milliunits per minute.

The patient began pushing at approximately 2213.

The epidural was stopped at approximately 2226.

The fetal tracing was suboptimal beginning at 2230 with episodes of drop out and decelerations noted. Not placing a fetal scalp electrode was below the accepted standard of care.

The patient was having repetitive decelerations beginning at 2243. The IV fluid was increased at 2244 and oxygen was placed at 2246. These findings mandated placement of a scalp electrode, an intrauterine device, discontinuing the pitocin and taking the patient to cesarean section. Not doing so was below the accepted standard of care.

Beginning at 2250 the patient was noted to be hyperstimulated associated with multiple repetitive severe variable decelerations, with loss of variability, mandating discontinuing the pitocin, placement of a scalp electrode and intrauterine pressure device, and performing an emergency cesarean section. Not doing so was below the accepted standard of care. According to the Hospital Policy and Procedure Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreasurring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.
4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent or correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

The pitocin was continued, a scalp electrode was not placed, and the patient was not taken to cesarean section. These deviations were below the accepted standard of care.

The severe variable decelerations became more pronounced after 2310, associated with late recovery and total loss of variability consistent with hypoxia and asphyxia. (SEE P/PR No. 61.2 above under "ominous fetal heart rate pattern") Not stopping the pitocin and performing an emergency cesarean section was negligent and below the accepted standard of care.

At 2306, oxygen via face mask at 10 L per minute was started.

At 2311, intravenous fluids were increased.

The severe variable decelerations were repetitive, more severe and associated with loss of variability and late components.

At 2338, an episode of terminal bradycardia occurred requiring emergent delivery. Not doing so was below the accepted standard of care.

At 2340, the fetal heart rate was essentially lost.

The pitocin was discontinued at 2343 and the nurse notes that the fetal heart rate was audible at 60 – 70.

Again the nurse notes on the strip at 2346 that the fetal heart rate was audible at 50 beats per minute and dropping at which time an order was received for the vacuum extractor which was applied. A second RN was called to the room.

At 2348 the nurse notes on the strip that the vacuum was applied by Dr. Kruszewski.

At 2350 the nurse notes on the fetal tracing that she was unable to capture the fetal heart rate.

At 2350 the nurse notes that the NICU was notified to come stat upon delivery of the infant's head.

At 2351 the nurse notes delivery time, vacuum assisted vaginal delivery female infant over media lateral episiotomy.

Dr. Kruszewski took infant to warmer, NICU staff present.

According to the obstetric discharge summary, completed by Dr. Kruszewski, the discharge diagnosis was term pregnancy delivered. None of antenatal risk factors including any that could be added were checked off.

According to history and physical examination done by Sundar Chandrasekhar, M.D.;

"Mikayla Rhoades was born by a spontaneous vaginal delivery assisted with the vacuum at 11:42 p.m. 15/10/02. The baby was noted to have a fetal bradycardia during the second stage of labor and delivery was assisted by vacuum, as mentioned. Cord pH was noted to be 7.13; loose cord around the neck was noted. The baby was limp at birth with no heart rate or respirations. Apgar at 1 minute was 0, at 5 minutes was 3, at 10 minutes was 4, at 20 minutes was 5. Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds, after which the heart rate went up to over 100 per minute. The baby was then transferred right away to the NICU for further management. First gas in the NICU showed a pH of 6.60, a second gas done at 12:30 a.m. showed a pH of 6.90, CO2 of 49, PO2 of 1021 vent settings of 100% oxygen."

Excerpts from the physical exam revealed that the central nervous system examination shows anterior fontanel open, pupils were small but did not appear to react to light. The baby did not have any response to painful stimuli. Deep tendon reflexes were not elicitable.

The impression was "large for gestational age female term baby with perinatal depression."

The plan was to provide prophylactic phenobarbital to prevent seizures.

According to the Pediatric Discharge Summary by Dr. Richard Grout, M.D.:

"This patient was transferred to Children's Hospital because of birth asphyxia with Apgar scores at 0 at 1 minute, 3 at 5 minutes, 4 at 10 minutes, 5 at 20 minutes."

Excerpts from the physical examination revealed a birth weight of 4400 g. "The patient was noted to be minimally responsive to external stimuli with some withdrawal to noxious stimuli only. The patient had some tremors and was given to boluses of Phenobarbital 10mg/kg for a total of20 mg/kg. The patient was catheterized and there was a small urine output which was sent for urine analysis."

The transferred diagnosis was: "severe birth asphyxia, term birth."

Reason for transfer was: "need for supervisory care of the pediatric neurologist and in conjunction with the familial request for transfer."

Excerpts from the Children's Hospital of Pittsburgh inpatient discharge summary dated 6/28/02 by Carol Gilmour M.D. indicate that;

"She did have chest compressions for less than 30 seconds for low heart rate."

"Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace.

The baby was evaluated for sepsis.

We also had neurology evaluate her. Her EEG times two showed no baseline activity, just intermittent focal sharp waves. She had a CT scan times two that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had lost a spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of severe hypoxic ischemic encephalopathy.

Over the next several days there was no change in Mikayla exam. There continued to be fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with neonatology, neurology, social work in the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life-support. The etiology is suspected to be acute perinatal total asphyxia. -- This was discussed thoroughly with the parents so the family did continue support of this infant."

According to the FINAL AUTOPSY REPORT dated 5/15/02, the final autopsy diagnoses were:

"A five day old female with hypoxic ischemic encephalopathy",
Brain – "Acute ischemic encephalopathy, severe."
Edematous and congested lungs,
Biventricular hypertrophy of the heart,
Congested hepatomegaly,
Congested spleen,
Thymic depletion,
Hemorrhagic adrenal glands,
Congested kidneys,
Pericardial fluid,
Generalized pitting edema.

Special Procedures:
CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord;

1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE

Microscopic Neuropathology revealed – "sections show widespread, severe acute ischemic damage in neurons in nearly all areas of the brain with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

Summary/Discussion – "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ——"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

To a reasonable degree of medical certainty I have reached the following conclusions and opinions in addition to those are ready mentioned;

1. The induction of labor was not indicated and conducted below the accepted standard of care.

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only."

According to ACOG, the indications for induction are;

"Abruptio Placenta
Chorioamnionitis
Fetal demise
Pregnancy induced hypertension
Premature rupture of membranes
Post term pregnancy

Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension)

Fetal compromise (e.g., severe fetal growth restriction, isoimmunization)
preeclampsia, eclampsia."[1]

"Labor also may be induced for logistical reasons, for example, risk of rapid labor, distance from hospital, or psychosocial indications."[2]

There was no indication for the induction. There is no documentation as to the indication for the induction.

The patient was not at risk for rapid labor and there were no logistical indications for labor induction.

The patient was never diagnosed with pregnancy induced hypertension or chronic hypertension. During the patient's last prenatal visit with Dr. Kruszewski, on 5/9/02, the patient's blood pressure was 126/88 and she had no protein in the urine. She had already had a negative workup for preeclampsia including blood work, an NST and a biophysical profile of 8/8. The last ultrasound performed on the patient was interpreted as normal. Even defense expert Dr. Sommer agreed that the pregnancy was "uncomplicated", noting that "preeclampsia was appropriately ruled out with normal lab studies, a normal biophysical profile, and an ultrasound that showed a baby that was slightly larger than average size." Dr. Sommer fails to note that the only way to accurately determine this was by noting the percentile weight for gestational age and that the fetal weight on ultrasound bordered on macrosomia or fetal weight >90%.

There was no medical indication for induction of labor.

According to ACOG, "assessment of gestational age and consideration of any potential risks to the mother or fetus are of paramount importance for appropriate evaluation and counseling before initiating cervical ripening or labor induction. The patient should be counseled regarding the indications for induction, the agents and methods of labor stimulation, and the possible need for repeat induction or cesarean delivery."[3]

Dr. Kruszewski never documented an indication for the induction in either the prenatal chart or hospital record. There is no documentation that Dr. Kruszewski ever discussed the reason for the induction with the patient. There is no documentation indicating that Dr. Kruszewski ever explained the risks associated with induction with Mrs. Rhoades and there was never a discussion about the possibility of a repeat induction or cesarean section with the patient. These deviations were below the accepted standard of care.

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[1] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.
[2] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

[3] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to ACOG, "Additional requirements for cervical ripening and induction of labor include cervical assessment, pelvic assessment, assessment of fetal size and presentation, and personnel familiar with the effects of uterine stimulants on the mother and fetus because uterine hyperstimulation may occur with induction of labor. Monitoring the fetal heart rate and uterine contractions is recommended as for any high risk patient in active labor. Although trained nursing personnel can monitor labor induction, a physician capable of performing a cesarean delivery should be readily available."[4]

There was nothing in the record to support that the maternal pelvis and fetal size were evaluated prior to induction. Dr. Kruszewski admitted that she never evaluated the baby's weight and thus failed to recognize that the baby was macrosomic as evidenced by a birth weight of approximately 4400 g. The nurses and Dr. Kruszewski were not familiar with the effects of uterine stimulants on the mother and fetus and failed to recognize and act on the hyperstimulation caused by the pitocin which resulted in severe periodic changes with loss of variability indicating asphyxia. They failed to monitor the patient appropriately by utilizing internal fetal monitoring with a scalp electrode and intrauterine pressure device. These deviations were below the accepted standard of care and lead to progressive and severe perinatal asphyxia.

2. The management of the induction, augmentation and labor were below the accepted standard of care;

A. Dr. Kruszewski failed to recognize that the patient was at risk for and had a labor abnormality. This was below the accepted standard of care:

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

[4] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to Williams Obstetrics, "Pelvic contraction and fetal malposition are common causes of uterine dysfunction. That moderate degrees of pelvic contraction and fetal malposition may cause hypotonic uterine dysfunction is of great clinical importance."[5]

The patient had no medical indications for induction. Ultrasound examinations during the pregnancy were consistent with a larger than normal baby and bordered on fetal macrosomia. On exam, the patient was noted to have an unengaged fetal head. In a primagravida patient this finding is associated with a poor prognosis for vaginal delivery and indicated cephalopelvic disproportion. Dr. Kruszewski admitted that she failed to evaluate the pelvis and fetal size. The baby's birth weight was approximately 4400 grams or nearly 9 pounds indicating fetal macrosomia which also placed the mother and fetus at risk for labor abnormalities that would not justify the aggressive pitocin induction and or augmentation.

The patient presented to the hospital on 5/10/02, for induction of labor in active labor with contractions at a frequency of 2-6 minutes apart. According to the nurses notes on admission the pelvic exam was 3-4cm/50%/-3 station. According To Dr. Kruszewski's exam the cervix was 3-4/75%/-3. According to the Hospital's Policy and Procedures, P/PR No. 76.1 entitled Active Management of Labor in Primipara, the diagnosis of labor is made as follows,

a. Diagnosis based on the following criteria:
    1. Contractions: At least 1 in 7 minutes.
    2. Show.
    3. Rupture of membranes.
    4. State of Cervix:
        a. If effacement at least 70%-80%
        b. Cervical dilation of 3 cm or greater.
        c. Contractions as above, then in labor."

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[6] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[7]

The patient presented to the hospital in the active phase of labor.

There is no notation as to why the pitocin was started. There is no notation that there was a discussion with the patient about the risks associated with induction and or augmentation of labor with pitocin, especially in light of the fact that the patient was already in active labor. These deviations were below the accepted standard of care.

The patient's membranes were ruptured by Dr. Kruszewski.

The patient was noted to be 3 to 4 cm at that time with an unengaged fetal head, and at 0740 the patient was having contractions almost every minute. From the time of admission until the pitocin was started at 12:39 p.m., the tocometer was readjusted and or zeroed on multiple occasions indicating the need for an intrauterine pressure device to accurately evaluate and

[5] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.
[6] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[7] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

monitor the contraction pattern prior to administering pitocin. Not doing so was below the accepted standard of care. The cervix was unchanged from the time of admission until the pitocin was started consistent with active phase arrest.

According to Williams Obstetrics, "Uterine dysfunction in any phase of cervical dilatation is characterized by lack of progress, for one of the prime characteristics of normal labor is its progression."[8] The patient had no cervical change for over four hours prior to starting pitocin.

According to Williams, "Uterine dysfunction is often a protection against some degree of pelvic contraction or abnormalities of fetal size or presentation. Fortunately, the uterus does not typically persist in spontaneous activity that would lead to rupture. Instead the usual forces of labor are replaced by hypotonic uterine dysfunction. Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[9]

Dr. Kruszewski failed to place an intrauterine pressure catheter and fetal scalp electrode. She failed to determine that the baby was macrosomic, that the patient was arrested in the active phase of labor, and failed to perform a cesarean section after two hours of labor with no cervical change. These deviations were below the accepted standard of care.

According to Williams Obstetrics, "There have been three significant advances in the treatment of uterine dysfunction:

(1) The realization that undue prolongation of labor may contribute to perinatal morbidity and mortality;

(2) The use of very dilute intravenous infusion of oxytocin in the treatment of certain types of uterine dysfunction; and

(3) The more frequent use of cesarean section to affect delivery rather than difficult midforceps delivery or if oxytocin fails or its use is inappropriate."[10]

B. Dr. Kruszewski and the nurses failed to recognize that this patient was arrested in the active phase in labor which was a contraindication to the use of intravenous pitocin. This was below the accepted standard of care.

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[8] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 341.

[9] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.

[10] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 342.

A summary of the patient's pelvic exams are as follows;

| TIME | DILATION | EFFACEMENT | STATION |
|---|---|---|---|
| 7:25 a.m. | 3-4cm | 50%-75% | -3 |
| 8:25 a.m. | 4cm | 60% | -3 |
| 9:30 a.m. | 4cm | 70% | -3 |
| 12:50 p.m. | 4cm | 70% | -2 |
| 3:40 p.m. | 4-5cm | 70% | -2 |
| 5:10 p.m. | 5cm | 75% | -2 |
| 6:50 p.m. | sve unchanged | | |
| 8:10 p.m. | 4-5cm | 80% | 0/-1 |
| 8:30 p.m. | 4-5cm | 80% | 0/-1 |
| 9:20 p.m | 8-9cm | 100% | 0/-1 |
| 10:00 p.m. | complete | | |

The chart indicates that the patient's cervical exam remained unchanged for approximately 12 hours.

The patient presented to the hospital actively contracting and was found to be 4 cm dilated on admission. The patient was re-examined over 4 hours later and her cervical exam was unchanged despite having contractions as often as 1 minute apart consistent with arrest in the active phase of labor. The standard treatment for arrest in the active phase of labor with evidence of cephalopelvic disproportion was and is a cesarean section. Not doing so was below the accepted standard of care.

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[11] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[12]

The patient presented to the hospital in the active phase of labor.

According to ACOG, arrest disorders constitute no cervical dilatation in a nullipara for more than two hours. This requires that the patient to have entered the active phase of labor to make a diagnosis.

Protraction Disorders:

1a. Multiparous - dilatation less than 1.5 centimeters per hour;
b. Multiparous - descent less than 2.0 centimeters per hour;

[11] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[12] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

2 a. Nulliparous - dilatation less than 1.2 centimeters per hour; and
b. Nulliparous - descent less than 1.0 centimeter per hour

Arrest disorders are defined as follows:

1a. Multiparous- No cervical dilatation for greater than two hours;
b. Multiparous - No descent of the presenting part for greater than one hour;

2a. Nulliparous - No cervical dilatation for greater than two hours;
b. Nulliparous - No descent of the presenting part for greater than one hour.[13]

According to ACOG, "It has been suggested that before the arrest disorder can be diagnosed in the first stage of labor, the following criteria should be met:

1. The latent phase is completed (*i.e.*, cervical dilatation is a minimum of 4 centimeters), and

2. A uterine contraction pattern exceeds 200 Montevideo Units for two hours without cervical change. "Assessment of powers during the active phase of the first stage of labor involves the investigation of uterine contractility. The minimal contraction pattern of 95 percent in spontaneous labor consists of three to five contractions in a ten minute window."[14] The patient was having in excess of 5 contractions in 10 minute windows.

"Several methods of quantifying uterine activity with internal monitors have been described."[15] "In a retrospective report an induction of labor with Oxytocin, 91% of women achieved at least 200 to 224 Montevideo Units and 40% achieved at least 300 Montevideo Units."[16] The only way to diagnose an active phase arrest associated with a hypotonic labor dysfunction was by placing an intrauterine pressure device.

According to Parer, with reference to the Tokodynamometer or external contraction monitor "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experience hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This

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[13] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[14] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[15] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[16] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[17] An intrauterine pressure device was not placed by Dr. Kruszewski to assess the powers of labor. This was below the accepted standard of care.

At 0725, the cervical exam was 3-4 cm. Her cervical exam was unchanged at the time pitocin was started at 12:39 p.m., 4 1/2 hours later. If an intrauterine pressure device had been placed prior to starting pitocin and indicated that the contractions were adequate, a cesarean section would have been indicated and pitocin unnecessary.

Starting pitocin, while the patient was actively contracting, in active labor, with no cervical change for over 4 hours, without first placing an intrauterine pressure device to document contraction adequacy was below the accepted standard of care.

According to Williams Obstetrics, "failure of the cervix to dilate or of the presenting part to descend is cause for concern. Prolongation of either the first or second stage of labor may result in increased perinatal and maternal morbidity. Any delay in cervical dilatation during the first stage or prolongation of the second stage of labor should alert the obstetrician to possible danger."[18]

There was no indication for the pitocin augmentation.

C. Aggressive pitocin augmentation was not indicated and below the accepted standard of care.

The patient was arrested in the active phase of labor for up to 12 hours. According to Williams Obstetrics, "oxytocin is a powerful drug, and it has killed or maimed mothers due to rupture of the uterus and even more babies through hypoxia from markedly hypertonic uterine contractions."[19]

According to Williams, oxytocin stimulation is appropriate if the following criteria for pelvic adequacy are met;

1. The diagonal conjugate is normal,
2. The pelvic sidewalls are nearly parallel,
3. The issue spines are not prominent,
4. The sacrum is not flat,
5. The suprapubic angle is not narrow,
6. The occiput is known to be the presenting part,
7. The fetal head is engaged or descends through the pelvic inlet with fundle pressure. ( the patient presented with an unengaged, floating head, at -3 station)

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[17] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[18] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 341.
[19] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345.

If these criteria are not met, the alternatives are cesarean delivery or possibly oxytocin stimulation. If oxytocin is used, it is mandatory that the fetal heart rate and the contraction pattern frequency, intensity, duration, and timing in relation to fetal heart rate be observed closely."[20]

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"POLICY:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

Dr. Kruszewski failed to perform clinical pelvimetry on this patient who presented with a macrosomic infant, and an unengaged floating head indicating cephalopelvic disproportion. Dr. Kruszewski failed to place an intrauterine pressure device to document contraction adequacy, and to accurately monitor the contraction pattern. Dr. Kruszewski started the pitocin augmentation without precise knowledge of contraction adequacy and after the patient was arrested in the active phase of labor for over 4 hours with contractions as close as 1 minute apart. She aggressively augmented this patient without first discussing and documenting the indications for its use. These deviations were below the accepted standard of care.

According to Williams, "the arrest disorders are considered to be present when there is no cervical dilatation for two hours, when the deceleration phase is prolonged, or when there is failure of the presenting part to descend for greater than one hour or longer. Friedman (1978) maintains that approximately one half of these patients have "insurmountable obstruction" and recommends the judicious use of intravenous oxytocin but cautions that such efforts, while effective in dilating the cervix and ultimately resulting in vaginal delivery, may subject the fetus to substantial risks of hypoxic injury as well as birth trauma[21]."

According to Williams Obstetrics, "one characteristic of intravenous oxytocin is that when successful, it acts promptly, leading to noticeable progress with little delay. For any given rate of infusion the plasma level reaches a plateau after about 30 to 40 minutes as the rate of infusion and rate of destruction by oxytocinase achieve equilibrium. Therefore, the drug need not be used for an indefinite period of time to stimulate labor. It should be employed for no more than a few hours; if, by then, the cervix is not changed appreciably and if predictably easy vaginal

[20] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 344
[21] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 346

delivery is not imminent, cesarean delivery should be performed."[22]"Ready resort to cesarean section in cases where oxytocin fails or in which there are contraindications to its use has served to diminish perinatal mortality and morbidity appreciably."[23]

D. The patient was exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive pitocin augmentation, resulting in progressive hypoxia, asphyxia and permanent central nervous system damage. This was below the accepted standard of care.

According ACOG, "the goal of oxytocin administration is to effect uterine activity that is sufficient to produce cervical change and fetal descent while avoiding uterine hyperstimulation and fetal compromise. Minimally effective uterine activity has been defined as 3 contractions per 10 minutes averaging greater than 25 mmhg above baseline."[24] "Typically, a goal of a maximum of five contractions in a 10 minute period with resultant cervical change is considered adequate."[25]

According to Dr. Kruszewski's deposition testimony,

Question – "What do you consider to be significant hyperstimulation of the uterus?" (pg. 28)

Answer – "If the uterus is staying contracted for more than two or three minutes and not relaxing."

Question – "Did you have any concerns about the administration of oxytocin or pitocin causing uterine hyperstimulation during the labor?"(96)

Answer – "No."

Question – "Did you make any observations which would indicate that Mrs. Rhodes was suffering from uterine hyperstimulation at any time during her labor?"(96)

Answer – "No."

Question - "Can hyperstimulation cause fetal stress?"(96)

Answer – "Yes."

Question – "Would this discontinuance of oxytocin be an intrauterine resuscitation procedure that could mitigate a worrisome fetal heart rate patterns?"(97)

Answer – "Possibly."

Question – "Do you believe that the administration of pitocin over the course of Kim's labor caused any complications of her pregnancy?"(97)

Answer – "No."

According to the deposition testimony of Gloria Bennett (referencing 3:26 when the pitocin was decreased),

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[22] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345

[23] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345

[24] ACOG Technical Bulletin, Dystocia—, No.218, December 1995

[25] ACOG Technical Bulletin, Dystocia—, No.218, December 1995

Question – "Okay. Now, why did you reduce the pitocin at that point that you've just described?"(29)

Answer - "Just to see the fetal response to a pitocin decrease."

Question - "Why would you do that, I mean what medical reason would you have for reducing the pitocin and how would that affect the infant response?" (29)

Answer - "If the contractions are close together which at that point they were very close together." "It can be over stimulating the fetus."

Question - "And when you say it's over stimulating the fetus, what do you mean? (29-30)

Answer - "Just means that it's not giving the baby a chance to recover between contractions."

According to the Hospital's Policy and Procedures Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinues oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.

According to ACOG, hyperstimulation is defined as "a persistent pattern of more than five contractions in 10 minutes, contractions lasting 2 minutes or more, or contractions of normal duration occurring within 1 minute of each other."[26]

According to Williams Obstetrics, "Uterine contractions must be evaluated continually and oxytocin shut off immediately if contractions exceed 5 in a 10 minute period or last longer than 1 minute or if the fetal heart rate decelerates significantly."[27]

The pitocin was started at 12:39 p.m. on 5/10/02, and progressively increased, without an intrauterine pressure device, to a maximum level of 28 milliunits per minute resulting in unrecognized iatrogenic hyperstimulation causing severe periodic changes, loss of variability, terminal bradycardia, profound hypoxia, asphyxia, and irreversible brain damage. The aggressive use of pitocin and the failure to recognize the uterine hyperstimulation and the repetitive periodic changes were below the accepted standard of care.

There were multiple episodes of hyperstimulation on pitocin throughout the fetal tracing beginning as early as 1431. Because of the difficulty the nurses were having maintaining a tracing with the tokometer, the poor tracing quality, elevated baseline, and uterine

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[26] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[27] Williams Obstetrics, 20th Edition, Cunningham et al., Dystocia—, 1997, pg 426.

hyperstimulation, placement of an intrauterine pressure device was mandatory. Not doing so was below the accepted standard of care.

According to Parer, with reference to the Tokodynamometer or external contraction monitor, "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experienced hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[28]

According to Williams, "Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[29]

The nurses and Dr. Kruszewski failed to recognize and act on the inadequate tracing of uterine contractions, uterine hypertonus, and failed to recognize the multiple episodes of uterine hyperstimulation. These deviations were below the accepted standard of care.

The nurse and Dr. Kruszewski failed to recognize and act on the repetitive severe fetal heart rate decelerations caused by the iatrogenic uterine hyperstimulation with pitocin. They failed to place an intrauterine pressure device and fetal scalp electrode to monitor fetal well-being and short term variability. They failed to realize that the repetitive severe decelerations associated with loss of variability signaled hypoxia, asphyxia and fetal compromise. They failed to discontinue the pitocin which was causing the hyperstimulation and the decelerations. Dr. Kruszewski failed to take this patient to cesarean section. These deviations were below the accepted standard of care and lead to the delivery of a profoundly asphyxiated and neurologically damaged infant.

According to ACOG, "if hyperstimulation with a non-reassuring fetal heart rate occurs, intravenous infusion of oxytocin should be decreased or discontinued to correct the pattern. Additional measures may include turning the woman on her side and administering oxygen or more intravenous fluid. If hyperstimulation persists, use of terbutaline or other tocolytics may be considered."[30]

According to the Hospital's Policy and Procedures Manual, No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.

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[28] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[29] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.

[30] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent, on correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

E. The nurses and Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability. This led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damage. These actions were below the accepted standard of care.

1. The nurses and Dr. Kruszewski were unfamiliar with the basic concepts and principles of fetal monitoring resulting in the unrecognized progressive iatrogenic fetal asphyxia.

Dr. Kruszewski admitted that she failed to review the entire fetal monitoring strip when she arrived at the hospital at 9:30 p.m. (deposition pg. 47). This was below the accepted standard of care.

Dr. Kruszewski demonstrated a lack of understanding of basic fetal monitoring as evidenced by her deposition testimony.

Question – "What do you mean when you say prolonged decelerations?" (pg. 25)

Answer – "Again, that varies from case to case. There is no strict definition of what a prolonged deceleration is."

According to a Parer, the definition of a prolonged deceleration is, "an abrupt decreased (defined as onset of deceleration to beginning of Nader of less than 30 seconds) in FHR from the baseline. The decrease in FHR below the baseline is at least 15 beats per minute, lasting (from baseline to baseline) at least 15 seconds and is greater than two minutes, but less than 10 minutes."[31]

Question – "What is a sustained bradycardia?" (pg. 49)

Answer – "That the heart rate went down below 100 beats per minute and stayed that way for more than two or three minutes."

According to Parer, "a bradycardia is considered to represent a decrease in heart rate below 110 beats per minute for 10 minutes or longer."[32]

Dr. Kruszewski also demonstrated a lack of understanding of the fetal scalp stimulation test by noting in her deposition (pg. 57),

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

When Gloria Bennett was asked about fetal scalp stimulation on page 42 of her deposition she responded,

Question - "What is fetal scalp stimulation?"

Answer - "Where you just rubbed the baby's head and watch how the heart rate responds."

Question - "Did the heart rate respond to that?"

Answer - "Yes, it would come up to baseline."

According to Parer, with reference to scalp stimulation, "in the case of suspected fetal acidosis the scalp is digitally stimulated during vaginal examination and a FHR monitor observed for acceleration of 15 seconds duration, peaking 15 beats per minute above the baseline FHR.[33]

2. The nurses and Dr. Kruszewski were unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia.

When Dr. Kruszewski was asked in her deposition, pg.49, whether or not the baby was asphyxiated she responded as follows,

Question – "Okay. Was the baby asphyxiated?" (pg. 50)

Answer – "No"

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[31] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg148.
[32] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg152.
[33] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 120

Question – "Do you know what the term asphyxiated means?" (50)
Answer – "Yes."
Question – "What does it mean to you, Doctor?"(50)
Answer – "Significant deprivation of oxygen causing metabolic abnormalities."
Question – "How did you determine the baby was not asphyxiated when it was delivered?"(51)
Answer – "By the cord pH."
Question – "You weren't able to make an observation?"(51)
Answer – "No."
Question - "And make that determination?"(51)
Answer – "No."
Question – "Is there any way that you could have determined whether or not the infant was experiencing asphyxia if she was prior to her delivery?"(66)
Answer – "No"
According to the Hospital Policy and Procedure, P/PR No. 76.1, entitled Active Management of labor in Primipara:
"Consider check scalp PH if suspicious of fetal distress."

Dr. Kruszewski was contradicted by the deposition testimony of Richard Grout, pg. 39, when he states,
Question – "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that as evidence of acidosis?"
Answer – "Correct."

This patient had a prolonged period of repetitive severe variable decelerations and fetal bradycardia with complete loss of short term variability. Dr. Kruszewski and the nurse failed to recognize the progressive fetal asphyxiation. Dr. Kruszewski failed to place an internal scalp electrode, failed to place an intrauterine pressure device, failed to stop the pitocin and failed to perform a cesarean section. These deviations were below the accepted standard of care.

According to Parer, "there is also general agreement that the fetus with absent FHR variability, a heart rate within or outside the normal range, and deep variable or late decelerations, is presumed to be asphyxiated, and expeditious delivery is indicated."[34]

According to Parer, "fetal asphyxia almost always occurs as a result of insufficient umbilical or insufficient uterine blood flow."[35] This can be seen with umbilical cord compression and with uterine hyperstimulation.

According to Parer, "In the presence of normal FHR variability, no matter what other FHR patterns may be present, the fetus is not suffering cerebral tissue asphyxia, because it has been able to successfully centralize the available oxygen and is thus is physiologically compensated. In the presence of excessive asphyxial stress, however, as evidenced by severe periodic changes or prolonged bradycardia, this compensation may break down, and the fetus

[34] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 201
[35] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg198.

may have progressive central tissue asphyxia (i.e., hypoxia in cerebral and myocardial tissues). In this case, it is theorized that fetal heart rate variability decreases and eventually is lost."[36]

According to Parer, "the presence of FHR variability indicates central (nervous system and or myocardial) normoxia, while its decrease in the presence of distress patterns indicates a decrease in the oxygenation of these organs."[37] A decrease in oxygenation leads to hypoxia, acidemia, and asphyxia.

According to ACOG, "the term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia, and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damage, including all of the following:

1. Profound metabolic or mixed acidemia (pH less than 7.00) on an umbilical cord arterial blood sample, if obtained.
2. Persistent Apgar scores of 0-3 for longer than five minutes.
3. Evidence of neonatal neurological sequelae (e.g., seizures, coma, hypotonia, and one or more of the following: cardiovascular, gastrointestinal, and the to logical, pulmonary, or renal system dysfunction)."[38]

According to the deposition testimony of Karen Constantino, she was called Stat close to midnight to the delivery room.

Question - "Did you perform a blood gas or did you extract the blood to submit to the lab for a blood gas test from the cord?"(7)

Answer - "We don't submit them to the lab. We run them and draw and them, it's a respiratory function."

Question - "So you do both testing and the obtaining of the blood sample to be tested?"(7)

Answer - "Right"

Question - "Did you do that in this case? (7)

Answer - "Yes I did."

Question - "How did you obtain the blood gas sample in this case?"(7)

Answer - "I used they -- we have pre-Heparinized syringes for drawing blood and just insert the needle in either the vein or the artery of the cord and draw sufficient amount to which each usually around 3 cc and then we put them in the blood gas machine which reads the values.

Question - "Do you keep a record of whether you put the needle in the vein or the artery?"(7)

Answer - "No, because sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed."

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[36] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 157.

[37] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 202.

[38] ACOG Committee Opinion, No. 197, February 1998.

Question - "OK. In this case would the chart show or would you have any record of where the sample actually came from?"

Answer - "No, it's just I would have marked it a cord gas."

According to the deposition of Richard Grout,

Question - "Dr. Chandrasrasekar also noted a cord pH of 7.13. What was the significance of that finding to you when you took over Mikayla's care?"(15)

Answer - "That indicates the infant had acidosis at the time of birth. The accuracy of that finding is difficult to assess sometimes because it's not always known whether that sample comes from the cord artery or the cord vein."

"Or it can be a mixture of the two together."

"And it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two."(16)

Question - "When you stated on the cord gas which I think was around midnight was taken, you indicated that was not reliable because you didn't know what vessel it came from?" (38)

Answer - "Correct"

Question - "And is that because of the person taking the sample, could you explain that a little more, I know you explained there were a vessel and an artery?"(38)

Answer - "I believe it has to do with the technique that's used to do it."

Question - "Do you know what technique was used here" (38)

Answer - "They still do it the same way. It is basically, the sample of the cord is isolated between two clamps, and a needle attached or syringe is inserted in the cord and they attempt to aspirate back blood and hopefully -- usually they try to go to the vein.

Question - "We have no evidence here, other than the fact there was the cord gas, we don't know whether they were in the vein or an artery, is that what you're saying?"(38)

Answer - "Correct, you don't know for absolute certainty which one."

Question - "So indeed it could be a valid test too?"(39)

Answer - "Well, its validity is, it certainly couldn't be any better than it was. I mean the best -- the sample coming from the vein with the blood going to the baby, and hopefully that would be the best that he could be."

Question - "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that is evidence of acidosis?(39)

Answer - "Correct."

According to the history and physical exam of Dr. Chandrasekhar, "the baby was limp at birth and with no heart rate or respirations. Apgar at one minute was 0/10, at five minutes was 3/10, at 10 minutes was 4/10 and at 20 minutes was 5/10." "Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds." The first gas in the NICU showed a pH of 6.60.

Dr. Grout admitted in his deposition that the cord pH obtained at delivery indicated fetal acidosis.

The baby's neurological exam was markedly abnormal and the baby was placed on prophylactic phenobarbital for seizures.

According to the discharge summary dictated by Dr. Richard Grout, the transferred diagnosis was, "severe birth asphyxia, term birth."

After evaluation at the Children's Hospital of Pittsburgh revealed no baseline brain activity, the baby was withdrawn from life support and died.

The final autopsy report indicated, "A five day old female with hypoxic encephalopathy (clinical)" and a brain with "acute ischemic encephalopathy, severe."

According to the Autopsy Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

In my opinion to a reasonable degree of medical certainty this baby was repetitively and progressively iatrogenically asphyxiated by the nursing staff and Dr. Kruszewski resulting in profound central nervous system destruction, and eventually the death of the baby.

3. The patient had multiple episodes of unrecognized iatrogenic asphyxial stress which required intervention by cesarean section. Not performing a cesarean section in this situation resulted in fetal asphyxia and permanent brain damage. This was below accepted standard of care.

The fetal monitor revealed episodes of prolonged decelerations, severe variable decelerations with and without late components, fetal bradycardia, and loss of variability.

In review of the fetal tracing the patient had a reassuring fetal tracing on admission which correlates highly with fetal well being.

The pitocin was started at approximately 12:39 p.m. after over 4 hours of no cervical change and active phase arrest. The patient was noted to have fetal bradycardia from 15:02 to 15:21 associated with uterine hyperstimulation. A scalp electrode and intrauterine pressure device should have been placed, the pitocin stopped, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

The tracing revealed a prolonged deceleration from 15:37 to 15:41 associated with uterine hyperstimulation. The variability was decreased after the prolonged deceleration mandating placement of a scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care. The hyperstimulation mandated placement of an intrauterine pressure device to accurately monitor the contraction pattern and the pitocin should have been discontinued. Not doing so was below the accepted standard of care. According to Dr. Kruszewski's deposition testimony,

Question - "what kind of things would you be looking for to determine whether intervention was an option during labor?" (pg. 25)

Answer – "prolonged decelerations or decelerations that were occurring very frequently with the mother remote from delivery, decreased in fetal heart rate variability." She defines

intervention as, "can be any number of things, it can be a C-section, it can be a vacuum assisted delivery." (pg. 24).

The nurse notes on the strip at 15:38, "SVE 4-5cm 70% -2.", "Dr. Kruszewski called in, report given of recent variable decels and pitocin changes." The pitocin should have been discontinued, and the patient taken to cesarean section for arrest in the active phase of labor. Not doing so was below the accepted standard of care.

The Toco revealed an increased baseline from 17:10 to 17:20, requiring the reference to be readjusted again. The nurse also noted on the fetal tracing that there were multiple maternal position changes making interpretation of the uterine contraction pattern even more difficult. Not placing an intrauterine pressure device was below the acceptable standard of care.

The nursing staff continued to increase the pitocin in the face of arrest in the active phase of labor associated with uterine hyperstimulation from 16:40 on. They did not inform Dr. Kruszewski that the patient was being iatrogenically hyperstimulated, they failed to stop the pitocin and to insist that Dr. Kruszewski come in to evaluate the patient. These deviations were below the accepted standard of care.

The hyperstimulation with pitocin continued and the nurse noted on the tracing that the patient was placed in the knee chest position at approximately 18:49. The tracing indicated at this point that the "UA INOP, CARDIO INOP". The fetal heart tracing from 18:50 to 19:11 was inadequate and unreliable. The nurse notes on the fetal tracing that, "poor fetal and uterine toco capture while pt in knee chest against BB." At this time the patient was hyperstimulated with contractions almost every minute. Dr. Kruszewski should have been notified, a fetal scalp electrode and intrauterine pressure device should have been placed, the pitocin should have been discontinued, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 20:08, the cervical exam was unchanged. The patient was arrested in the active phase of labor for over 12 hours, associated with uterine hyperstimulation. A cesarean section was indicated. Not performing one was below the accepted standard of care.

At 20:31, the nurse again documents a note indicating that "Dr. Kruszewski on phone aware of last 2 exams, Pit level, periods of hypertonic appearing FHR average variability, IV fluid bolus. The nurse should have insisted that Dr. Kruszewski come in to evaluate the patient and discontinue the pitocin. The nurse should have insisted that Dr. Kruszewski be present to manage the patient. She should have discontinued the pitocin augmentation because of the arrest in the active phase of labor and because of the uterine hyperstimulation. These deviations were below the accepted standard of care.

Instead, the nurse increased the pitocin to 26 mu/min. If Dr. Kruszewski failed to respond, the nurse should have involved the nursing supervisor, Chief of Obstetrics and or the Hospital Administrator. According to the Hospital Policy and Procedures, No. 82, entitled Physician Notification in Maternal/Fetal Distress:

"When patients demonstrate maternal or fetal distress, the attending Physician will be notified immediately and his specific orders carried out."

"The hospital Supervisor should be notified."

"In the event the attending Physician fails to respond, the Labor Room Nurse will notify the Manager or Supervisor. The Chief of Service may be notified for advice."

Other procedures noted are to "See Medical Staff Chain of command."

The nurse documents that Dr. Kruszewski was notified of the last 2 pelvic exams, periods of hypertonic appearing UC, fetal heart rate with average variability, and that an IV fluid bolus was given. The pelvic exam at that time was 4-5 cms. The patient's cervical exam was unchanged despite aggressive pitocin augmentation. A cesarean section was indicated. Not performing a cesarean section and proceeding with the aggressive pitocin augmentation was below the accepted standard of care and lead to iatrogenic hyperstimulation, severe periodic changes, loss of variability, end stage bradycardia and eventually profound and irreversible brain damage.

At 2057, the patient had an episode of bradycardia lasting approximately 16 minutes associated with hyperstimulation, and an increased contraction baseline requiring placement of a scalp electrode, intrauterine pressure device, and discontinuing the pitocin. Not doing so was below the accepted standard of care. Although the nurse notes on the strip that the fetal heart rate was consistent with "maternal" heart rate, the only way to differentiate maternal from fetal heart rate was by placement of a scalp electrode.

The nurse failed to make Dr. Kruszewski aware of the fetal bradycardia, abnormal uterine activity pattern, uterine hyperstimulation, and increased baseline tone. She failed to insist that Dr. Kruszewski evaluate the patient. She failed to place a scalp electrode and intrauterine pressure device. She failed to discontinue the pitocin. These deviations were below the accepted standard of care.

At around 2120, the fetal strip revealed variable decelerations.

At 2131 the pitocin was decreased to 20mu and maternal position was changed.

The variability was decreased to absent from 2138 and through 2200. The nurse notes the EFM tracing "to present" reviewed by Dr. Kruszewski. At that time a pelvic exam was done by Dr. Kruszewski and the pitocin was decreased to 16mu.

The patient began pushing at approximately 2213. The patient had an abnormal uterine activity pattern. The strip revealed areas of drop out and difficulty monitoring the contraction pattern with multiple recalibrations of the UA reference mandating placement of a fetal scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care.

The fetal heart tracing demonstrates that the patient was having decelerations at approximately 22:37.

In reference to the fetal tracing at 10:54 (22:54), Nurse Bennett states in her deposition,
Question – "Did the decelerations at this point concern you in any manner?"(36-37).
Answer - "I'd like to see the patient delivered."

The fetal tracing from 22:40 forward was suboptimal with areas of drop out, severe periodic changes and loss of variability.

There are multiple references by the nurses regarding difficulty tracing the fetal heart rate during labor. According to the deposition testimony of Gloria Bennett when asked about the variable decelerations at 1037,

Question - "You lost the heart rate on the monitor?"(34)

Answer - "Right, when they're doing this, baby's usually moving to get off the cord so you don't always keep capture the whole way through."

With reference to a variable at 1039,

Question – "Ok. And how long would that have lasted?"(35)

Answer – "That's indeterminate because of inadequate capture."

When referring to a variable at 1052 she states,

Answer - "At 52, there was shown a returning to baseline of 120's but there is not an accurate measure of whether it was maternal heart rate were capturing or fetal, so I can't determine that."(36-37)

Answer – "54, same scenario, 90s -- returning from the 90s after inadequate capture."(36-37)

Answer - "When the mother is pushing to, they're often in the position, where they're bumping the monitor she can't keep in the fetal heart rate all in the entire time."(36-37)

When referring to a deceleration at 2331 she states,

Answer - "At which time capture was lost for seconds, and when it recaptured was 120's."(40)

According to the deposition testimony of Sherry Kizina,

When asked about a variable deceleration at approximate 8:45 a.m. (on page 88 of the transcript),

Answer – "that's not clear; it's not captured the whole way."

According to Parer, with reference to the external heart monitor, "although this device is simple to apply and can be used before rupture of the membranes, it sometimes is unreliable during labor because of maternal and fetal movement. A greater disadvantage is that it may not always give a valid indication of beat to beat variability, because the Doppler signal is broad and slurred, and the machine is not always able to select accurately and consistently a point on this slurred curve to represent the exact time of a cardiac event. Hence, an artificial short term variability can be portrayed by the apparatus. Long term variability, however may be displayed reasonably accurately."[39] According to Parer, with reference to a fetal scalp electrode, "this mode gives the most valid FHR tracing because of the discreteness of the signal; therefore, it best depicts beat to beat variability."[40]

An IV fluid bolus was given at 2244; oxygen was started at 2247 via nasal cannula. A scalp electrode and intrauterine pressure catheter were mandatory in this situation. Not utilizing these modalities was below the accepted standard of care.

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[39] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 103

[40] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 102.

At and after 2250 the patient was hyperstimulated, was having repetitive severe periodic changes and loss of variability consistent with fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care

At 2306, .02 via facemask was applied at 10 L per minute, the patient had an abnormal uterine activity pattern and was having decelerations which were more severe associated with loss of variability signaling fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 2312 an IV fluid bolus was given and continued.

From 2310 forward the patient continued to have an abnormal uterine activity pattern, with severe periodic changes now with late components and loss of variability signaling fetal asphyxia and central nervous system compromise. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

Dr. Kruszewski stated in her deposition testimony (pg. 23) that "fetal stress can be some heart rate decelerations, changes in the variability of a heart rate pattern."

Question – "what do you consider to be non-reassuring fetal monitoring tracing?"(pg.28).

Answer – "frequent decelerations, decelerations with each contraction or almost every contraction that don't respond spontaneously to the end of the contraction, significant decrease in fetal heart rate variability." Allowing the patient to continue to labor in the face of progressive repetitive severe variable decelerations with loss of variability, resulted in fetal asphyxia and central nervous system damage. This was below the accepted standard of care.

According to Parer, severe variable decelerations are described as,

"A. Below 60 beats per minute and

B. Longer than 60 seconds in duration."[41]

Other practitioners use the "rule of 60s" as a guideline:

"When severe variable decelerations are present, vigorous efforts should be made to abolish them, because it is likely that even the normally grown fetus with normal placental function eventually will decompensate, although usually not before 30 minutes."[42]

According to Parer, "during severe variable decelerations the heart rate pattern must be observed for an intermittent reduction in FHR variability during and following the variable deceleration. Should this begin to occur and still abolition of the decelerations can not be achieved by the means outlined above (resuscitation maneuvers), then delivery is recommended. Delivery is recommended before the total loss of variability because this may signify asphyxial decompensation, and indeed must be present to do so unless asphyxia can be ruled out by ancillary methods."[43]

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[41] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[42] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[43] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

"Severe variable decelerations in the presence of frequent uterine activity may become confluent and form a prolonged deceleration, and eventually a bradycardia. Therefore in the presence of persistent severe variable decelerations it is prudent to attempt to maintain uterine contractions more than two minutes apart."[44] At 2330, the tracing revealed multiple severe variable decelerations with loss of variability associated with uterine hyperstimulation consistent with fetal asphyxia and central nervous system damage. This pattern finally terminated in severe bradycardia at 2338. The fetal tracing at this point was not traceable and unreliable.

The nurse notes that the pitocin was discontinued at 2343 and that the fetal heart rate was audible from 60 to 70. Emergent delivery was mandatory.

Dr. Kruszewski admits in her deposition that,

Question - "What can happen in a situation where the heart rate is that low and stays down?"(49)

Answer - "The baby's deprived of oxygen."

Question - "What happened in this case?"

Answer - "The baby was acidotic."

If Dr. Kruszewski contends that the startup time for her cesarean section was excessive, then this knowledge should have been applied to the management of the asphyxial stress due to the severe periodic changes by earlier delivery. Not doing so was below the accepted standard of care.

It is my opinion that the progressive, repetitive, severe variable decelerations with total loss of variability associated with uterine hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, rendering mode of delivery at this point irrelevant.

The nurse notes on the fetal tracing that the heart rate was audible at 50 beats per minute and dropping.

At 2346, the orders are received for vacuum. A second RN was called to the room.

According to the notation on the fetal tracing;

The vacuum was applied by Dr. Kruszewski at 2348 and at 2350 nurses are unable to capture the fetal heart rate.

At 2351, the time of delivery, the NICU was notifying to come stat upon delivery of the infant. The baby was delivered by Dr. Kruszewski.

On page 49 of her deposition when asked about her recollections of labor and delivery Dr. Kruszewski notes, "she was complete about 10 p.m. and started to push, and the progress of pushing was going relatively well, and then towards the end, just before the baby delivered, she began having decels, that didn't respond to scalp stimulation and other interventions, and the baby was crowning at that time so I asked for a vacuum to facilitate the delivery. Dr. Kruszewski's deposition testimony was contradicted by the fetal tracing and her own deposition testimony. The fetal tracing revealed multiple repetitive severe variable decelerations with loss of variability and bradycardia for up to one hour prior to delivery of Mikayla. The baby was not crowning but was noted to be at the +1 to +2 station at the time of the vacuum application. Dr. Kruszewski in her deposition (pg. 57) states,

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[44] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised.

Severe repetitive periodic changes were present as early as 2237 which became more severe and atypical until they resulted in the end stage bradycardia documented by the nurse prior to delivery. A scalp electrode was not placed to evaluate variability and fetal well being. An intrauterine pressure device was not placed in light of the uterine hyperstimulation and difficulty maintaining the external toco. The pitocin was not discontinued when the iatrogenic pitocin augmentation resulted in repetitive severe periodic changes terminating in fetal bradycardia. A cesarean section was not performed when the severe periodic changes became repetitive and resulted in loss of variability. These deviations were below the accepted standard of care.

When Dr. Kruszewski was asked whether there is a time when bradycardia becomes significant in whether the child will be delivered healthy, she answered "not that I'm aware of."(pg. 55)

In review of the report of Dr. Sommers, there were numerous inaccuracies and omissions:

She notes that the baby was transferred to Children's Hospital of Pittsburgh and that "over the next few days her condition deteriorated." According to the inpatient discharge summary authored by Carol Gilmour on 6/28/02; "Neurology's impression was that of a severe hypoxic ischemic encephalopathy." "Over the next several days there was no change in Mikayla's exam".

Dr. Sommers notes that, "An autopsy was performed and the clinical diagnosis was acute total asphyxia of unknown etiology and subsequent perinatal hypoxic/ischemic encephalopathy."

According to the Final Autopsy Report: The final autopsy diagnosis was "a five day old female with hypoxic encephalopathy (clinical)."

According to the Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

Dr. Sommers did not address the lack of an indication for the induction, the failure to discuss the reason for and risks associated with induction and or augmentation with the patient, the fact that the patient had evidence of fetal macrosomia, cephalopelvic disproportion, and that

the Mrs. Rhoades was not examined by Dr. Kruszewski for fetal size or clinical pelvimetry prior to the induction and or augmentation.

Dr. Sommers failed to question the lack of documentation indicating the reason for the pitocin augmentation. She did not address the management of this patient who was arrested in the active phase of labor for up to 12 hours. She did not question why the pitocin augmentation was started after 4 hours of no cervical change and why the patient was not taken to cesarean section after 2 hours with no cervical change.

Dr. Sommers did not note that the nurses and Dr. Kruszewski failed to recognize and properly manage the prolonged episodes of uterine hyperstimulation.

Dr. Sommers failed to question why an intrauterine pressure device wasn't placed after the nurses were having difficulty maintaining the external tracing, after the multiple attempts at recalibration by the nurses were noted, after the baseline tone was increased and because of the uterine hyperstimulation.

Dr. Sommers did not address the inability of the nurses and Dr. Kruszewski to recognize asphyxial stress and to appropriately manage it. Dr. Sommers failed to question why a fetal scalp electrode was not placed with fetal bradycardia, prolonged decelerations, with extensive fetal dropout (while in knee chest), with decreased variability, and with repetitive decelerations.

Dr. Sommers failed to address why the pitocin was continued and the patient not taken to Cesarean section despite the recurrent severe periodic changes, uterine hyperstimulation, and the ominous fetal heart pattern with loss of variability indicating fetal asphyxia.

Nurse Comport's report contained numerous inaccuracies:

She notes that "an ultrasound done on 4/13/02, just 22 days prior to delivery, revealed a fetus at 3383 grams or 7#7oz confirming an average sized infant." She than goes on to mention that "the hospital staff did not make a determination of fetal weight either clinically or sonographically. However, this is refuted by the fact that ultrasound assessment had just been recently done revealing a normal sized infant."

The ultrasound examination was done more than 3 weeks prior to delivery and was not done "recently." Nurse Comport fails to substantiate how she concluded that the baby was "average size" since there was no percentile weight for gestational age given in the ultrasound report. Using standard tables, the percentile weight for gestational age approached the 90$^{th}$ percentile. What actually did happen was that Dr. Kruszewski failed to evaluate the fetal weight and pelvis on admission, failed to recognize that this baby was macrosomic, and failed to realize that an unengaged fetal head at -3 station indicated cephalopelvic disproportion. These deviations were below the accepted standard of care.

Nurse Comport opines that "a second issue addressed is the lack of appropriate nursing, assessments and responsiveness to the fetal heart rate changes." As illustrated in my report, the nurses were unfamiliar with the basic concepts of fetal monitoring, and principles of labor and delivery. They failed to recognize that this patient was arrested in the active phase of labor. They failed to insist that an intrauterine pressure device was placed after numerous attempts at recalibration, after abnormal uterine activity patterns were noted, and because of the iatrogenic

uterine hyperstimulation with pitocin (see P/PR No. 61.2). They failed to place or have Dr. Kruszewski place a fetal scalp electrode when the tracing revealed dropout, prolonged decelerations, bradycardia, repetitive decelerations and loss of variability (see P/PR No. 61.3). They failed to discontinue pitocin with the presence of nonreasurring and or ominous fetal heart rate patterns and when abnormal uterine activity patterns were present as per the Hospital's Policy and Procedures, P/PR No. 61.2.

Nurse Comport than goes on to note that, "Criticism has been raised that the pitocin was only decreased and not discontinued, but this is an appropriate course of action. You want to decrease the pitocin to decrease the contraction frequency, which in turn facilitates more oxygenated blood to the fetus." Even more of a reason to discontinue the pitocin optimizing blood flow and oxygenation to the baby. Nurse Comport failed to review the Hospital's Policy and Procedures P/PR, No. 61.2, which states that the procedure indicated for nonreasurring, ominous and abnormal uterine activity patterns is to "Discontinue oxytocin if in use."

She than mentions that "However, you also want to expedite the delivery especially if there are any signs of a change in the fetal heart rate pattern such as variable deceleration." Another way to expedite delivery, without exposing the baby to the asphyxial stress caused by variable decelerations, is by performing a Cesarean Section. Not doing so was below the accepted standard of care.

Nurse Comport finally goes on to note that, "During the second stage or the time the patient was pushing there were times when the fetal heart rate pattern was concerning. This is a relatively common occurrence with pushing as the uteroplacental blood flow is diminished during the pushing effort." Nurse Comport admits that there were times that the fetal heart rate pattern was concerning but fails question why a fetal scalp electrode was not placed, why the pitocin was not discontinued, and why the nurses did not insist that Dr. Kruszewski stop the pitocin augmentation and take this patient to cesarean section.

Nurse Comport recognizes that uteroplacental blood flow is diminished during the pushing effort. She failed to recognize that, in this case, the aggressive pitocin augmentation with uterine hyperstimulation and pushing resulted in decreased blood flow resulting in repetitive severe variable decelerations associated with loss of variability indicated hypoxia and asphyxia. The nurses did not stop the pitocin. They did not recognize that Mrs Rhoades was hyperstimulated and was having decelerations requiring placement of a fetal scalp electrode, intrauterine pressure device, discontinuing the pitocin and insisting that Dr. Kruszewski take this patient to cesarean section. These deviations were below the accepted standard of care.

If the nurses had truly recognized the significance of the fetal tracing, the nurses could have followed Hospital Policy and Procedure P/PR No. 82, entitled Physician Notification in Maternal/Fetal Distress. They chose not to. They did not recognize and act on the progressive iatrogenic fetal asphyxia caused by the aggressive pitocin augmentation and uterine hyperstimulation.

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I reserve the right to amend this report if and when any further information becomes available to me.

Sincerely,

James L. Mollick, M.D., FACOG

Kimberly Rhodes

Expert Witness Report

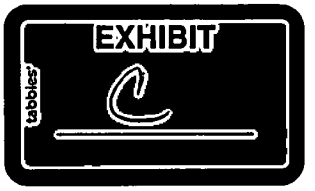
Labor and Delivery Nursing Care of
Kimberly Rhoades and infant

This report is based on a review of the medical records for Kimberly Rhodes at Du Bois Medical Center including the fetal monitoring records, records from Dr. Kruszewski, and the records from Children's Hospital of Pittsburg. In addition the depositions of the attending RN's, and MD neonatologist as well as the deposition of Dr. Kruszewski attending obstetrician were reviewed. Furthermore the policy and procedure manual sections related to maternity and neonatal from Du Bois Medical Center were also reviewed.

Mrs. Kimberly Rhodes was a 33 year old G1P0 Caucasian female with a history of infertility, when she presented for her first obstetrical visit on November 1, 2001 with an LMP of 8/1/01 giving her a EDD of 5/10/02. This EDD was later confirmed by ultrasound. Mrs. Rhodes is 5'6" with a pre-pregnancy weight of 123 pounds and a BP of 108/72. She had a total of 13 prenatal visits which showed adequate fetal growth and movement, normal NST's, ultrasounds and BPP. Mrs. Rhodes developed edema of her hands, feet and face as well as a rise in her blood pressure along with a 47 pound weight gain. PIH laboratory work was ordered along with an ultrasound and NST and BPP, they were reported as normal but there is no evidence in the prenatal notes of any further care, teaching or advice. Since she is an "elderly primipara" there is a higher incidence of pre-eclampsia to be concerned about.

While the record shows the baby to have adequate FHT's and movement and to be in a vertex position it does not give the exact position of the head, the station or an estimated fetal weight even after the mother raised concerns on the size of the baby. There is a late ultrasound with an EFW of 3500 grams which translates to an slightly larger than average size baby of approximately 7 pounds 11.5 ounces but no follow-up clinically either prior to labor or when she was admitted to the hospital in labor. The labor examination does not include an evaluation of fetal size, engagement of the fetal head or position all of which are important in a primipara especially when the vaginal examination shows a – 3 station and the plan is induction/augmentation of labor.

An induction of labor was scheduled at DuBois Regional Medical Center on May 10, 2002. The admission report indicates Kimberly Rhoades was having contractions on her own and was 3-4 cm dilated, 50-75% effaced and -3 vertex at 740 a.m.. The membranes were artificially ruptured and clear fluid presented. Fetal Monitoring tracing indicate the FHT was baseline at 150 with good variability with some occasional small minor variable decelerations. Contraction pattern shows q 1.5 to 2 minutes and are reported to be of mild intensity based on manual palpation and maternal reporting. There is no report on a concern for prolapsed cord which is a strong possibility with a -3 station. In addition with the external electronic monitor on the uterus it is not possible to determine the actual strength or uterine baseline of the contractions or the accuracy of the FHT in response to contractions.



Furthermore, it is unusual to find a primipara with 50-75% effacement at 3-4 cm of dilation. It is also a warning sign of CPD (cephalopelvic disproportion) to have a primipara with a -3 station upon the start of active labor; the fetal head usually drops into the pelvis about 36 weeks of pregnancy. There is a higher incidence of cesarean section among primiparas who enter labor when the fetal head has not engaged in the pelvis by the active phase of labor; it is an indication of CPD and must be monitored closely. There is also no record of the fetal position which can influence CPD. This potential for CPD was the case with Mrs. Rhodes so that position, presentation and station are all important variables to be closely monitored.

Mrs. Rhoades was still 4 cm, 60% and -3, despite spontaneous contraction every 2-3 minutes, by 12:37 pm, five hours later. This constitutes arrest of cervical dilation and arrest of fetal decent. Induction/augmentation of labor was started with 2 mu. at 1237 p.m. and increased to 4 mu. at 1250 p.m. by nurse SK. The FHT baseline at the time of augmentation of labor was 130 with mild variability, variability increased with signs of accelerations and contraction pattern was every 2-3 minutes. Pitocin increased again at 1320 to 6 mu. and the FHT responded by baseline of 140 and decreased variability. By 1440 the BP has risen to 135/84 and a pulse of 93, contractions q1.5 to 2 minutes, FHT 140-150's and some variable decelerations. The nurse, SK, appropriately moves the patient to her left side.

Pitocin is increased again to 10 mu. by nurse SK, and contractions respond with increased baseline and frequency every minute. The FHT responds with decreased variability. At 1500 an epidural is placed and during that time there is no FHT picked up. The heart rate on the tracing is the maternal. Maternal BP is 133/79 and pulse is 105. By 1540 there is a 6 minute combination late/variable deceleration of the fetal heart rate. The nurse, GB, reduces the pitocin to 8 mu. Turns the mother on her right side, does a SVE finding the patient to be virtually unchanged at 4-5 cm, 70% and -2 with a the maternal BP is 185/161 with a pulse of 111 and there is another episode of fetal heart rate deceleration. The heart rate recovers but with minimal variability. This represents the first of several episodes that follow where there are decelerations followed by recovery but with minimal variability, showing there is not adequate fetal recovery. Nurse, GB, calls the DO to inform her of FHT pattern, results of SVE and pitocin induction status.

The nurse, GB, appropriately called the physician to report. However if she had reported the contraction pattern and FHT with the reminder of the definition of adequate contraction patters, i.e. 7 contractions in a 15 minute period and the patient had 9 contractions in a 15 minute period; there should have been an alternate plan to monitor this mother and fetus. The continued plan to increase the pitocin despite the fetal and uterine response does not follow safe practice in light of the initial and continued maternal-fetal condition. To provide an adequate safe trial of labor the continued increase in dosing of pitocin must be followed by an alternate plan such as the use of internal electronic monitoring to properly assess the patient's condition.

Despite nurse GB giving a 1000 cc bolus of fluids and turning the maternal position the FHT still had minimal variability for over 24 minutes. There is a repeated episode of uterine hyperstimulation which does not allow for fetal recovery. By 1620 the nurse, GB, again increases the pitocin to 10 mu. and the fetus responds with some minor variable

decelerations. At no time was there any attempt to place an internal fetal monitor to determine if the FHT and uterine tracing was accurate and to determine the true strength, baseline and frequency of contractions to properly adjust the pitocin dosage. The nursing intervention was to change the maternal position, provide fluids and adjust the Toco on the monitor.

By 1850, the cervix and fetal position are unchanged 11 hours later despite increasing the pitocin. She has prolonged arrest of dilation and decent and this should have been reported to the physician with a request for further medical evaluation, application of internal monitoring and preparation for a cesarean section particularly in light of the increasing pattern of decelerations, decreased beat to beat variability and an erratic contraction pattern and a maternal blood pressure that is erratic. Furthermore the absence of an FHT when placing an epidural should have also been a warning sign to place an internal fetal monitor in light of the other compounding factors

Pr 2

Overall there is a lack of safety precautions and following standard of care in relation to the use of pitocin induction or augmentation of labor in light of the initial maternal-fetal examination, arrest of decent and dilation, uterine contraction pattern and fetal heart rate response to the induction/augmentation process. A safer course of action would have been to use an internal fetal monitor to get a true picture of the fetal and uterine response and when there was an arrest despite an adequate contraction pattern to recommend considération of a cesarean section. While the nurse does not make this decision the nurse can follow the hospital protocol by properly informing the physician of the facts and if there is not an adequate response based on the nurses professional judgment, to follow the required hospital protocol for further evaluation.

Therefore in light of the above evaluation of this case it is my professional opinion with a reasonable degree of certainty that the labor and delivery room nurses attending Mrs. Rhodes during her labor failed to act in accordance with a reasonable standard of nursing care in the provision of labor and delivery nursing services to Mrs. Kimberly Rhoades and her infant and this failure was the cause of the medical problems experienced by the infant at the time of birth.

Dianne S. Moore PhD, RN, CNM, MN, MPH

Dianne S Moore

1212 West Paul Ave
Fresno CA 93711
914 572 6879

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within document has been served upon the following counsel of record and same placed in the U.S. Mails on this 7th day of July, 2006:

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State College, PA 16801

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

ORDER OF COURT

AND NOW, to wit, on this _____ day of _____, 2006, upon consideration of the motion in limine to prohibit plaintiffs from pursuing liability theories at trial which have not been plead in the amended complaint, it is hereby ORDERED, ADJUDGED and DECREED that said motion is GRANTED.

Plaintiffs are prohibited from introducing any evidence or testimony that DuBois Regional Medical Center and/or any members of its nursing staff breached the standard of care toward the plaintiffs by: (1) failing to follow hospital policies; (2) negligently inducing labor through pitocin augmentation; (3) failing to make appropriate documentation of care and treatment; (4) failing to properly monitor the condition of mother-plaintiff and the fetus; (5) failing to provide appropriate care and treatment for any time prior to May 10, 2002; and (6) negligence pertaining to the initial labor examination on May 10, 2002.

In all other respects, the testimony of plaintiffs' expert witnesses as to liability will be confined to those allegations plead against DuBois Regional Medical Center set forth in paragraph 33 of the amended complaint.

_____J.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

**MOTION IN LIMINE TO PRECLUDE PLAINTIFFS' EXPERT DR. MOLLICK FROM OFFERING ANY OPINION AS TO THE NURSING STANDARD OF CARE**

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.

Counsel of Record for This Party:

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PA I.D. #26409

Brad R. Korinski, Esquire
PA I.D. #86831

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FILED NO CC
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JUL 10 2006 GK

William A. Shaw
Prothonotary/Clerk of Courts

MOTION IN LIMINE TO PRECLUDE PLAINTIFFS' EXPERT DR. MOLLICK FROM OFFERING ANY OPINION AS TO THE NURSING STANDARD OF CARE

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and files the following motion in limine.

1. This is a medical malpractice case in which the allegations against DuBois Regional Medical Center require expert testimony.

2. In general terms, at issue is the fetal demise of Mikayla Rhoades, whose mother, Kimberly Rhoades, was an obstetrical patient of co-defendant Mary C. Kruszewski, M.D. As to this defendant, the amended complaint (per ¶ 33) alleges that the nursing staff deviated from the standard of care in its handling of Mrs. Rhoades in-hospital pregnancy care.

3. To support their allegations at trial, plaintiffs have disclosed their intention to call upon two expert witnesses: James Mollick, M.D., an obstetrician/gynecologist; and Diane S. Moore, Ph.D., R.N., a nurse. The reports of these experts are attached hereto as exhibits "A" and "B," respectively.

4. Dr. Mollick is trained as a physician. Attached as exhibit "C" is the curriculum vitae of Dr. Mollick. He has never practiced medicine as a nurse, received any education in the nursing field, nor has he himself educated nurses. Accordingly, he should be precluded from offering any opinion testimony on the subject of the whether the nursing staff deviated from the

applicable standard of care, since, based upon his education and experience, Dr. Mollick cannot be reasonably acquainted with that standard of care.

5. Nonetheless, despite his absence of professional qualifications, portions of Dr. Mollick's report contain criticisms of the nursing staff. This defendant, therefore, is moving in limine to preclude Dr. Mollick from offering any opinions with regard to the standard of care for nurses and/or whether the nursing staff met that applicable standard of care.

6. Because he possess training and experience only as a physician, Dr. Mollick is not competent under Rule of Evidence 702 to offer expert testimony with regard to the nursing standard of care.

7. Additionally, Dr. Mollick and Diane S. Moore, Ph.D., R.N. are critical of identical aspects of the care and treatment rendered by the nursing staff which they opine fell below the standard of care. As a result of the foregoing, the expert testimony of Dr. Mollick is cumulative in that he will be offering the same opinions as to the standard of care and causation as already given by Nurse Moore. Thus, Dr. Mollick's opinion as to the nursing staff should be excluded for being cumulative under Rule of Evidence 403.

8. Finally, any probative value that the opinion of Dr. Mollick may posses as to the nursing standard of care - which is scant since he has no training, experience or education as a nurse - is substantially outweighed by the unfair prejudice which will inure to this defendant if Dr. Mollick is permitted to express such an opinion. Inherently, a jury may accord improper

weight to Dr. Mollick's testimony against the nursing staff simply because of his status as a physician, and the public's mistaken perception that a physician has superior knowledge and skill to that of a nurse, solely by virtue of his occupational title, and out of all proportion of his or her actual knowledge and experience on the subject matter of nursing.

9. This defendant also moves in limine to preclude any attorney or witness from referencing those portions of Dr. Mollick's report where he is critical of the hospital and the nursing staff.

WHEREFORE, this defendant, DuBois Regional Medical Center, moves in limine to preclude Dr. Mollick from offering any opinions as an expert witness at time of trial with regard to any alleged acts or omissions of the nurses, any applicable nursing standard of care and/or whether any acts or omissions by the nurses were a cause of the plaintiffs' injuries and damages. Defendant further requests an order of court which precludes all attorneys and witnesses from referencing any comments within Dr. Mollick's reports which are critical of the hospital or its nurses.

Respectfully Submitted,

THOMSON, RHODES & COWIE, P.C.

Brad Korinski

David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within documenthas been served upon the following counsel of record and same placed in the U.S. Mails on this _____ day of _____, 2006:

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Confluence, PA 15424

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THOMSON, RHODES & COWIE, P.C.

Brad Korinski

David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | |
|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | CIVIL DIVISION |
| | No. 03-1268 CD |
| Plaintiffs, | Issue No. |

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

ORDER OF COURT

AND NOW, this _____ day of _____, 2006, after consideration of the motion in limine filed on behalf of DuBois Regional Medical Center, it is hereby ordered that:

1. Plaintiffs' expert, James Mollick, M.D. is precluded from offering any expert testimony against DuBois Regional Medical Center as to any alleged breach of the standard of care by its nursing staff; and all persons, including witnesses or attorneys, are precluded from referring to any reports by Dr. Mollick which are critical of DuBois Regional Medical Center or its nurses.

BY THE COURT:

_____ J.

PHONE (610) 279-6621

NORRISTOWN OB-GYN ASSOCIATES, P.C.
*WOMEN'S CENTER*
1437 MEDICAL ARTS BUILDING • SUITE 101
1437 DEKALB STREET
NORRISTOWN, PA 19401-3405

J. J. FITZGERALD, III, D.O.

J. L. MOLLICK, M.D.

February 15, 2005

Received DRJ

FEB 2 1 2005

Place ( ) Discussed on ( )
Diary/Note ( )
Copy to Chart ( ) Other Med/Social ( )

Robert P. Ging
2095 Humbert Road
Confluence, PA 15424-2371

Re: Kim Rhoades

Dear Mr. Ging,

Thank you for allowing me to review the Rhoades case. I have reviewed the following medical records:

1. Amended Complaint,

2. Answer and New Matter to Plaintiffs' Amended Complaint filed on behalf of Mary C. Kruszewski, D.O.,

3. Answers and Objections to Interrogatories to Dr. Kruszewski and Request for Production of Documents,

4. Answers to interrogatories to the Dubois Regional Medical Center and request for production of documents,

5. Supplemental answers to interrogatories to the Dubois Regional Medical Center,

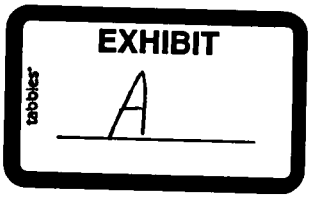
6. Amended answers to interrogatories to Dubois Regional Medical Center,

7. Objections and responses to interrogatories to the Dubois Regional Medical

8. Response to request for production of expert reports,

9. Medical records of Kimberly D. Rhoades (including prenatal records 2001-02), Mary C. Kruszewski D.O. and the Dubois Regional Medical Center (2002 admission),

10. Medical records of Mikayla Rhoades (birth to death 2002) including records of Sundar Chandrasekhar, M.D., Dubois Regional Medical Center (2002), Children's Hospital of Pittsburgh (2002) and the Final autopsy Report (2002),



11. Deposition's of Mary Kruszewski, D.O., Gloria Bennett, R.N., Tina Newell, R.N., Sheri Kizina, R.N., Suzanne McCullough, R.N., Shawn Welsh, R.N., Desiree Smith, R.N., Karen Consentino, Brian Yeskevich, M.D., Richard Grout, M.D.,

12. Expert Reports of Deborah Sommer, M.D., Diane Moore, PhD, RN, William Houston Reed, PhD, and Kimberly A. Comport RN.

After review of the records, depositions, an expert reports, I have reached the following opinions and conclusions to a reasonable degree of medical certainty:

Kim Rhoades was a 33-year-old white female G1P0000 with an LMP of 8/3/02, an EDC of 5/10/02 confirmed by a 13.5 week ultrasound done on 11/1/01. Prior to becoming pregnant she had a workup for infertility including hysterosalpingogram and semen analysis.

She was followed prenatally by Mary Kruszewski, D.O., and was seen for 13 prenatal visits. The patient was noted to have several elevated blood pressures during her pregnancy with negative workups.

The patient had several ultrasound examinations during her pregnancy. Dr. Kruszewski did not recognize that the reports failed to include a percentile weight for gestational age. The ultrasound done on 4/18/02 revealed a 38 week and five day fetus with an estimated fetal weight of 3382 grams. There was a normal amount of amniotic fluid present. A biophysical profile at that time was 8/8.

Her final prenatal visit was recorded on 5/9/02 at which time the patient was 39.6 weeks, had a blood pressure of 126/88, negative urine protein, and a cervical exam which was posterior and soft with no indication of cervical dilatation. Induction was scheduled for the A. M. of 5/10/02. I could not find documentation indicating the reason for the induction, and/or any documentation of a conversation explaining the indications for and risks of induction of labor with the patient. These deviations were below the accepted standard of care.

The patient was admitted Dubois Regional Medical Center on 5/9/02 for induction of labor (see orders for protocol for induction of labor using IV pitocin and routine labor/delivery). A verbal order was given by Dr. Kruszewski at 1200 on 5/10/02 to start pitocin per protocol.

According to the admission note by Dr. Kruszewski dated 5/10/02 at 7:40 a.m.:

"Prenatal course was unremarkable except blood pressure has been increasing slowly the past couple of weeks. Preeclampsia labs, BPP, and NST were done 4/18 and were all normal." "Monitor shows good FHT variability. Mild contractions q 1 -- 2 minutes." "Cx exam was performed and membranes ruptured during exam. Cx 3-4/75%/-3/Vertex."

According to the Dubois Regional Medical Center's Maternity Department Policy and Procedure Manual (hereafter "Hospital's Policy and Procedure"), Policy and Procedure, No. 76.1, entitled Active Management of Labor in Primipara:

"In patients admitted in spontaneous labor make a definitive diagnosis as soon as possible.

A. Diagnosis based on the following criteria:
   1. Contractions: At least 1 in 7 minutes.
   2. Show.
   3. Rupture of membranes.
   4. State of Cervix:
      a. If effacement at least 70%-80%
      b. Cervical dilation of 3 cm or greater.
      c. Contractions as above, then in labor."

These criteria support that this patient was in labor on admission.

According to Dr. Kruszewski's admission note, "Hook was used to rupture membranes further and large amount of clear fluid was obtained."

Dr. Kruszewski deviated from the Hospital's Policy and Procedures, P/PR No. 79, entitled Protocol for Amniotomy which states:

"The artificial rupture of membranes may only be carried out by a physician. The fetal head must be fully engaged in the pelvis prior to amniotomy."

According to the progress record authored by Dr. Kruszewski on 5/10/02 at 9:30 p.m.:

"The patient was noted to be 8 to 9 cm/100%/minus 1-0/vertex.... FHT's have been good throughout."

This was the only progress note written by Dr. Kruszewski from the time of admission until delivery.

According to Dr. Kruszewski's Delivery Note on 5/11/02 at to 12:55 a.m.:

"Patient was complete approximately 10:00 p.m... She pushed well and vertex came down to plus 1 to plus 2 station. Baby had a sustained bradycardia and vacuum was applied. Delivery was accomplished in one to two minutes after vacuum applied. Baby was suctioned and NICU personnel were called for resuscitation. Baby was delivered from OA positioned with vacuum over a midline episiotomy. Birth time was 11:52 p.m.. Placenta delivered intact at 11:54 p.m. A cord pH was 7.13."

In review of the Vacuum Assisted Delivery Sheet dated 5/11/02 at 12:50 a.m., the fetal station was noted to be +1-+2, consistent with a midpelvic delivery. There were 4 pulls recorded, 2 pop offs and a duration of cup application of 3 minutes. The pressure was not reduced between contractions.

According to progress record the patient was discharged at 5:00 p.m. on 5/11/02.

According to the nursing progress record:

The patient was admitted at the 0653.
An IV was started at 0700.
The patient's vital signs on admission were normal with a blood pressure of 110/76.
The nurse documents a cervical exam at 0725 of 3-4 centimeters/50%/minus three station.
The pelvic exam documented by Dr. Kruszewski in her note of 7:40 a.m. was noted to be 3-- 4 cm/75%/minus 3/vertex.
The nurse documents contractions from between two to six minutes apart.
She documents AROM large amount of clear fluid at 0725.
The patient was started on pitocin at 12:40 p.m. on 5/10/02. According to the Hospital's Policy and Procedure, P/PR No. 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

There was no indication for induction and or augmentation with pitocin. There was no notation by Dr. Kruszewski as to why the pitocin was started. She failed to discuss the risks of and indications for induction and or augmentation with the patient. She did not evaluate the baby for fetal size and failed to perform clinical pelvimetry. These deviations were below the accepted standard of care.

The pitocin was steadily increased to a maximum level of 28 milliunits per minute.
On 5/10/02 and 1500 the patient received an epidural anesthetic.

According to the nursing patient progress note dated 5/10/02:

5:30p.m. - Dr. Kruszewski was notified of coupling and tripling pattern with pitocin and of the average fetal heart rate variability. The nurse was instructed to continue gradual increase of pitocin per protocol.

8:30p.m. - Dr. Kruszewski was advised of the uterine contraction pattern with extended periods out of duration increased, and fetal heart rate variability after reviewing the prior 2 hours of the fetal heart rate tracing. The nurse received an order to continue increasing the pitocin. A late entry indicates that Dr. Kruszewski was informed of an increased temperature on the patient.

According to the nursing patient progress notes dated 5/11/02;

1:00 a.m. late entry narrative - Dr. Kruszewski in attendance assisting. Patient with pushing from 2212. Fetal heart rate baseline 150s with average long term variability onset of pushing. The epidural was discontinued by anesthesia.

The fetal heart tracing demonstrated variable deceleration pattern increasing with progressive pushing. Occasionally variable with late onset.

IV bolus 1000 and LR with 800 cc.

At 2244, 02 increased to 5 L per minute via nasal cannula at 2246 as nursing a measure.

At 2300 depth of variable decelerations reached a fetal heart rate level of 60s returned to baseline 130 – 140's after less than 1 minute. Dr. Kruszewski questioned re. patient resting through a few contractions. Instructed to proceed with pushing.

800 CC fluid bolus infused by 2312 and 02 at 10 L per minute.

As of 2330 variable decelerations to 58 – 72 bpm lasting 30 – 80 seconds noted with UC.

Patient proceeding to push vertex to +2 station. Fetal heart rate return to normal parameters. Fetal heart rate with scalp stimulation by Dr. Kruszewski with variables.

2342 Fetal heart rate capture lost on external fetal monitor. Pitocin discontinued per nursing measure at 2343.

2344 Fetal heart rate audible 60 – 70s. Fetal scalp stimulation by Dr. Kruszewski.

2346 Fetal heart rate audible at 50bpm and dropping.

2347 Order received verbally for vacuum.

2349 Vacuum extractor applied by Dr. Kruszewski with continuous effort made until vacuum assisted the vaginal delivery a female infant over median episiotomy by Dr. Kruszewski.

2354 spontaneous vaginal delivery of placenta by Dr. Kruszewski.

In review of the fetal heart tracing and notations, I note:

The patient was having contractions with a notation on the tracing of "AROM large clear fluid with the patient at 3 – 4 cm/50%." (Tracing #55105)

As seen on fetal tracing number 55109 the patient was contracting almost every minute.

Beginning on 55133 the contraction baseline was elevated after up to 17 attempts to calibrate the external monitor to this point.

Pitocin was started at 2 milliunits per minute at approximately 1239.

The patient was noted to have hyperstimulation with bradycardia. The fetal heart rate was below 110 from 1502 through 1521 at which point the standard of care required placement of a scalp electrode, intrauterine pressure device, discontinuing the pitocin, and to notify Dr. Kruszewski. Not doing so was below the accepted standard of care.

The patient was noted to have a prolonged deceleration beginning at approximately 1536 through 1541 associated with uterine hyperstimulation requiring that the nurses place a scalp electrode, an intrauterine pressure device, discontinue the pitocin and notify Dr. Kruszewski. Not doing so was below the accepted standard of care. Shortly after this episode, the fetal heart variability was decreased requiring placement of a scalp electrode and testing for fetal well being. Not doing so was below the accepted standard of care.

At 1845, a pelvic exam revealed the cervix to be unchanged and the patient was noted to have at least seven contractions in 10 minutes.

At 1849, the patient was positioned in the knee chest position and the pitocin increased to 22 milliunits per minute. The fetal heart tracing was inadequate and uninterpretable from 1848 through 1914. The notation on the fetal strip was "UA INOP CARDIO INOP."

At 1855, the nurse notes on the tracing, "poor fetal and uterine toco capture while in knee chest against BB."

At 20:32, Dr. Kruszewski was notified by phone of the last two pelvic exams, pitocin level, the periods of hypertonic appearing contractions, fetal heart rate with average variability and IV fluid bolus at 2031. The pitocin was then increased to 26 milliunits/min.

The pitocin finally reached its maximum level of 28 mu/min at 2050.

The patient had an episode of fetal bradycardia beginning at 2057 associated with an increased contraction baseline and hyperstimulation with contractions less than a minute apart. The bradycardia terminated at 2116. The nurse documents on the fetal tracing "maternal heart rate". Dr. Kruszewski was not made aware of this finding. An internal fetal scalp electrode was not placed. These deviations were below the accepted standard of care. The only way to accurately determine the difference between the fetal and maternal heart rate was by placement of a scalp electrode or by ultrasound. According to the Hospital's Policy/Procedures, P/PR No. 61.3 entitled, Fetal Scalp Electrode:

"Application of Fetal Scalp Electrode by nursing personnel is permitted by order of the Physician after documented education, training and supervised practice." "In emergency situations, nursing may apply fetal scalp electrodes before notifying Physicians."

At 2120, the patient was having variable decelerations requiring placement of a scalp electrode. Not doing so was below the accepted standard of care.

Dr. Kruszewski performed a pelvic exam at 2123 and the cervix was found to be 8 to 9 cm and 100% effaced. A note by the nurse at that time revealed that the electronic fetal monitoring strip to present was reviewed by Dr. Kruszewski. A scalp lead was not placed during the pelvic exam. This was below the accepted standard of care.

The pitocin was decreased to 20 milliunits per minute at 2131.

The fetal heart rate variability was decreased from 2138 through 2158 associated with uterine hyperstimulation. Dr. Kruszewski failed to place a fetal scalp electrode and/or intrauterine pressure device. Not doing so was below the accepted standard of care.

At 2146 the pitocin was decreased to 18 milliunits per minute. The variability was still decreased.

At 2200, the nurse notes that the electronic fetal monitoring tracing was reviewed to present by Dr. Kruszewski. Dr. Kruszewski also performed a pelvic exam, and the patient was found to be completely dilated. The pitocin was decreased to 16 milliunits per minute.

The patient began pushing at approximately 2213.

The epidural was stopped at approximately 2226.

The fetal tracing was suboptimal beginning at 2230 with episodes of drop out and decelerations noted. Not placing a fetal scalp electrode was below the accepted standard of care.

The patient was having repetitive decelerations beginning at 2243. The IV fluid was increased at 2244 and oxygen was placed at 2246. These findings mandated placement of a scalp electrode, an intrauterine device, discontinuing the pitocin and taking the patient to cesarean section. Not doing so was below the accepted standard of care.

Beginning at 2250 the patient was noted to be hyperstimulated associated with multiple repetitive severe variable decelerations, with loss of variability, mandating discontinuing the pitocin, placement of a scalp electrode and intrauterine pressure device, and performing an emergency cesarean section. Not doing so was below the accepted standard of care. According to the Hospital Policy and Procedure Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreasurring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.
4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent or correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

The pitocin was continued, a scalp electrode was not placed, and the patient was not taken to cesarean section. These deviations were below the accepted standard of care.

The severe variable decelerations became more pronounced after 2310, associated with late recovery and total loss of variability consistent with hypoxia and asphyxia. (SEE P/PR No. 61.2 above under "ominous fetal heart rate pattern") Not stopping the pitocin and performing an emergency cesarean section was negligent and below the accepted standard of care.

At 2306, oxygen via face mask at 10 L per minute was started.

At 2311, intravenous fluids were increased.

The severe variable decelerations were repetitive, more severe and associated with loss of variability and late components.

At 2338, an episode of terminal bradycardia occurred requiring emergent delivery. Not doing so was below the accepted standard of care.

At 2340, the fetal heart rate was essentially lost.

The pitocin was discontinued at 2343 and the nurse notes that the fetal heart rate was audible at 60 – 70.

Again the nurse notes on the strip at 2346 that the fetal heart rate was audible at 50 beats per minute and dropping at which time an order was received for the vacuum extractor which was applied. A second RN was called to the room.

At 2348 the nurse notes on the strip that the vacuum was applied by Dr. Kruszewski.

At 2350 the nurse notes on the fetal tracing that she was unable to capture the fetal heart rate.

At 2350 the nurse notes that the NICU was notified to come stat upon delivery of the infant's head.

At 2351 the nurse notes delivery time, vacuum assisted vaginal delivery female infant over media lateral episiotomy.

Dr. Kruszewski took infant to warmer, NICU staff present.

According to the obstetric discharge summary, completed by Dr. Kruszewski, the discharge diagnosis was term pregnancy delivered. None of antenatal risk factors including any that could be added were checked off.

According to history and physical examination done by Sundar Chandrasekhar, M.D.;

"Mikayla Rhoades was born by a spontaneous vaginal delivery assisted with the vacuum at 11:42 p.m. 15/10/02. The baby was noted to have a fetal bradycardia during the second stage of labor and delivery was assisted by vacuum, as mentioned. Cord pH was noted to be 7.13; loose cord around the neck was noted. The baby was limp at birth with no heart rate or respirations. Apgar at 1 minute was 0, at 5 minutes was 3, at 10 minutes was 4, at 20 minutes was 5. Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds, after which the heart rate went up to over 100 per minute. The baby was then transferred right away to the NICU for further management. First gas in the NICU showed a pH of 6.60, a second gas done at 12:30 a.m. showed a pH of 6.90, CO2 of 49, PO2 of 1021 vent settings of 100% oxygen."

Excerpts from the physical exam revealed that the central nervous system examination shows anterior fontanel open, pupils were small but did not appear to react to light. The baby did not have any response to painful stimuli. Deep tendon reflexes were not elicitable.

The impression was "large for gestational age female term baby with perinatal depression."

The plan was to provide prophylactic phenobarbital to prevent seizures.

According to the Pediatric Discharge Summary by Dr. Richard Grout, M.D.:

"This patient was transferred to Children's Hospital because of birth asphyxia with Apgar scores at 0 at 1 minute, 3 at 5 minutes, 4 at 10 minutes, 5 at 20 minutes."

Excerpts from the physical examination revealed a birth weight of 4400 g. "The patient was noted to be minimally responsive to external stimuli with some withdrawal to noxious stimuli only. The patient had some tremors and was given to boluses of Phenobarbital 10mg/kg for a total of20 mg/kg. The patient was catheterized and there was a small urine output which was sent for urine analysis."

The transferred diagnosis was: "severe birth asphyxia, term birth."

Reason for transfer was: "need for supervisory care of the pediatric neurologist and in conjunction with the familial request for transfer."

Excerpts from the Children's Hospital of Pittsburgh inpatient discharge summary dated 6/28/02 by Carol Gilmour M.D. indicate that;

"She did have chest compressions for less than 30 seconds for low heart rate."

"Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace.

The baby was evaluated for sepsis.

We also had neurology evaluate her. Her EEG times two showed no baseline activity, just intermittent focal sharp waves. She had a CT scan times two that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had lost a spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of severe hypoxic ischemic encephalopathy.

Over the next several days there was no change in Mikayla exam. There continued to be fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with neonatology, neurology, social work in the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life-support. The etiology is suspected to be acute perinatal total asphyxia. – This was discussed thoroughly with the parents so the family did continue support of this infant."

According to the FINAL AUTOPSY REPORT dated 5/15/02, the final autopsy diagnoses were:

"A five day old female with hypoxic ischemic encephalopathy",
Brain – "Acute ischemic encephalopathy, severe."
Edematous and congested lungs,
Biventricular hypertrophy of the heart,
Congested hepatomegaly,
Congested spleen,
Thymic depletion,
Hemorrhagic adrenal glands,
Congested kidneys,
Pericardial fluid,
Generalized pitting edema.

Special Procedures:
CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord;

1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE

Microscopic Neuropathology revealed – "sections show widespread, severe acute ischemic damage in neurons in nearly all areas of the brain with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

Summary/Discussion – "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ——"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

To a reasonable degree of medical certainty I have reached the following conclusions and opinions in addition to those are ready mentioned;

1. The induction of labor was not indicated and conducted below the accepted standard of care.

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only."

According to ACOG, the indications for induction are;

"Abruptio Placenta
Chorioamnionitis
Fetal demise
Pregnancy induced hypertension
Premature rupture of membranes
Post term pregnancy

Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension)

Fetal compromise (e.g., severe fetal growth restriction, isoimmunization)
preeclampsia, eclampsia."[1]

"Labor also may be induced for logistical reasons, for example, risk of rapid labor, distance from hospital, or psychosocial indications."[2]

There was no indication for the induction. There is no documentation as to the indication for the induction.

The patient was not at risk for rapid labor and there were no logistical indications for labor induction.

The patient was never diagnosed with pregnancy induced hypertension or chronic hypertension. During the patient's last prenatal visit with Dr. Kruszewski, on 5/9/02, the patient's blood pressure was 126/88 and she had no protein in the urine. She had already had a negative workup for preeclampsia including blood work, an NST and a biophysical profile of 8/8. The last ultrasound performed on the patient was interpreted as normal. Even defense expert Dr. Sommer agreed that the pregnancy was "uncomplicated", noting that "preeclampsia was appropriately ruled out with normal lab studies, a normal biophysical profile, and an ultrasound that showed a baby that was slightly larger than average size." Dr. Sommer fails to note that the only way to accurately determine this was by noting the percentile weight for gestational age and that the fetal weight on ultrasound bordered on macrosomia or fetal weight >90%.

There was no medical indication for induction of labor.

According to ACOG, "assessment of gestational age and consideration of any potential risks to the mother or fetus are of paramount importance for appropriate evaluation and counseling before initiating cervical ripening or labor induction. The patient should be counseled regarding the indications for induction, the agents and methods of labor stimulation, and the possible need for repeat induction or cesarean delivery."[3]

Dr. Kruszewski never documented an indication for the induction in either the prenatal chart or hospital record. There is no documentation that Dr. Kruszewski ever discussed the reason for the induction with the patient. There is no documentation indicating that Dr. Kruszewski ever explained the risks associated with induction with Mrs. Rhoades and there was never a discussion about the possibility of a repeat induction or cesarean section with the patient. These deviations were below the accepted standard of care.

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[1] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.
[2] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

[3] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to ACOG, "Additional requirements for cervical ripening and induction of labor include cervical assessment, pelvic assessment, assessment of fetal size and presentation, and personnel familiar with the effects of uterine stimulants on the mother and fetus because uterine hyperstimulation may occur with induction of labor. Monitoring the fetal heart rate and uterine contractions is recommended as for any high risk patient in active labor. Although trained nursing personnel can monitor labor induction, a physician capable of performing a cesarean delivery should be readily available."[4]

There was nothing in the record to support that the maternal pelvis and fetal size were evaluated prior to induction. Dr. Kruszewski admitted that she never evaluated the baby's weight and thus failed to recognize that the baby was macrosomic as evidenced by a birth weight of approximately 4400 g. The nurses and Dr. Kruszewski were not familiar with the effects of uterine stimulants on the mother and fetus and failed to recognize and act on the hyperstimulation caused by the pitocin which resulted in severe periodic changes with loss of variability indicating asphyxia. They failed to monitor the patient appropriately by utilizing internal fetal monitoring with a scalp electrode and intrauterine pressure device. These deviations were below the accepted standard of care and lead to progressive and severe perinatal asphyxia.

2. The management of the induction, augmentation and labor were below the accepted standard of care;

A. Dr. Kruszewski failed to recognize that the patient was at risk for and had a labor abnormality. This was below the accepted standard of care:

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

[4] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to Williams Obstetrics, "Pelvic contraction and fetal malposition are common causes of uterine dysfunction. That moderate degrees of pelvic contraction and fetal malposition may cause hypotonic uterine dysfunction is of great clinical importance."[5]

The patient had no medical indications for induction. Ultrasound examinations during the pregnancy were consistent with a larger than normal baby and bordered on fetal macrosomia. On exam, the patient was noted to have an unengaged fetal head. In a primagravida patient this finding is associated with a poor prognosis for vaginal delivery and indicated cephalopelvic disproportion. Dr. Kruszewski admitted that she failed to evaluate the pelvis and fetal size. The baby's birth weight was approximately 4400 grams or nearly 9 pounds indicating fetal macrosomia which also placed the mother and fetus at risk for labor abnormalities that would not justify the aggressive pitocin induction and or augmentation.

The patient presented to the hospital on 5/10/02, for induction of labor in active labor with contractions at a frequency of 2-6 minutes apart. According to the nurses notes on admission the pelvic exam was 3-4cm/50%/-3 station. According To Dr. Kruszewski's exam the cervix was 3-4/75%/-3. According to the Hospital's Policy and Procedures, P/PR No. 76.1 entitled Active Management of Labor in Primipara, the diagnosis of labor is made as follows,

a. Diagnosis based on the following criteria:
    1. Contractions: At least 1 in 7 minutes.
    2. Show.
    3. Rupture of membranes.
    4. State of Cervix:
        a. If effacement at least 70%-80%
        b. Cervical dilation of 3 cm or greater.
        c. Contractions as above, then in labor."

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[6] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[7]

The patient presented to the hospital in the active phase of labor.

There is no notation as to why the pitocin was started. There is no notation that there was a discussion with the patient about the risks associated with induction and or augmentation of labor with pitocin, especially in light of the fact that the patient was already in active labor. These deviations were below the accepted standard of care.

The patient's membranes were ruptured by Dr. Kruszewski.

The patient was noted to be 3 to 4 cm at that time with an unengaged fetal head, and at 0740 the patient was having contractions almost every minute. From the time of admission until the pitocin was started at 12:39 p.m., the tocometer was readjusted and or zeroed on multiple occasions indicating the need for an intrauterine pressure device to accurately evaluate and

[5] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.
[6] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[7] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

monitor the contraction pattern prior to administering pitocin. Not doing so was below the accepted standard of care. The cervix was unchanged from the time of admission until the pitocin was started consistent with active phase arrest.

According to Williams Obstetrics, "Uterine dysfunction in any phase of cervical dilatation is characterized by lack of progress, for one of the prime characteristics of normal labor is its progression."[8] The patient had no cervical change for over four hours prior to starting pitocin.

According to Williams, "Uterine dysfunction is often a protection against some degree of pelvic contraction or abnormalities of fetal size or presentation. Fortunately, the uterus does not typically persist in spontaneous activity that would lead to rupture. Instead the usual forces of labor are replaced by hypotonic uterine dysfunction. Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[9]

Dr. Kruszewski failed to place an intrauterine pressure catheter and fetal scalp electrode. She failed to determine that the baby was macrosomic, that the patient was arrested in the active phase of labor, and failed to perform a cesarean section after two hours of labor with no cervical change. These deviations were below the accepted standard of care.

According to Williams Obstetrics, "There have been three significant advances in the treatment of uterine dysfunction:

(1) The realization that undue prolongation of labor may contribute to perinatal morbidity and mortality;

(2) The use of very dilute intravenous infusion of oxytocin in the treatment of certain types of uterine dysfunction; and

(3) The more frequent use of cesarean section to affect delivery rather than difficult midforceps delivery or if oxytocin fails or its use is inappropriate."[10]

B. Dr. Kruszewski and the nurses failed to recognize that this patient was arrested in the active phase in labor which was a contraindication to the use of intravenous pitocin. This was below the accepted standard of care.

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[8] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 341.

[9] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.

[10] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 342.

A summary of the patient's pelvic exams are as follows;

| TIME | DILATION | EFFACEMENT | STATION |
|---|---|---|---|
| 7:25 a.m. | 3-4cm | 50%-75% | -3 |
| 8:25 a.m. | 4cm | 60% | -3 |
| 9:30 a.m. | 4cm | 70% | -3 |
| 12:50 p.m. | 4cm | 70% | -2 |
| 3:40 p.m. | 4-5cm | 70% | -2 |
| 5:10 p.m. | 5cm | 75% | -2 |
| 6:50 p.m. | sve unchanged | | |
| 8:10 p.m. | 4-5cm | 80% | 0/-1 |
| 8:30 p.m. | 4-5cm | 80% | 0/-1 |
| 9:20 p.m | 8-9cm | 100% | 0/-1 |
| 10:00 p.m. | complete | | |

The chart indicates that the patient's cervical exam remained unchanged for approximately 12 hours.

The patient presented to the hospital actively contracting and was found to be 4 cm dilated on admission. The patient was re-examined over 4 hours later and her cervical exam was unchanged despite having contractions as often as 1 minute apart consistent with arrest in the active phase of labor. The standard treatment for arrest in the active phase of labor with evidence of cephalopelvic disproportion was and is a cesarean section. Not doing so was below the accepted standard of care.

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[11] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[12]

The patient presented to the hospital in the active phase of labor.

According to ACOG, arrest disorders constitute no cervical dilatation in a nullipara for more than two hours. This requires that the patient to have entered the active phase of labor to make a diagnosis.

Protraction Disorders:

1a. Multiparous - dilatation less than 1.5 centimeters per hour;
b. Multiparous - descent less than 2.0 centimeters per hour;

[11] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[12] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

2 a. Nulliparous - dilatation less than 1.2 centimeters per hour; and
b. Nulliparous - descent less than 1.0 centimeter per hour

Arrest disorders are defined as follows:

1a. Multiparous- No cervical dilatation for greater than two hours;
b. Multiparous - No descent of the presenting part for greater than one hour;

2a. Nulliparous - No cervical dilatation for greater than two hours;
b. Nulliparous - No descent of the presenting part for greater than one hour.[13]

According to ACOG, "It has been suggested that before the arrest disorder can be diagnosed in the first stage of labor, the following criteria should be met:

1. The latent phase is completed (*i.e.*, cervical dilatation is a minimum of 4 centimeters), and

2. A uterine contraction pattern exceeds 200 Montevideo Units for two hours without cervical change. "Assessment of powers during the active phase of the first stage of labor involves the investigation of uterine contractility. The minimal contraction pattern of 95 percent in spontaneous labor consists of three to five contractions in a ten minute window."[14] The patient was having in excess of 5 contractions in 10 minute windows.

"Several methods of quantifying uterine activity with internal monitors have been described."[15] "In a retrospective report an induction of labor with Oxytocin, 91% of women achieved at least 200 to 224 Montevideo Units and 40% achieved at least 300 Montevideo Units."[16] The only way to diagnose an active phase arrest associated with a hypotonic labor dysfunction was by placing an intrauterine pressure device.

According to Parer, with reference to the Tokodynamometer or external contraction monitor "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experience hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This

[13] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[14] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[15] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[16] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[17] An intrauterine pressure device was not placed by Dr. Kruszewski to assess the powers of labor. This was below the accepted standard of care.

At 0725, the cervical exam was 3-4 cm. Her cervical exam was unchanged at the time pitocin was started at 12:39 p.m., 4 1/2 hours later. If an intrauterine pressure device had been placed prior to starting pitocin and indicated that the contractions were adequate, a cesarean section would have been indicated and pitocin unnecessary.

Starting pitocin, while the patient was actively contracting, in active labor, with no cervical change for over 4 hours, without first placing an intrauterine pressure device to document contraction adequacy was below the accepted standard of care.

According to Williams Obstetrics, "failure of the cervix to dilate or of the presenting part to descend is cause for concern. Prolongation of either the first or second stage of labor may result in increased perinatal and maternal morbidity. Any delay in cervical dilatation during the first stage or prolongation of the second stage of labor should alert the obstetrician to possible danger."[18]

There was no indication for the pitocin augmentation.

C. Aggressive pitocin augmentation was not indicated and below the accepted standard of care.

The patient was arrested in the active phase of labor for up to 12 hours. According to Williams Obstetrics, "oxytocin is a powerful drug, and it has killed or maimed mothers due to rupture of the uterus and even more babies through hypoxia from markedly hypertonic uterine contractions."[19]

According to Williams, oxytocin stimulation is appropriate if the following criteria for pelvic adequacy are met;

1. The diagonal conjugate is normal,
2. The pelvic sidewalls are nearly parallel,
3. The issue spines are not prominent,
4. The sacrum is not flat,
5. The suprapubic angle is not narrow,
6. The occiput is known to be the presenting part,
7. The fetal head is engaged or descends through the pelvic inlet with fundle pressure. ( the patient presented with an unengaged, floating head, at -3 station)

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[17] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[18] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 341.
[19] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345.

If these criteria are not met, the alternatives are cesarean delivery or possibly oxytocin stimulation. If oxytocin is used, it is mandatory that the fetal heart rate and the contraction pattern frequency, intensity, duration, and timing in relation to fetal heart rate be observed closely."[20]

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"POLICY:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

Dr. Kruszewski failed to perform clinical pelvimetry on this patient who presented with a macrosomic infant, and an unengaged floating head indicating cephalopelvic disproportion. Dr. Kruszewski failed to place an intrauterine pressure device to document contraction adequacy, and to accurately monitor the contraction pattern. Dr. Kruszewski started the pitocin augmentation without precise knowledge of contraction adequacy and after the patient was arrested in the active phase of labor for over 4 hours with contractions as close as 1 minute apart. She aggressively augmented this patient without first discussing and documenting the indications for its use. These deviations were below the accepted standard of care.

According to Williams, "the arrest disorders are considered to be present when there is no cervical dilatation for two hours, when the deceleration phase is prolonged, or when there is failure of the presenting part to descend for greater than one hour or longer. Friedman (1978) maintains that approximately one half of these patients have "insurmountable obstruction" and recommends the judicious use of intravenous oxytocin but cautions that such efforts, while effective in dilating the cervix and ultimately resulting in vaginal delivery, may subject the fetus to substantial risks of hypoxic injury as well as birth trauma[21]."

According to Williams Obstetrics, "one characteristic of intravenous oxytocin is that when successful, it acts promptly, leading to noticeable progress with little delay. For any given rate of infusion the plasma level reaches a plateau after about 30 to 40 minutes as the rate of infusion and rate of destruction by oxytocinase achieve equilibrium. Therefore, the drug need not be used for an indefinite period of time to stimulate labor. It should be employed for no more than a few hours; if, by then, the cervix is not changed appreciably and if predictably easy vaginal

[20] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 344
[21] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 346

delivery is not imminent, cesarean delivery should be performed."[22]"Ready resort to cesarean section in cases where oxytocin fails or in which there are contraindications to its use has served to diminish perinatal mortality and morbidity appreciably."[23]

D. The patient was exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive pitocin augmentation, resulting in progressive hypoxia, asphyxia and permanent central nervous system damage. This was below the accepted standard of care.

According ACOG, "the goal of oxytocin administration is to effect uterine activity that is sufficient to produce cervical change and fetal descent while avoiding uterine hyperstimulation and fetal compromise. Minimally effective uterine activity has been defined as 3 contractions per 10 minutes averaging greater than 25 mmhg above baseline."[24] "Typically, a goal of a maximum of five contractions in a 10 minute period with resultant cervical change is considered adequate."[25]

According to Dr. Kruszewski's deposition testimony,

Question – "What do you consider to be significant hyperstimulation of the uterus?" (pg. 28)

Answer – "If the uterus is staying contracted for more than two or three minutes and not relaxing."

Question – "Did you have any concerns about the administration of oxytocin or pitocin causing uterine hyperstimulation during the labor?"(96)

Answer – "No."

Question – "Did you make any observations which would indicate that Mrs. Rhodes was suffering from uterine hyperstimulation at any time during her labor?"(96)

Answer – "No."

Question - "Can hyperstimulation cause fetal stress?"(96)

Answer – "Yes."

Question – "Would this discontinuance of oxytocin be an intrauterine resuscitation procedure that could mitigate a worrisome fetal heart rate patterns?"(97)

Answer – "Possibly."

Question – "Do you believe that the administration of pitocin over the course of Kim's labor caused any complications of her pregnancy?"(97)

Answer – "No."

According to the deposition testimony of Gloria Bennett (referencing 3:26 when the pitocin was decreased),

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[22] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345

[23] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 345

[24] ACOG Technical Bulletin, Dystocia—, No.218, December 1995

[25] ACOG Technical Bulletin, Dystocia—, No.218, December 1995

Question – "Okay. Now, why did you reduce the pitocin at that point that you've just described?"(29)

Answer - "Just to see the fetal response to a pitocin decrease."

Question - "Why would you do that, I mean what medical reason would you have for reducing the pitocin and how would that affect the infant response?" (29)

Answer - "If the contractions are close together which at that point they were very close together." "It can be over stimulating the fetus."

Question - "And when you say it's over stimulating the fetus, what do you mean? (29-30)

Answer - "Just means that it's not giving the baby a chance to recover between contractions."

According to the Hospital's Policy and Procedures Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinues oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.

According to ACOG, hyperstimulation is defined as "a persistent pattern of more than five contractions in 10 minutes, contractions lasting 2 minutes or more, or contractions of normal duration occurring within 1 minute of each other."[26]

According to Williams Obstetrics, "Uterine contractions must be evaluated continually and oxytocin shut off immediately if contractions exceed 5 in a 10 minute period or last longer than 1 minute or if the fetal heart rate decelerates significantly."[27]

The pitocin was started at 12:39 p.m. on 5/10/02, and progressively increased, without an intrauterine pressure device, to a maximum level of 28 milliunits per minute resulting in unrecognized iatrogenic hyperstimulation causing severe periodic changes, loss of variability, terminal bradycardia, profound hypoxia, asphyxia, and irreversible brain damage. The aggressive use of pitocin and the failure to recognize the uterine hyperstimulation and the repetitive periodic changes were below the accepted standard of care.

There were multiple episodes of hyperstimulation on pitocin throughout the fetal tracing beginning as early as 1431. Because of the difficulty the nurses were having maintaining a tracing with the tokometer, the poor tracing quality, elevated baseline, and uterine

[26] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[27] Williams Obstetrics, 20th Edition, Cunningham et al., Dystocia—, 1997, pg 426.

hyperstimulation, placement of an intrauterine pressure device was mandatory. Not doing so was below the accepted standard of care.

According to Parer, with reference to the Tokodynamometer or external contraction monitor, "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experienced hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[28]

According to Williams, "Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[29]

The nurses and Dr. Kruszewski failed to recognize and act on the inadequate tracing of uterine contractions, uterine hypertonus, and failed to recognize the multiple episodes of uterine hyperstimulation. These deviations were below the accepted standard of care.

The nurse and Dr. Kruszewski failed to recognize and act on the repetitive severe fetal heart rate decelerations caused by the iatrogenic uterine hyperstimulation with pitocin. They failed to place an intrauterine pressure device and fetal scalp electrode to monitor fetal well-being and short term variability. They failed to realize that the repetitive severe decelerations associated with loss of variability signaled hypoxia, asphyxia and fetal compromise. They failed to discontinue the pitocin which was causing the hyperstimulation and the decelerations. Dr. Kruszewski failed to take this patient to cesarean section. These deviations were below the accepted standard of care and lead to the delivery of a profoundly asphyxiated and neurologically damaged infant.

According to ACOG, "if hyperstimulation with a non-reassuring fetal heart rate occurs, intravenous infusion of oxytocin should be decreased or discontinued to correct the pattern. Additional measures may include turning the woman on her side and administering oxygen or more intravenous fluid. If hyperstimulation persists, use of terbutaline or other tocolytics may be considered."[30]

According to the Hospital's Policy and Procedures Manual, No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.

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[28] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[29] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.
[30] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent, on correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

E. The nurses and Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability. This led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damage. These actions were below the accepted standard of care.

1. The nurses and Dr. Kruszewski were unfamiliar with the basic concepts and principles of fetal monitoring resulting in the unrecognized progressive iatrogenic fetal asphyxia.

Dr. Kruszewski admitted that she failed to review the entire fetal monitoring strip when she arrived at the hospital at 9:30 p.m. (deposition pg. 47). This was below the accepted standard of care.

Dr. Kruszewski demonstrated a lack of understanding of basic fetal monitoring as evidenced by her deposition testimony.

Question – "What do you mean when you say prolonged decelerations?" (pg. 25)

Answer – "Again, that varies from case to case. There is no strict definition of what a prolonged deceleration is."

According to a Parer, the definition of a prolonged deceleration is, "an abrupt decreased (defined as onset of deceleration to beginning of Nader of less than 30 seconds) in FHR from the baseline. The decrease in FHR below the baseline is at least 15 beats per minute, lasting (from baseline to baseline) at least 15 seconds and is greater than two minutes, but less than 10 minutes."[31]

Question – "What is a sustained bradycardia?" (pg. 49)

Answer – "That the heart rate went down below 100 beats per minute and stayed that way for more than two or three minutes."

According to Parer, "a bradycardia is considered to represent a decrease in heart rate below 110 beats per minute for 10 minutes or longer."[32]

Dr. Kruszewski also demonstrated a lack of understanding of the fetal scalp stimulation test by noting in her deposition (pg. 57),

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

When Gloria Bennett was asked about fetal scalp stimulation on page 42 of her deposition she responded,

Question - "What is fetal scalp stimulation?"

Answer - "Where you just rubbed the baby's head and watch how the heart rate responds."

Question - "Did the heart rate respond to that?"

Answer - "Yes, it would come up to baseline."

According to Parer, with reference to scalp stimulation, "in the case of suspected fetal acidosis the scalp is digitally stimulated during vaginal examination and a FHR monitor observed for acceleration of 15 seconds duration, peaking 15 beats per minute above the baseline FHR.[33]

2. The nurses and Dr. Kruszewski were unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia.

When Dr. Kruszewski was asked in her deposition, pg.49, whether or not the baby was asphyxiated she responded as follows,

Question – "Okay. Was the baby asphyxiated?" (pg. 50)

Answer – "No"

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[31] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg148.
[32] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg152.
[33] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 120

Question – "Do you know what the term asphyxiated means?" (50)
Answer – "Yes."
Question – "What does it mean to you, Doctor?"(50)
Answer – "Significant deprivation of oxygen causing metabolic abnormalities."
Question – "How did you determine the baby was not asphyxiated when it was delivered?"(51)
Answer – "By the cord pH."
Question – "You weren't able to make an observation?"(51)
Answer – "No."
Question - "And make that determination?"(51)
Answer – "No."
Question – "Is there any way that you could have determined whether or not the infant was experiencing asphyxia if she was prior to her delivery?"(66)
Answer – "No"
According to the Hospital Policy and Procedure, P/PR No. 76.1, entitled Active Management of labor in Primipara:
"Consider check scalp PH if suspicious of fetal distress."

Dr. Kruszewski was contradicted by the deposition testimony of Richard Grout, pg. 39, when he states,
Question – "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that as evidence of acidosis?"
Answer – "Correct."

This patient had a prolonged period of repetitive severe variable decelerations and fetal bradycardia with complete loss of short term variability. Dr. Kruszewski and the nurse failed to recognize the progressive fetal asphyxiation. Dr. Kruszewski failed to place an internal scalp electrode, failed to place an intrauterine pressure device, failed to stop the pitocin and failed to perform a cesarean section. These deviations were below the accepted standard of care.

According to Parer, "there is also general agreement that the fetus with absent FHR variability, a heart rate within or outside the normal range, and deep variable or late decelerations, is presumed to be asphyxiated, and expeditious delivery is indicated."[34]

According to Parer, "fetal asphyxia almost always occurs as a result of insufficient umbilical or insufficient uterine blood flow."[35] This can be seen with umbilical cord compression and with uterine hyperstimulation.

According to Parer, "In the presence of normal FHR variability, no matter what other FHR patterns may be present, the fetus is not suffering cerebral tissue asphyxia, because it has been able to successfully centralize the available oxygen and is thus is physiologically compensated. In the presence of excessive asphyxial stress, however, as evidenced by severe periodic changes or prolonged bradycardia, this compensation may break down, and the fetus

[34] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 201
[35] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg198.

may have progressive central tissue asphyxia (i.e., hypoxia in cerebral and myocardial tissues). In this case, it is theorized that fetal heart rate variability decreases and eventually is lost."[36]

According to Parer, "the presence of FHR variability indicates central (nervous system and or myocardial) normoxia, while its decrease in the presence of distress patterns indicates a decrease in the oxygenation of these organs."[37] A decrease in oxygenation leads to hypoxia, acidemia, and asphyxia.

According to ACOG, "the term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia, and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damage, including all of the following:

1. Profound metabolic or mixed acidemia (pH less than 7.00) on an umbilical cord arterial blood sample, if obtained.
2. Persistent Apgar scores of 0-3 for longer than five minutes.
3. Evidence of neonatal neurological sequelae (e.g., seizures, coma, hypotonia, and one or more of the following: cardiovascular, gastrointestinal, and the to logical, pulmonary, or renal system dysfunction)."[38]

According to the deposition testimony of Karen Constantino, she was called Stat close to midnight to the delivery room.

Question - "Did you perform a blood gas or did you extract the blood to submit to the lab for a blood gas test from the cord?"(7)

Answer - "We don't submit them to the lab. We run them and draw and them, it's a respiratory function."

Question - "So you do both testing and the obtaining of the blood sample to be tested?"(7)

Answer - "Right"

Question - "Did you do that in this case? (7)

Answer - "Yes I did."

Question - "How did you obtain the blood gas sample in this case?"(7)

Answer - "I used they -- we have pre-Heparinized syringes for drawing blood and just insert the needle in either the vein or the artery of the cord and draw sufficient amount to which each usually around 3 cc and then we put them in the blood gas machine which reads the values.

Question - "Do you keep a record of whether you put the needle in the vein or the artery?"(7)

Answer - "No, because sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed."

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[36] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 157.

[37] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 202.

[38] ACOG Committee Opinion, No. 197, February 1998.

Question - "OK. In this case would the chart show or would you have any record of where the sample actually came from?"

Answer - "No, it's just I would have marked it a cord gas."

According to the deposition of Richard Grout,

Question - "Dr. Chandrasrasekar also noted a cord pH of 7.13. What was the significance of that finding to you when you took over Mikayla's care?"(15)

Answer - "That indicates the infant had acidosis at the time of birth. The accuracy of that finding is difficult to assess sometimes because it's not always known whether that sample comes from the cord artery or the cord vein."

"Or it can be a mixture of the two together."

"And it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two."(16)

Question - "When you stated on the cord gas which I think was around midnight was taken, you indicated that was not reliable because you didn't know what vessel it came from?" (38)

Answer - "Correct"

Question - "And is that because of the person taking the sample, could you explain that a little more, I know you explained there were a vessel and an artery?"(38)

Answer - "I believe it has to do with the technique that's used to do it."

Question - "Do you know what technique was used here" (38)

Answer - "They still do it the same way. It is basically, the sample of the cord is isolated between two clamps, and a needle attached or syringe is inserted in the cord and they attempt to aspirate back blood and hopefully -- usually they try to go to the vein.

Question - "We have no evidence here, other than the fact there was the cord gas, we don't know whether they were in the vein or an artery, is that what you're saying?"(38)

Answer - "Correct, you don't know for absolute certainty which one."

Question - "So indeed it could be a valid test too?"(39)

Answer - "Well, its validity is, it certainly couldn't be any better than it was. I mean the best -- the sample coming from the vein with the blood going to the baby, and hopefully that would be the best that he could be."

Question - "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that is evidence of acidosis?(39)

Answer - "Correct."

According to the history and physical exam of Dr. Chandrasekhar, "the baby was limp at birth and with no heart rate or respirations. Apgar at one minute was 0/10, at five minutes was 3/10, at 10 minutes was 4/10 and at 20 minutes was 5/10." "Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds." The first gas in the NICU showed a pH of 6.60.

Dr. Grout admitted in his deposition that the cord pH obtained at delivery indicated fetal acidosis.

The baby's neurological exam was markedly abnormal and the baby was placed on prophylactic phenobarbital for seizures.

According to the discharge summary dictated by Dr. Richard Grout, the transferred diagnosis was, "severe birth asphyxia, term birth."

After evaluation at the Children's Hospital of Pittsburgh revealed no baseline brain activity, the baby was withdrawn from life support and died.

The final autopsy report indicated, "A five day old female with hypoxic encephalopathy (clinical)" and a brain with "acute ischemic encephalopathy, severe."

According to the Autopsy Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

In my opinion to a reasonable degree of medical certainty this baby was repetitively and progressively iatrogenically asphyxiated by the nursing staff and Dr. Kruszewski resulting in profound central nervous system destruction, and eventually the death of the baby.

3. The patient had multiple episodes of unrecognized iatrogenic asphyxial stress which required intervention by cesarean section. Not performing a cesarean section in this situation resulted in fetal asphyxia and permanent brain damage. This was below accepted standard of care.

The fetal monitor revealed episodes of prolonged decelerations, severe variable decelerations with and without late components, fetal bradycardia, and loss of variability.

In review of the fetal tracing the patient had a reassuring fetal tracing on admission which correlates highly with fetal well being.

The pitocin was started at approximately 12:39 p.m. after over 4 hours of no cervical change and active phase arrest. The patient was noted to have fetal bradycardia from 15:02 to 15:21 associated with uterine hyperstimulation. A scalp electrode and intrauterine pressure device should have been placed, the pitocin stopped, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

The tracing revealed a prolonged deceleration from 15:37 to 15:41 associated with uterine hyperstimulation. The variability was decreased after the prolonged deceleration mandating placement of a scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care. The hyperstimulation mandated placement of an intrauterine pressure device to accurately monitor the contraction pattern and the pitocin should have been discontinued. Not doing so was below the accepted standard of care. According to Dr. Kruszewski's deposition testimony,

Question - "what kind of things would you be looking for to determine whether intervention was an option during labor?" (pg. 25)

Answer – "prolonged decelerations or decelerations that were occurring very frequently with the mother remote from delivery, decreased in fetal heart rate variability." She defines

intervention as, "can be any number of things, it can be a C-section, it can be a vacuum assisted delivery." (pg. 24).

The nurse notes on the strip at 15:38, "SVE 4-5cm 70% -2.", "Dr. Kruszewski called in, report given of recent variable decels and pitocin changes." The pitocin should have been discontinued, and the patient taken to cesarean section for arrest in the active phase of labor. Not doing so was below the accepted standard of care.

The Toco revealed an increased baseline from 17:10 to 17:20, requiring the reference to be readjusted again. The nurse also noted on the fetal tracing that there were multiple maternal position changes making interpretation of the uterine contraction pattern even more difficult. Not placing an intrauterine pressure device was below the acceptable standard of care.

The nursing staff continued to increase the pitocin in the face of arrest in the active phase of labor associated with uterine hyperstimulation from 16:40 on. They did not inform Dr. Kruszewski that the patient was being iatrogenically hyperstimulated, they failed to stop the pitocin and to insist that Dr. Kruszewski come in to evaluate the patient. These deviations were below the accepted standard of care.

The hyperstimulation with pitocin continued and the nurse noted on the tracing that the patient was placed in the knee chest position at approximately 18:49. The tracing indicated at this point that the "UA INOP, CARDIO INOP". The fetal heart tracing from 18:50 to 19:11 was inadequate and unreliable. The nurse notes on the fetal tracing that, "poor fetal and uterine toco capture while pt in knee chest against BB." At this time the patient was hyperstimulated with contractions almost every minute. Dr. Kruszewski should have been notified, a fetal scalp electrode and intrauterine pressure device should have been placed, the pitocin should have been discontinued, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 20:08, the cervical exam was unchanged. The patient was arrested in the active phase of labor for over 12 hours, associated with uterine hyperstimulation. A cesarean section was indicated. Not performing one was below the accepted standard of care.

At 20:31, the nurse again documents a note indicating that "Dr. Kruszewski on phone aware of last 2 exams, Pit level, periods of hypertonic appearing FHR average variability, IV fluid bolus. The nurse should have insisted that Dr. Kruszewski come in to evaluate the patient and discontinue the pitocin. The nurse should have insisted that Dr. Kruszewski be present to manage the patient. She should have discontinued the pitocin augmentation because of the arrest in the active phase of labor and because of the uterine hyperstimulation. These deviations were below the accepted standard of care.

Instead, the nurse increased the pitocin to 26 mu/min. If Dr. Kruszewski failed to respond, the nurse should have involved the nursing supervisor, Chief of Obstetrics and or the Hospital Administrator. According to the Hospital Policy and Procedures, No. 82, entitled Physician Notification in Maternal/Fetal Distress:

"When patients demonstrate maternal or fetal distress, the attending Physician will be notified immediately and his specific orders carried out."

"The hospital Supervisor should be notified."

"In the event the attending Physician fails to respond, the Labor Room Nurse will notify the Manager or Supervisor. The Chief of Service may be notified for advice."
Other procedures noted are to "See Medical Staff Chain of command."

The nurse documents that Dr. Kruszewski was notified of the last 2 pelvic exams, periods of hypertonic appearing UC, fetal heart rate with average variability, and that an IV fluid bolus was given. The pelvic exam at that time was 4-5 cms. The patient's cervical exam was unchanged despite aggressive pitocin augmentation. A cesarean section was indicated. Not performing a cesarean section and proceeding with the aggressive pitocin augmentation was below the accepted standard of care and lead to iatrogenic hyperstimulation, severe periodic changes, loss of variability, end stage bradycardia and eventually profound and irreversible brain damage.

At 2057, the patient had an episode of bradycardia lasting approximately 16 minutes associated with hyperstimulation, and an increased contraction baseline requiring placement of a scalp electrode, intrauterine pressure device, and discontinuing the pitocin. Not doing so was below the accepted standard of care. Although the nurse notes on the strip that the fetal heart rate was consistent with "maternal" heart rate, the only way to differentiate maternal from fetal heart rate was by placement of a scalp electrode.

The nurse failed to make Dr. Kruszewski aware of the fetal bradycardia, abnormal uterine activity pattern, uterine hyperstimulation, and increased baseline tone. She failed to insist that Dr. Kruszewski evaluate the patient. She failed to place a scalp electrode and intrauterine pressure device. She failed to discontinue the pitocin. These deviations were below the accepted standard of care.

At around 2120, the fetal strip revealed variable decelerations.

At 2131 the pitocin was decreased to 20mu and maternal position was changed.

The variability was decreased to absent from 2138 and through 2200. The nurse notes the EFM tracing "to present" reviewed by Dr. Kruszewski. At that time a pelvic exam was done by Dr. Kruszewski and the pitocin was decreased to 16mu.

The patient began pushing at approximately 2213. The patient had an abnormal uterine activity pattern. The strip revealed areas of drop out and difficulty monitoring the contraction pattern with multiple recalibrations of the UA reference mandating placement of a fetal scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care.

The fetal heart tracing demonstrates that the patient was having decelerations at approximately 22:37.

In reference to the fetal tracing at 10:54 (22:54), Nurse Bennett states in her deposition,
Question – "Did the decelerations at this point concern you in any manner?"(36-37).
Answer - "I'd like to see the patient delivered."

The fetal tracing from 22:40 forward was suboptimal with areas of drop out, severe periodic changes and loss of variability.

There are multiple references by the nurses regarding difficulty tracing the fetal heart rate during labor. According to the deposition testimony of Gloria Bennett when asked about the variable decelerations at 1037,

Question - "You lost the heart rate on the monitor?"(34)

Answer - "Right, when they're doing this, baby's usually moving to get off the cord so you don't always keep capture the whole way through."

With reference to a variable at 1039,

Question – "Ok. And how long would that have lasted?"(35)

Answer – "That's indeterminate because of inadequate capture."

When referring to a variable at 1052 she states,

Answer - "At 52, there was shown a returning to baseline of 120's but there is not an accurate measure of whether it was maternal heart rate were capturing or fetal, so I can't determine that."(36-37)

Answer – "54, same scenario, 90s -- returning from the 90s after inadequate capture."(36-37)

Answer - "When the mother is pushing to, they're often in the position, where they're bumping the monitor she can't keep in the fetal heart rate all in the entire time."(36-37)

When referring to a deceleration at 2331 she states,

Answer - "At which time capture was lost for seconds, and when it recaptured was 120's."(40)

According to the deposition testimony of Sherry Kizina,

When asked about a variable deceleration at approximate 8:45 a.m. (on page 88 of the transcript),

Answer – "that's not clear; it's not captured the whole way."

According to Parer, with reference to the external heart monitor, "although this device is simple to apply and can be used before rupture of the membranes, it sometimes is unreliable during labor because of maternal and fetal movement. A greater disadvantage is that it may not always give a valid indication of beat to beat variability, because the Doppler signal is broad and slurred, and the machine is not always able to select accurately and consistently a point on this slurred curve to represent the exact time of a cardiac event. Hence, an artificial short term variability can be portrayed by the apparatus. Long term variability, however may be displayed reasonably accurately."[39] According to Parer, with reference to a fetal scalp electrode, "this mode gives the most valid FHR tracing because of the discreteness of the signal; therefore, it best depicts beat to beat variability."[40]

An IV fluid bolus was given at 2244; oxygen was started at 2247 via nasal cannula. A scalp electrode and intrauterine pressure catheter were mandatory in this situation. Not utilizing these modalities was below the accepted standard of care.

[39] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 103
[40] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 102.

At and after 2250 the patient was hyperstimulated, was having repetitive severe periodic changes and loss of variability consistent with fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care

At 2306, .02 via facemask was applied at 10 L per minute, the patient had an abnormal uterine activity pattern and was having decelerations which were more severe associated with loss of variability signaling fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 2312 an IV fluid bolus was given and continued.

From 2310 forward the patient continued to have an abnormal uterine activity pattern, with severe periodic changes now with late components and loss of variability signaling fetal asphyxia and central nervous system compromise. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

Dr. Kruszewski stated in her deposition testimony (pg. 23) that "fetal stress can be some heart rate decelerations, changes in the variability of a heart rate pattern."

Question – "what do you consider to be non-reassuring fetal monitoring tracing?"(pg.28).

Answer – "frequent decelerations, decelerations with each contraction or almost every contraction that don't respond spontaneously to the end of the contraction, significant decrease in fetal heart rate variability." Allowing the patient to continue to labor in the face of progressive repetitive severe variable decelerations with loss of variability, resulted in fetal asphyxia and central nervous system damage. This was below the accepted standard of care.

According to Parer, severe variable decelerations are described as,

"A. Below 60 beats per minute and

B. Longer than 60 seconds in duration."[41]

Other practitioners use the "rule of 60s" as a guideline.

"When severe variable decelerations are present, vigorous efforts should be made to abolish them, because it is likely that even the normally grown fetus with normal placental function eventually will decompensate, although usually not before 30 minutes."[42]

According to Parer, "during severe variable decelerations the heart rate pattern must be observed for an intermittent reduction in FHR variability during and following the variable deceleration. Should this begin to occur and still abolition of the decelerations can not be achieved by the means outlined above (resuscitation maneuvers), then delivery is recommended. Delivery is recommended before the total loss of variability because this may signify asphyxial decompensation, and indeed must be present to do so unless asphyxia can be ruled out by ancillary methods."[43]

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[41] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[42] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[43] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

"Severe variable decelerations in the presence of frequent uterine activity may become confluent and form a prolonged deceleration, and eventually a bradycardia. Therefore in the presence of persistent severe variable decelerations it is prudent to attempt to maintain uterine contractions more than two minutes apart."[44] At 2330, the tracing revealed multiple severe variable decelerations with loss of variability associated with uterine hyperstimulation consistent with fetal asphyxia and central nervous system damage. This pattern finally terminated in severe bradycardia at 2338. The fetal tracing at this point was not traceable and unreliable.

The nurse notes that the pitocin was discontinued at 2343 and that the fetal heart rate was audible from 60 to 70. Emergent delivery was mandatory.

Dr. Kruszewski admits in her deposition that,

Question - "What can happen in a situation where the heart rate is that low and stays down?"(49)

Answer - "The baby's deprived of oxygen."

Question - "What happened in this case?"

Answer - "The baby was acidotic."

If Dr. Kruszewski contends that the startup time for her cesarean section was excessive, then this knowledge should have been applied to the management of the asphyxial stress due to the severe periodic changes by earlier delivery. Not doing so was below the accepted standard of care.

It is my opinion that the progressive, repetitive, severe variable decelerations with total loss of variability associated with uterine hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, rendering mode of delivery at this point irrelevant.

The nurse notes on the fetal tracing that the heart rate was audible at 50 beats per minute and dropping.

At 2346, the orders are received for vacuum. A second RN was called to the room.

According to the notation on the fetal tracing;

The vacuum was applied by Dr. Kruszewski at 2348 and at 2350 nurses are unable to capture the fetal heart rate.

At 2351, the time of delivery, the NICU was notifying to come stat upon delivery of the infant. The baby was delivered by Dr. Kruszewski.

On page 49 of her deposition when asked about her recollections of labor and delivery Dr. Kruszewski notes, "she was complete about 10 p.m. and started to push, and the progress of pushing was going relatively well, and then towards the end, just before the baby delivered, she began having decels, that didn't respond to scalp stimulation and other interventions, and the baby was crowning at that time so I asked for a vacuum to facilitate the delivery. Dr. Kruszewski's deposition testimony was contradicted by the fetal tracing and her own deposition testimony. The fetal tracing revealed multiple repetitive severe variable decelerations with loss of variability and bradycardia for up to one hour prior to delivery of Mikayla. The baby was not crowning but was noted to be at the +1 to +2 station at the time of the vacuum application. Dr. Kruszewski in her deposition (pg. 57) states,

[44] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised.

Severe repetitive periodic changes were present as early as 2237 which became more severe and atypical until they resulted in the end stage bradycardia documented by the nurse prior to delivery. A scalp electrode was not placed to evaluate variability and fetal well being. An intrauterine pressure device was not placed in light of the uterine hyperstimulation and difficulty maintaining the external toco. The pitocin was not discontinued when the iatrogenic pitocin augmentation resulted in repetitive severe periodic changes terminating in fetal bradycardia. A cesarean section was not performed when the severe periodic changes became repetitive and resulted in loss of variability. These deviations were below the accepted standard of care.

When Dr. Kruszewski was asked whether there is a time when bradycardia becomes significant in whether the child will be delivered healthy, she answered "not that I'm aware of."(pg. 55)

In review of the report of Dr. Sommers, there were numerous inaccuracies and omissions:

She notes that the baby was transferred to Children's Hospital of Pittsburgh and that "over the next few days her condition deteriorated." According to the inpatient discharge summary authored by Carol Gilmour on 6/28/02, "Neurology's impression was that of a severe hypoxic ischemic encephalopathy." "Over the next several days there was no change in Mikayla's exam".

Dr. Sommers notes that, "An autopsy was performed and the clinical diagnosis was acute total asphyxia of unknown etiology and subsequent perinatal hypoxic/ischemic encephalopathy."

According to the Final Autopsy Report: The final autopsy diagnosis was "a five day old female with hypoxic encephalopathy (clinical)."

According to the Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

Dr. Sommers did not address the lack of an indication for the induction, the failure to discuss the reason for and risks associated with induction and or augmentation with the patient, the fact that the patient had evidence of fetal macrosomia, cephalopelvic disproportion, and that

the Mrs. Rhoades was not examined by Dr. Kruszewski for fetal size or clinical pelvimetry prior to the induction and or augmentation.

Dr. Sommers failed to question the lack of documentation indicating the reason for the pitocin augmentation. She did not address the management of this patient who was arrested in the active phase of labor for up to 12 hours. She did not question why the pitocin augmentation was started after 4 hours of no cervical change and why the patient was not taken to cesarean section after 2 hours with no cervical change.

Dr. Sommers did not note that the nurses and Dr. Kruszewski failed to recognize and properly manage the prolonged episodes of uterine hyperstimulation.

Dr. Sommers failed to question why an intrauterine pressure device wasn't placed after the nurses were having difficulty maintaining the external tracing, after the multiple attempts at recalibration by the nurses were noted, after the baseline tone was increased and because of the uterine hyperstimulation.

Dr. Sommers did not address the inability of the nurses and Dr. Kruszewski to recognize asphyxial stress and to appropriately manage it. Dr. Sommers failed to question why a fetal scalp electrode was not placed with fetal bradycardia, prolonged decelerations, with extensive fetal dropout (while in knee chest), with decreased variability, and with repetitive decelerations.

Dr. Sommers failed to address why the pitocin was continued and the patient not taken to Cesarean section despite the recurrent severe periodic changes, uterine hyperstimulation, and the ominous fetal heart pattern with loss of variability indicating fetal asphyxia.

Nurse Comport's report contained numerous inaccuracies:

She notes that "an ultrasound done on 4/13/02, just 22 days prior to delivery, revealed a fetus at 3383 grams or 7#7oz confirming an average sized infant." She than goes on to mention that "the hospital staff did not make a determination of fetal weight either clinically or sonographically. However, this is refuted by the fact that ultrasound assessment had just been recently done revealing a normal sized infant."

The ultrasound examination was done more than 3 weeks prior to delivery and was not done "recently." Nurse Comport fails to substantiate how she concluded that the baby was "average size" since there was no percentile weight for gestational age given in the ultrasound report. Using standard tables, the percentile weight for gestational age approached the 90$^{th}$ percentile. What actually did happen was that Dr. Kruszewski failed to evaluate the fetal weight and pelvis on admission, failed to recognize that this baby was macrosomic, and failed to realize that an unengaged fetal head at -3 station indicated cephalopelvic disproportion. These deviations were below the accepted standard of care.

Nurse Comport opines that "a second issue addressed is the lack of appropriate nursing, assessments and responsiveness to the fetal heart rate changes." As illustrated in my report, the nurses were unfamiliar with the basic concepts of fetal monitoring, and principles of labor and delivery. They failed to recognize that this patient was arrested in the active phase of labor. They failed to insist that an intrauterine pressure device was placed after numerous attempts at recalibration, after abnormal uterine activity patterns were noted, and because of the iatrogenic

uterine hyperstimulation with pitocin (see P/PR No. 61.2). They failed to place or have Dr. Kruszewski place a fetal scalp electrode when the tracing revealed dropout, prolonged decelerations, bradycardia, repetitive decelerations and loss of variability (see P/PR No. 61.3). They failed to discontinue pitocin with the presence of nonreasurring and or ominous fetal heart rate patterns and when abnormal uterine activity patterns were present as per the Hospital's Policy and Procedures, P/PR No. 61.2.

Nurse Comport than goes on to note that, "Criticism has been raised that the pitocin was only decreased and not discontinued, but this is an appropriate course of action. You want to decrease the pitocin to decrease the contraction frequency, which in turn facilitates more oxygenated blood to the fetus." Even more of a reason to discontinue the pitocin optimizing blood flow and oxygenation to the baby. Nurse Comport failed to review the Hospital's Policy and Procedures P/PR, No. 61.2, which states that the procedure indicated for nonreasurring, ominous and abnormal uterine activity patterns is to "Discontinue oxytocin if in use."

She than mentions that "However, you also want to expedite the delivery especially if there are any signs of a change in the fetal heart rate pattern such as variable deceleration." Another way to expedite delivery, without exposing the baby to the asphyxial stress caused by variable decelerations, is by performing a Cesarean Section. Not doing so was below the accepted standard of care.

Nurse Comport finally goes on to note that, "During the second stage or the time the patient was pushing there were times when the fetal heart rate pattern was concerning. This is a relatively common occurrence with pushing as the uteroplacental blood flow is diminished during the pushing effort." Nurse Comport admits that there were times that the fetal heart rate pattern was concerning but fails question why a fetal scalp electrode was not placed, why the pitocin was not discontinued, and why the nurses did not insist that Dr. Kruszewski stop the pitocin augmentation and take this patient to cesarean section.

Nurse Comport recognizes that uteroplacental blood flow is diminished during the pushing effort. She failed to recognize that, in this case, the aggressive pitocin augmentation with uterine hyperstimulation and pushing resulted in decreased blood flow resulting in repetitive severe variable decelerations associated with loss of variability indicated hypoxia and asphyxia. The nurses did not stop the pitocin. They did not recognize that Mrs Rhoades was hyperstimulated and was having decelerations requiring placement of a fetal scalp electrode, intrauterine pressure device, discontinuing the pitocin and insisting that Dr. Kruszewski take this patient to cesarean section. These deviations were below the accepted standard of care.

If the nurses had truly recognized the significance of the fetal tracing, the nurses could have followed Hospital Policy and Procedure P/PR No. 82, entitled Physician Notification in Maternal/Fetal Distress. They chose not to. They did not recognize and act on the progressive iatrogenic fetal asphyxia caused by the aggressive pitocin augmentation and uterine hyperstimulation.

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I reserve the right to amend this report if and when any further information becomes available to me.

Sincerely,

James L. Mollick, M.D., FACOG

Kimberly Rhodes

Expert Witness Report

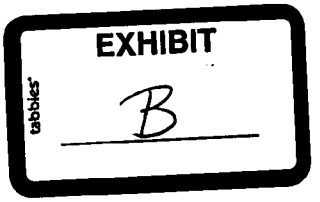
Labor and Delivery Nursing Care of
Kimberly Rhoades and infant

This report is based on a review of the medical records for Kimberly Rhodes at Du Bois Medical Center including the fetal monitoring records, records from Dr. Kruszewski, and the records from Children's Hospital of Pittsburg. In addition the depositions of the attending RN's, and MD neonatologist as well as the deposition of Dr. Kruszewski attending obstetrician were reviewed. Furthermore the policy and procedure manual sections related to maternity and neonatal from Du Bois Medical Center were also reviewed.

Mrs. Kimberly Rhodes was a 33 year old G1P0 Caucasian female with a history of infertility, when she presented for her first obstetrical visit on November 1, 2001 with an LMP of 8/1/01 giving her a EDD of 5/10/02. This EDD was later confirmed by ultrasound. Mrs. Rhodes is 5'6" with a pre-pregnancy weight of 123 pounds and a BP of 108/72. She had a total of 13 prenatal visits which showed adequate fetal growth and movement, normal NST's, ultrasounds and BPP. Mrs. Rhodes developed edema of her hands, feet and face as well as a rise in her blood pressure along with a 47 pound weight gain. PIH laboratory work was ordered along with an ultrasound and NST and BPP, they were reported as normal but there is no evidence in the prenatal notes of any further care, teaching or advice. Since she is an "elderly primipara" there is a higher incidence of pre-eclampsia to be concerned about.

While the record shows the baby to have adequate FHT's and movement and to be in a vertex position it does not give the exact position of the head, the station or an estimated fetal weight even after the mother raised concerns on the size of the baby. There is a late ultrasound with an EFW of 3500 grams which translates to an slightly larger than average size baby of approximately 7 pounds 11.5 ounces but no follow-up clinically either prior to labor or when she was admitted to the hospital in labor. The labor examination does not include an evaluation of fetal size, engagement of the fetal head or position all of which are important in a primipara especially when the vaginal examination shows a – 3 station and the plan is induction/augmentation of labor.

An induction of labor was scheduled at DuBois Regional Medical Center on May 10, 2002. The admission report indicates Kimberly Rhoades was having contractions on her own and was 3-4 cm dilated, 50-75% effaced and -3 vertex at 740 a.m.. The membranes were artificially ruptured and clear fluid presented. Fetal Monitoring tracing indicate the FHT was baseline at 150 with good variability with some occasional small minor variable decelerations. Contraction pattern shows q 1.5 to 2 minutes and are reported to be of mild intensity based on manual palpation and maternal reporting. There is no report on a concern for prolapsed cord which is a strong possibility with a -3 station. In addition with the external electronic monitor on the uterus it is not possible to determine the actual strength or uterine baseline of the contractions or the accuracy of the FHT in response to contractions.



Furthermore, it is unusual to find a primipara with 50-75% effacement at 3-4 cm of dilation. It is also a warning sign of CPD (cephalopelvic disproportion) to have a primipara with a -3 station upon the start of active labor; the fetal head usually drops into the pelvis about 36 weeks of pregnancy. There is a higher incidence of cesarean section among primiparas who enter labor when the fetal head has not engaged in the pelvis by the active phase of labor; it is an indication of CPD and must be monitored closely. There is also no record of the fetal position which can influence CPD. This potential for CPD was the case with Mrs. Rhodes so that position, presentation and station are all important variables to be closely monitored.

Mrs. Rhoades was still 4 cm, 60% and -3, despite spontaneous contraction every 2-3 minutes, by 12:37 pm, five hours later. This constitutes arrest of cervical dilation and arrest of fetal decent. Induction/augmentation of labor was started with 2 mu. at 1237 p.m. and increased to 4 mu. at 1250 p.m. by nurse SK. The FHT baseline at the time of augmentation of labor was 130 with mild variability, variability increased with signs of accelerations and contraction pattern was every 2-3 minutes. Pitocin increased again at 1320 to 6 mu. and the FHT responded by baseline of 140 and decreased variability. By 1440 the BP has risen to 135/84 and a pulse of 93, contractions q1.5 to 2 minutes, FHT 140-150's and some variable decelerations. The nurse, SK, appropriately moves the patient to her left side.

Pitocin is increased again to 10 mu. by nurse SK, and contractions respond with increased baseline and frequency every minute. The FHT responds with decreased variability. At 1500 an epidural is placed and during that time there is no FHT picked up. The heart rate on the tracing is the maternal. Maternal BP is 133/79 and pulse is 105. By 1540 there is a 6 minute combination late/variable deceleration of the fetal heart rate. The nurse, GB, reduces the pitocin to 8 mu. Turns the mother on her right side, does a SVE finding the patient to be virtually unchanged at 4-5 cm, 70% and -2 with a the maternal BP is 185/161 with a pulse of 111 and there is another episode of fetal heart rate deceleration. The heart rate recovers but with minimal variability. This represents the first of several episodes that follow where there are decelerations followed by recovery but with minimal variability, showing there is not adequate fetal recovery. Nurse, GB, calls the DO to inform her of FHT pattern, results of SVE and pitocin induction status.

The nurse, GB, appropriately called the physician to report. However if she had reported the contraction pattern and FHT with the reminder of the definition of adequate contraction patters, i.e. 7 contractions in a 15 minute period and the patient had 9 contractions in a 15 minute period; there should have been an alternate plan to monitor this mother and fetus. The continued plan to increase the pitocin despite the fetal and uterine response does not follow safe practice in light of the initial and continued maternal-fetal condition. To provide an adequate safe trial of labor the continued increase in dosing of pitocin must be followed by an alternate plan such as the use of internal electronic monitoring to properly assess the patient's condition.

Despite nurse GB giving a 1000 cc bolus of fluids and turning the maternal position the FHT still had minimal variability for over 24 minutes. There is a repeated episode of uterine hyperstimulation which does not allow for fetal recovery. By 1620 the nurse, GB, again increases the pitocin to 10 mu. and the fetus responds with some minor variable

decelerations. At no time was there any attempt to place an internal fetal monitor to determine if the FHT and uterine tracing was accurate and to determine the true strength, baseline and frequency of contractions to properly adjust the pitocin dosage. The nursing intervention was to change the maternal position, provide fluids and adjust the Toco on the monitor.

By 1850, the cervix and fetal position are unchanged 11 hours later despite increasing the pitocin. She has prolonged arrest of dilation and decent and this should have been reported to the physician with a request for further medical evaluation, application of internal monitoring and preparation for a cesarean section particularly in light of the increasing pattern of decelerations, decreased beat to beat variability and an erratic contraction pattern and a maternal blood pressure that is erratic. Furthermore the absence of an FHT when placing an epidural should have also been a warning sign to place an internal fetal monitor in light of the other compounding factors

PT 2

Overall there is a lack of safety precautions and following standard of care in relation to the use of pitocin induction or augmentation of labor in light of the initial maternal-fetal examination, arrest of decent and dilation, uterine contraction pattern and fetal heart rate response to the induction/augmentation process. A safer course of action would have been to use an internal fetal monitor to get a true picture of the fetal and uterine response and when there was an arrest despite an adequate contraction pattern to recommend consideration of a cesarean section. While the nurse does not make this decision the nurse can follow the hospital protocol by properly informing the physician of the facts and if there is not an adequate response based on the nurses professional judgment, to follow the required hospital protocol for further evaluation.

Therefore in light of the above evaluation of this case it is my professional opinion with a reasonable degree of certainty that the labor and delivery room nurses attending Mrs. Rhodes during her labor failed to act in accordance with a reasonable standard of nursing care in the provision of labor and delivery nursing services to Mrs. Kimberly Rhoades and her infant and this failure was the cause of the medical problems experienced by the infant at the time of birth.

Dianne S. Moore PhD, RN, CNM, MN, MPH

Dianne S Moore

1212 West Paul Ave
Fresno CA 93711
914 572 6879

Rhoads

Received DRJ

FEB 2 1 2005

Place ( ) Dictated on ( )
Diary/ Note ( )
Copy to DRJ ( ) Copy Key Sec.( )

JAMES L. MOLLICK, M.D.
2114 Country View Lane
Lansdale, Pa. 19446
215-661-1066

EDUCATION

ALBRIGHT COLLEGE
Reading, Pa — Graduated: 1982

Bachelor of Science (Magna Cum Laude)... Major: Biology

TEMPLE UNIVERSITY SCHOOL OF MEDICINE — Graduated: 1986
Philadelphia, PA

Doctor of Medicine

PROFESSIONAL EXPERIENCE

TEMPLE UNIVERSITY HOSPITAL
Philadelphia, PA

OB/GYN Resident — 1986 to 1990

Academic Chief Resident — 1989 to 1990

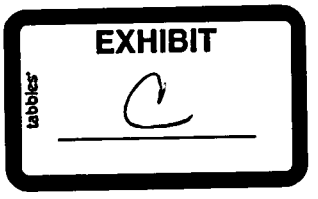
CERTIFICATIONS

Laser Certification-Temple University Hospital — 1990
Clinical Instructor-Temple University Hospital
Laser Course

American Board of Obstetrics and Gynecology — 1992

Diplomate National Board of Medical Examiners

AMA Physicians Recognition Award — 11/1/90 to Present



JAMES L. MOLLICK, M.D.

## EXTENDED EDUCATION

| | |
|---|---|
| Advances in Maternal-Fetal Medicine<br>Vail, Colorado | 1987 |
| Ultrasonography (Dr. Hobbins)<br>Yale University | 1988 |
| Advances in Maternal-Fetal Medicine<br>Vail, Colorado | 1990 |
| American College of Obstretrics and Gynecology<br>Annual Meeting<br>San Francisco, California | 1990 |
| Vaginal Surgery "A Panorama"<br>Temple University | 1991 |
| Hysteroscopy- Master's Course<br>San Francisco, California | 1992 |
| Laparoscopy - "The Easy Way"<br>Orlando, Florida | 1992 |
| Colposcopy/LEEP Seminar<br>Wyoming, Wisconsin | 1991 |
| Laparascopic Hysterectomy ( Dr. Reich)<br>Kingston, Pennsylvania | 1991 |
| Osler Institute Review Course<br>Nashville, Tennessee | 1992 |

## AWARDS AND HONORS

| | |
|---|---|
| Who's Who's<br>Among outstanding business executives | 1996 |
| Resident of the Year<br>Awarded by Ortho Pharmaceuticals | 1990 |
| Berlex Education Award<br>For Academic Excellence | 1989 |
| Chief Resident Recorder<br>Awarded by Syntex Pharmaceuticals for<br>1990 ACOG meeting, San Francisco, California | 1990 |
| Ortho Pharmaceutical Resident's Day Bowl<br>Third Place | 1990 |

JAMES L. MOLLICK, M.D.

## MANUSCRIPTS IN PREPARATION

Incidence of Actinomycosis Associated with IUD use

Follow-Up Treatment/Response of IUD Related Actinomycosis Infection

Case Report: Meckel's Gruber Syndrome

Retrospective Study: The Biophysical Profile as a Method of Antenatal Surveillance in Premature Rupture of Membranes

## PROFESSIONAL MEMBERSHIPS

1. American Medical Association
2. Pennsylvania Medical Society
3. Montgomery County Medical Society
4. Fellow of the American College of Obstetrics and Gynecology
5. The Society of Laparoendoscopic Surgeons
6. Society of Gynecological Laparoscopists.
7. The Cincinnatus Society

## SPEAKING ENGAGEMENTS

| | |
|---|---|
| Women During the Reproductive Years<br>Sacred Heart Hospital | 1992 |
| Diabetes/Sexuality<br>Sacred Heart Hospital<br>OB/GYN Department | 1992 |
| Women's Issues<br>Business Women's Association of Montgomery County | 1992 |
| Genital Cancer<br>Sacred Heart Hospital | 1991 |
| Women's Health Issues<br>Montgomery Hospital | 1999 to 2001 |
| Montgomery County Bar Association<br>Topic - The expert witness | 2004 |
| Pennsylvania Bar Institute<br>Topic - Birth Trauma<br>Pittsburgh and Philadelphia | 2004 |

James L. Mollick, M.D.

## HOSPITAL COMMITTEES

Suburban General Hospital
Norristown, PA
- Surgical Audit Committee
- Quality Assurance Committee

Montgomery Hospital
Norristown, PA
-Tissue (Invasive Procedure) Committee 2000 to 2004
Quality Assurance Committee 2004 to Present

Sacred Heart Hospital
Norristown, Pa.
- Credentials Committee
- JOAH Review Coordinator
- Ethics Committee

## Special Committees:

Independence Blue Cross Cesarean Section advisory committee 1996

## Appointments:

Assistant Chairman- Dept. OB/GYN
Montgomery Hospital 1999 to Present

## PERSONAL DATA

Date of Birth: 12-01-59
PA Medical License Number: MD-039900-E
DEA Number: BM-1354442

## REFERENCES

Personal and professional references will be furnished upon request.

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within documenthas been served upon the following counsel of record and same placed in the U.S. Mails on this 7th day of July, 2006:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424

Victor H. Pribanic, Esquire
Pribanic & Pribanic
1735 Lincoln Way
White Oak, PA 15131

John W. Blasko, Esquire
McQuaide Blasko Schwartz Fleming & Faulkner, Inc.
811 University Drive
State College, PA 16801

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

ORDER OF COURT

AND NOW, this _____ day of _____, 2006, after consideration of the motion in limine filed on behalf of DuBois Regional Medical Center, it is hereby ordered that:

1. Plaintiffs' expert, James Mollick, M.D. is precluded from offering any expert testimony against DuBois Regional Medical Center as to any alleged breach of the standard of care by its nursing staff; and all persons, including witnesses or attorneys, are precluded from referring to any reports by Dr. Mollick which are critical of DuBois Regional Medical Center or its nurses.

BY THE COURT:

_____ J.

CA

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

FILED 3cc
012:14 BA Atty Ging
JUL 10 2006
William A. Shaw
Prothonotary/Clerk of Courts

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**RULE TO SHOW CAUSE**
**ORDER**

AND NOW to wit this 10 day of July, 2006, upon consideration of the Motion in Limine of the Plaintiffs to preclude the testimony of Drs. Depp and Fox on issues relating to pathology and neuropathology, it is hereby Ordered that:

1. A rule is issued upon the Respondent to show cause why the moving party is not entitled to the relief requested;

2. The Respondent shall file an answer to the Motion within 10 days of this date.
PJA

3. The Motion shall be decided under Pa.R.C.P. 206.7.

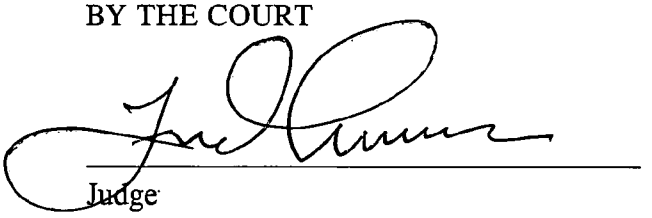
4. Depositions and all other discovery shall be completed within _____ days of this date.

5. An evidentiary hearing on disputed issues of material fact shall be held on _____, in the Clearfield County Courthouse, Clearfield, Pennsylvania, in Courtroom No. _____.

6. Argument shall be held on July 24, 2006 @ 9:00 AM., in Courtroom No. 1 of the Clearfield County Courthouse, and

7. Notice of the entry of this Order shall be provided to all parties by the moving party.

BY THE COURT



Judge

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ORDER**

AND NOW, to wit, this _____ day of _____, 2006 upon Motion of the Plaintiffs, it appearing that neither Dr. Depp nor Dr. Fox practice in the specialty of pathology, it further appearing that neither Dr. Fox nor Dr. Depp are trained as pathologists, it is hereby Ordered that Dr. Depp and Dr. Fox are precluded on testifying contrary to the opinions and findings of the pathologist and neuropathologist in the autopsy report.

BY THE COURT

_____

Judge

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

**JOINDER IN DR. KRUSZEWSKI'S MOTION IN LIMINE TO PRECLUDE PLAINTIFFS' ECONOMIC LOSS EXPERT**

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.

Counsel of Record for This Party:

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FILED NO CC
JUL 10 2006
William A. Shaw
Prothonotary/Clerk of Courts

JOINDER IN DR. KRUSZEWSKI'S MOTION IN
LIMINE TO PRECLUDE PLAINTIFFS' ECONOMIC LOSS EXPERT

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and files the following joinder in Dr. Kruszewski's motion in limine to preclude plaintiffs' economic loss expert.

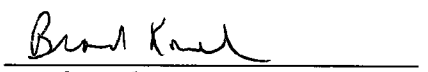
1. This defendant incorporates by reference the averments in the motion in limine regarding plaintiffs' economic loss expert filed by Dr. Kruszewski as if same were set forth herein at length.

2. As stated and explained in Dr. Kruszewski's motion in limine, the expert report (and necessarily the testimony) of plaintiffs' economic loss expert, William Houston Reed, Ph.D., patently violates Pennsylvania Rules of Evidence 403 and 703, and also runs afoul of the requirements of 40 P.S. § 1303.510. Moreover, as Dr. Kruszewski's motion in limine makes clear, Dr. Reed is woefully unqualified by virtue of his training, education and professional experience to offer any meaningful expert opinion to the jury on the projected economic loss damages for which purpose his testimony is being offered. In other words, the opinions contained within Dr. Reed's report are not worth the price of the paper on which they appear.

WHEREFORE, this defendant, DuBois Regional Medical Center, respectfully requests that this Honorable Court grant its joinder in Dr. Kruszewski's motion in limine to preclude plaintiffs' economic loss expert, thereby prohibiting the testimony of plaintiffs' identified expert, William Houston Reed, Ph.D.

Respectfully Submitted,

THOMSON, RHODES & COWIE, P.C.



David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center,
one of the defendants.

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within document has been served upon the following counsel of record and same placed in the U.S. Mails on this 7th day of July, 2006:

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David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | |
|---|---|
| DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES, | CIVIL DIVISION<br><br>No. 03-1268 CD |
| Plaintiffs, | Issue No. |
| Vs. | |
| MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER, | |
| Defendants. | |

ORDER OF COURT

AND NOW, to wit, on this _____ day of _____, 2006, it is hereby ORDERED that the joinder of defendant DRMC to Dr. Kruszewski's motion in limine to preclude plaintiffs' economic loss expert is hereby GRANTED. Plaintiffs shall be precluded, estopped and barred from presenting or referring to the expert report of William Houston Reed, Ph.D., and shall thus be precluded from offering any testimony by Dr. Reed at trial.

BY THE COURT:

_____J.

CA

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES )
individually and as personal representatives )
of the ESTATE OF MIKAYLA RHOADES,)
)
Plaintiffs, )
)
vs. )
)
MARY C. KRUSZEWSKI, D.O. and )
DUBOIS REGIONAL MEDICAL )
CENTER, )
)
)
Defendants. )

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading: Response to Plaintiffs' Motion to Exclude Scientific Testimony Pursuant to Pa.R.C.P. 207.1 and a Request for a Hearing Pursuant to Rule 207(a)(b) Prior to Trial

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Case settled 7-14-06 just place in file Thank you R

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JUL 14 2006 GK

William A. Shaw
Prothonotary/Clerk of Courts

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiffs,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

***DEFENDANT, MARY C. KRUSZEWSKI'S D.O.'S RESPONSE TO PLAINTIFFS' MOTION TO EXCLUDE SCIENTIFIC TESTIMONY PURSUANT TO PA.R.C.P. 207.1 AND A REQUEST FOR A HEARING PURSUANT TO RULE 207.1(a)(b) PRIOR TO TRIAL***

***A. Motion to Dismiss***

1. On December 7, 2005, the Court Ordered a Status Scheduling Conference among the parties. At that time all counsel appeared before the Court, and, the Court entered an Order requesting correspondence from each counsel on their position concerning deadlines for discovery, motions, and trial.

2. Plaintiffs' counsel responded by letters dated December 8, 2005 and December 12, 2005. Defendant's counsel responded on December 12, 2005 and December 13, 2005. All parties provided the Court with suggestions on the proposed Order.

3. On January 9, 2006, this Honorable Court entered a Scheduling Order stating:

> "following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule . . ."

An Order was entered attached hereto marked Exhibit "A."

4. At no time did the Plaintiffs object to the Court's Order.

5. Under the Court's Order of January 9, 2006, the scheduled cut-off time for Defendants to file their expert reports and discovery completed was March 15, 2006.

6. The Plaintiffs' counsel did not in any of his correspondence with the Court in arriving at the Scheduling Order request additional time or date for filing rebuttal reports to the Defendants' experts' reports.

7. On June 16, 2006, the Plaintiffs, under the guise of Motion to Exclude Scientific Testimony of Defendants' Expert, filed a rebuttal report of their expert, James L. Mollick, M.D. dated June 13, 2006 which was approximately 3 months after the Defendants filed their expert reports and the discovery deadline.

8. The Plaintiffs' rebuttal report dated June 13, 2006 was not provided at the Pre-Trial Conference of April 20, 2005 or attached to the Pre-Trial Statement as required by Local Rule 212.4.

9. At no time did the Plaintiffs file a Petition or Motion for permission to file a rebuttal report to Defendants' experts.

10. The submittal of the rebuttal report of June 13, 2006 on the eve of trial, under the guise of Motion to Exclude Scientific Testimony, is in violation of this Court's Order and Local Rules and should be dismissed.

11. The basis of Plaintiffs' Motion and the rebuttal report of Dr. Mollick is simply that Defendant's experts, Drs. Depp and Fox reviewed the same records that Dr. Mollick reviewed, but the Defendant's experts' opinions and conclusions were different than that of Plaintiffs' expert, and, as a result, Defendant's experts' testimony should be excluded.

12. The Plaintiffs' expert has opined that Defendant's experts ignored facts that should not have been ignored by Defendant's experts, and, therefore, the Defendant's experts' opinions should be excluded.

13. The Plaintiffs' expert, in effect, criticizes the weight of the evidence and the credibility of Defendant's experts which is not a proper basis to exclude under the Frye theory for the reasons that it is the function of the jury which will be guided by the following instructions:

> (a) An expert opinion only has value when the jury accepts the facts on which it is based. This is true whether the facts come from the expert's personal knowledge, from some other source or from some combination. Pa. Stand. Jury Instruction 5.13 [civ]
>
> (b) In resolving any conflict that may exist in the testimony of expert witnesses, the jury are to weigh the opinion of one expert against the opinion of another. In doing this, the jury should consider the relative qualification and reliability of the expert witnesses, as well as the reasons for each opinion and the facts and other matters upon which it was based. Pa. Stand. Jury Instruction 5.33 [civ]
>
> (c) A witness who has special knowledge, skill, experience, training or education in a particular science, profession, or occupation may give an opinion as an expert as to any matter in which he or she is skilled. In determining the weight to be given to the expert's opinion, you should consider the qualifications and reliability of the expert and the reasons and facts given for the opinion. **You are not bound by an expert's** opinion merely because he or she is an expert; you may accept or reject it, as in the case of other witnesses. **Give it the weight, if any, to which you deem it entitled**.
>
> (d) The Plaintiffs' rebuttal report of Dr. Mollick dated June 13, 2006, can be accepted or rejected by a jury as with any other expert report, and, in doing so would consider the experts' qualifications, methodology, and, other facts relied on by the expert.

(e) The Plaintiffs' Motion is simply an attempt to usurp the function of the jury, and, have the Court substitute its judgment for that of the jury on a finding as to the weight of the evidence, and, credibility which is improper as a matter of law.

WHEREFORE, it is requested that Plaintiffs' Motion to Exclude Scientific Testimony be dismissed with prejudice.

***II.***

***ANSWER TO PLAINTIFFS' MOTION TO EXCLUDE SCIENTIFIC TESTIMONY***

1. It is admitted that the Plaintiffs seek to exclude the testimony of Defendants' experts, Dr. William Fox and Dr. O. Richard Depp, under the guise or attempt to submit a rebuttal or supplemental report by their expert to the reports of Drs. Fox and Depp, which is improper as a matter of law.

2. Paragraph 2 is denied. Dr. Depp is a world renowned expert in obstetrics and gynecology, with a subspecialty in maternal-fetal medicine He is a full professor at the Drexel University College of Medicine and is active in clinical research, lecturing extensively to practicing obstetrics and gynecologist physicians on a national level, as well as medical residents and students and conducts a significant continuing medical educational program for obstetrics, gynecology and maternal-fetal medicine. He was one of thirteen members of a National Task Force on Neonatal Encephalopathy and Cerebral Palsy which is a joint statement by the American Colleges of Obstetricians/Gynecologists and the American Academy of Pediatrics which has set and established a consensus on the standard of care on the very issues involved in this case and endorsed by multiple U.S. specialties and subspecialty organizations as well as multiple international medical societies. Copes of introduction to the ACOG study and National

Task Force is attached hereto as Exhibit "B." In the attached publication, Exhibit "B", the task force, including Dr. Depp, set forth the standards applicable to the issues involved in this case and consists of 85 pages which will be submitted to the Court at argument. In addition, Dr. Depp has written various articles in Peer Reviewed Journals, and has acted in the capacity of peer reviewer for journal articles relating to obstetrics, gynecology and maternal-fetal medicine. He has been involved in preparing the ACOG standards as well as the author of various textbooks in cooperation with other experts which even Plaintiffs' expert, Dr. Mollick, cites as being authoritative on the standard of care.

3. Paragraph 3 of the Motion is denied as stated. Defendant's expert, William W. Fox, M.D. is Board certified by the American Board of Pediatrics with a Board certified subspecialty in Neonatal/Perinatal medicine, specialties and certifications, which Dr. Mollick, Plaintiffs' expert does not have. Dr. Fox is a professor of pediatrics at the Children's Hospital, Philadelphia, University of Pennsylvania and involved in a daily clinical practice. Dr. Fox is an author and publisher of Fetal and Neonatal Physiology, Volumes 1 and 2, 3rd Edition published by Saunders which is a recognized text as being authoritative throughout the world by pediatrics, neonatologists, and neonatal/perinatal specialties, a copy of the cover page, together with the Table of Contents of the subjects included within the two volume treatise are attached hereto marked Exhibit "C."

3[sic]. The Plaintiffs have had the reports of Drs. Fox and Depp for over three months before filing their rebuttal report.

4. Paragraph 4 is admitted that Drs. Depp and Fox have not treated Mrs. Rhoades or her baby. Dr. Mollick, Plaintiffs' expert, did not treat Mrs. Rhoades or the baby.

5. Dr. Fox, an expert neonatologist with a subspecialty of neonatal and perinatal medicine, reviewed the appropriate records which his specialty and subspecialty would require in rendering his report of March 7, 2006.

6. Dr. Depp, an expert and board certified OB/GYN with a subspecialty in maternal fetal medicine, reviewed the appropriate records to prepare his report of March 8, 2006.

7. It is admitted that Dr. Mollick is Plaintiffs' hired expert and a medical physician and Board certified by the American College of Obstetrics and Gynecology. In reviewing Dr. Mollick's curriculum vitae attached as Exhibit 5 to Plaintiffs' Motion and compared to the curriculum vitae of Defendant's experts, Dr. Fox and Dr. Depp there is no question of the superb expertise of Dr. Fox and Dr. Depp over that of Dr. Mollick. Dr. Fox is Board certified in Neonatology and in the subspecialty of Neonatal and Perinatal medicine certified by the American Board of Pediatrics and American Subspecialty Board of Neonatal/Perinatal medicine. Dr. Mollick is not a pediatrician and is not certified in Dr. Fox's specialty or subspecialty. Further, the expertise of Dr. Fox in his 18 page curriculum vitae needs to be compared with Dr. Mollick's 4 page curriculum vitae. Dr. Fox has held various positions in health tertiary and teaching institutions throughout the United States, but, Dr. Mollick does not have such experience. Dr. Fox has at least 15 or 16 awards, honors and memberships in honorary societies, but Dr. Mollick does not. Dr. Fox has editorial positions as a scientific reviewer for journals in pediatrics, critical care medicine, pediatric research, developmental pharmacology and therapeutics, and pediatric pulmonology. Dr. Mollick is not a reviewer for any journal. Dr. Fox had several appointments to academic committees of hospitals, which Dr. Mollick does not. Dr. Fox is an attending physician in intensive care at Children's Hospital, a pediatric lecturer, a physiology lecturer, OB/GYN lecturer, a neonatal fellowship program participant, and lecturer in

wilderness medicine course which Dr. Mollick does not do. Dr. Fox has given over 20 lectures over the years by invitation to other physicians but Dr. Mollick has none except for what he refers to as "speaking engagements." Dr. Fox, over the years, has 107 research publications which have been peer reviewed in the pediatric neonatal and perinatal medicine area, but, Dr. Mollick has no such publications. Dr. Fox has published over 17 abstracts in neonatal medicine, including articles related to infection and death, the issues involved in this case, and, Dr. Mollick has none. Dr. Fox, in addition to his two volume treatise on Fetal and Neonatal Physiology, has 33 editorials, reviews and Chapters in authoritative text, Dr. Mollick has none in either the fetal and neonatal area or obstetrics or gynecology. Dr. Fox has published six treatises and texts, and, Dr. Mollick has none.

As to Dr. Depp, he not only has a certification in OB/GYN, but, a subspecialty certification in Maternal-Fetal medicine which Dr. Mollick does not have. Dr. Depp was founder and Chief of maternal-fetal medicine and Chief of obstetrics at a major university which Dr. Mollick never had. Dr. Depp has various memberships as a member and fellow in professional associations which Dr. Mollick does not have. Dr. Depp has been examiner for the oral test for the OB/GYN Boards, American Board of Obstetrics and Gynecology. Dr. Mollick never had such a position. Dr. Depp as an examiner would be the expert who passes on whether a physician is qualified to be certified as an OB/GYN, but Dr. Mollick never held such a position. Dr. Depp has been a professor of obstetrics and gynecology for years, and, Dr. Mollick has not. Dr. Depp has been a member of various committees on caesarean deliveries, obstetric practice, perinatal brain damage, and obstetrical practice of the American College of Obstetrics and Gynecology. Dr. Mollick has never been a member of such committees. Dr. Depp has been involved in membership in societies and maternal-fetal medicine and child health human

development which membership Dr. Mollick does not possess. Dr. Depp is on the committee for accreditation appeals in obstetrics and gynecology but Dr. Mollick has never been a member. Dr. Depp has had various professional appointments at the Thomas Jefferson University, Northwestern University, Drexel University of Medicine which Dr. Mollick does not have on his resume. Dr. Depp has been editor of Gynecology and Obstetrics, Volumes II and III, a member of the editorial board of fetal medicine, and, a peer reviewer for the American Journal of Obstetrics and Gynecology, Journal of the American Medical Association, International Journal of Gynecology and Obstetrics and Journal of Reproductive Medicine, which Dr. Mollick has never accomplished. Dr. Depp has over 79 publications and abstracts in the area of OB/GYN as well as maternal-fetal medicine which Dr. Mollick does not have. Dr. Depp has written 18 books and chapters on OB/GYN fetal monitoring and fetal medicine, maternal medicine, and, Dr. Mollick has not written any. Dr. Depp has had various abstracts in gynecological and perinatal investigation which Dr. Mollick has not.

Clearly, Dr. Mollick does not have the credentials to criticize either Dr. Fox or Dr. Depp.

8. Paragraph 8 as to the request of Plaintiffs of Dr. Mollick is unknown to the Defendant, and, it is denied. Strict proof is demanded at a hearing. The remainder of Paragraph 8 is denied as being a statement of Plaintiffs' legal position to which a response is unnecessary. To an extent a response is necessary, the curriculum vitae of Drs. Depp and Fox should be compared with Dr. Mollick. The tardy report of Dr. Mollick dated June 13, 2006 is an attempted late rebuttal to the reports of Drs. Depp and Fox. Dr. Mollick who is unqualified in the area of neonatal medicine or in the subspecialty of fetal monitoring, also is holding himself out as an expert in the law on Frye Motions, in that, his report is labelled as the "Frey report." [sic] The second paragraph of his report sets forth what Dr. Mollick states are the legal principles on the

burden of proof applicable to a "Frey" [sic] motion. According to Dr. Mollick's curriculum vitae, he has never attended law school or studied law, and the second paragraph of his report is an attempt to also usurp the function of this Court.

Contrary to the allegations of Paragraph 8, Plaintiffs are engaged in a transparent attempt to improperly boast their claim by filing the late report, the essence of which is that the Defendant's experts "**ignored** the facts of the case" and "largely **ignored** all of the evidence contained in the medical records and depositions", and, as a result reached opinions and conclusions about the cause of the infant's condition at birth and demise different from that of their own expert, Dr. Mollick. The delayed rebuttal report of Dr. Mollick is essentially an improper attempt to challenge the basis of the reports and opinions of the Defendant's experts, Drs. Fox and Depp, through statements of his own personal beliefs concerning the weight of the evidence and his judging the credibility of Drs. Depp and Fox. In summarizing the quotations from the various publications (which are not Dr. Mollick's opinions), Dr. Mollick asserts that "they (Drs. Fox and Depp) **ignored** the facts of this case including the autopsy that confirmed the cause of death was 'severe hypoxic encephalopathy' most likely due to perinatal asphyxia." (Mollick's report, p. 19). Evidently, as Plaintiffs would have it, the defense should be precluded from obtaining the expert opinions of any physician that does not agree with the assessment of their expert, and, the facts upon which their expert has relied on in reaching his conclusions.

9. Dr. Depp followed all standards required of an expert testimony in the field of OB/GYN as well as maternal-fetal medicine of which subspecialty Dr. Mollick is not certified. Dr. Depp, with his superior expertise to that of Dr. Mollick, analyzed the records and reached a conclusion contrary to Dr. Mollick. His conclusions were based on the medical record and fully explained in his report. Simply because Dr. Depp, with his superior expertise, reached a different

conclusion than that of Dr. Mollick, does not mean his opinions are inadmissible. Dr. Depp's opinions are, in part, that at the time of birth an infection existed which accounted for the baby's condition. Infection as it relates to the child's condition and ultimate demise is not "novel science" as alleged by Plaintiffs, but, is known and accepted by authorities in the fields of fetal-maternal medicine and maternal perinatal/placental medicine as a medical disease which can cause death. Evidently, Dr. Mollick thinks "infection" is "novel science."

10. Dr. Mollick's conclusions on the extent of Dr. Depp's evaluation are simply Dr. Mollick's opinions on Dr. Depp's credibility as well as the weight of the evidence. Dr. Mollick simply asserts that no one who has a subspecialty in the fetal-maternal medicine, such as Dr. Depp, could reach a conclusion from the medical records other than reached by Dr. Mollick, a general OB/GYN. Dr. Mollick complains that Dr. Depp reviewed the records and facts, as Dr. Mollick did, but reached a different conclusion. Dr. Depp's review is an accepted methodology.

11. Dr. Mollick's findings as to the etiology of maternal tachycardia illustrates his lack of experience and knowledge in the maternal-fetal medicine area. Dr. Depp carefully reviewed the monitoring strips, the maternal heart rate and pulse, the temperature, and the fluids administered at the time and appropriately reached a conclusion as set forth in his report. Dr. Mollick is not a specialist in maternal/fetal medicine which may account for his inability to perform an accurate analysis which Dr. Depp did in reaching his conclusion.

12. Paragraph 12 is again an erroneous opinion and conclusion of Dr. Mollick based on his review. Dr. Depp sets forth in his report the maternal and fetal heart rate, temperature, the administration of fluids, the pH of the cord blood on birth, and properly concluded the effect on Mikayla Rhoades.

13, 14, 15, 16. The Plaintiffs allege that the keystone of the hypothesis of Dr. Depp in this case is the cord gas of 7.13 which Dr. Depp evidently improperly relied upon as being from an artery. Dr. Mollick's reasoning is fallacious for he assumes that the cord gas of 7.13 was from blood of a vein rather than an artery. Dr. Mollick also improperly ignored the cord gas of 7.13 without considering the other factors of the maternal heart rate, fluids, and temperature. The surgical pathology of the placenta at the DuBois Regional Medical Center indicates there were three blood vessels in the umbilical cord. Here, Dr. Mollick ignores the testimony of Dr. Richard Grout, the DRMC neonatologist, that "this baby had two arteries and one vein." (Depo. p. 16) Dr. Grout also stated that a blood sample can be pure vein, pure artery or the mixture of the two. Dr. Kruszewski ordered an arterial blood gas. Dr. Mollick assumes it was venous, when, indeed, there is over a 66% chance that it was arterial or both. In addition, Dr. Mollick ignores the Pco2 which was 50, which is still normal, and, the base deficit was -13, and, when compared to the pH taken some 35 minutes later where it was 6.60 with the base deficit of 0 supports Dr. Depp's conclusion. Regardless, it was appropriate for Dr. Depp as a maternal-fetal medicine expert, to conclude that taking the maternal temperatures, as associated with the administration of fluid, and, the rise in the maternal pulse as recorded on the FHR strip would reflect maternal tachycardia which is consistent with a cord gas of 7.13 and a base deficit of -13. Accordingly, Dr. Depp rendered his opinion within his subspecialty based on all of the factors contained in the records and reached a conclusion different than Dr. Mollick alleges that he should have had. Dr. Mollick is not a maternal-fetal specialist and is attempting to pass on the weight of the evidence and questions Dr. Depp's credibility which is a jury function. Dr. Mollick's report is an attempt to give opinions on the facts, credibility, and, the law applicable to a Frye Motion.

17. Dr. Mollick's opinion listing that there were 11 different items found in the records which were ignored is merely his statement or opinion of what he considers relevant. The list on page 18 of Dr. Mollick's report of 11 items found in the records but ignored by Dr. Depp are, of no relevance or significance, and, are Dr. Mollick's opinion in an effort to boot strap Plaintiffs' claims by the tardy report which goes to the ultimate issue regarding the cause of the infant's demise. Simply by using the catch phrases " to a reasonable degree of medical certainty" that the methodology is not generally accepted does not legitimize the otherwise unsound and completely improper opinions as set forth in Dr. Mollick's report and Plaintiffs' self styled Frye Motion. In view of Dr. Mollick's lack of credentials, it is obvious he is not qualified to opine within a reasonable degree of medical certainty what the general accepted methodology is in maternal/fetal medicine or neonatology. Dr. Depp, a world renowned expert, reviewed the records, considered the relevancy of the facts to his opinion, and, arrived at conclusions pertaining to infection and otherwise, which is a standard methodology leading to a conclusion of infection which is not novel. Dr. Mollick may consider it "novel" since he does have the requisite knowledge or experience to make the analysis.

18-19. Dr. Mollick's criticism that Dr. Fox and Dr. Depp's opinion are outside their fields of expertise is without merit. Dr. Mollick who is not a neonatologist and does not have a specialty in pediatrics or neonatal or perinatal medicine is not qualified to pass on the report of Dr. Fox. As to Dr. Depp, Dr. Mollick does not have a subspecialty in maternal-fetal medicine. Further, the standard of care is that applicable to Dr. Kruszewski an OB/GYN specialist, not the pathologist who performed the autopsy at Children's Hospital. Indeed, Dr. Depp has published a peer review article, entitled "Perinatal Asphyxia: Assessing its Causal Role and Timing." Sem Ped Neuro, 1995, Volume II, pps. 3 to 36 which is the very issue involved in this case. He has

also published on the identification and management of the fetus at risk for acidosis. In addition to his study, research and experience, Dr. Depp is highly qualified to render opinions on inflammation and infection in this case. In the deposition of Dr. Grout (the neonatologist at DRMC), Plaintiffs established that as a neonatologist, he did not make a determination of what caused the baby's condition. (NT, p. 35) Dr. Grout further testified as follows:

> "Q: You also noted ampicillin had been given to the infant.
>
> A: Correct.
>
> Q: And what would be the reason for that doctor.
>
> A: Any infant that is born with this severe illness is often thought to be possible infection and, again as we discussed the Acyclovir one must treat the possibility of infection until he can prove that it doesn't exist." (NT, pp. 30-31)

The Plaintiffs have taken the depositions of the pathologists who also state as a matter of history, that antibiotics were given to the infant, as Dr. Grout had testified to, from the time of birth through its transfer to the Children's Hospital at Pittsburgh. The Plaintiffs place much emphasis on the fact that the blood cultures were negative, however, Dr. Mollick ignores the fact that you would expect such cultures when antibiotics have been given which would in effect mask the infection. Again Dr. Depp reasoned in his report as follows:

> "Newborn laboratory evaluation at DuBois Regional Medical Center revealed a significantly elevated newborn WBC count with 5% bands, 36% segs and 185,000 platelets.
>
> Later findings at Children's Hospital at Pittsburgh are also of interest. Infectious disease was number 3 of 5 of initial assessment and plans by Beverly Brozanski. She made note of a further evaluation of the WBC to 42.2 with 55 polys, 13 bands."

Dr. Depp then goes on to say:

> "The surprising appearance of the change of the baby at birth with a blood gas of 7.13 to that of an hour later with a gas 6.60 indicates an inability of the child to adapt to the transition."

Dr. Depp further states the transition difficulty of this child from a fetus to newborn is based on the laboratory findings and follows other factors presenting "a clinical picture identical to that of severe metabolic acidosis including the Apgar scores (which conflicts with the observed cord blood gases)" pulse rate and temperature.

Likewise, Dr. Fox who is a specialist in the field, other than which Dr. Mollick is qualified, has concluded that given the white blood count of 32,000 which subsequently increased to 42,000 was indicative of acute infection at the time of birth which would have been responsible for the shock and clinical deterioration of the infant which had occurred at least 24 hours prior to the baby's delivery. Dr. Fox also states that based on his experience the fact that the blood cultures were negative would be of no import, in that, 50% of neonatal blood cultures are negative in acute sepsis such as the infant experienced. He further states that the placenta does not have to show choreoamnitis in order to have a major reaction such as occurred in this baby. The pathologist testified the baby was on antibiotics from the time of birth. Further, the pathologist in this case has testified that the acidosis occurring during the perinatal period could be any time from 20 weeks gestation to 27 days after life. The pathologist testified that:

> "The cause of death is most likely acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia."

The conclusion of "most likely" was not within a reasonable degree of medical certainty and perinatal would be from 20 weeks gestation to 27 days of life. The pathologist also stated that the:

> "The clinician's principle diagnosis was a full term infant with acute total asphyxia of 'unknown etiology' and subsequent perinatal hypoxic ischemic encephalopathy."

Again the etiology of cause was unknown, and, it was subsequent to the perinatal event. Interestingly, the Plaintiffs have taken the deposition of Dr. Gilmour, a neonatologist at Children's Hospital, who concluded the diagnosis was of an "unknown etiology." Now, Plaintiffs' OB/GYN expert is asserting that Dr. Fox, a neonatologist, even though he is in the same specialty as Dr. Gilmour and who Plaintiffs rely on for the etiology, is not qualified to given an opinion.

Further Paragraph 19 is a statement of Dr. Mollick's opinion going to the weight of evidence and the credibility of Dr. Depp. In further response, the explanation contained in Dr. Depp's report as well as his curriculum vitae clearly qualifies him to give the opinions set forth therein, including the cause of the child's condition at the time of birth. Interesting, Plaintiffs allege that Dr. Depp is an obstetric gynecologist, and, not an neonatologist, and, therefore not qualified to offer an opinion. However, Dr. Mollick is not an neonatologist, but Plaintiffs are offering his opinions as to the methodology of a neonatologist, Dr. Fox.

20. Paragraph 20 is a statement of Plaintiffs' legal position to which a response is not necessary.

21. Paragraph 21 is denied, in that, Dr. Mollick is basing his opinions on the weight of the evidence which he states should have been considered by Dr. Fox, a neonatologist, which is beyond Dr. Mollick's specialty and qualifications.

22. Paragraph is a statement of Plaintiffs' legal position, and, the above paragraphs explaining Drs. Depp and Fox's reports are by this reference incorporated herein.

23. Paragraph 23 is a statement of Plaintiffs' legal position to which a response is not necessary. As set forth above, Dr. Mollick in his report also sets forth the legal requirements for a Frye motion which is beyond his expertise.

24. Paragraph 24 is a statement of Plaintiffs' legal position to which a response is not necessary.

25. Paragraph 25 is a statement of Plaintiffs' legal position to which a response is not necessary.

26. Paragraph 26 is a statement of Plaintiffs' legal position to which a response is not necessary. To an extent a response is necessary, Drs. Depp and Fox have clearly set forth their opinions and the basis thereof.

27. Paragraph 27 is a statement of Plaintiffs' legal position and interpretation of the Grady vs. Frito Lay case, and, a response is not necessary.

28-31. Paragraphs 28 through 31 are statements of Plaintiffs' legal position to which a response is not necessary. To the extent a response is necessary, the Plaintiffs' Motion is based on a misguided assertion that the conclusions reached by Drs. Depp and Fox are "novel" science (i.e. infection causing the child's problems) and are allegedly unsupported by facts in the medical records and reached after employing a methodology not accepted in the medical community. Drs. Depp and Fox reviewed all the facts and records to reach their conclusion on the infectious disease. Contrary to Plaintiffs couching their motion as a challenge to the methodology used by Drs. Fox and Depp, a review of Plaintiffs' motion indicates an attempt to improperly bolster the credibility of their expert by filing a late expert report. Dr. Mollick's delayed rebuttal report is simply used as a tool to improperly challenge the credibility of Defendant's experts through statements of his own personal belief concerning the weight of the evidence and, his judgment on

the credibility of Drs. Fox and Depp. Essentially, Plaintiffs are taking the position that the defense should be precluded from obtaining expert reports of any physician that does not agree with the assessment of their expert, Dr. Mollick, and, the facts which Dr. Mollick has relied on.

WHEREFORE, it is requested that Plaintiffs Motion to Exclude Testimony of Drs. Depp and Fox be dismissed with prejudice, and, that the Plaintiffs be Ordered to reimburse the Defendant for all costs and expense in preparing a defense to the Plaintiffs' Motion

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.

Date: July 13, 2006

By: _____
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EXHIBIT A

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

I hereby certify this to be a true and attested copy of the original statement filed in this case.

JAN 10 2006

Attest.

Prothonotary/
Clerk of Courts

DENNIS R. and KIMBERLY RHOADES *
individually and as personal representatives *
of the ESTATE OF MIKAYLA RHOADES, *
Plaintiffs *
vs. * NO. 03-1268-CD
MARY C. KRUSZEWSKI, D.O. and *
DuBOIS REGIONAL MEDICAL CENTER, *
Defendants *

**ORDER**

NOW, this 9th day of January, 2006, following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule, it is the ORDER of this Court as follows:

1. By no later than March 15, 2006 the Defendants shall have provided all expert reports and discovery in the case shall be completed.

2. The case will be on the civil trial list for call on April 4, 2006.

3. The civil pre-trial conference will be held as per the Court's schedule on April 19, 20, or 21, 2006, as will be determined at civil call.

4. The jury selection will be on April 27, 2006.

5. Jury trial is hereby scheduled for eight (8) days being August 7th through 11th and August 14th, 15th and 16th, 2006, Courtroom No. 1, Clearfield County Courthouse, Clearfield, Pennsylvania.

6. Any mediation of the case shall be conducted at least thirty (30) days prior to the trial date.

7. Any party filing any motion or petition regarding limitation or exclusion of evidence or testimony to be presented at trial, including but not limited to motions in limine, shall be filed no more than thirty (30) days prior to the trial date.

8. The party's petition or motion shall be accompanied by an appropriate brief. The responding party thereto shall file an answer and submit an appropriate response no later than fifteen (15) days prior to trial.

9. All depositions which are to be used for trial purposes shall be completed no later than forty (40) days prior to the commencement of trial or the same will not be available for use at trial. A copy of the transcript of any such deposition shall be provided to opposing counsel within no more than ten (10) days following completion of the deposition.

10. Any party making objections relative to testimony provided by a witness in the form of a deposition at the time of trial shall submit the objections to the Court, in writing, no later than thirty (30) days prior to commencement of trial. All objections shall reference specific page and line numbers within the deposition in question along with party's brief relative to same. The opposing party shall submit a brief in opposition to the objections no later than fifteen (15) days prior to the commencement of trial.

11. At the time of jury selection, the Plaintiffs shall have four pre-emptory challenges, Dr. Kruszewski shall have two pre-emptory challenges and DRMC shall have two pre-emptory challenges.

12. Plaintiff's Motion to Preclude Filing of Additional Expert Reports to Preclude Expert Testimony of Dr. Mary Kruszewski is withdrawn.

BY THE COURT,

/s/ Fredric J. Ammerman

FREDRIC J. AMMERMAN
President Judge

# Neonatal Encephalopathy and Cerebral Palsy

## Defining the Pathogenesis and Pathophysiology

The American College of Obstetricians and Gynecologists

*Women's Health Care Physicians*

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

*Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology* was developed under the direction of the Task Force on Neonatal Encephalopathy and Cerebral Palsy. The information in *Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology* should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice. Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted. The purpose of these guidelines will be well served if they provide a firm basis on which local norms may be built.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I Evidence obtained from at least one properly designed randomized controlled trial.

II-1 Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

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# Contents


ACOG Task Force on Neonatal Encephalopathy and Cerebral Palsy v

Endorsements ix

Foreword xi

Preface xiii

Executive Summary xvii

Chapter 1: Background 1

Neonatal Encephalopathy and Cerebral Palsy: How They Differ in Major Gestational Age or Birth Weight Groups 1

Neonatal Encephalopathy: Epidemiology and Long-Term Neurologic Outcomes 2

Relationship of Intrapartum Hypoxia and Cerebral Palsy 8

Chapter 2: Maternal Conditions 13

Third-Trimester Maternal Bleeding as a Risk Factor 13

Maternal Trauma During Pregnancy 14

Inflammation, Infection, Coagulation Abnormalities, and Autoimmune Disorders 14

Thyroid Disorders (Hypothyroidism) and Cerebral Palsy 19

Epilepsy and Antiepileptic Drugs 19

Environmental Factors, Chemicals, Alcohol Use, and Illicit Drug Use 19

Chapter 3: Antepartum and Intrapartum Considerations and Assessment 25

Antepartum Events 25

Fetal Heart Rate Monitoring 26

Neonatal Neurologic Outcome Following Acute Catastrophic Intrapartum Asphyxia: The Effect of Time from Diagnosis to Delivery 29

**Chapter 4: Fetal Considerations** 39
Neurologic Outcome in Multiple Pregnancy 39
Intrauterine Growth Restriction and Neonatal Encephalopathy 43
Meconium and Cerebral Palsy 46
The Relative Impact of Postterm Birth Versus Postmaturity on Subsequent Neonatal Encephalopathy and Cerebral Palsy 47

**Chapter 5: Neonatal Assessment** 53
Evaluation of the Term or Near-Term Infant with Encephalopathy 53
Apgar Score 54
The Role of Neuroimaging in Defining the Timing and Severity of Neonatal Encephalopathy and Cerebral Palsy 55
Neonatal Electroencephalography 57
Placental Pathology Related to Neonatal Encephalopathy and Cerebral Palsy 58
Nucleated Red Blood Cells and Lymphocyte Counts and Neurologic Impairment 59
Focal Ischemic Stroke as a Mechanism of Cerebral Injury in the Perinatal Period 59

**Chapter 6: Genetic, Anatomic, and Metabolic Etiologies of Neonatal Encephalopathy** 63
Neonatal Hypoglycemia 64
Hyperammonemia 64
Organic Acid Abnormalities 65
Degenerative Diseases 65
Lower Motor Neurons 65
Primary Anatomic Abnormalities 66
Chromosome Abnormalities 66
Altered Susceptibility to External Forces 67

**Chapter 7: Obstetric Pharmacologic Approaches to the Prevention of Neonatal Hypoxic–Ischemic Encephalopathy: Current Status and Future Directions** 71
Current Status 71
Future Directions 71

**Chapter 8: Criteria Required to Define an Acute Intrapartum Hypoxic Event as Sufficient to Cause Cerebral Palsy** 73

**Research Recommendations** 81

**Glossary** 83

**Index** 87

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# PREFACE

Advances in both science and technology, ranging from imaging modalities to advanced molecular biology techniques, indicate that most cases of neonatal encephalopathy and cerebral palsy do not originate during the process of labor and delivery. It is now accepted that most neonatal encephalopathy and cerebral palsy have their origins in developmental abnormalities, metabolic abnormalities, autoimmune and coagulation defects, infection, trauma, or combinations of these factors. The best evidence from multiple clinical epidemiologic studies confirms the overwhelming majority of cases of cerebral palsy do not result from isolated intrapartum hypoxia with resultant asphyxia and organ damage. In 2000, Dr. Frank Miller, then president of the American College of Obstetricians and Gynecologists (ACOG), initiated the Task Force on Neonatal Encephalopathy and Cerebral Palsy to address current evidence on the causes of neonatal encephalopathy. At that time Dr. Miller issued the following mission statement:

> "To create a multidisciplinary task force to review and consider the current state of scientific knowledge about the mechanisms and timing of possible etiologic events which may result in neonatal encephalopathy. The purpose of such review will be to produce a consensus statement, report or monograph for Fellows of the College which will succinctly summarize the neuroscience of neonatal encephalopathy and provide a framework for explaining to patients and the general public, in understandable language, medicine's ability and capacity (and limitations) to detect, treat or in any way affect the pathophysiologic mechanisms which result in neonatal encephalopathy."

## Methods

The ACOG Task Force on Neonatal Encephalopathy and Cerebral Palsy was convened in 2000 and comprised several physicians with expertise in the various issues in this field. Liaison members from the American Academy of Pediatrics also were appointed. Beginning in 2000, the Task Force met four times over the span of 2 years. At the first meeting, members outlined the subject matter to be covered, identified clinicians and scientists with particular expertise in the field, and solicited written contributions based on an extensive review of the literature from those clinicians and scientists. At subsequent meetings, the Task Force evaluated the written material, reached consensus, recruited expert authors to write the sections, and reviewed all draft documents. Throughout the process, primary source documents were cited to the fullest extent possible.

Once the draft was completed, numerous federal agencies and professional organizations endorsed the report and have indicated support of the Task Force's review of the evidence and its recommendations as follows: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; the Child Neurology Society; March of Dimes Birth Defects Foundation; National Institute of Child Health and Human Development, National Institutes of Health, U.S. Department of Health and Human Services; The Royal Australian and New Zealand College of Obstetricians and Gynecologists; Society for Maternal–Fetal Medicine; and the Society of Obstetricians and Gynaecologists of Canada. The American Academy of Pediatrics continued to be involved throughout the project as a liaison and is a co-author of the report.

## Task Force Goals

The Task Force identified four specific goals of overriding importance:

1. To broaden the understanding of neonatal encephalopathy, especially that which is associated with subsequent cerebral palsy, by summarizing the topic using the best available primary source scientific data and the expertise of highly qualified individuals who have been major contributors in the field
2. To develop recommendations for evaluation of the newborn with encephalopathy to assist the clinician in defining both the cause and timing of the encephalopathy
3. To identify areas in which further research is needed
4. To raise awareness of the need for standardization of terminology and precision in its use, which is imperative to allow meaningful research on neonatal encephalopathy and cerebral palsy

## The Role of Intervention

The pathogenesis of cerebral palsy is complex and incompletely understood, making prevention—while desirable—elusive. Although the sensitivity and specificity of tests to identify variables associated with cerebral palsy are unrelated to the prevalence of cerebral palsy, both the positive and negative predictive values of tests used as markers of events—such as intrapartum hypoxia as a causal antecedent of cerebral palsy—are highly affected by disease prevalence. Accordingly, because cerebral palsy is a rare event, caution is urged in ascribing specific interventions designed to prevent its occurrence without a thorough cost–benefit analysis for both the pregnant woman, the fetus, and the woman's potential future pregnancies.

## About This Document

The Task Force acknowledges that this publication is a work in progress; it incorporates advanced concepts as they are currently understood, and it serves as another building block toward our complete understanding of these important conditions and their predecessors. This document includes data from several epidemiologic studies that identify specific preconceptional, antepartum, intrapartum, and neonatal associations with both neonatal encephalopathy and with cerebral palsy. Interpreting and understanding these studies requires familiarity with terms such as relative risk, adjusted relative risk, sensitivity, specificity, positive predictive value, and negative predictive value. These and other terms used throughout the document are defined in the glossary.

Gary D. V. Hankins, MD, FACOG
Chair, Task Force on Neonatal Encephalopathy and Cerebral Palsy

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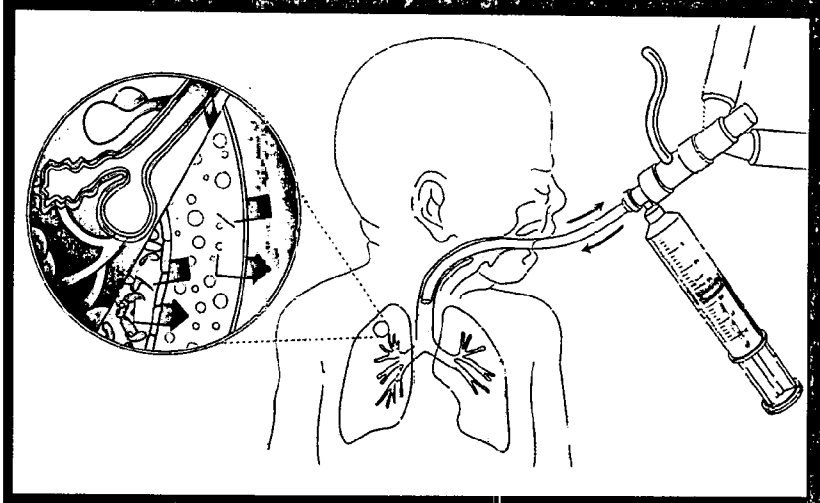

Volume II

# Fetal and Neonatal Physiology

SAUNDERS

# Fetal and Neonatal PHYSIOLOGY

**VOLUME 1 / THIRD EDITION**


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# CONTENTS

**VOLUME 1**


## I Genetics and Embryology 1

**1** Basic Genetic Principles 1
*Fred Levine*

**2** Molecular Genetics: Developmental and Clinical Implications 16
*George A. Diaz and Kurt Hirschhorn*

**3** Basic Embryology 25
*David L. Bolender and Stanley Kaplan*

**4** Regulation of Embryogenesis 41
*Harold C. Slavkin and David Warburton*

**5** The Extracellular Matrix in Development 52
*Peter Lloyd Jones*

**6** Stem Cell Biology 57
*Evan Y. Snyder and Stephen Yip*

**7** Homeobox Genes 65
*Heber C. Nielsen*

**8** Apoptosis and Necrosis 72
*Huseyin Mehmet, Jacqueline Beesley, and A. David Edwards*

**9** Angiogenesis 79
*Elisabeth A. Aron and Russell V. Anthony*

## II Placenta and Intrauterine Environment 85

**10** Placental Development 85
*Peter Kaufmann and Hans-Georg Frank*

**11** Regulation of Placental Circulation 97
*Charles R. Rosenfeld*

**12** Pathophysiology of Preterm Birth 103
*Julian N. Robinson and Errol R. Norwitz*

**13** Mechanisms of Transfer Across the Human Placenta 111
*Colin P. Sibley and Robert D. H. Boyd*

**14** Endocrine and Paracrine Function of the Human Placenta 122
*Theresa M. Siler-Khodr*

**15** Fetal and Maternal Responses to Intrauterine Infection 131
*Roberto Romero, Tinnakorn Chaiworapongsa, and Maria-Teresa Gervasi*

**16** Maternal Cardiovascular Disease and Fetal Growth and Development 142
*Douglas A. Woelkers*

**17** Fetal Origins of Adult Disease 160
*David J. P. Barker*

**18** Physiologic Effects of Multiple Pregnancy on Mother and Fetus 165
*Jane Cleary-Goldman and Mary E. D'Alton*

## III Developmental Pharmacology and Pharmacokinetics 179

**19** Basic Pharmacologic Principles 179
*Sylvain Chemtob*

**20** Basic Pharmacokinetic Principles 190
*Ralph A. Lugo and Robert M. Ward*

21 Physicochemical and Structural Properties Regulating Placental Drug Transfer 197
*Sabine Luise Plonait and Heinz Nau*

22 Pharmacogenetics 211
*Denis M. Grant*

23 Drug Distribution in Fetal Life 218
*Marianne Garland*

24 Developmental Pharmacology of Adrenergic Agents 227
*James F. Padbury and Robert A. Berg*

25 Maternal Drug Abuse: Effects on Fetus and Neonate 234
*Ernest A. Kopecky and Gideon Koren*

26 Drug Excretion During Lactation 249
*Michael J. Rieder*

IV
Intrauterine and Postnatal Growth 259

27 Circulatory and Metabolic Changes Accompanying Fetal Growth Restriction 259
*Frederick C. Battaglia*

28 Endocrine Factors Affecting Neonatal Growth 266
*Dennis M. Styne*

29 Human Milk Composition and Function in the Infant 275
*Margit Hamosh*

30 Physiology of Lactation 284
*Margaret C. Neville and James McManaman*

31 Nutritional Assessment 291
*Gilberto R. Pereira*

V
Perinatal Iron, Mineral, and Vitamin Metabolism 303

32 Calcium-Regulating Hormones 303
*Jorge A. Prada*

33 Calcium, Phosphorus, and Magnesium Transport Across the Placenta 314
*Shahid M. Husain, M. Zulficar Mughal, and Reginald C. Tsang*

34 Neonatal Calcium, Phosphorus, and Magnesium Homeostasis 323
*Ran Namgung and Reginald C. Tsang*

35 Zinc in the Fetus and Neonate 342
*K. Michael Hambidge and Nancy F. Krebs*

36 Vitamin A Metabolism in the Fetus and Neonate 347
*Jayant P. Shenai*

37 Vitamin E Nutrition in the Fetus and Newborn 353
*Lois H. Johnson*

38 Vitamin K Metabolism in the Fetus and Neonate 369
*Reidar Wallin and Susan M. Hutson*

VI
Lipid Metabolism 375

39 Maternal-Fetal Transfer of Lipid Metabolites 375
*Emilio Herrera and Miguel Angel Lasunción*

40 Accretion of Lipid in the Fetus and Newborn 388
*John E. Van Aerde, Michaelann S. Wilke, Miguel Feldman, and M. Thomas Clandinin*

41 Brown Adipose Tissue: Development and Function 404
*Jan Nedergaard and Barbara Cannon*

42 Lipids as an Energy Source for the Premature and Full-Term Neonate 415
*Guy Putet*

43 Ketone Body Production and Metabolism in the Fetus and Neonate 419
*Dermot H. Williamson and Paul S. Thornton*

44 Long Chain Fatty Acids in the Developing Retina and Brain 429
*Socheata Un and Susan E. Carlson*

45 Lipoprotein Metabolism and Nutritional Programming in the Fetus and Neonate 440
*Glen E. Mott*

VII
Carbohydrate Metabolism 449

46 Metabolism of Glucose and Methods of Investigation in the Fetus and Newborn 449
*Satish C. Kalhan*

47 Carbohydrate Metabolism During Pregnancy 464
*Edward S. Ogata*

48 Oxygen Consumption and General Carbohydrate Metabolism in the Fetus 465
*Anthony F. Philipps*

49 Role of Glucoregulatory Hormones in Hepatic Glucose Metabolism During the Perinatal Period 478
*Richard M. Cowett*

50 Cell Glucose Transport and Glucose Handling During Fetal and Neonatal Development 487
*Rebecca A. Simmons*

51 Pathophysiology of Hypoglycemia 494
*Charles A. Stanley and Neil Caplin*

VIII
Protein Metabolism 501

52 General Concepts of Protein Metabolism 501
*Dwight E. Matthews and Johannes B. van Goudoever*

53 Fetal Requirements and Placental Transfer of Nitrogenous Compounds 509
*William W. Hay, Jr., and Timothy R. H. Regnault*

54 Protein and Amino Acid Metabolism and Requirements 527
*William C. Heird and Sudha Kashyap*

IX
Thermoregulation 541

55 Perinatal Thermal Physiology 541
*Gordon G. Power, Arlin B. Blood, and Christian J. Hunter*

56 Temperature Control in Newborn Infants 548
*Rakesh Sahni and Karl Schulze*

57 Physics and Physiology of Human Neonatal Incubation 570
*Gunnar Sedin*

58 Responses of the Fetus and Neonate to Hypothermia 582
*Alistair J. Gunn and Laura Bennet*

X
Skin 589

59 Structure and Development of the Skin and Cutaneous Appendages 589
*David H. Chu and Cynthia A. Loomis*

60 Physiologic Development of the Skin 597
*Steven B. Hoath*

XI
Fetal and Neonatal Cardiovascular Physiology 613

61 Development of the Fetal Heart 613
*Margaret L. Kirby*

62 Molecular Determinants of Embryonic Vascular Development 621
*H. Scott Baldwin and Justin C. Grindley*

63 Cardiovascular Function During Development and the Response to Hypoxia 635
*Page A. W. Anderson, Charles S. Kleinman, George Lister, and Norman S. Talner*

64 Developmental Electrophysiology in the Fetus and Neonate 669
*Arthur S. Pickoff*

65 Developmental Biology of the Pulmonary Vasculature 690
*Marlene Rabinovitch*

66 Development of the Gastrointestinal Circulation in the Fetus and Newborn 701
*David A. Clark and Upender K. Munshi*

67 Physiology of Congenital Heart Disease in the Neonate 705
*Thomas J. Kulik*

68 Neural Regulation of Blood Pressure During Fetal and Newborn Life 717
*Jeffrey L. Segar*

69 Programming of the Fetal Circulation 727
*Lucy R. Green and Mark A. Hanson*

70 Physiology of Nitric Oxide in the Developing Lung 733
*John P. Kinsella and Philip W. Shaul*

71 Mechanisms Regulating Closure of the Ductus Arteriosus 743
*Ronald I. Clyman*

72 Regulation of Umbilical Blood Flow 748
*S. Lee Adamson, Leslie Myatt, and Bridgette M. P. Byrne*

73 Fetal and Placental Circulation During Labor 758
*Karel Maršál*

74 Physiology of Resuscitation 765
*Ola Didrik Saugstad*

75 Pathophysiology of Shock in the Fetus and Neonate 772
*Shahab Noori, Philippe S. Friedlich, and Istvan Seri*

XII
The Lung 783

76 Normal and Abnormal Structural Development of the Lung 783
*Susan E. Wert*

77 Regulation of Alveolarization 794
*Jeanne M. Snyder*

78 Physiologic Mechanisms of Normal and Altered Lung Growth 802
*Richard Harding and Stuart B. Hooper*

79 Molecular Mechanisms of Lung Development and Lung Branching Morphogenesis 812
*Minke van Tuyl and Martin Post*

80 Regulation of Liquid Secretion and Absorption by the Fetal and Neonatal Lung 822
*Pierre M. Barker and Kevin W. Southern*

81 Upper Airway Structure: Function, Regulation, and Development 834
*Thomas H. Shaffer and Marla R. Wolfson*

82 Regulation of Lower Airway Function 842
*Richard J. Martin and Musa A. Haxhiu*

83 Functional Development of Respiratory Muscles 848
*Gary C. Sieck, Carlos B. Mantilla, and Mohamed A. Fahim*

84 Mechanics of Breathing 864
*Jacopo P. Mortola*

85 Pulmonary Gas Exchange in the Developing Lung 870
*William Edward Truog*

86 Oxygen Transport and Delivery 880
*Maria Delivoria-Papadopoulos and Jane E. McGowan*

87 Control of Breathing in Fetal Life and Onset and Control of Breathing in the Neonate 890
*Henrique Rigatto*

88 Basic Mechanisms of Oxygen-Sensing and Response to Hypoxia 900
*Dan Zhou and Gabriel G. Haddad*

89 Pathophysiology of Apnea of Prematurity 905
*Martha J. Miller and Richard J. Martin*

90 Evaluation of Pulmonary Function in the Neonate 919
*Soraya Abbasi, Emidio M. Sivieri, and Vinod K. Bhutani*

91 Pathophysiology of Hyaline Membrane Disease (Excluding Surfactant) 926
*Robert B. Cotton*

92 Mechanisms of Neonatal Lung Injury 934
*Richard L. Auten, Jr.*

93 Impaired Lung Growth After Injury in Premature Lung 942
*Kurt H. Albertine and Theodore J. Pysher*

94 Antenatal Factors That Influence Postnatal Lung Development and Injury 949
*Alan H. Jobe and Suhas Kallapur*

95 Pathophysiology of Chronic Lung Disease 954
*Eduardo Bancalari*

96 Assisted Ventilation: Physiologic Implications and Complications 961
*Jay S. Greenspan, Thomas H. Shaffer, William W. Fox, and Alan R. Spitzer*

97 High-Frequency Ventilation 979
*David J. Durand and Jeanette M. Asselin*

98 Liquid Ventilation 985
*Thomas H. Shaffer and Marla R. Wolfson*

Index i

**VOLUME 2**

## XIII Surfactant 1003


**99** Historical Perspective 1003
*Mary Ellen Avery*

**100** Composition of Pulmonary Surfactant Lipids and Proteins 1005
*Jeffrey A. Whitsett*

**101** Physicochemical Aspects of Pulmonary Surfactant 1014
*Fred Possmayer*

**102** Structure of Alveolar Epithelial Cells and the Surface Layer During Development 1034
*Scott H. Randell and Steven L. Young*

**103** Regulation of Surfactant-Associated Phospholipid Synthesis and Secretion 1041
*Seamus A. Rooney*

**104** Pathophysiology of Respiratory Distress Syndrome and Surfactant Metabolism 1055
*Alan H. Jobe and Machiko Ikegami*

**105** Hormonal Therapy for Prevention of Respiratory Distress Syndrome 1069
*Ian Gross and Philip L. Ballard*

**106** Surfactant Treatment 1074
*Alan H. Jobe*

**107** Genetics and Physiology of Surfactant Protein Deficiencies 1085
*Lawrence M. Nogee*


## XIV Physiology of the Gastrointestinal Tract in the Fetus and Neonate 1095


**108** Trophic Factors and Regulation of Gastrointestinal Tract and Liver Development 1095
*Douglas G. Burrin*

**109** Organogenesis of the Gastrointestinal Tract 1101
*Arthur J. Ross III*

**110** Development of the Enteric Nervous System 1110
*Delma L. Broussard and Steven M. Altschuler*

**111** Development of Gastric Secretory Function 1117
*Chris J. Dickinson*

**112** Gastrointestinal Motility 1125
*Taher I. Omari and Colin D. Rudolph*

**113** Fetal and Neonatal Intestinal Motility 1139
*Douglas G. Field and A. Craig Hillemeier*

**114** Development of the Exocrine Pancreas 1142
*Steven L. Werlin and P. C. Lee*

**115** Digestion-Absorption Functions in Fetuses, Infants, and Children 1151
*Otakar Koldovský and Carol Lynn Berseth*

**116** Pathophysiology of Gastroesophageal Reflux 1163
*Joshua R. Friedman and Chris A. Liacouras*

**117** Pathophysiology and Prevention of Neonatal Necrotizing Enterocolitis 1169
*Michael S. Caplan*


## XV Liver and Bilirubin Metabolism 1175


**118** Organogenesis and Histologic Development of the Liver 1175
*Steven Lobritto*

**119** Bile Acid Metabolism During Development 1179
*John C. Bucuvalas and Kenneth Setchell*

**120** Bile Formation and Cholestasis 1186
*David A. Horst and Saul J. Karpen*

**121** Bilirubin Metabolism and Toxicity in the Newborn 1199
*William J. Cashore*

**122** Mechanisms of Action of Phototherapy 1205
*John F. Ennever*

**123** Pathophysiology of Metabolic Disease of the Liver 1211
*James B. Gibson and Gerard T. Berry*

**124** Neonatal Cholestasis: Pathophysiology, Etiology, and Treatment 1218
*Michael R. Narkewicz*

## XVI

## The Kidney 1223

**125** Embryogenesis and Anatomic Development of the Kidney 1223
*William E. Sweeney, Jr., and Ellis D. Avner*

**126** Functional Development of the Kidney *In Utero* 1229
*Patrick D. Brophy and Jean E. Robillard*

**127** Postnatal Maturation of Renal Blood Flow 1242
*Michael J. Solhaug and Pedro A. Jose*

**128** Development of the Renin-Angiotensin System 1249
*Victoria F. Norwood, Lucas G. Fernandez, Alda Tufro, and R. Ariel Gomez*

**129** Postnatal Development of Glomerular Filtration Rate 1256
*Jean-Pierre Guignard*

**130** Renal Transport of Sodium During Early Development 1267
*Leonard G. Feld and Howard E. Corey*

**131** Potassium Homeostasis in the Fetus and Neonate 1279
*Corinne Benchimol and Lisa M. Sailin*

**132** Role of the Kidney in Calcium and Phosphorus Homeostasis 1286
*Robert P. Woroniecki, Susan E. Mulroney, Aviad Haramati, Adrian Spitzer, and Frederick J. Kaskel*

**133** Transport of Amino Acids During Early Development 1294
*Aaron L. Friedman*

**134** Developmental Aspects of Organic Acid Transport 1299
*Deborah P. Jones and F. Bruder Stapleton*

**135** Concentration and Dilution of the Urine 1303
*Michael A. Linshaw*

**136** Urinary Acidification 1327
*Eileen D. Brewer*

**137** Response to Nephron Loss in Early Development 1330
*Robert L. Chevalier*

**138** Pathophysiology of Acute Renal Failure in the Neonatal Period 1335
*Tracy E. Hunley and Valentina Kon*

## XVII

## Fluid and Electrolyte Metabolism 1341

**139** Fluid Distribution in the Fetus and Neonate 1341
*Robert A. Brace*

**140** Fetal and Neonatal Body Water Compartment Volumes with Reference to Growth and Development 1351
*John M. Lorenz*

**141** Pathophysiology of Edema 1357
*David P. Carlton*

**142** Regulation of Acid-Base Balance in the Fetus and Neonate 1361
*Philippe S. Friedlich and Istvan Seri*

## XVIII

## Developmental Hematopoiesis 1365

**143** Biology of Stem Cells and Stem Cell Transplantation 1365
*Mervin C. Yoder*

**144** Developmental Biology of the Hematopoietic Growth Factors 1374
*Mervin C. Yoder and Kurt R. Schibler*

**145** Developmental Granulocytopoiesis 1388
*Akhil Maheshwari and Robert D. Christensen*

**146** Developmental Erythropoiesis 1397
*Robin K. Ohls*

**147** Developmental Megakaryocytopoiesis in Fetal and Neonatal Physiology 1421
*Thomas A. Olson*

## XIX Hemostasis 1435


**148** Developmental Hemostasis 1435
*Paul Monagle and J. Nathan Hagstrom*

**149** Pathophysiology of Bleeding Disorders in the Newborn 1447
*J. Nathan Hagstrom*

**150** Pathophysiology of Neonatal Disseminated Intravascular Coagulation and Thrombosis 1460
*Marilyn J. Manco-Johnson*


## XX Developmental Immunobiology 1475


**151** Host Defense Mechanisms Against Bacteria 1475
*Timothy R. La Pine and Harry R. Hill*

**152** Host Defense Mechanisms Against Fungi 1487
*László Maródi and Richard B. Johnston, Jr.*

**153** Host Defense Mechanisms Against Viruses 1490
*David B. Lewis*

**154** T-Cell Development 1512
*Marcia McDuffie and Anthony R. Hayward*

**155** B-Cell Development 1518
*James E. Crowe, Jr., Joern-Hendrik Weitkamp, and John V. Williams*

**156** Mononuclear Phagocyte System 1523
*Kurt R. Schibler*

**157** Neonatal Neutrophil Normal and Abnormal Physiology 1538
*Elvira Parravicini, Carmella van de Ven, and Mitchell S. Cairo*

**158** The Complement System of the Fetus and Neonate 1549
*Jerry A. Winkelstein*

**159** Cytokines and Inflammatory Response in the Fetus and Neonate 1555
*Laurie Kilpatrick and Mary Catherine Harris*

**160** Integrins and Cell Adhesion Molecules 1572
*M. Michele Mariscalco*

**161** Stimulus-Response Coupling in Phagocytic Cells 1591
*Helen M. Korchak*

**162** Fetal Wound Healing 1604
*N. Scott Adzick*

**163** Immunology of Human Milk and Host Immunity 1610
*Sadhana Chheda, Susan E. Keeney, and Armond S. Goldman*

**164** Neonatal Pulmonary Host Defense Mechanisms 1620
*Andrew Metinko*


## XXI Neurology 1675


**165** Development of the Nervous System 1675
*Scott L. Pomeroy and Nicole J. Ullrich*

**166** Development of the Blood-Brain Barrier 1699
*John Laterra and Gary W. Goldstein*

**167** Development of Neurotransmitters 1706
*Michael V. Johnston and Faye S. Silverstein*

**168** Perinatal Brain Metabolism 1713
*Robert C. Vannucci and Susan J. Vannucci*

**169** Electroencephalography in the Premature and Full-Term Infant 1726
*Robert Ryan Clancy*

**170** Cerebral Blood Flow in Premature Infants: Regulation, Measurement, and Pathophysiology of Intraventricular Hemorrhage 1745
*Jeffrey M. Perlman*

**171** Pathophysiology of Intraventricular Hemorrhage in the Neonate 1757
*Terrie E. Inder and Joseph J. Volpe*

**172** Pathophysiology of Neural Tube Defects 1772
*Enrico Danzer, Natalie E. Rintoul, Timothy M. Crombleholme, and N. Scott Adzick*

**173** Trophic Factor and Nutritional and Hormonal Regulation of Brain Development 1785
*Jeanette Pleasure and David Pleasure*

**174** Development of Pain Sensation 1792
*Margaret A. Myers*

## XXII

## Special Sensory Systems in the Fetus and Neonate 1797

**175** Retinal Development and the Pathophysiology of Retinopathy of Prematurity 1797
*Graham E. Quinn*

**176** Early Development of the Human Auditory System 1803
*Lynne A. Werner*

**177** Development of Taste and Smell in the Neonate 1819
*Beverly J. Cowart, Gary K. Beauchamp, and Julie A. Mennella*

## XXIII

## Orthopedics 1829

**178** The Growth Plate: Embryologic Origin, Structure, and Function 1829
*Bulent Erol, Kathrin V. Halpern, and John P. Dormans*

**179** Common Musculoskeletal Conditions Related to Intrauterine Compression: Effects of Mechanics on Endochondral Ossification 1838
*Kathrin V. Halpern, Bulent Erol, and John P. Dormans*

**180** Defective Limb Embryology 1844
*Walid K. Yassir, Benjamin A. Alman, and Michael J. Goldberg*

**181** Ontogenesis of Striated Muscle 1849
*Harvey B. Sarnat*

## XXIV

## Endocrine Function 1871

### PITUITARY

**182** Hypothalamus: Neuroendometabolic Center 1871
*Adda Grimberg and Jessica Katz Kutikov*

**183** Growth Factor Regulation of Fetal Growth 1880
*Diva D. De León, Pinchas Cohen, and Lorraine E. Levitt Katz*

**184** Growth Hormone and Prolactin 1891
*P. D. Gluckman and C. S. Pinal*

**185** Luteinizing Hormone and Follicle-Stimulating Hormone Secretion in the Fetus and Newborn Infant 1896
*Leona Cuttler and Mark R. Palmert*

**186** Development of the Corticotropin-Releasing Hormone–Corticotropin/β-Endorphin System in the Mammalian Fetus 1907
*James C. Rose, Jeffrey Schwartz, and Sharla Young*

### ADRENAL

**187** Fetal and Neonatal Adrenocortical Physiology 1915
*Jeremy S. D. Winter*

### THYROID

**188** Fetal and Neonatal Thyroid Physiology 1926
*Daniel H. Polk and Delbert A. Fisher*

## XXV

## Ovary and Testis 1935

**189** Genetics of Sex Determination and Differentiation 1935
*Robert P. Erickson and Stan R. Blecher*

**190** Differentiation of the Ovary 1941
*Anne Grete Byskov and Lars Grabow Westergaard*

**191** Testicular Development 1950
*Ahmet R. Aslan, Barry A. Kogan, and Bernard Gondos*

**192** Testicular Descent 1956
*Ahmet R. Aslan and Barry A. Kogan*

Index i

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the ***DEFENDANT, MARY C. KRUSZEWSKI'S D.O.'S RESPONSE TO PLAINTIFFS' MOTION TO EXCLUDE SCIENTIFIC TESTIMONY PURSUANT TO PA.R.C.P. 207.1 AND A REQUEST FOR A HEARING PURSUANT TO RULE 207.1(a)(b) PRIOR TO TRIAL***, in the above-referenced matter was served by first class regular mail, this _____ day of July, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
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Confluence, PA 15424-2371

David Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

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McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
FREDERICK R. BATTAGLIA
Attorneys for Defendant
Mary C. Kruszewski, D.O.

FILED

JUL 14 2006

William A. Shaw
Prothonotary/Clerk of Courts

**McQUAIDE BLASKO** ATTORNEYS AT LAW

811 University Drive, State College, Pennsylvania 16801-6699 (814) 238-4926 FAX (814) 234-5620
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July 13, 2006

William Shaw, Prothonotary
Clearfield County Courthouse
230 East Market Street
Clearfield, PA 16830

**In Re: Rhoades vs. Kruszewski, et al.**
**Docket No: 03-1268-CD**

Dear Mr. Shaw:

Enclosed herewith please find the Response to Plaintiffs' Motion to Exclude Scientific Testimony Pursuant to Pa.R.C.P. 207.1 and a Request for a Hearing Pursuant to Rule 207(a)(b) Prior to Trial on behalf of Defendant Mary C. Kruszewski, D.O., along with a Certificate of Service in the above-captioned matter.

Thank you for your attention to this matter.

Very truly yours,

McQUAIDE, BLASKO

By: JOHN W. BLASKO

JWB:nls
Enclosure
cc: Robert P. Ging, Jr., Esquire (w/enc.)
cc: Victor H. Pribanic, Esquire (w/enc.)
cc: David Johnson, Esquire (w/enc.)

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

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John G. Love (1893-1966) Roy Wilkinson, Jr (1915-1995) Delbert J. McQuaide (1936-1997)

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**NOTICE OF SERVICE OF ORDER OF COURT DATED JULY 10, 2006**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

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FILED NO CC
JUL 17 2006
William A. Shaw
Prothonotary/Clerk of Courts

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF SERVICE OF ORDER OF COURT DATED JULY 10, 2006**

TO: WILLIAM A, SHAW, PROTHONOTARY

Please take notice that the Order of this Court dated July 10, 2006 in the nature of a Rule to Show Cause regarding the Motion in Limine of the Plaintiffs to preclude the testimony of Drs. Depp and Fox was served this day on all counsel of record by U.S. First Class Mail, postage pre-paid.

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Notice of Service of Order of Court was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
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DATED: July 13, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

7/24

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

**MEDICAL PROFESSIONAL LIABILITY ACTION**

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**BRIEF IN SUPPORT OF THE PLAINTIFFS' MOTION IN LIMINE TO PRECLUDE THE TESTIMONY OF DRS. DEPP AND FOX ON ISSUES RELATING TO PATHOLOGY AND NEUROPATHOLOGY**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

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**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**BRIEF IN SUPPORT OF THE PLAINTIFFS' MOTION IN LIMINE TO PRECLUDE THE TESTIMONY OF DRS. DEPP AND FOX ON ISSUES RELATING TO PATHOLOGY AND NEUROPATHOLOGY.**

**FACTS**

Defendant has identified William W. Fox, a pediatrician and Richard Depp, an Ob/Gyn as individuals who may testify as experts on her behalf in the above captioned case. Both Dr. Fox and Dr. Depp conclude that Mikayla Rhoades was born critically ill and "appeared" to be in septic shock. Dr. Depp opined that the infant's death was inconsistent with hypoxia, arising in labor, and more consistent with infection and its consequences.

Neither Dr. Depp nor Dr. Fox, according to the curriculum vitaes provided by the Defendant's counsel, are qualified as a pathologist or neuropathologist by training or speciality.

The trial depositions of Dr. Ranganathan, M.D., a pediatric pathologist, and Dr. Ronald L. Hamilton, M.D., a neuropathologist were taken in the above captioned case. Dr. Ranganathan and Dr. Hamilton were the attending pathologists who performed the autopsy.

Dr. Hamilton testified, consistent with the autopsy report, that he performed both gross and microscopic neuropathology testing on the deceased infant. His microscopic neuropathological examination showed severe acute ischemic damage in neurons in nearly all areas of the brain and nearly all areas of the cerebral cortex. His final diagnosis was acute ischemic encepalopathy severe.

Dr. Ranganathan testified, consistent with the autopsy report, that he performed the autopsy procedure, and that based upon that procedure he concluded, as the attending pathologist, that the most significant finding was severe hypoxic encepalopathy most likely due to perinatal asphyxia. He also found congestion of the organs with hypoxic changes in the cardiac muscle, in the liver, and in other organs.

Dr. Ranganathan specifically found that there were no significant infections or congenital anomalies noted at autopsy. Dr. Ranganathan found that the cause of death was acute ischemic and hypoxic encepalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor. Dr. Ranganathan found that there was no evidence of chorioamnionitis in the placenta. Dr. Ranganathan also found that the neurology impression of Dr. Hamilton was severe perinatal total asphyxia.

Despite the findings of the two attending pathologists, Dr. Fox steps outside of his specialty, and in his report suggests that the baby appeared to be in septic shock. This hypothesis in Dr. Fox's report requires him to render opinions outside of his speciality as a pediatrician and clearly contradictory to the testimony of the attending pathologist and neuropathologist. Dr. Fox hypothesizes that there is no other explanation in Mikayla's case for her condition except for sepsis, again contradicting the findings of the attending pathologist and neuropathologist, and

rendering opinions outside of his area of specialization..

Dr. Depp likewise steps out of his area of specialization, as an OB/GYN, and despite admitting in his report (page 5) that there is no evidence of chorioamnionitis, and his agreement that the autopsy indicates a full term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic ischemic encepalopathy (page 6) opines that Mikayla was "not severely asphyxiated" (page 7, paragraph 8), and that corioamneonitus and associated fetal infection were the likely causes of the infant's neonatal condition.

Dr. Ranganathan specifically testified that there was no evidence of virus or infection in the infant based upon the autopsy.

Section 512 of the M-Care Statute, 40 P.S. §1303.512( c)(2) prohibits a person from being competent or offering an expert medical opinion in a medical professional liability action unless that individual practices in the same sub-speciality or a sub-speciality which has a substantially similar standard of care for a specific care at issue. Although sub-section ( c)(2) addresses standard with care, sub-section (b) indicates that an expert testifying on a medical matter including causation must meet that qualification.

Neither Dr. Depp nor Dr. Fox are pathologists, nor do their curriculum vitaes indicate that they are trained as pathologists, and thus under the M-Care Act they would be precluded from offering opinions contrary to those of the pathologist and neuropathologist as set forth in the autopsy report.

**ARGUMENT**

Section 512 of the M-Care Act provides that no person shall be competent to offer an exert

medical opinion in a medical professional liability action against a physician unless that person possesses sufficient education, training, knowledge and experience to provide credible, competent testimony and fulfills the additional qualifications set forth in that section.

The action sub judice is a medical professional liability action against a physician.

Section 512 of the M-Care Act, 40 P.S. §1303.512 provides that an expert testifying on a medical matter, including the standard of care, risks, alternatives, **causation and the nature and extent of the injury**, must meet the following criteria:

> "( c)(2) Practice in the same sub-speciality as the defendant physician or in a sub-speciality which has substantially similar standard of care for the specific care at issue..."

There is also an exception for practicing in the same sub-speciality where the expert is trained in the diagnosis or treatment of a condition as applicable.

The most nearly analogous case to the case currently before the Court is *Capan vs. Devine Providence Hospital*, 410 A.2d 1282 (Pa. Super. 1980).

In that case, the Superior Court considered whether or not an anestethiologist could testify concerning an autopsy report. The Superior Court ruled that the trial Court appropriately sustained an objection to the admission of the anesthesiologist's testimony regarding the autopsy report because they were anestethiologists and not pathologists.

This case is distinguishable from other cases where the standard of care between various sub-specialities was substantially similar, in that the issues which the Defendant seeks to enlist the

opinions of Drs. Depp and Fox on relate to causation and not standard of care. Neither Dr. Depp nor Dr. Fox performed an autopsy, and their opinions regarding the pathology in this case are clearly contrary to those of the pathologist and neuropathologist in this case.

In this case, as set forth in the autopsy report and the trial depositions of the pathologist and neuropathologist, Mikayla Rhoades died from hypoxic encepalopathy, acute ischemic encepalopathy, severe, and the insult to various other organs.

Dr. Ranganathan, the pathologist opined in the autopsy report and his testimony that the most significant finding in the autopsy was severe hypoxic encepalopathy most likely due to perinatal asphyxia. He found there were no significant infections or congenital anomalies noted at autopsy, and no evidence to suggest a metabolic or viral etiology. He found no evidence of chorioamnionitis, and found that the cause of death was acute ischemic and hypoxic encepalopathy due to sever perinatal asphyxia precipitated by hypoxia during labor.

He found no infections or viruses during the autopsy. Likewise, Dr. Hamilton the neuropathologist had a final neuropathological diagnosis of acute ischemic encepalopathy, severe, and found severe acute ischemic damage in neurons in nearly all of the areas of the brain.

Contrary to the findings of the pathologist, Dr. Richard Depp, in his report, although agreeing that there was no evidence of chorioamnionitis found at autopsy,(report, p.5) nevertheless concluded that chorioamnionitis and associated fetal infection or sepsis was the likely consideration for the course of Mikayla Rhoades. (Depp Report, p.7)

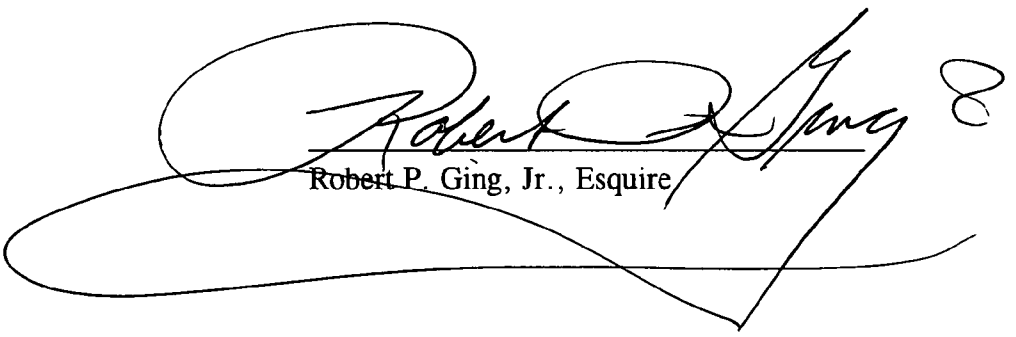
Dr. William W. Fox in his report indicated that the baby was born critically ill and "appeared" to be septic shock. He also recognized that there was no evidence of chorioamnionitis, and chose to ignore the findings of the pathologist and neuropathologist that

there was no etiology suggestive of infection or virus.

Neither Dr. Fox nor Dr. Depp's curriculum vitaes suggested they have ever been trained as a pathologist or neuropathologist, and thus, they would be precluded from presenting testimony contrary to the pathologist and neuropathologist under both the M-Care Act, and existing case law in the Commonwealth of Pennsylvania.

WHEREFORE, the Court is respectfully requested to preclude Drs. Depp and Fox from testifying contrary to the testimony of the pathologist and neuropathologist in this case, and from rendering opinions that Mikayla Rhoades died from the complications of sepsis or septic shock.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Brief in Support of Motion in Limine was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail

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DATED: July 5, 2006

Respectfully submitted,

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July 10, 2006

David S. Meholick, Court Administrator
Clearfield County Courthouse
230 East Market Street
Clearfield, PA 16830

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COURT ADMINISTRATOR'S OFFICE

**In Re:** **Rhoades vs. Kruszewski, et al.**
**Docket No:** **03-1268-CD**

Dear Mr. Meholick:

Enclosed please find the Brief in Support of the Motions of Defendant, Mary C. Kruszewski, D.O., along with a Certificate of Service in the above captioned matter.

Thank you for your attention to this matter.

Very truly yours,

McQUAIDE, BLASKO

By: JOHN W. BLASKO

JWB:nls
Enclosure
cc: Robert P. Ging, Jr., Esquire
cc: Victor H. Pribanic, Esquire
cc: David R. Johnson, Esquire
[all w/enc.]

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IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
BRIEF IN SUPPORT OF THE MOTIONS

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787

FREDERICK BATTAGLIA
Court I.D. No. 91624

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Counsel of Record for
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OFFICE

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| | ) | NO. 03-1268 CD |
| Plaintiffs, | ) | |
| | ) | JURY TRIAL DEMANDED |
| vs. | ) | |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

***BRIEF IN SUPPORT OF THE MOTIONS OF DEFENDANT, MARY C. KRUSZEWSKI, D.O.***

***Preliminary Statement***

This Brief is submitted in support of the Defendant's Motions. The outline of the Brief will follow that of the Motions. The Brief will not address Parts III or VI of the Motion relating inconsistencies between the Plaintiffs' expert reports of Dr. Gonzales and Dr. Mollick and the preclusion of cumulative expert testimony by both of Plaintiffs' experts. The Plaintiffs have filed of record a statement that Dr. Gonzales will not be called by them as an expert at trial.

**I.**

**MOTION IN FOR PARTIAL SUMMARY JUDGMENT RE USE OF VACUUM EXTRACTOR NOT ADDRESSED BY PLAINTIFFS' EXPERTS, PAGE 8 OF MOTION**

Defendant filed a Motion for Partial Summary Judgment pursuant to Pa.R.C.P. 1035.2 on the basis that although Plaintiffs' pleadings included a theory of negligent use of a vacuum extraction, at trial Plaintiffs' will be unable to offer expert testimony which establishes a *prima facie* case of negligence related to the performance of the vacuum extraction since their expert

does not address the issue. (Compare, Amended Complaint, ¶ 32(b) Paragraphs 2 and 7 quoted in Defendant's Motion, pp. 3, 5 with Exhibit "A," Plaintiffs' expert report attached thereto). Similarly, Plaintiffs will be unable to establish that Dr. Kruszewski personally breached a standard of care and caused Plaintiffs harm by failing to have "all equipment necessary for use of vacuum assisted delivery present in the delivery room." (Compare, Amended Complaint, ¶ 32(e), Paragraph 2 of Defendant's Motion, p. 4 and Exhibit "A," Plaintiffs' expert report attached thereto).

In support of the above theories pled against Dr. Kruszewski in this medical malpractice action, it is well-established that the burden of proof is upon the Plaintiffs to present competent expert testimony establishing that Dr. Kruszewski failed to exercise reasonable skill and knowledge required under the circumstances, and that the harm suffered was due to the conduct of the Defendant. See Brannan v. Lankenau Hospital, 490 Pa. 588, 417 A.2d 196, 199 (1980); Hamil v. Bashline, 481 Pa. 256, 392 A.2d 1280, 1284 (1978); Geibel v. U.S., 667 F. Supp. 215, 219 (W.D. Pa. 1987), aff'd., 845 F.2d 1011 (3rd Cir. 1988). This burden must be sustained by a preponderance of the evidence. Hamil, 392 A.2d at 1284. In order to set forth a *prima facie* case of malpractice, a plaintiff must plead and prove the following four elements: "(1) a duty owed by the physician to the patient; (2) a breach of duty from the physician to the patient; (3) that the breach of duty was the proximate cause, or a substantial factor in, bringing about the harm suffered by the patient; and, (4) damages suffered by the patient that were a direct result of the harm." Mitzelfelt v. Kamarin, 526 Pa. 54, 584 A.2d 888, 891 (1990); Gregorio v. Zeluck, 451 Pa. Super. 154, 678 A.2d 810, 813 (1996); Flanagan v. Labe, 446 Pa. Super. 107, 666 A.2d 333, 335 (1995), aff'd., 547 Pa. 254, 690 A.2d 183 (1997).

Testimony of a medical expert must be introduced in order to support these four elements. Robinson v. Wirts, 387 Pa. 291, 127 A.2d 706, 709 (1956). The opinion of an expert is necessary to establish the standard of care required under the circumstances, that a deviation from said standard existed, and the alleged injuries were proximately caused by the deviation from the standard of care. See Brannan, supra, 417 A.2d at 199. Pennsylvania law declares that ". . .expert testimony is necessary to establish the causal nexus of the injury to the tortious conduct in those cases where the connection is not obvious." Maliszewski v. Rendon, 374 Pa. Super. 109, 542 A.2d 170, 172 (1988), appeal denied, 520 Pa. 617, 554 A.2d 510 (1988). Importantly, it has recently been re-affirmed that, in determining whether a plaintiff has met the foregoing burden of proof, a trial court is required to analyze each aspect of the claimed damages, and to determine whether the plaintiff has met his burden of causation for each and every aspect of damages claimed. See Watkins v. Hospital of Univ. of Penn., 1999 Pa. Super 181, 737 A.2d 263 (1999).

In this regard, experts are limited to the four corners of their expert reports and are precluded from testifying at trial inconsistent with or beyond the scope of said reports. See Pa.R.C.P. 4003.5. Per Pennsylvania Rule of Civil Procedure 4003.5: "To the extent that the facts known or opinions held by an expert have been developed in discovery proceedings under subdivision (a)(1) or (2) of this Rule, the direct testimony of the expert at the trial may not be inconsistent with or go beyond the fair scope of his or her testimony in the discovery proceedings as set forth in his deposition, answer to interrogatory, separate report, or supplement thereto." Pa.R.C.P. 4003.5(c). The comment to Rule 4003.5(c) indicates that this Rule serves "to prevent incomplete or 'fudging' of reports which would fail to reveal fully the facts and opinions of the expert or his grounds there-fore."

This is certainly not a situation where causation of a given injury is obvious, such as a broken arm occurring during an automobile accident. As a result, Plaintiffs were required to present expert testimony in support of their allegations. Nevertheless, Plaintiffs' expert report does not specifically opine that the **use of vacuum extraction** was inappropriate, that the performance of such was a breach in the standard of care, and that the breach caused harm to the decedent. To the contrary, with respect to vacuum extraction Plaintiffs' expert opines the following:

> It is my opinion that progressive, repetitive, severely variable declarations with total loss of variability associated with uterine hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, **rendering mode of delivery at this point irrelevant**.

(See Motion Exhibit "A," p. 32 of 36).

> Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. **The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised.**

(See Motion Exhibit "A," p. 33 of 36).

Therefore, Plaintiffs' expert should be precluded from offering testimony alleging that the **use** of vacuum extraction was inappropriate in this situation, represented a departure from good and acceptable standards of medical care, and that such act harmed the decedent. Plaintiffs' expert has unequivocally stated in his report that the decision to employ vacuum extraction did **not** cause the harm alleged because he states the decision to employ vacuum extraction at that time was futile since the baby was already debilitated.

Further, Plaintiffs' expert does not opine that the standard of care required Dr. Kruszewski to stock the delivery room with equipment for vacuum extraction or that the failure

to have certain equipment in the delivery room harmed the decedent. Rather, it is clearly Dr. Mollick's opinion that the child was "**already asphyxiated**" at the time the vacuum extraction was considered and performed. (See Motion Exhibit "A", p. 33 of 36).

Pursuant to the well-established laws of this Commonwealth, Plaintiffs' experts are limited to the four corners of their expert reports and are precluded from testifying at trial inconsistent with or beyond the scope of said reports. Because the Defendant relied on Plaintiffs' reports in defense of this case it would be prejudicial to the Defendant to permit Plaintiffs to amend their expert reports on the eve of trial to comment on the decision to employ vacuum extraction and/or the supplies available as a standard or breach, or as causing harm. Further, permitting Plaintiffs' expert to raise the issue despite his failure to include it in his report would work a considerable injustice in that same would seem inconsistent with Plaintiffs' expert's opinion that "irreversible fetal asphyxia" had already occurred prior to delivery, "rendering mode of delivery at this point **irrelevant**." (See Motion Exhibit "A," p. 32). This is just the type of "fudging" of reports the Rules are intended to prevent.

Because Plaintiffs will be unable to offer competent medical testimony at trial which establishes that the decision to employ vacuum extraction and/or the failure to ensure supplies were available was a breach in the applicable standard of care and caused harm, Plaintiffs will be unable to establish a *prima facie* case of medical negligence based on the theories of liability found at paragraphs 32(b) and 32(e) of the Amended Complaint. Accordingly, Plaintiffs' claims of negligence based on Dr. Kruszewski's decision to employ vacuum extraction and the failure to have all necessary equipment in the delivery room must be dismissed.

## *A. ARGUMENT TO II A OF MOTION*

***The Court Order of February 23, 2004, dismissed any theories based on Failure to Obtain Informed Consent Prior to Induction of Labor, Failure to explain risks of induction of labor or explain augmentation thereof by Pitocin and/or failure to explain any risks of induction of labor by Pitocin with Plaintiff/wife or otherwise.***

This is in support of Paragraphs 30-32 of the Motion. In order to appreciate this argument, reference is made to the Court's Order of February 23, 2004 which provided:

> "1. Relative the Preliminary Objections filed on behalf of Dr. Kruszewski to to the Plaintiffs' remaining claim of breach of informed consent contained in their Amended Complaint, **it is the ORDER of this Court that the demurrer contained in Defendants' Preliminary Objections on this point is hereby GRANTED.**" [Emphasis added.]

The Defendant's Preliminary Objections and Demurrer were to Paragraphs 17, 18, 19, 32(a), 32(f), 34, 35, 36, 39, 45(g) and Paragraphs 47 and 48 of Plaintiffs' Amended Complaint. The Demurrer's prayer for relief was that all informed consent base language be stricken and dismissed from the Plaintiffs' Amended Complaint with prejudice. (Defendant's Preliminary Objections to Plaintiffs' Amended Complaint Paragraphs 16 through 32, pp. 4 through 9.)

The Court by its Order in effect deleted the following allegations from the Plaintiffs' Amended Complaint:

> "17. At the time of the admission of Mrs. Rhoades to the Medical Center there was **no effort made during the pre-admission procedure to obtain the informed consent** of the parents regarding the following:
>
> (a) **vacuum assisted vaginal delivery over midline episiotomy**
>
> (b) **repair of episiotomy**
>
> (c) **amniotonomy**
>
> (d) **administration of continuous epidural anesthesia during labor**
>
> (e) **Pitocin augmentation of labor and delivery of a large baby**

18. There was **no discussion with either of the parents with respect to the nature of Pitocin induced delivery or any material facts, risks, complications or alternatives to Pitocin induced delivery of a large bodied infant, nor was there any discussion with the parents that a caesarean section delivery was an alternative.**

19. The failure to evaluate fetal weight **and to properly counsel a patient when she had a large baby, regarding the Pitocin augmentation of labor and vacuum assisted vaginal delivery of the infant over a midline episiotomy** and **alternatives to this method of delivery,** was a departure from good and accepted standards of medical care, and a battery.

32(a) **Dr. Kruszewski failed to** evaluate fetal weight and **properly counsel a patient with a macrosomic baby as to the potential risks of induced labor as opposed to other methods of delivery** of a huge baby.

32(f) Dr. Kruszewski **failed to obtain the informed consent of the parents regarding the delivery** of a macrosomic baby.

34. **Dr. Kruszewski committed a** battery on the Plaintiff Kimberly Rhoades in performing the procedures described herein by failing **to obtain the informed consent of the Plaintiff Kimberly Rhoades** for the procedures previously described, **in connection with the vacuum assisted vaginal delivery over a midline episiotomy, and continuous administration of epidural anesthesia, surgical procedures within the meaning** of the Health Care Services Malpractice Act 40 P.S. §1303.504, and **she breached her duty to provide sufficient material information necessary for a patient to determine whether** to proceed with the surgical or operative procedure being performed. The battery was committed in the presence of the Plaintiffs, Dennis and Kimberly Rhoades.

35. Dr. Kruszewski **failed to obtain the informed consent of the parents regarding the procedures she employed during the delivery of the infant Mikayla,** and failed to provide them with sufficient material information necessary for them to determine whether to proceed with the suggested operative procedures being performed.

36. The failure on the part of Dr. Kruszewski **to obtain the informed consent** of the parents to perform the surgical procedure set forth in prior paragraphs as to the manner of delivery of the infant Mikayla caused the infant Mikayla to suffer severe birth asphyxia resulting in her death.

39. **The failure to obtain informed consent** of the parents with respect to the procedure performed by Dr. Kruszewski and employees of the hospital, given the infant's condition, and to provide the parents with **alternatives to surgical procedures** performed on Mrs. Rhoades constituted an intentional tort, to wit, battery and resulted in severe birth asphyxia and death.

45(g) For damages arising out of the failure to obtain the Plaintiffs' informed consent.

47. Plaintiffs bring this action against Dr. Kruszewski, as an intentional tort, in that **Dr. Kruszewski failed to obtain the informed consent of the Plaintiffs to perform the type of procedures which were performed on Mrs. Rhoades without fully advising her that Mikalya was a large baby**, and of the **potential complications arising from of the type of delivery conducted** by the Defendants for a large baby and her mother.

48. As a direct and proximate cause of the failure of the Defendants to obtain informed consent of the Plaintiffs, the Plaintiffs, individually, on their own behalf, and to the extent allowable under the law claim compensatory, and, if appropriate, punitive damages as follows:

(a) For pain, suffering and inconvenience to the extent recoverable under the law and loss of enjoyment of life.

(b) For infliction of emotional distress.

(c) For economic damages arising out of the battery."

The Court's Orders had the effect of excluding all the allegations under Paragraph 17 of informed consent on pre-admission procedure including Pitocin augmentation, vacuum assisted delivery, episiotomy, and anesthesia; under Paragraph 18, discussion as to the nature of administering Pitocin, risks, complications, etc.; Paragraph 19 the failure to discuss Pitocin augmentation and vacuum assisted vaginal delivery and alternative methods; Paragraphs 32(a) and (f) relate to delivery of a large baby; Paragraph 34, informed consent as to the vacuum assisted vaginal delivery and episiotomy, etc.; Paragraph 35, failure to obtain informed consent on the method of delivery; Paragraph 36, informed consent as to the manner of delivery causing

birth asphyxia; Paragraph 39, informed consent as to the infant's condition and alternatives to surgical procedures; and Paragraphs 47 and 48, Count I.

By sustaining the above Objections, the Court expressly dismissed all claims "**contained in Defendants' Preliminary Objections**" as above quoted. Despite this, the Plaintiffs' expert Dr. Mollick in his report states that Dr. Kruszewski did not comply with the standard of care because she failed to discuss the risks and indications for induction and augmentation of Pitocin with the patient. Exhibit "A" to Motion, pp. 2, 4, 18.

Further, Pennsylvania does not recognize a cause of action based on the negligent informed consent or on the administration of medication. The MCare Act, 40 P.S. §1303.504, specifically provides that informed consent is limited to surgery, administration of radiation and chemotherapy, administration of a blood infusion, experimental medication and/or inserting a surgical device. Under the Court's Orders, the allegations relating to informed consent were dismissed, and the Plaintiffs' expert report of Dr. Mollick concerning a breach of informed consent on negligence standards would be inadmissible. The report raises theories of negligent informed consent which, as a matter of law, have been dismissed and are not part of this case.

## ***ARGUMENT TO II B, C, D, E, AND F OF MOTION***

***Preliminary***

Pennsylvania is a fact pleading state. As such, specificity in pleading is required. Rule 1019(a) of the Pennsylvania Rules of Civil Procedure requires that a plaintiff plead "[t]he material facts on which a cause of action or defense is based...in a concise and summary form." This has been interpreted to mean that "[a] complaint must not only give the defendant notice of what the plaintiff's claim is and the grounds upon which it rests, but it must also formulate the issues by summarizing those facts essential to support the claim." Brownawell v. Bryan, 40 D.&

C. 3d 604, 606 (Cumberland Cty. 1986), *citing* Baker et al. v. Rangos et al., 229 Pa.Super. 33, 324 A.2d 498 (1974).

It is hornbook law that the proof at trial must meet the theories pled. This rule has been summarized as follows: "[A] plaintiff cannot file a complaint which avers one cause of action, and be permitted, on the trial, to prove a different cause of action." Smith v. County of Allegheny, 397 Pa. 404, 406, 155 A.2d 615, 616 (1959). This principle has also been phrased as a requirement that probata concur with allegata. Freer v. Parker, 411 Pa. 346, 192 A.2d 348, 349 (1963). The pleadings are said to limit the court's agenda and to "determine the issues in any given case." Anflick v. Gruhler, 353 Pa. 470, 472, 46 A.2d 161, 162 (1946). The importance of this concept is underscored by a statement made by the Superior Court in the case of Allegheny Ludlum Industries, Inc. v. CPM Engineers, Inc., 278 Pa.Super. 201, 420 A.2d 500 (1980). Therein, the court noted that where there is a "fatal variance between the allegata and probata," a new trial is required. *Id.*, 420 A.2d at 502. The Superior Court in Allegheny Ludlum also stated: "The wrong which may be proved must be the wrong which has been alleged, not merely another wrong in the same legal category. *Id.*, 420 A.2d at 501, *citing* Aland v. Post Gazette Publishing Co., 337 Pa. 259, 10 A.2d 5 (1940).

The following are the remaining theories of negligence against Dr. Kruszewski after the Court had sustained the Preliminary Objections:

(a) Dr. Kruszewski **failed to evaluate fetal weight**;

(b) The use of vacuum extraction was inappropriate in this situation and represented departure from the good and accepted standard of medical care;

(c) The failure of Dr. Kruszewski **to order the discontinuance of the administration of Pitocin** when she became aware of severe and progressive variable decelerations was a departure from good and acceptable standards of care;

(d) Dr. Kruszewski's failure to deliver by caesarean section represented the deviation of good and accepted medical standard of care;

(e) Dr. Kruszewski **failed to have all the equipment necessary** for the use of vacuum assisted delivery present in the delivery room;

The Plaintiffs filed an Original and an Amended Complaint. They have had more than an ample opportunity to adequately describe their theories. The Amended Complaint which was filed on about October 14, 2003 consists of 21 pages and 72 paragraphs. The Plaintiffs' allegations and theories of negligence are as set forth above.

Despite the above allegations, Dr. Mollick discusses in his report a number of theories which are not pleaded. The following theories are raised by Dr. Mollick as criticism to Dr. Kruszewski in his reports but not pleaded by Plaintiffs:

> "To a reasonable degree of medical certainty I have reached the following conclusions and opinions in addition to those already mentioned;
>
> 1. **The induction of labor was not indicated and conducted below the** acceptable standard of care; ... Exhibit "A", p. 10 to the Motion.
>
> 2. **The management of the induction, augmentation and labor were below** the accepted standard of care; ... Exhibit "A", p. 12 to Motion.
>
> A. Dr. Kruszewski **failed to recognize that the patient was at risk for and had a labor abnormality**. This was below the accepted standard of care: ... Exhibit "A", p. 12 to Motion.
>
> B. Dr. Kruszewski and the nurses **failed to recognize that this patient was arrested in the active phase of labor which was a contraindication to the use of intravenous Pitocin**. This was below the accepted standard of care.... Exhibit "A", p. 14 to Motion.
>
> C. **Aggressive Pitocin augmentation was not indicated** and below the accepted standard of care.... Exhibit "A", p. 17 to Motion.
>
> D. The patient was **exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive Pitocin augmentation, resulting in progressive hypoxia, asphyxia** and permanent central nervous system damage. This was below the standard of care.... Exhibit "A", p. 19 to Motion.

E. The nurses and Dr. Kruszewski **failed to identify and act upon the severe periodic changes and loss of variability**. This led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damage. These actions were below the accepted standard of care... Exhibit "A", p. 22 to Motion.

1. The nurses and Dr. Kruszewski **were unfamiliar with the basic concepts and principles of fetal monitoring** resulting in the unrecognized progressive iatrogenic fetal asphyxia... Exhibit "A", p. 22 of Motion.

2. The nurses and Dr. Kruszewski **were unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia**.... Exhibit "A", p. 23 to Motion.

3. The patient had multiple episodes of unrecognized iatrogenic asphyxial stress which required intervention by cesarean section. Not performing a cesarean section in this situation resulted in fetal asphyxia and permanent brain damage. This was below the standard of care..." Exhibit "A", p. 27.

None of the highlighted portions of Plaintiffs' expert report above are within the remaining theories of liability set forth above.

**B. MOTION FOR SUMMARY JUDGMENT AND/OR MOTION IN LIMINE RE APPLICATION OF NURSING POLICIES TO CONDUCT OF DR. KRUSZEWSKI, PHYSICIAN DEFENDANT, AS THE STANDARD OF CARE**

Plaintiffs' Amended Complaint does **not** assert a cause of action against Dr. Kruszewski for negligence based on a failure to follow hospital policies or procedures. (See allegations of Amended Complaint, pp. 5 and 6 of Defendant's Motion). The statute of limitations has passed for all claims related to Plaintiff/infant's birth and Plaintiffs failed to plead any facts which would toll the statute and allow for an additional theory of liability to be raised at this late juncture. Accordingly, a Motion for Summary Judgment should be granted as to the untimely allegations of negligence in which DRMC policies which govern nursing practice are utilized to criticize Dr. Kruszewski. More important, this Court in Herzing v. Kruszewski, et al, entered an

Order on the identical issue precluding the application of the Hospital policies to Dr. Kruszewski's conduct by Order dated October 4, 2005, wherein this Court held:

> "4. Defendant's Motion to preclude the application of DuBois Regional Medical Center nursing policies to the conduct of Defendant Kruszewski is HEREBY GRANTED." Copy attached as Exhibit "A"

In the alternative, Defendants seek to preclude any and all testimony, evidence, or argument related to theories of negligence which are not pled in the Amended Complaint but are espoused upon in the Plaintiffs' expert report.

Despite the great quantity of allegations contained within the Second Amended Complaint, in his first report (Motion Exhibit "A"), Dr. Mollick apparently attempts to construct a theory whereby DRMC policies which govern nursing practice are utilized to criticize Dr. Kruszewski. The passages in question were not plead by Plaintiffs and are reproduced below:

> According to Dr. Kruszewski's admission note, "Hook was used to rupture membranes further and large amount of clear fluid was obtained." Dr. Kruszewski deviated from the **Hospital's Policy and Procedures, P/PR No. 79, entitled Protocol for Amniotomy which states**: "The artificial rupture of membranes may only be carried out by a physician. The fetal head must be fully engaged in the pelvis prior to amniotomy.

(See Motion Exhibit "A," p. 3 of 36)(emphasis supplied).

> According to the **Hospital's Policy and Procedure, P/PR No. 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor**: Intravenous induction will be used form medical indications only. The following criteria must be met:
>
> a. Patient will be at or near term with ripe, soft cervix.
> b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
> c. Patient willing to be induced.
> d. Vertex presentation.

There was no indication for induction and or augmentation with Pitocin. There was no notation by Dr. Kruszewski as to why the Pitocin was started. She failed to discuss the risks of and indication for induction and or augmentation with the patient. She did not evaluate the baby for fetal size and failed to perform clinical pelvimetry. Therese deviations were below the accepted stand of care.

(See Motion Exhibit "A," p. 4 of 36, p. 10 of 36)(emphasis supplied).

According to the **Hospital Policy and Procedure Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:**

A nonreassuring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.
4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent or correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15 mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75 mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge Angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.

5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

The Pitocin was continued, a scalp electrode was not placed, and the patient was not taken to cesarean section. These deviations were below the accepted standard of care.

(See Motion Exhibit "A," p 7 of 36, addressing Hospital Policy and Procedure Manual, P/PR No. 61.2 entitled Fetal Monitoring, Nonreassuring Patterns)(emphasis supplied).

1. The induction of labor was not indicated and conducted below the accepted standard of care.

According to the **Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:**
Intravenous induction will be used for medical indications only.

(See Motion Exhibit "A," p. 10 of 36, addressing Hospital Policy and Procedure Manual, P/PR No. 76 Entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor).

According to the **Hospital's Policy and Procedures, P/PR No. 76.1 entitled Active Management of Labor in Primipara**, the diagnosis of labor is made as follows,

a. Diagnosis based on the follow criteria:

1. Contractions: At least 1 in 7 minutes.
2. Show.
3. Rupture of membranes.
4. State of cervix.
    a. If effacement at least 70%-80%
    b. Cervical dilation of 3 cm or greater
    c. Contractions as above, then in labor.

The patient presented to the hospital in the active phase of labor.

There is no notation as to why the Pitocin was started. There is no notation that there was a discussion with the patient about the risks associated with induction and or augmentation of labor with Pitocin, especially in light of the fact that the patient was already in active labor. These deviations were below the accepted standard of care.

(See Motion Exhibit "A," p. 13 of 36, addressing Hospital Policy and Procedure Manual, P/PR No. 76.1 entitled Active Management of Labor in Primipara)(emphasis supplied).

> According to the **Hospital's Policy and Procedures, P/PR No. 76.1 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor.**
>
> POLICY:
> Intravenous induction will be used for medical indications only. The following criteria must be met:
>
> a. Patient will be at or near term with ripe, soft cervix.
> b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
> c. Patient willing to be induced.
> d. Vertex presentation.
>
> Use of an IUPC is to be considered for these patients.
>
> It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor.
>
> Dr. Kruszewski failed to perform clinical pelvimetry on this patient who presented with a macrosomic infant, and an unengaged floating head indicating cephalopelvic disproportion. Dr. Kruszewski failed to place an intrauterine pressure device to document contraction adequacy, and to accurately monitor the contraction pattern. Dr. Kruszewski started the Pitocin augmentation without precise knowledge of contraction adequacy and after the patient was arrested in the active phase of labor for over 4 hours with contractions as close as 1 minute apart. She aggressively augmented this patient without first discussing and documenting the indications for its use. These deviations were below the accepted standard of care.

(See Exhibit "A," p. 18 of 36, addressing Hospital Policy and Procedure Manual, P/PR No. 76)(emphasis supplied).

Based on the above language, it appears that Dr. Mollick is contending that the care and treatment provided by Dr. Kruszewski's during the course of delivery, including her decision to rupture the membrane, to induce labor via the administration of Pitocin, and to deliver the

Plaintiff/infant vaginally, were somehow contradicted by DRMC policies which relate to a nurse's duty regarding the induction and stimulation of labor. Plaintiffs elected not to plead any negligence, and, indeed could not plead same, based on the failure to follow any hospital policies or protocols. The Amended Complaint does not allege that Dr. Kruszewski breached the standard of care as regards same. Therefore, criticism based on the failure to follow various Policy and Procedures are wholly irrelevant and inappropriate under Pennsylvania law.

Dr. Mollick's opinions on Dr. Kruszewski's purported failure to follow hospital policies or protocols would constitute inappropriate testimony for several additional reasons, as well. First and perhaps most obvious is the fact that nurses and physicians are governed by completely different standards of care. This point requires no citation, and the defense fully expects that Plaintiffs would agree. Dr. Mollick may certainly testify as to the ways in which Dr. Kruszewski, in his opinion, failed to comply with the standards of care applicable to physicians practicing in the field of obstetrics. However, it is a completely different thing to state or imply that Dr. Kruszewski was negligent on the basis of a policy which directs nursing conduct. It appears that DRMC nursing policies may be used to measure the conduct of DRMC nurses in this case. It is a far different matter to apply these standards in criticizing a physician.

Because the nursing policy cannot be utilized to measure a physician's conduct, this line of testimony should be precluded on the basis of Pennsylvania Rule of Evidence 403. The probative value of such a course of criticism is outweighed by the danger of confusing and misleading the jury. Of course, trial judges enjoy broad discretion regarding the admission of potentially misleading or confusing evidence. Daset Mining Corp. v. Industrial Fuels Corp., 326 Pa.Super. 14, 473 A.2d 584 (Pa.Super.1984). Trial judges also have the authority to exclude relevant evidence if its probative value is substantially outweighed by the danger of unfair

prejudice or confusion. Whistler Sportswear, Inc. v. Rullo, 289 Pa.Super. 230, 433 A.2d 40 (1981). These general common law rules were codified at Rule 403, which provides that: "Although relevant, evidence may be excluded if its probative value is outweighed by the danger of unfair prejudice, confusion of the issues or misleading the jury...".

In this case, there is no probative value of the nursing policies with respect to Dr. Kruszewski's conduct. This has already been decided by this Court in Herzing v. Kruszewski, et al., Exhibit "A" attached. The danger of prejudicing this Defendant is manifestly obvious. A jury could easily be confused on this point, and may in some fashion apply this nursing policy against the physician Dr. Kruszewski. Therefore, this Defendant requests that Plaintiffs be precluded from comparing Dr. Kruszewski's conduct in any manner with the requirements of a DRMC policy which was crafted for the purpose of governing nursing conduct.

## C. NEGLIGENCE IN FAILING TO PROPERLY DOCUMENT CARE AND TREATMENT PROVIDED IN THE MEDICAL RECORDS

As noted above, the Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on the failure to properly document, within the medical records, the care and treatment provided to the Plaintiffs. Yet, Plaintiffs' expert repeatedly criticizes Dr. Kruszewski for failing to document at various points during the labor and delivery. On page 2 of Dr. Mollick's report, he opines "I could not find documentation indicating the reason for the induction and/or any documentation of a conversation . . ." Page 3 "This was the only progress note written by Dr. Kruszewski." Page 18 "She aggressively augmented the **patient without first discussing and documenting** the indications for its use."

Since no cause of action for negligence was pled based on the adequacy of Dr. Kruszewski's documentation, Plaintiffs are precluded from presenting any expert testimony or

argument that Dr. Kruszewski was negligent based on the extent or frequency of her documentation.

### D. NEGLIGENCE IN FAILING TO PROPERLY EVALUATE THE MATERNAL PELVIS OR PERFORM A CLINICAL PELVIMETRY

The Plaintiffs' Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on a failure to evaluate the maternal pelvis or perform a clinical pelvimetry. In contrast as noted above, the only criticism of Dr. Kruszewski is the failure to evaluate the fetal weight. However, the expert report states that Dr. Kruszewski breached the standard of care by not performing clinical pelvimetry (Exhibit "A", p. 18 to Motion). Accordingly, the Plaintiffs should be precluded at trial from presenting evidence, testimony, or argument to the effect that Dr. Kruszewski was negligent based on the failure to evaluate the maternal pelvis or perform clinical pelvimetry because this has not been pled.

### E. NEGLIGENCE IN FAILING TO MONITOR THE DECEDENT INCLUDING THE FAILURE TO APPLY SCALP ELECTRODES AND/OR AN INTRAUTERINE PRESSURE DEVICE

The Amended Complaint does not allege a cause of action against Dr. Kruszewski for negligence based on **failure to monitor the decedent or utilize specific devices to monitor the decedent during labor**. Again as noted above, none of these allegations are included within the five remaining allegations. There is no allegation against Dr. Kruszewski on a **failure to perform the task of monitoring**. The expert report is replete with opinions that Dr. Kruszewski breached the standard of care by **not using the correct type of monitoring and applying a scalp electrode and/or intrauterine pressure device; and by not reading the monitoring strips.** As indicated in Plaintiffs' report, page 6, Exhibit "A" to the Motion, the expert opinions as negligent failure to have "a scalp lead . . . placed during the pelvic exam" and "Dr. Kruszewski

failed to place a fetal scalp electrode and/or intrauterine pressure device." Throughout the report there are opinions of negligence concerning the **failure to place the electrode and intrauterine pressure device** (Exhibit "A", pp. 6, 7 18 and 30 to Motion). None of these assertions in the report are alleged the Complaint and the Plaintiffs are precluded from presenting any evidence, testimony or argument that Dr. Kruszewski was negligent based on the failure to apply the correct modality of monitoring, namely, scalp electrodes or intrauterine pressure catheters, and/or that Dr. Kruszewski failed to monitor the patient.

F. **NEGLIGENCE IN THE INITIATION OF INTRAVENOUS INDUCTION, EMPLOY INTRAVENOUS INDUCTION OR ADMINISTRATION OF PITOCIN**

Plaintiffs' Amended Complaint does not assert a cause of action against Dr. Kruszewski for negligence based on the initial decision to employ intravenous inductions (administration of Pitocin). Rather, **the Amended Complaint asserts that the Pitocin should have been discontinued at signs of fetal bradycardia and fetal distress**. The allegation is the discontinuance of Pitocin not the initiation or administration. The Plaintiffs' expert report asserts that Dr. Kruszewski breached the standard of care by **initiating** Pitocin to **augment** labor (Exhibit "A", p. 18 of Motion). Specifically, Dr. Mollick opines that "Dr. Kruszewski **started Pitocin or its augmentation** without precise knowledge of contraction adequacy . . ." Accordingly the Plaintiffs must be precluded at trial from presenting evidence or testimony to effect that Dr. Kruszewski was negligent based on **the initiation of Pitocin augmentation** because the theory is not pled in the Complaint. The above-objected theories are materially different from the allegations of the Complaint.

The Superior Court addressed a similar question in Reynolds v. Thomas Jefferson University Hospital, 450 Pa.Super. 327, 676 A.2d 1205 (1996), *appeal denied* , 549 Pa. 703, 700

A.2d 442 (1996). In that medical malpractice action, the plaintiff's complaint contained allegations that various agents of the defendant hospital acted negligently in the placing and removing of an endotracheal tube which was required to assist breathing, with resulting damage to the throat. At trial, the plaintiff's experts testified that the treating physicians had been negligent with regard to follow up care and for failing to refer the patient to a specialist when hoarseness persisted. *Id.*, 676 A.2d at 1207-08. After a jury verdict in favor of the plaintiff, the hospital appealed, raising the following issues:

> "A. Did the trial court err when it allowed plaintiff to introduce a new cause of action where the applicable statute of limitations had expired over four years prior thereto?
>
> B. Did the trial court err when it allowed plaintiff to present evidence at trial that was absolutely at variance with the cause of action pled in her complaint?"

*Id.*, 676 A.2d at 1209.

The court surveyed Pennsylvania law relevant to its consideration of the matter, including the following excerpts from Standard Pennsylvania Practice:

> "**A variance denotes difference and in reference to legal proceedings it refers to a disagreement or difference between the allegations made and the proof shown, not in the sense that there is a failure of proof, but that, contrary to the fundamental principle of good pleading and practice, the proof fails to materially correspond to the allegations.** A material variance consists of a departure in the evidence from the issues on which the cause of action must depend.
>
> ....
>
> [A]mong the typical and most damaging variance problems ... **are those cases where the proof at trial establishes a cause of action that was not alleged in the party's pleadings,** ... in which cases the expiration of a statute of limitation in the meantime ... may be fatal to the party's claims. "

*Id.*, *citing* Standard Pennsylvania Practice 2d, §§ 33:1, 33:6, 33:7, 33:8 (1994)(emphasis added). After outlining the law and defining the issue as whether the new theories introduced at trial constituted a new cause of action, the court went on to explore the meaning of "cause of action":

> "The Pennsylvania Supreme Court has never adopted a comprehensive definition of 'cause of action'; however, relevant to negligence actions, this court has previously stated:
>
> > A cause of action in negligence has been defined as the negligent act or acts which occasioned the injury for which relief is sought. Cox v. Wilkes-Barre Railway Corporation, 334 Pa. 568, 570, 6 A.2d 538, 539 (1939); Martin v. Pittsburgh [sic] Railways Company, 227 Pa. 18, 20, 75 A. 837, 837 (1910). A new cause of action does not exist if plaintiff's amendment merely adds to or amplifies the original complaint or if the original complaint states a cause of action showing that the plaintiff has a legal right to recover what is claimed in the subsequent complaint. Wilson v. Howard Johnson Restaurant, 421 Pa. 455, 460, 219 A.2d 676, 678-79 (1966); Arner v. Sokol, 373 Pa. 587, 591, 96 A.2d 854, 855-56 (1953); 3 Standard Pennsylvania Practice 682. **A new cause of action does arise, however, if the amendment proposes a different theory or a different kind of negligence than the one previously raised or if the operative facts supporting the claim are changed.** 2B Anderson Pennsylvania Civil Practice, §§ 1033.28 and 1033.31."

*Id.*, 676 A.2d at 1210, *quoting* Junk v. East End Fire Dept., 262 Pa.Super. 473, 490-91, 396 A.2d 1269, 1277 (1978)(emphasis added).

The court in Reynolds noted "further support" for the Junk definition in a Supreme Court opinion in which the court stated that "[a]n amendment of the complaint under Rule 1033 which adds or changes the theory of recovery upon which relief is sought through the introduction of new factual allegations generally constitutes a new cause of action..." *Id.*, *quoting* Sarancina v. Cotoia, 417 Pa. 80, 208 A.2d 764 (1978). Of course, it is the running of the statute of limitations

which necessitates an inquiry into whether a proposed amendment would introduce a new cause of action. *See* Del Turco v. Peoples Home Savings Association, 329 Pa.Super. 258, 274, 478 A.2d 456, 464 (1984). No amendment was proposed in Reynolds, and none has yet been proposed herein on this particular point. However, herein, as in Reynolds, the principles which govern late amendment are also relevant to whether evidence is at variance with the pleadings, i.e., whether the evidence constitutes a new cause of action.

The Superior Court in Reynolds found that a material variance existed between the claim set forth in the complaint and the claim proven at trial. Reynolds, 676 A.2d at 1212. The Court ordered that judgment in favor of plaintiff be vacated and that a judgment in favor of the hospital be entered. It should be noted that in Reynolds, the plaintiff submitted expert reports containing the "new" theories of recovery in March of 1993 (after the statute expired), and the case did not go to trial until 1995. *Id.*, 676 A.2d at 1206. Because the new claim was based upon a "separate set of operative facts," it was found to be barred by the statute of limitations. *See also* Rachlin v. Edmison, 813 A.2d 862, 872 (Pa.Super. 2002)(approving trial court decision to preclude expert testimony setting forth a new cause of action based upon the post-operative care rendered by a non-party physician); Cambria-Stoltz Enterprises v. TNT Investments, 747 A.2d 947, 953 (Pa.Super. 2000)(affirming trial court's conclusion that the appellant was unable to collect damages accrued in years that were not properly pled in the complaint).

The principles upon which Reynolds, Rachlin, and TNT Investments, were based are applicable and dictate that Plaintiffs' expert, Dr. Mollick, should not be permitted to express opinions based upon theories which have not been pled in Plaintiff's Second Amended Complaint. The objected-to theories of negligence represent completely different types and

allegations of negligence than that which has been previously asserted and should be barred pursuant to the legal precedent outlined above.

## IV.

## MOTION IN LIMINE TO EXCLUDE USE OF PUBLICATIONS OR LITERATURE AS TO STANDARD OF CARE, AND ANY OPINIONS OF DR. MOLLICK BASED THEREON

Throughout both his first report of February 15, 2005 (Motion Exhibit "A") and a second report of June 13, 2006 (attached to Plaintiffs' Frye Motion as Exhibit "6"),[1] Dr. Mollick repeatedly adopts and quotes directly from various publications that Dr. Kruszewski did not meet the pertinent standard of care in this case, and that doing so contributed to Plaintiff/infant's demise. As set forth in Defendant's Motion, Dr. Mollick does not rely on his own experience or education in establishing a standard of care, but instead adopts publications of others footnoted 44 times in his first report and 26 times in his second report. Said publications are as follows:

a. **ACOG Practice Bulletin**, Induction of Labor, No. 10, November, 1999; pp. 11, 12 (first report).

b. **ACOG Technical Bulletin**, Dystocia and Augmentation of Labor, No. 218, December. 1995; pp. 13, 15, 16, 19, 21 (first report).

c. **Williams Obstetrics**, 18th Ed. Cunningham et al. Dystocia 1989; pp. 13, 14, 17, 18, 19, 20, 21 (first report), p. 4 (second report).

d. **Handbook of FHR Monitoring**, 2nd Ed., Parer, et al., 1997; pp. 21, 23, 24, 25, 30, 31, 32 (first report), pp. 8, 9, 16, 17 (second report).

[1] Plaintiffs' untimely and improper attempt to introduce a supplemental report by Dr. Mollick via a supposed "Frye Motion" is discussed in detail in Defendant's Response to same. In light of the fact that said report was not available at the time Defendant's Motion in Limine was filed, Defendant has also addressed Dr. Mollick's second report in the instant Brief. This issue is raised to the extent that said report, rather than his own opinions, as Defendant surmises, constitutes a backdoor attempt to improperly provide the basis for Dr. Mollick's expert opinions as set forth in his first report and in anticipation of Plaintiffs' reliance on same at trial.

e. **ACOG Practice Bulletin**, Induction of Labor, No. 10, November, 1999; (first report)(second report).

f. Dr. Mollick states that his opinions are that Dr. Kruszewski violated the standard of care as described in the above publications.

g. **ACOG, Code of Professional Ethics**, Article V, Sections 5, 6, 2004; p. 2 (second report).

h. **Harrison's Principals of Internal Medicine**, Fauci, et al., 15th Edition, 2001; p. 3 (second report).

i. **Maternal fetal Medicine**, Creasy/Resnick, 2nd Edition, Cunningham, et al., 2001; p. 4 (second report).

j. **Neonatal-Perinatal Medicine**, 7th Edition, Fanarof et al., 2002; pp. 4, 17 (second report).

k. **ACOG Committee Opinion**, No. 197, Feb. 1998; p. 9 (second report).

Learned writings, and expert opinions based thereon, which are offered to prove the truth of the matters therein are hearsay and may not properly be admitted into evidence for consideration by the jury. The Pennsylvania Rules of Evidence specifically *did not* adopt the Federal Rules of Evidence F.R.E. 803(18), which allows testimony relating to "learned treatises" as an exception to the hearsay rule.[2] Moreover, the Supreme Court's Ad Hoc Committee on

[2] Federal Rule of Evidence 803(18) provides an exception to the hearsay rule for learned treatises as follows:

**Rule 803. Hearsay Exceptions; Availability of Declarant Immaterial.**

The following are not excluded by the hearsay rule, even though the declarant is available as a witness:

**(18) Learned Treatises**

To the extent called to the attention of an expert witness upon cross-examination or relied upon by the expert witness in direct examination, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice. If admitted, the statements may be read into evidence but may not be received as exhibits.

Evidence expressly acknowledged that the Superior Court decision in Majdic v. Cincinnati Machine Co., 370 Pa. Super. 611, 537 A.2d 334 (en banc 1988), cert. denied, 520 Pa. 594, 552 A.2d 249, stated the current Pennsylvania Rule of Evidence with respect to the use of "learned treatises" at trial.

Majdic involved a strict liability action against the manufacturers of a power press for failing to provide safety guards on the equipment. The plaintiff's expert opined that safety guards were available and could have been added to the equipment at the time of manufacture. In addition, the plaintiff sought to introduce into evidence various articles from trade publications and learned treatises upon which plaintiff's expert relied in forming his opinion. Plaintiff further offered to have his expert read the written excerpts to the jury. Although the trial court permitted the expert to refer to these articles, the court refused to allow the articles to be received as substantive evidence or to be read to the jury.

On appeal, the Superior Court set forth the law in Pennsylvania regarding the use of learned treatises as follows:

> The law in this Commonwealth is well-settled that an expert witness may be cross-examined on the contents of a publication upon which he or she has relied in forming an opinion, and also with respect to any other publication which the expert acknowledged to be a standard work in the field. *See, Cummings v. Borough of Nazareth,* 430 Pa. 255, 242 A.2d 460 (1968); *Walheim v. Kirkpatrick,* 305 Pa. Super. 590, 451 A.2d 1033 (1982); and, *Brannan v. Lankenau Hospital*, 254 Pa. Super. 352, 385 A.2d 1376 (1978), *rev'd. on other grounds*, 490 Pa. 588, 417 A.2d 196 (1980). In such cases, the publication or literature is not admitted for the truth of the matter asserted, but only to challenge the credibility of the witness' opinion and the weight to be accorded thereto. *Brannan v. Lankenau Hospital, supra.,* at 385 A.2d at 1383. Learned writings which are offered to prove the truth of the matters therein are hearsay and may not properly be admitted into evidence for consideration by the jury. *See: McCormick on Evidence* §321, at 899 (3d ed. 1984).

Majdic, 537 A.2d 339.

The Superior Court, therefore, concluded that where the learned writings are offered to prove the truth of the matter asserted, they are hearsay and, thus, are inadmissible as substantive evidence. Moreover, the fact that opinions/information in such a document is proposed to be read into evidence by the expert witness does not change its inadmissibility. The court noted "[i]t is the purpose for which the information is offered, not the manner in which it is introduced, which makes it objectionable." Majdic, 537 A.2d at 339-40. Accordingly, the Superior Court concluded that the trial court properly refused to allow the articles to be received as substantive evidence or to be read to the jury. Id.; see also Christiansen v. Silfies, 446 Pa. Super. 464, 667 A.2d 396, 403 (1995) (trial court did not abuse its discretion in precluding reference at trial to Commercial Driver's Manual); Jones v. Constantino, 429 Pa. Super. 73, 631 A.2d 1289, 1297 (1993) (unpublished paper which had been presented at medical conference was inadmissible and, thus, trial court did not abuse its discretion in ordering a new trial where expert read the paper into evidence).

Because the purpose for which treatises may be referenced on direct examination is generally limited to explaining the reasons underlying the opinion, the trial court should exercise careful control over their use to prevent them from being made the focus of the examination. This subject was addressed by the Pennsylvania Supreme Court in Aldridge v. Edmunds, 750 A.2d 292 (Pa. 2000). In Aldridge, the Court undertook a detailed analysis of the subject. An excerpt is reproduced below:

> When offered at a trial to establish principles or theories from their contents, texts and periodicals fall within the traditional definition of hearsay--an extrajudicial declaration offered to prove the truth of the matter asserted. *See* Majdic v. Cincinnati Machine Co., 370

> Pa.Super. 611, 621-22, 537 A.2d 334, 338-39 (1988) (*en banc* ). Thus, at common law, the evidentiary rules restricting the presentation of hearsay statements precluded parties from employing treatise materials as substantive proof of their contents. *See generally* 29A AM.JUR.2D EVIDENCE § 1413 (1994); Jones v. Constantino, 429 Pa.Super. 73, 88-89, 631 A.2d 1289, 1297 (1993)(finding that learned writings which are offered to prove the truth of their contents are hearsay and may not properly be admitted into evidence), *appeal dismissed,* 538 Pa. 671, 649 A.2d 673 (1994)....While other jurisdictions, including the federal courts, have moved away from the common law exclusion in favor of an exception permitting the admission of treatise materials as substantive evidence on a limited basis, *see, e.g.,* F.R.E. 803(18), Pennsylvania has not done so. *See* P.R.E. 803(18) (providing that "Pennsylvania does not recognize an exception to the hearsay rule for learned treatises" (citing Majdic, 370 Pa.Super. at 611, 537 A.2d at 334))....

*Id.*, 750 A.2d 292 at 296 - 297 (footnotes omitted).

The Court recognized that learned treatises may be utilized for limited purposes, such as on cross examination, but must be subject to "appropriate constraints." Id., 750 A.2d at 298. However, it is clear that use of literature or treatises as substantive evidence is prohibited. This Court has so ruled in Herzing v. Kruszewski, et al., by Order dated October 4, 2005, stating:

> "Defendant's Motion to preclude medical literature as substantive evidence to establish the relevant standard of care is HEREBY GRANTED." Exhibit "A" attached.

Further, since Dr. Mollick's opinions are based on the cited publications, his opinions would also be hearsay and inadmissible. Dr. Mollick cannot simply cite publications as his opinions. Therefore, Dr. Mollick must be prohibited from introducing medical literature as substantive evidence at trial via any testimony based thereon, as set forth throughout his reports.

## V. MOTION IN LIMINE RE NURSES' DEPOSITION TESTIMONY OR OTHER EVIDENCE AS TO STANDARD OF CARE OF DEFENDANT PHYSICIAN AND AN OB/GYN PHYSICIAN

It cannot be credibly be disputed that the relevant standard of care is the standard applicable to OB/GYN physicians because the delivery procedure at issue was to be performed by same. See Yacoub v. Lehigh Valley Medical Associates, P.C., 805 A.2d 579, 592 (Pa. Super. 2002). The question then becomes whether the nurses were qualified to render an opinion as to the standard of care employed by OB/GYN physicians.

In some of those depositions, the nurses were asked, for example:

> Q: Did the accelerations at this point concern you in any manner.
>
> A: I would like to see the patient delivered." (Nurse Benner depo, p. 37).
>
> Q: So you have worked with Dr. Kruszewski long enough or the doctors long enough that you can communicate non-verbally.
>
> A: Uh huh.
>
> Q: Did you communicate non-verbally with Dr. Kruszewski during the labor and delivery and express non-verbal concerns to her about the condition of the baby.
>
> A: I can say that I probably looked at her a few times.
>
> Q: Okay, and why would you be doing that Gloria.
>
> A: Like I said I don't like my babies to be below 120s to 160s.

(Nurse Benner's Depo., NT, p. 44).

In point of fact, none of the nurses have an M.D., and therefore are obviously not specialized in the field of OB/GYN medicine. Despite their nursing experiences, it is clear that same are neither authorized to nor have they ever performed the delivery method employed or contemplated herein. Similarly, it is also clear that professional experience as a nurse cannot in

any way constitute the qualifications necessary for testimony concerning the decision to induce labor, the proper method delivery in a given circumstance or under what circumstances the performance of a cesearian section surgery is warranted.

Decisions regarding the qualifications of expert witnesses are within the discretion of the trial judge. Taylor v. Spencer Hospital, 222 Pa.Super. 17, 23, 292 A.2d 449, 452 (1972). The general rule is that witnesses should be qualified where he or she "has any reasonable pretension to specialized knowledge on the subject under investigation." Id. However, the Legislature and the courts of this Commonwealth have limited the degree to which an expert of a given profession may provide testimony in medical malpractice cases for obvious reasons. It is essential that a witness' generalized expertise "fit" the precise area of controversy both under common and statutory law.

In this regard, the nurses testimony is inadmissible under subsection (b) of the MCARE Act. See 40 P.S. §1303.512(b). Section 512(a) of the MCARE Act — "Expert Qualifications" provides:

> (a) General rule. — No person shall be competent to offer an expert medical opinion in **a medical professional liability action** against a physician unless that person possesses sufficient education, training, knowledge and experience to provide credible, competent testimony **and fulfills the additional qualifications set forth in this section** as applicable." 40 P.S. §1350.512 (emphasis added).

The phrase "medical professional liability action" is defined as "**any proceeding** in which a medical professional liability claim is asserted, including an action in a court of law or an arbitration proceeding." 40 P.S. §1303.103.

Section 512(b) provides:

> Medical testimony. — An expert testifying on a medical matter, including the **standard of care**, risks and alternatives, **causation**

and the **nature and extent of the injury, must** meet the following qualifications:

> (1) **Possess an unrestricted physician's license** to practice medicine in any state or the District of Columbia.
>
> (2) Be engaged in or retired within the previous five years from active clinical practice or teaching.

Provided, however, the court may waive the requirements of this subsection for an expert **on a matter other than the standard of care if** the court determined that the expert is otherwise competent to testify about medical or scientific issues by virtue of education, training or experience.

40 P.S. §1303.512(b).

The requirement that Plaintiffs present expert medical testimony in a malpractice case stems from the fact that the relevant standard of care and the causative effect of any breach of the standard of care in a complex case such as this, is beyond the knowledge or experience of laypersons. See Brannan v. Lankenau Hospital, 417 A.2d 196, 199-200 (Pa. 1980). Section 512 of the MCare Act requires that standard of care testimony can only be given by qualified physicians, not nurses. 40 P.S. §1303.512. Since the nurses are not physicians, they are prohibited from testifying as to the standard of care.

In fact, non-physician medical professionals are quite limited in the scope of their permissible expert testimony by common law, notwithstanding the MCare Act. The Supreme Court of Pennsylvania recently examined a similar issue in Flanagan v. Labe, 690 A.2d 183 (Pa. 1997). Summary judgment was granted by the Philadelphia Court of Common Pleas on a finding that the plaintiff's nurse-expert, Audrey Stephan, was incompetent to testify with regard to causation of subcutaneous emphysema following allegedly substandard nursing care. The Supreme Court recognized that the nurse was competent to provide expert testimony regarding

applicable standards of nursing care and whether nursing procedures were appropriately followed. Id., 690 A.2d at 185. However, the Court held that Nurse Stephan could not testify "regarding the identity and cause of Flanagan's medical condition." The Court's analysis is reproduced below, in pertinent part:

> Ordinarily, therefore, the test to be applied is whether the witness has a reasonable pretension to specialized knowledge on the subject matter in question. (citation omitted) Here, however, the normal test of competency is constrained by a statutory provision limiting the deemed competency of nurses.
>
> The Professional Nursing Law, 63 P.S. § 211 et seq., provides the following definition of the practice of nursing:
>
> (1) The "Practice of Professional Nursing" means *diagnosing* and treating *human responses* to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The foregoing *shall not be deemed to include acts of medical diagnosis* or prescription of medical therapeutic or corrective measured, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations shall be implemented by the Board.

63 P.S. § 212 (1) (emphasis added). Id.

The Court went on to define a "medical diagnosis" as "an identification of a disease based on its signs and symptoms." Id., 690 A.2d at 182. Summary judgment was upheld on the basis that Nurse Stephan's opinion regarding the specific identity and cause of Flanagan's condition would have constituted a medical diagnosis. Id.

The Pennsylvania Superior Court's decision in Taylor, supra, is particularly instructive regarding the implications for physician's assistants offering expert testimony, even though the expert testimony at issue concerned the standard of care and not causation.

In Taylor, the Superior Court held that the trial court erred in striking the testimony of a doctor who testified to a standard of nursing care. Id. at 22, 292 A.2d 452. The plaintiff's expert,

a medical doctor, testified that "the nursing staff did not take the necessary measures to prevent [plaintiff] from getting out of her restraints and going out the window." Id. at 21, 292 A.2d at 451. The court held that the testimony was appropriate because nurses only practice medicine under the supervision of doctors. Id. at 22, 292 A.2d at 452. The court stated that "not allowing a medical doctor to give testimony on the standard of nursing care suggests that nurses are permitted to practice in some areas of medicine from which doctors are excluded." Id. Because "[a]ll areas of medical expertise within the knowledge of nurses are also within the knowledge of medical doctors," the court found that the doctor's testimony on the standard of nursing care was proper. Id. at 24, 292 A.2d at 453. Therefore, the Taylor decision stands for the proposition that the key question is whether the expert witnesses knowledge and practice encompasses the area of expertise for which they are offering an opinion, i.e., non-physicians knowledge and practice clearly does not cover that of physicians. See id.

The Seventh Circuit Court of Appeals examined the competency of another type of non-physician medical expert in Stutzman v. CRST, Inc., 997 F.2d 291 (7th Cir. 1993). Therein, the Appeals Court upheld the trial court's preclusion of testimony by a physical therapist that she had a treatment plan which if implemented could improve the plaintiff's strength and coordination to the point where he could resume light farming duties. The court found that such testimony would have constituted a medical prognosis which a physical therapist was not qualified to make. Id. at 298. The Stutzman opinion included a citation to Bolton v. CNA Ins. Co., 821 S.W. 2d 932 (Tenn. 1991) wherein the court held that a physical therapist was not competent to give an opinion as to permanence and extent of disability. Id.

Nursing experience does not "fit" the issue in question. They are simply unqualified to testify as to the pertinent standard of care because they are not physicians, and moreover do not

make decisions regarding whether various delivery procedures will be performed on a patient. Under Pennsylvania common law and the pertinent provisions of the MCARE Act, because they are not medically qualified said nurses must be precluded from offering any medical testimony and restricted to providing factual testimony only.

## VII.

## EXCLUSION OF EVIDENCE OF NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

We also filed a Motion in Limine to exclude any evidence on negligent infliction and emotional distress. The Plaintiffs, in their Pre-Trial Statement said there was a claim for negligent infliction of emotional distress. To foreclose any evidence on this issue, we filed the Motion. The basis of the Motion is this Court's Order of February 23, 2004 sustaining demurrer to Count VII of the Complaint excluding such cause of action referenced in Paragraph 6 of the Motion. Accordingly, all evidence on emotional distress should be excluded and the Plaintiffs prevented from testifying or arguing before the jury as to such evidence.

## VIII. MOTION IN LIMINE RE THE "FRYE TEST" IS APPLICABLE TO DR. MOLLICK'S TESTIMONY

### A. THE FRYE STANDARD GOVERNS ADMISSIBILITY OF SCIENTIFIC EVIDENCE IN PENNSYLVANIA

When the production of expert testimony becomes necessary, a plaintiff must first lay the appropriate foundation for the admissibility of such testimony before it is permitted to reach the jury. See Commonwealth v. Rodgers, 605 A.2d 1228 (Pa.Super.1992). The admissibility to proposed expert testimony is governed by Pennsylvania Rule of evidence 702, which states:

> If scientific, technical or other specialized knowledge beyond that possessed by a layperson will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as

> an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise.

Pennsylvania's test for the admissibility of novel expert testimony was first enunciated in Frye v. United States, 293 F. 1013 (D.C. 1923). Frye was adopted in Commonwealth v. Topa, 471 Pa. 223, 369 A.2d 1277 (1977), and continues to govern the disposition of this issue. Under Frye, novel scientific evidence is admissible if the methodology that underlies the evidence has general acceptance in the relevant scientific community. Frye, 293 F. 1013, 1019. Recently, the Pennsylvania Supreme Court has confirmed that the Frye standard continues to controls the admissibility of expert testimony in Pennsylvania. Grady v. Frito-Lay,Inc., 576 Pa. 546, 839 A.2d 1038 (2003); see also Pa.R.E. 702, *comment.*

The admissibility of scientific evidence under Rule of Evidence 702 and Frye may be addressed during pre-trial proceedings. During these pre-trial hearings, the judge acts as gatekeeper with an obligation to ensure that untrustworthy evidence is not presented to the jury. Checchio v. Frankfurt Hosp., 717 A.2d 1058, 1062 (Pa. Super. 1998); McKenzie v. Westinghouse Electric Corp., 674 A.2d 1167 (1996). Significantly, the plaintiffs in McKenzie sought to bypass the trial court's mandated "gatekeeping" role, as defined by Topa and Frye, by asserting that: "[I]f the expert is wrong, . . . it is up to the jury to determine that fact after hearing the evidence." McKenzie , 674 A.2d at 1171. However, the Appellate Court expressly rejected this argument, and in doing so, affirmed the trial court's pre-trial decision to exclude the testimony of the plaintiffs' expert.

Within the decision, the McKenzie court offered very instructive reasoning regarding a plaintiff's burden in trying to admit expert testimony, and just as importantly, reinforced the trial court's responsibility to admit only such evidence that has first been shown to have gained

general acceptance within the relevant medical and/or scientific community. The court held that "this is especially true where the party opposing the admission of such testimony adduces evidence to establish that the data and studies used to support the reliability of the expert's testimony have been criticized." Id.

Shortly after McKenzie, the Pennsylvania Superior Court continued to reinforce the "gatekeeping" role of the Frye test by issuing two opinions (within one year of each other), which mandated the exclusion of proposed expert and/or scientific evidence from jury consideration where such evidence was not shown to have been generally accepted within the relevant medical and/or scientific community. See Blum v. Merrell Dow Pharmaceuticals, Inc., 705 A.2d 1314 (1997);[3] see also Checchio v. Frankfurt Hospital, 717 A.2d 1058 (1998).

In Blum, the Superior Court reversed a trial court's decision to admit the plaintiffs' proffered expert testimony because the trial court had failed to perform its "gatekeeping" function in determining the admissibility of scientific evidence. Importantly, the trial court had erroneously admitted the testimony based upon an apparent "confidence in the power of cross-examination to expose incredible, unscientific, and unreliable expert testimony for what it is." Blum, 705 A.2d at 1321. In rejecting this line of reasoning, the Superior Court reinforced the persuasiveness of the holding in McKenzie, and cautioned trial courts that an analysis of the scientific validity of the methodologies underlying the testimony is simply beyond the

[3] The Superior Court's decision in Blum was affirmed by the Pennsylvania Supreme Court at Blum v. Merrell Down Pharm., 764 A.2d 1 (Pa. 2000). The Supreme Court's decision, however, was limited to a consideration of whether the Frye rule would continue to govern the admissibility of expert scientific testimony in Pennsylvania or whether the Federal rule announced in Daubert v. Merrell Dow, Inc., 509 U.S. 579, 113 S. Ct. 2786, 125 L.Ed.2d 469 (1993), had superseded it.

capabilities of most lay persons. Blum, 705 A.2d at 1325. Therefore, the gatekeeping role of the court provides essential support for the jury's proper function by precluding the admission of "material whose complexity merely hides its unreliability." Id.

B. THE TESTIMONY DR. MOLLICK MUST BE PRECLUDED AS INADMISSIBLE UNDER FRYE

In the instant case, Dr. Mollick failed to utilize a methodology which is recognized by the medical community and therefore his testimony should be precluded. Pennsylvania law dictates that the admissibility of novel scientific evidence depends upon the "general acceptance of its validity by those scientists active in the field to which the evidence belongs". Grady v. Frito-Lay,Inc., 576 Pa. 546, 839 A.2d 1038, 1044 (2003). The Pennsylvania Supreme Court has explained:

> Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, *the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.*

Commonwealth v. Topa, 369 A.2d at 1281 quoting Frye v. United States, 54 App. D.C. 46, 293 F.1013, 1014 (1923). In addition, the Court has stated:

> [The] scientific methodology and conclusions must initially be scrutinized by the Court **to ensure that what might appear to the jury to be science is not in fact speculation in disguise.**"

Blum v. Merrell Dow Pharmaceuticals, Inc., 705 A.2d 1314, 1325 (Pa. Super. 1997), affirmed, 764 A.2d 1 (Pa. 2000)(addressing a pharmaceutical products liability action); see also, Checchio v. Frankfurt Hospital, 717 A.2d 1058 (Pa. Super. 1998) (precluding expert's testimony which failed to demonstrate any scientific basis, other than his own subjective beliefs and no authority,

statistical or otherwise was offered on these points in a case where plaintiff's alleged negligence in managing respiratory distress syndrome); Trach v. Fellin, 817 A.2d 1102 (Pa. Super.2003) (allowing experts' opinions only after a showing that the medical literature demonstrated the general acceptance of the principles and methodologies the plaintiffs' experts used to reach the causation opinion).

Pennsylvania Appellate Courts have repeatedly used the Frye test to determine the admissibility of novel scientific and medical expert testimony. See, e.g., Checchio v. Frankfurt Hosp., 717 A.2d 1058 (Pa. Super. 1998); Blum v. Merrell Dow Pharm., Inc., 705 A.2d 1314 (Pa.Super.1997) and, McKenzie v. Westinghouse Electric Corp., 674 A.2d 1167 (Pa.Cmwlth. 1996). Two recent decisions, Grady v. Frito-Lay,Inc., 576 Pa. 546, 839 A.2d 1038 (2003) and Trach v. Fellin, 817 A.2d 1102 (Pa. Super. 2003), establish the current state of Pennsylvania law. In providing the most recent clarification of the Frye doctrine, Grady left the analysis of the cases cited above largely intact. See Grady, 576 Pa. 546, 839 A.2d 1038, n. 13, citing McKenzie, supra , 674 A.2d at 1167.

Grady clarified two important Frye issues which are relevant to the case at bar. First, the Court clarified that the burden of establishing all of the elements for the admission of expert medical testimony rests solidly on the shoulders of the proponent of the expert testimony. Grady, 576 Pa. 546, 839 A.2d 1038, 1045. Second, the Supreme Court clarified that Frye's general acceptance test applies only to a scientific expert's methodology (not that expert's conclusions) while maintaining the validity of the balance of the discussion of McKenzie, Blum, and Checchio, supra.

As stated by the Pennsylvania Supreme Court in Grady:

> One of the primary reasons we embraced the *Frye* test . . . was its assurance that judges would be guided by scientists when assessing the reliability of a scientific method. . . . Given the ever-increasing complexity of scientific advances, this assurance is at least as compelling today as it was in 1977, when we decided that case. We believe now, as we did then, that requiring judges to pay deference to the conclusions of those who are in the best position to evaluate the merits of scientific theory and technique when ruling on the admissibility of scientific proof, as the *Frye* rule requires, is the better way of insuring that only reliable expert scientific evidence is admitted at trial.

Grady, 576 Pa. 546, 557, 839 A.2d 1038, 1045.

In Grady, a consumer tore his esophagus while eating Doritos, a popular brand of tortilla chips. The injured consumer alleged that the Doritos were unsafe and defective for human consumption because they fracture into hard, sharp fragments when chewed that are capable of lacerating the esophagus when swallowed. The testimony at issue was that of a chemical engineer who performed tests on Doritos tortilla chips and concluded that the sharp corners of the triangular chips had caused a tear in plaintiff's esophagus when he ate them. The trial judge had granted Frito-Lay's motion for compulsory non-suit after excluding the plaintiffs' expert opinion, calling it "junk science" and finding it failed to meet the Frye standard. The Pennsylvania Superior Court, sitting en banc, reversed the trial court and concluded that the expert was competent to testify on the physical characteristics of Doritos and that his testimony satisfied the Frye test because his calculations were based on standard scientific principles.

Taking the opportunity to examine its stance regarding the applicability of Frye in Pennsylvania, the Pennsylvania Supreme Court reversed. Id. at 8. The Court concluded that the expert's report "misses the mark" by failing to connect his methodology with his conclusion. Id. at 7-8. Indeed, the report contained no evidence that the downward force test was a generally accepted method used by experts in food safety to determine if specific foods could be chewed

and swallowed safely. Id. Thus, the Court held that the expert's opinions did not pass muster under Frye. Id.

Turning to the instant case, Dr. Mollick's expert opinions are not based on generally accepted principles or methodologies as regards the pathophysiology and clinical presentation of hypoxic events and fetal asphyxia. In his first report, Dr. Mollick states on page 22 (Motion Exhibit "A") that Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability shown on the monitoring strips. In his opinion this led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damages which were below the standard of care. On page 23, he concludes that Dr. Kruszewski was "unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia." On page 25, the second full paragraph, he states:

> According to ACOG, (standards published by the American College of Obstetrics and Gynecology) the term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damages including all of the following:
>
> [a] Profound metabolic or mixed acidemia (pH less than 7.0) on an umbilical cord arterial blood sample, if obtained.
>
> [b] Persistent apgar scores of 0-3 for longer than 5 minutes.
>
> [c] Evidence of neonatal neurological sequela (e.g. seizures, coma, hypotonia and one more of the following: cardiovascular, gastrointestinal, and, the two logical, pulmonary or renal dysfunction).

However, a careful review of the ACOG standards reveals that Dr. Mollick's methodology in analyzing the pertinent criteria clearly conflicts with same. Contrary to Dr.

Mollick's report and reliance on the supposed standard, the ACOG consensus and standards are stated as follows:

> The criteria to define an acute intrapartum event (prior to delivery) sufficient to cause cerebral palsy . . . are listed as follows:
>
> Essential criteria (must meet all four):
>
> (1) Evidence of a metabolic acidosis and fetal umbilical cord arterial blood obtained at delivery (pH less than 7 . . .)
>
> (2) Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation.
>
> (3) Cerebral palsy of the spastic quadriplegic or dyskinetic type.
>
> (4) Exclusion of other identifiable etiologies such as trauma, coagulation disorders, infectious conditions or genetic disorder.

"Criteria that collectively suggest an intrapartum timing (within close proximity to labor and delivery, e.g., 0 to 48 hours), but are non-specific asphyxial insults." Id. All four essential criteria must be met before there can be an hypoxic event. (ACOG report, Motion Exhibit "C", p. 74).

> (1) A sentinel (signal) hypoxic event occurring immediately before or during labor.
>
> (2) A sudden and sustained fetal bradycardia or the absence of fetal heart rate variability in the presence of persistent, late or variable decelerations, usually after hypoxic sentinel event when a pattern was previously normal.
>
> (3) Apgar scores of 0 to 3 beyond 5 minutes.
>
> (4) Onset of multi-system involvement within 72 hours of birth.

(5) Early imaging studies showing evidence of acute non-focal cerebral abnormality.

(See excerpts, ACOG consensus, attached to Motion Exhibit "C").

According the ACOG criteria on which Dr. Mollick purportedly relies, the Plaintiff-baby would not have had hypoxic signs of damages, in that, the pH at the time of birth was in excess of 7.10 and the apgar scores which Dr. Mollick relies on for asphyxia and neurological damage clearly states apgars are "non-specific" to asphyxia. Moreover, there were **no other identifiable etiologies excluded** by Dr. Mollick in his report as required by the above ACOG consensus standards. Under the ACOG standard cited by Dr. Mollick, the infant child would not have asphyxia which caused the death.

Included with Defendant's Motion are excerpts from the **definitive consensus** sponsored by the National Institute of Child Health and Human Development. Same is a joint statement by the American College of Obstetricians and Gynecologist (ACOG) and the American Academy of Pediatricians (AAP) which has been endorsed by multiple national and international specialty and subspecialty organizations that addresses the specific recognized methodology criteria required to establish causation of birth asphyxia, cerebral palsy in the case of this exact nature, and highlights the medical community's rejection of the methodology Dr. Mollick attempted to employ in his interpretation of the fetal monitoring strips. (The ACOG Neonatal Encephalopathy and Cerebral Palsy: Defining Pathogeneses and Pathophysiology is voluminous and will be presented at argument as Exhibit "B").

The Neonatal Encephalopathy and Cerebral Palsy portions of the ACOG consensus study cannot be avoided in addressing the issues of causation in this case. All four essential criteria established set forth under paragraph 79 must be met before an intrapartum hypoxic event can be

considered as a cause of death. By way of example, and particular relevance herein, the ACOG Consensus Criteria requires that a sufficient level of metabolic acidosis exists in cord blood obtained at delivery and that all other causes be excluded respectively. (ACOG consensus, pp. 73-75, Motion Exhibit "C"). If and only if the above criteria are **all** met, does one properly proceed to examine the next category or criteria that need "to be present to establish the relationship between acute intrapartum hypoxia and cerebral palsy." (ACOG consensus, Motion Exhibit "C"). Because Dr. Mollick's' testimony does not and cannot establish that the first and fourth essential criteria were met, Dr. Mollick's reliance and citation of ACOG standards in support of his methodology is not only contrary to same, but also pure fabrication. Thus, the appropriate methodology in analyzing the ACOG consensus standards demonstrates that Plaintiff/infant's condition cannot be properly considered to have intrapartum hypoxia as opined by Dr. Mollick.

Similarly, Dr. Mollick's reliance on the fetal heart monitoring strips for the criticism of Dr. Kruszewski's management is also misplaced according to the ACOG standards consensus. Despite Plaintiffs' expert Dr. Mollick's attempts to show error on the part of Dr. Kruszewski regarding her interpretation of the fetal heart rate (FHR) strips, the fact is that the interpretation of fetal heart rate (FHR) and strips is very subjective and a source of considerable debate as is reaffirmed by the ACOG task force on Neonatal Encephalopathy and Cerebral Palsy. (See ACOG Consensus, Motion Exhibit "C", pp. 26-29 and p. xvii). The ACOG Consensus states as follows:

> For instance, Nelson Associates have shown that use of non-reassuring fetal heart patterns to predict subsequent cerebral palsy had a 99% false-positive rate. Use of such non-specific markers for perinatal asphyxia identifies a large number of individuals as being exposed to inappropriately diagnosed

> 'perinatal asphyxia.' Thus it is not surprising that removing the exposure to such non-specific markers has failed to change the risk for the disease.

(ACOG Consensus, Motion Exhibit "C", p. xvii).

In reaching his conclusions, Dr. Mollick's theories and methodology are both fundamentally flawed and based on substandard non-consensus terminology and standards. Under the Frye standards of evidentiary admissibility, the Plaintiffs will be unable to present any expert testimony to establish the "general acceptance" of their theories that Mikayla's fetal heart rate monitoring strip records were so abnormal during labor such that alternative intervention was indicated and/or harm caused thereby. Additionally, Plaintiffs will be unable to present any "generally accepted" expert testimony to establish that acute hypoxic ischemic injury occurred during the period of labor at DRMC that resulted in the child's eventual demise. Indeed, the Plaintiffs' novel theories of causation and standard of care are demonstratively contrary to well established general accepted medical scientific principles and consensus standards. This Court must perform its "gatekeeping" function with respect to the proffered medical and/or scientific evidence, and preclude Plaintiffs from submitting their inadmissible expert testimony regarding the standard of causation of harm and fetal monitoring strip interpretation issues in this case which are contrary to the very ACOG standards upon which their expert purports to rely.

## IX. MOTION IN LIMINE RE THE "FRYE TEST" IS APPLICABLE TO DR. REED'S TESTIMONY

Plaintiffs have also provided a report of William Houston Reed, vocational expert, dated May 11, 2004 stating the report was a vocational economic analysis of earning capacity of decedent, Mikayla Rhoades. (See Motion Exhibit "D"). Dr. Reed failed to utilize a methodology which is recognized by the economic community and therefore his testimony should be

precluded. For purposes of efficiency, Defendant hereby incorporates the proceeding discussion of the pertinent standards regarding the "Frye test" and legal authority in support of same.

The method used by Dr. Reed in his report to project Plaintiff/infant's earnings is not accepted by the greater community of labor economists because it is not scientifically based on recognized economic theories. Said community of economists focuses its research on the earnings of the individual and provides the standards that are accepted by the economist profession. Dr. Reed's report does not utilize the accepted standards of theories in the community of economists and his report directly contradicts the underlying theories and the very methodology which economic educators teach regarding the application of empirical data to individual earnings.

In the field of labor economics, the only accepted method for projecting an individual's future earnings is by the "human capital earning function," as recognized and applied by academic economists, research institutes and governments throughout the world. The "human capital earning function" has become the standard for economic analysis of earnings regarding an individual and is recognized by the Bureau of Census, Bureau of Labor and Statistics, Department of Education, and, Federal Reserve Board and other national institutions.

By way of example, Dr. Reed erroneously assumes that the earnings of workers at each level of experience will rise at 4.76%. In that case, person A, in an entry level position this year, receives a pay raise of 4.76% as he or she moves next year to a position with one year experience. That is, after only one year (e.g., 2007), person A will earn 4.76% more than the entry level position pays today, in 2006. However, Dr. Reed also increases the wage for the entry level position by that same 4.76% because he ignores the effect of experience. Consequently, in his report, the entry level person who starts in 2007, person B, will receive 4.76% more than the

entry level position pays in 2006. Because in 2007 both persons A and B will be paid the 4.76% more than the entry level position pays in 2006 they will both earn the same amount in 2007 even though person B is a new hire and person A has a year of experience. The next year, the same effect under his fallacious theory would be repeated. Thus, under Dr. Reed's improper methodology and analysis of the earnings for all positions, said earnings would necessarily be equal regardless of variability in work experience. This is inconsistent with reality and thereby inconsistent with the accepted methodology, principals and methodology of professional economists.

Dr. Reed's assumption that Plaintiff/infant's earnings would increase at an average rate of 4.76% is from data regarding increases in the **average** earnings of all workers in America - over 100,000,000 people. Dr. Reed ignores sound economic principles and seeks to apply simple arithmetic based on the American population as a whole to an individual in the future. This oversimplified "method" is not only inaccurate, but it is not recognized by economists for determining the future earnings of an individual person because of the effect of changing experience and is not a method economist use for future growth in wages.

Indeed, Dr. Reed relies on so-called "forensic economics" written by non-economists that is limited to calculating damages for purposes of providing testimony in personal injury cases. Said publications are **not** peer reviewed economic journals or textbooks recognized by the community of economists. Neither the Journal of Forensic Economics or Journal of Legal Economics appear in any rankings of the prestigious and peer review journals in economics, and, are unreliable as sources acceptable in the economist community.

Further, Dr. Reed uses a starting point for his projected earnings of a new college graduate in the year 2024 but does not specify what it is or his source. He identifies the current

population survey as a source for $30,347 as the earnings of the "average female college graduate" and what he says "would have been her age cohort" in 2002. In this regard, he has misused the CPS (Current Population Survey) data and other data available as to sex, education, and full time earners. Neither earnings figures cited by Dr. Reed is consistent with earnings of $76,175 as being a starting salary for Mikayla in 2004. In this regard, he erroneously relies on a salary survey conducted by NACE which is a very small sample and has been rejected as being irrelevant under accepted economic principles.

The use of the growth figure of 4.76% per year is unacceptable and unsupported by the economic community principles or literature and contrary to §510 of the MCare Act, 40 P.S. §1303.510.[4] His discount rate of 5.54% is undocumented as he only cites Gerald D. Martin, who is not an economist. He has made an error in discounting the unreliable earnings of $6,177,403 back to present value. His present value figure of $1,414, 265 results from the assumption that Mikayla would have begun her new career at the earning level of what he calculates as the average earnings of a female college graduate in 2024, but that she begins earning this in 2013 at the age of 11, not at her age at 2024 when she would be the age of 22. Even though there is an inaccurate work life assumption, the present value of $6,177,403 under his own inaccurate analysis would be $781,525.

Dr. Reed's methodology is contrary to acceptable economic practices and theories in other respects as well. In this regard, he relies on Determining Economist Damages (a 3-ring binder) by Gerald D. Martin as to fringe benefits. Professional Economists do not consider the

[4] Section 510 provides that future damages for lost earnings or earning capacity "shall be reduced to present value based upon the return...on a secure fixed income investment," with "competent evidence of the effect of productivity and inflation over time" and at a "discount rate based upon competent evidence." 40 P.S. §1303.510.

binder a source of reliable information. Moreover, because fringe benefits include vacation pay, sick pay, holiday pay, health insurance and other benefits do not benefit either a survivor or an estate such considerations are irrelevant to alleged damages caused by the death of a single person without dependents. Dr. Reed also improperly makes speculative assumptions on personal maintenance, and an assumption that Mikayla would have married. Dr. Reed's assumptions fail to recognize that in such speculative events, the expenditure data, as well as income, are based on a household. Lastly, he failed to consider the income tax consequence in his calculations in determining earning capacity .

Tellingly, Dr. Reed does not even have a degrees in economics. In fact, his master thesis is entitled "A Survey of Students, Teachers and Employers regarding the Effectiveness of Vocational Distributive Education in Pittsburgh Public Schools" , and, his doctoral thesis is "The differential Effect of a Vocational Training Program and a Group Therapy Program on the Frequency of Misconduct of Inmates and in a State Correctional Institution." Dr. Reed's educational degree is in rehabilitation counselling and consulting, statistical analysis and research methodology. He has an ME in vocational education, and, a BS in business administration.

In sum, Dr. Reed's assumption of a constant percentage increases in earning is nothing more than an oversimplified arithmetical calculation that has no basis in economic science or bona fide empirical data. Similarly, his assumptions regarding work life, income, maintenance costs, etc., are fundamentally flawed in multiple respects. Dr. Reed's strained methodology is simply an artifice for use in the courtroom only. It is not supported by the economic community or the standards of professional economists. A report by Dr. John Scarbrough on Dr. Reed's non-scientific report is attached hereto as Exhibit "C." Accordingly, Defendant's Motion in

Limine to preclude Plaintiffs from submitting any expert testimony from Dr. Reed regarding any alleged economic loss must be granted.

## X. MOTION IN LIMINE RE EVIDENCE OF BIRTH OF SUBSEQUENT CHILD AND TREATMENT RELATED THERETO

The Plaintiffs have listed Bart Matson, D.O. as a witness to be called in their case. Dr. Matson was the Plaintiff/wife's obstetrician subsequent to the birth of Mikayla in May, 2002. Notably, Dr. Matson's notes indicate that Plaintiffs had Dr. Matson review the records of DRMC and Dr. Kruszewski involving the delivery of Mikayla. Nevertheless, Dr. Matson has not provided an expert report.

Pursuant to Pennsylvania Rule of Civil Procedure 4003.5, a party may discover the identity of and the facts known and opinions held by an expert witness of the opposing party. This may be accomplished by serving the opposing party with interrogatories requesting the expert so identified to state the "substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion." Pa.R.C.P. 4003.5(a)(1)(b). Rule 4003.5(a)(1)(b) allows the party answering the interrogatories to submit a report prepared by the expert in lieu of answering each individual interrogatory.

Furthermore, Pa.R.C.P. 4003.5(b) provides that an expert witness shall not be permitted to testify at the trial of an action if the defaulting party did not make full disclosures as set forth in Pa.R.C.P. 4003.5(a)(1). Appropriate sanctions are imposed for failure to comply with discovery requests, including the exclusion of expert testimony when there has been a failure to disclose the identity and, more importantly, the nature of their testimony. See Dion v. Graduate Hospital of the Univ. of Pennsylvania, 360 Pa. 416, 427, 520 A.2d 876, 882 (1997). Absent extenuating circumstances, Rule 4003.5(b) is a rule of mandatory preclusion. Id.

Such testimony is indirect conflict with the fundamental right protected by Rule 4003.5 - the opposing party's right to a fair trial. See Sindler v. Goldman, 309 Pa.Super. 7, 14, 454 A.2d 1054, 1057 (1982).

In discussing said right, the Sindler Court found as follows:

> The purpose of the discovery rules is to prevent surprise and unfairness and to allow a trial on the merits. **When expert testimony is involved, it is even more crucial that surprise be prevented, since the attorneys will not have the requisite knowledge of the subject with which to effectively rebut unexpected testimony.** By allowing for early identification of expert witnesses and their conclusions, the opposing side can prepare to respond appropriately instead of trying to match years of expertise on the spot. Thus, the rule serves as more than a procedural technicality; it provides a shield to prevent the unfair advantage of having a surprise witness testify.

Sindler, 309 Pa. Super. at 12, 452 A.2d at 1056 (emphasis added). If expert testimony is admitted in violation of a pretrial discovery request or order, the party will be deprived of effective rebuttal which can lead to the inability to afford a fair trial. Id., at 14-15, 452 A.2d at 1058. The defense pursues this Motion in order to avoid prejudice and to ensure a fair trial.

Herein, Plaintiffs have failed to meet the requirements that an expert report on liability be provide by Dr. Matson. Based on Plaintiffs' failure in this regard, the well-established laws of this Commonwealth mandate that Dr. Matson must be precluded from testifying at trial in order to preserve the Defendant's right to a fair trial. See Dion, supra.; see also Sindler, supra.; Pa.R.C.P. 4003.5(a)(1). If Dr. Matson is permitted to testify about the details surrounding the birth of Plaintiffs subsequent child and/or his medical opinions related thereto, this court would be sanctioning some sort of exception for any medical professional who happen to be subsequent treating physicians of a plaintiff, i.e., that medical professionals can review the pertinent medical records concerning the care provided by a defendant physician and can proceed to testify on any

topic at trial without first submitting an expert report. Because this issue is resolved by a textbook application of the Rules, no further discussion on this point should be warranted, and, per the mandates of the above authority, this line of questioning must be denied in all respects.

However, for the sake of completeness, there are additional reasons that also demonstrate why Dr. Matson must not be permitted to testify concerning his prenatal care or delivery of Plaintiffs' subsequent viable child via c-section. It is undisputed that the Plaintiff/wife became pregnant and delivered a viable male child on May 19, 2004 by caesarean section ("c-section") performed by Dr. Matson. Defendant does not object to information about the number of children in the family or other factual data surrounding the nature of Plaintiffs' family. Such information is typically provided for the benefit of the jury.

However, any evidence, testimony or otherwise elicited from Dr. Matson concerning his prenatal care or delivery of the viable child via c-section to Plaintiff/wife would not be relevant to the issues in this case and should be precluded on the basis of Pennsylvania Rule of Evidence 403. The instant matter concerns health and condition of Plaintiff/infant up to the point of the infant's demise, and the treatment decisions of Dr. Kruszewki related thereto. The circumstances surrounding Plaintiff/wife's successful delivery of a subsequent child, though obviously fortunate in this regard, add nothing to question of liability in this case.

Instead, and even assuming said evidence is determined to be relevant herein, albeit erroneously, it is prone to be construed as support for the standard of care in this case, and thereby significantly prejudice the defense. The probative value of such a course of criticism, either direct or indirect, is thereby substantially outweighed by the danger of confusing and misleading the jury, as well as the danger of unfair prejudice. See Whistler Sportswear, Inc., supra. Further, the introduction of said evidence would not only be collateral, but would also

create a case within a case. See, e.g., Giosa v. School Dist. of Philadelphia, 157 Pa. Cmwlth. 489, 630 A.2d 511 (1993), overruled on other grounds by Fernandez v. City of Pittsburgh, 164 Pa.Cmwlth. 662, 643 A.2d 1176 (Pa.Cmwlth. 1994). Lastly, the Plaintiffs should nevertheless be prohibited from introducing any such evidence because to permit such evidence would also be in derogation of Section 512 of the MCARE Act (discussed supra).

Simply put, there is no authority, statutory or otherwise, which would permit introduction of such evidence. As a result of the foregoing, Plaintiffs must be prohibited from introducing any evidence or testimony of a subsequent pregnancy, delivery or argument concerning same.

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.

Date: July 10, 2006

By: _____
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EXHIBIT A

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| MICHELLE HERZING and JEFFREY A. JARVIS, Individually, in their own right, and as Administrators of the Estate of JANELL HEZING, a minor, deceased, Plaintiffs, | : | No. 02-169-CD |
| v. | : | I hereby certify this to be a true and attested copy of the original statement filed in this case. |
| MARY C. KRUSZEWSKI, DUBOIS REGIONAL MEDICAL CENTER, JERJIE T. ALAJAJI, and RUSSELL E. CAMERON, Defendants. | : | OCT 05 2005 Attest. Prothonotary/ Clerk of Courts |

**ORDER**

NOW, this 4th day of October, 2005, after consideration of the Four Part Motion in Limine filed on behalf of Defendant Mary C. Kruszewski on September 21, 2005, the Court HEREBY FINDS AS FOLLOWS:

1. Defendant's Motion to preclude theories not pled is HEREBY GRANTED, except, the Plaintiff shall be permitted to include evidence of the alleged failure to discuss risks and benefits of vaginal delivery.
2. Defendant's Motion related to Informed Consent based theories is HEREBY GRANTED in part and DENIED in part. The Plaintiff shall be precluded from introducing evidence at trial pursuing an informed consent based theory. The Plaintiff shall be permitted to introduce evidence of the alleged failure to advise the patient of the risks and alternatives to vaginal delivery.
3. Defendant's Motion to preclude medical literature as substantive evidence to establish the relevant standard of care is HEREBY GRANTED.

4. Defendant's Motion to preclude the application of DuBois Regional Medical Center nursing policies to the conduct of Defendant Kruszewski is HEREBY GRANTED.

BY THE COURT:

/s/ Fredric J. Ammerman

FREDERIC J. AMMERMAN
President Judge

# NEONATAL ENCEPHALOPATHY AND CEREBRAL PALSY

## DEFINING THE PATHOGENESIS AND PATHOPHYSIOLOGY

The American College of Obstetricians and Gynecologists

*Women's Health Care Physicians*

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

*Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology* was developed under the direction of the Task Force on Neonatal Encephalopathy and Cerebral Palsy. The information in *Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology* should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice. Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted. The purpose of these guidelines will be well served if they provide a firm basis on which local norms may be built.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

- I Evidence obtained from at least one properly designed randomized controlled trial.
- II-1 Evidence obtained from well-designed controlled trials without randomization.
- II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
- II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

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# Contents


ACOG Task Force on Neonatal Encephalopathy and Cerebral Palsy v

Endorsements ix

Foreword xi

Preface xiii

Executive Summary xvii

Chapter 1: Background 1

Neonatal Encephalopathy and Cerebral Palsy: How They Differ in Major Gestational Age or Birth Weight Groups 1

Neonatal Encephalopathy: Epidemiology and Long-Term Neurologic Outcomes 2

Relationship of Intrapartum Hypoxia and Cerebral Palsy 8

Chapter 2: Maternal Conditions 13

Third-Trimester Maternal Bleeding as a Risk Factor 13

Maternal Trauma During Pregnancy 14

Inflammation, Infection, Coagulation Abnormalities, and Autoimmune Disorders 14

Thyroid Disorders (Hypothyroidism) and Cerebral Palsy 19

Epilepsy and Antiepileptic Drugs 19

Environmental Factors, Chemicals, Alcohol Use, and Illicit Drug Use 19

Chapter 3: Antepartum and Intrapartum Considerations and Assessment 25

Antepartum Events 25

Fetal Heart Rate Monitoring 26

Neonatal Neurologic Outcome Following Acute Catastrophic Intrapartum Asphyxia: The Effect of Time from Diagnosis to Delivery 29

**Chapter 4: Fetal Considerations** 39
Neurologic Outcome in Multiple Pregnancy 39
Intrauterine Growth Restriction and Neonatal Encephalopathy 43
Meconium and Cerebral Palsy 46
The Relative Impact of Postterm Birth Versus Postmaturity on Subsequent Neonatal Encephalopathy and Cerebral Palsy 47

**Chapter 5: Neonatal Assessment** 53
Evaluation of the Term or Near-Term Infant with Encephalopathy 53
Apgar Score 54
The Role of Neuroimaging in Defining the Timing and Severity of Neonatal Encephalopathy and Cerebral Palsy 55
Neonatal Electroencephalography 57
Placental Pathology Related to Neonatal Encephalopathy and Cerebral Palsy 58
Nucleated Red Blood Cells and Lymphocyte Counts and Neurologic Impairment 59
Focal Ischemic Stroke as a Mechanism of Cerebral Injury in the Perinatal Period 59

**Chapter 6: Genetic, Anatomic, and Metabolic Etiologies of Neonatal Encephalopathy** 63
Neonatal Hypoglycemia 64
Hyperammonemia 64
Organic Acid Abnormalities 65
Degenerative Diseases 65
Lower Motor Neurons 65
Primary Anatomic Abnormalities 66
Chromosome Abnormalities 66
Altered Susceptibility to External Forces 67

**Chapter 7: Obstetric Pharmacologic Approaches to the Prevention of Neonatal Hypoxic–Ischemic Encephalopathy: Current Status and Future Directions** 71
Current Status 71
Future Directions 71

**Chapter 8: Criteria Required to Define an Acute Intrapartum Hypoxic Event as Sufficient to Cause Cerebral Palsy** 73

**Research Recommendations** 81

**Glossary** 83

**Index** 87

**COMMENTS RE: REPORT OF WILLIAM H. REED, Ph.D.**
**In Re: Mikayla Rhoades**

1. The method used by Dr. Reed to project infant plaintiff's earnings in this case is not accepted by the community of labor economists, which is the community of economists that focuses its research on the earnings of individuals. Rather, his method is used only by what has become known as the "forensic economics" community. The forensic economics literature that supports plaintiff's expert's method was created solely for personal injury litigation, almost exclusively on behalf of plaintiffs, and is not used outside of a courtroom. Dr. Reed's method directly contradicts the method taught in the classroom, its underlying theories and most importantly, reality as demonstrated by the empirical data.

2. In the field of labor economics, the accepted method for projecting an individual's future earnings is the human capital earnings function (also referred to as the age-earnings profile, the experience-earnings profile, the earnings equation and the Mincer equation). The human capital earnings function is the method used by academic economists, research institutions and governments throughout the world.

3. The human capital earnings function is based upon extensive research that explains the decades-old observation that an individual's earnings generally rise at a declining rate as he or she ages and gains experience. Today, it is generally accepted that many factors determine the annual rate of increase in the earnings of an individual, including age, experience, education, occupation and job tenure. The "age-earnings profile" or "human-capital earnings function" is the method economists use to reflect these accepted empirical facts. It describes the relationship between age and/or experience, education, occupation and earnings. *Wage Determinants: A Survey and Reinterpretation of Human Capital Earnings Functions*, Handbook of Labor Economics, Volume I, Edited by O. Ashenfelter and R. Layard, Elsevier Science Publishers BV, 1986.

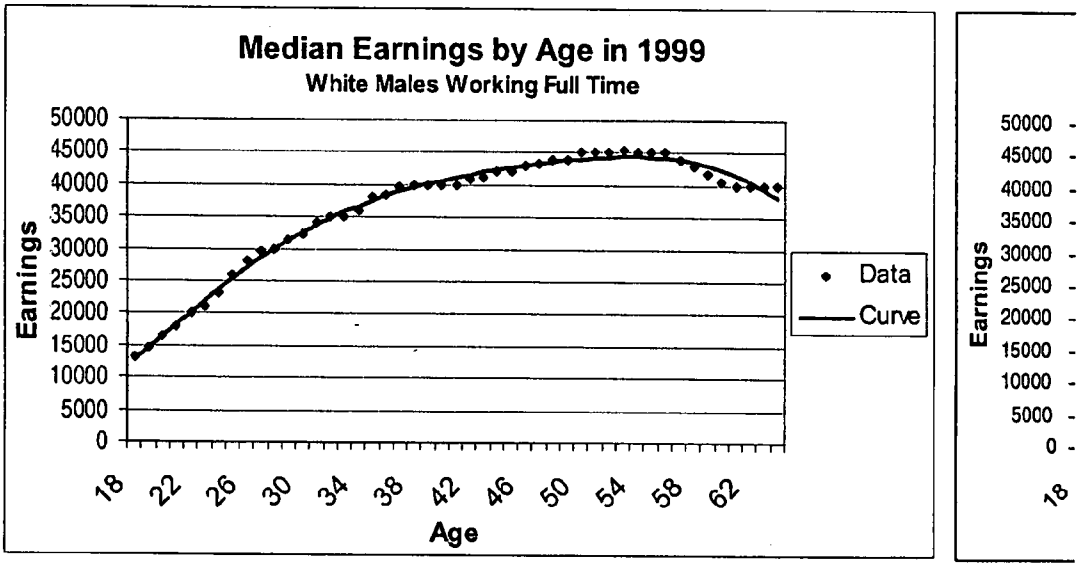
4. Over the past fifty years, the human capital earnings function has become the standard for economic analysis of the earnings regarding an individual. The Bureau of the Census, the Bureau of Labor Statistics, the Department of Education and the Federal Reserve Board are but a few of the governmental organizations that have interest in, and publish research regarding, the earnings of individuals. Research pertaining to lifetime earnings published by these groups universally demonstrates the accuracy of the human capital earnings function across data sets in all countries in the world. (See *The Economics of Earnings*, S.W. Polachek, W.S. Siebert, Cha. 2, p. 16, Cambridge University Press, 1993 (Exhibit 1); *Economic Inequality and Income Distribution*, DG Champernowne and FA Cowell, p.143 -149, Cambridge University Press, 1998 (Exhibit 2).

5. It must be emphasized that the human capital earnings function is not a theory. It is an empirical observation drawn from reams of data over many years. In this case, the "theory" came into being as the data were being collected and analyzed. The economic

explanation for the observed data is very simple. An individual begins his or her working life after obtaining formal education but with little or no experience. In the early years of an individual's working life, the individual makes huge gains in experience, knowledge and efficacy. However, the more experience and knowledge gained, the less there is to gain. In other words, there are declining returns to gaining experience and knowledge. At the same time, the value of the formal education wanes, as the individual moves further and further away from his or her school days. As a result, the steep part of the income curve comes early in one's working life, and the curve flattens out and even declines in later years.

6. The term "human capital earnings function" may sound odd to a lay person. However, the function simply estimates the amount of money an individual earns in a given year based upon his or her age and/or acquired experience.

7 This can be demonstrated graphically as follows:




The data points in the graph show the median earnings in 1999 of white males in the United States who worked full time. The general shape of the curve is determined by human capital theory and one can see that it fits these data almost perfectly. Going forward through time, the earnings curve would be adjusted to include the effects of inflation and productivity. While Reed's approach, that of increasing earnings by 4.76 percent per year, is analogous to the impact of inflation and productivity on a large cohort, it ignores the reality of the effects of age or experience on the earnings of an individual, the effects of which are clearly demonstrated by the graph.

8 Dr. Reed assumes that the earnings of workers at each level of experience will rise at 4.76 percent. In that case, person A, in an entry-level position this year, receives a raise of 4.76 percent as he or she moves next year to a position with one year of experience. That is, next year, 2007, person A will earn 4.76 percent more than the entry-level position pays today, in

2006. However, Dr. Reed also increases the wage for that entry-level position by that same 4.76 percent, because he ignores the effect of experience. Consequently, the entry-level person who starts in 2007, call him or her person B, will also receive 4.76 percent more than the entry-level position pays in 2006. Because in 2007 both person A and person B will be paid 4.76 percent more than the entry-level position pays in 2006, they will both earn the same amount in 2007, even though one is new, and the other has a year of experience. The next year, the same effect would occur again, with persons A and B each receiving 4.76 percent raises, earning the same amount as a new hire, person C, who takes the entry-level position in 2008, which also increased by 4.76 percent. By extension of the example, it is seen that the pay for all positions, regardless of experience, would necessarily be equal if Dr. Reed's model were accurate. This is inconsistent with reality, as shown in the above graph and, indeed, any individual can look around his or her workplace and see that it is not the case that everyone is paid the same regardless of experience. Not surprisingly, this is also inconsistent with economic thinking and accepted methodology. Experience matters, which is why people with more experience generally earn more than those with less experience.

9. According to data from the Bureau of Labor Statistics, average hourly earnings in the U.S. have not risen by as much as 4.76 percent since 1983. Since 1958, earnings rose by 4.76 percent or more in the years 1968 to 1982, a period in which inflation averaged 7.56 percent.

10 Dr. Reed assumes that the earnings of the infant-plaintiff would have increased at an average annual rate of 4.76 percent, taking this assumption from data regarding increases in the average earnings of all workers in America, well over 100 million people. Not only is this clearly not a method that economists recognize for determining the future earnings of an individual person, because of the effect of changing experience and the like, it is not even the method they would use to predict future growth in the wages for that 100 million people. Economic science focuses on the reasons for the data being what they are. There is nothing in economics that recognizes the blind application of a historical average to anything. Future earnings and prices are no exception. When analyzing the earnings of an individual, as opposed to the average earnings of all laborers, support for an assumption that an individual's earnings grow at a any constant rate, let alone some historical average (that is, independently of age and experience) cannot be found in mainstream economic journals or in the data. In short, the fallacy of Dr. Reed's analysis is that he ignores economic principles and applies simple arithmetic using historical data from the population as a whole, applying it to an individual in the future.

11 There are two journals that principally contain the methods of so-called forensic economics, *Journal of Forensic Economics* and *Journal of Legal Economics*. A few books, most written by non-economists, are devoted to calculating damages for the purpose of providing testimony in personal injury cases. They are not economic journals or textbooks in the usual sense of those terms.

12 The *Journal of Forensic Economics* and the *Journal of Legal Economics* do not\ embody generally accepted economic thought. For instance, no Nobel laureate in economic science has published in the *Journal of Forensic Economics* or the *Journal of Legal Economics*.

By comparison, five Nobel laureates have published in the *Journal of Labor Economics*, a journal that contains many articles referencing the human capital earnings function and which is the same age as the *Journal of Forensic Economics* and the *Journal of Legal Economics*.

13 Further evidence of the fact that neither the *Journal of Forensic Economics* nor the *Journal of Legal Economics* is a mainstream economics journal is seen within university librarysystems. For example, not one of the top twenty universities in the U.S. has the *Journal of Forensic Economics* or the *Journal of Legal Economics* in its research library. Rather, some universities have one or both journals in their Law libraries. They are not generally found in research libraries used by economists.

14 Moreover, neither the *Journal of Forensic Economics* nor the *Journal of Legal Economics* appears in the rankings of prestigious journals in economics. In fact, both were absentfrom a recent ranking of the top 42 journals (Pieters and Baumgartner, "Who Talks to Whom? Intra- and Interdisciplinary Communication of Economics Journals," *Journal of Economic Literature, 2002*). Furthermore, neither journal was mentioned in another ranking of the top 159 journals in economics (Kalaitzidakis, Mamuneas, Stengos, "Rankings of Academic Journals and Institutions in Economics", 2003).

15 On the other hand, the human capital earnings function is universally accepted within the economics literature. A research paper published by the Bureau of Labor Statistics (BLS) in 1996 indicated that "the increasing and concave age-earnings profile is one of the most commonly accepted facts in economics" (Mark Loewenstein and James Spletzer, "Belated Training: The Relationship Between Training, Tenure, and Wages", Bureau of Labor Statistics, 1996).

16 According to "Empirical Age-Earnings Profiles," *Journal of Labor Economics*, Finis Welch and Kevin Murphy, 1990:

> the human capital earnings function, in which earnings are expressed as a quadratic in potential experience, is probably the most widely accepted empirical specification in economics.... There is perhaps no convention in empirical economics as standard as the specification of age-earnings profiles. (Exhibit 3).

It should be noted that Kevin Murphy was the 1997 recipient of the American Economic Association's John Bates Clark medal, awarded once every two years to an economist under 40 years of age for outstanding work. Previous recipients include Milton Friedman, Paul Samuelson and many others who went on to win the Nobel Prize in economics.

17. The specification of the age-earnings profile is attributed to Jacob Mincer, Professor Emeritus at Columbia University, considered by many to be the "Father of Modern Labor Economics". In 1992, Sherwin Rosen, then of the University of Chicago, wrote in the *Journal of Economic Perspectives,* published by the American Economic Association:

> "The labor economics community has adopted it [Mincer's age-earnings profile] as its standard earnings function. It has become an almost universal reference....It is virtually a rite of passage for every young labor economist....It is seldom the case in economics that we see replication of the same ideas and, more importantly, the accumulation of empirical results bearing on a specific problem on this scale".

18. Moreover, when "earnings function" or "earnings equation" is "Googled", tens of thousands of results point to the "Mincer equation", the "age-earnings profile" or the "human capital earnings function". Essentially none refers to a constant increase in earnings for an individual, unless the word "forensic" is included.

19. Finally, there are hundreds of published papers in top economics journals that use the human capital earnings function, but not a single one that supports the contention that earnings rise at a constant rate from year to year. In fact, since 1911, when the American Economic Association began publishing the *American Economic Review*, there have been 1,254 articles published in the *American Economic Review* alone referencing 'Human Capital'. The *American Economic Review* is consistently rated the most prestigious economics journal in the world. The *Journal of Economic Literature*, also published by the American Economic Association, lists 3,375 articles referencing human capital. Conversely, no articles are listed that refer to a constant rate of increase in earnings for an individual.

20. In contrast, Reed references the book *Determining Economic Damages*, Gerald D. Martin and Ted Vavoulis, James Publishing Inc. Note that neither of the authors is an economist. Gerald Martin holds a doctorate in finance and statistics and taught finance at California State University, Fresno. Mr. Vavoulis holds a masters degree in operations research from the University of California, Berkeley. He claims to have taught economics and statistics at California State University, Fresno. Note also that, while this book is found is some law libraries, it is not found in research libraries where economists perform their research. In fact, according to WorldCat, the worldwide library catalogue service, the book is not found in any Arizona college or university libraries, law or research, is not at any library, law or research, at the University of California, Berkeley, and it is not found in any library, law or research, at the University of California, Davis. Martin received his Ph.D. at Arizona State University, Vavoulis received his masters at Berkeley, and they both say they taught at University of California, Davis. To say that this book is not generally accepted by economists as an authority regarding an individual's earnings, expenditures, fringe benefits or discounting seems obvious. Reed cites this book for his wage growth rate assumption and technique, his worklife assumption, his assumption regarding fringe benefits and his assumption regarding personal maintenance. In other words, every calculation in his report is based on a book not written by economists and one which, not surprisingly, is devoid of generally accepted economic principles. It is his only

citation for his methods or techniques.

21. The book *Determining Economic Damages* is actually a three-ringed binder. The only author currently listed on it is Gerald D. Martin, Ph.D. That this book is not a source of reliable information for economists is evidenced by the following statement in the introductory section.

> This guide will explore and explain what the economist can do for you and how you and the economist can work together to give the jury a complete and accurate picture of the monetary value of a case.

The book is written for lawyers, not for economists. "You should use an economist, not become one", is clearly not a statement aimed at economists. Such a treatise cannot qualify as a reliable source of information for economists.

22. The economics literature does support the argument that the level of earnings and education achieved by the parents are both highly correlated with the eventual educational attainment level of the children. The education of the mother appears to be somewhat more important than that of the father. Of course, since education and income are highly correlated, most studies have had difficulty distinguishing between the effects of the two. Other factors have also been found to impact eventual educational attainment of children. Based solely on the education and income of the parents, it is not unreasonable to assume Mikayla would have completed college.

23. Reed obviously uses a starting point for his projection of the earnings of a new college graduate in 2024, but does not specify what it is or his source. He identifies the Current Population Survey (CPS) as the source for $30,347 as the earnings of the "average female college graduate" in what he says "would have been her age cohort" in 2002. The CPS data are broken down by sex, education, race and full-time versus all who had earnings. His wording suggests that he used all races, part-time and full-time workers. Finally, note that the age cohort Reed cites is ages 18 through 24. He uses the earnings as if they are for age 23. Since most college graduates are likely age 23 or 24, and since those age 24 earn more than those age 23, as they would have one year more experience, using the average for the cohort necessarily overstates the starting earnings. Data for the individual ages are available, but it requires some effort. Also, note that the CPS is a relatively small sample size. As a result, it is common to see large disparities between the earnings reported for one year and those reported for another.

24. Reed also refers to the "Salary Survey" conducted by NACE. This survey is also a small sample. Its value is that it gives the starting salaries by college major. Clearly, this is irrelevant for an infant such as Makayla. Neither earnings figure cited by Reed is consistent with earnings of $76,175, Reed's figure for Mikayla's starting earnings in 2024.

25. As stated above, the use of a growth figure of 4.76 percent per year is totally unsupported by economic thinking, principles or literature. His discount rate of 5.54 percent is

undocumented, as he only cites Martin's book. If his earnings figure for 2024 is escalated by 4.76 percent for his 34-year worklife assumption, the result is his $6,177,403. however, it appears that he made an arithmetic error in discounting these earnings back to present value. His present value figure of $1,414,265 results from an assumption that Mikayla would have begun her new career at the earnings level of what he calculates is the average earnings of a female college graduate in 2024, but that she begins earning this in 2013, not in 2024. In other words, it appears that he made a mistake in his discounting. Discounting properly, with earnings beginning in 2024, the earnings he produces have an undiscounted total of $6,177,403, as he said in his report, but have a discounted or present value of only $781,525

26. Reed states that fringe benefits average 27.1 percent of wages, again citing Martin's book. He applies this to his inflated present value of earnings and arrives at $383,266 for lost fringe benefits. Of course, since his present value calculation is roughly double what he should have calculated, his fringe benefits calculation is similarly incorrect. However, the 27.1 percent figure is irrelevant. Even if Martin's book is correct, the percentage can only be the average cost to employers of providing fringe benefits to employees, with that cost expressed as a percentage of payroll. Fringe benefits include vacation pay, sick pay, holiday pay, health insurance and many other benefits that do not benefit either survivors or an estate. As such, they are completely irrelevant to the damages caused by the death of a single person without dependents. The only benefit of value in this case would be the expected contributions of Mikayla's eventual employer to a pension or savings fund.

27. Reed states that Mikayla would have spent most of her income on personal maintenance until she got married, adding that her expenditures, as a percentage of income, would further fall as she had children, and that they would rise as a percentage after the children left the home. On average, he says they would be 30 percent of her income. He again cites Martin's book. He is right to say that her personal maintenance expenditures would be a large portion of her income. According to the Consumer Expenditure Survey, an ongoing survey conducted by the Bureau of labor Statistics, a single female with the real income she likely would have had spends roughly 60 percent of her income on what in Pennsylvania is called personal maintenance. It would be pure speculation to assume when she would have married and, more importantly, what would her eventual husband's income have been. Reed refers to her eventual marriage but fails to mention, probably because he does not know, that consumption expenditure data are by household, and that the income reported is household income. Should Mikayla have married a man of significant income or wealth, her expenditures could be far in excess of her own earnings. Moreover, those personal maintenance expenditures would be expected to continue beyond retirement, even thought her income would have ceased. By taking expenditures as a simple percentage of earnings, personal maintenance after retirement is essentially assumed to be zero.

28. Finally, Reed appears to have mistyped his footnotes on the first page of his report. His third footnote, that should have been marked with "***", appears to have been combined with his second footnote. Also, on the next page, his footnote marked as footnote "1" does not

appear to be listed in the text, although it states that Martin's book says something about a 70% probability of being a college graduate.

29. In short, the assumption of a constant percentage increase in earnings is nothing more than an arithmetic calculation that has no basis in economic science or empirical data. This assumption is a creation of experts, usually testifying for the plaintiff, whose only application of that rule is in a courtroom. While scientists do not always agree on the theory used to explain phenomena or to make projections, the use of the human capital earnings function to project lifetime earnings for an individual is one instance where there is near unanimity within the relevant scientific community.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the ***DEFENDANT, MARY C. KRUSZEWSKI'S D.O.'S BRIEF IN SUPPORT OF MOTIONS***, in the above-referenced matter was served by first class regular mail, this 10th day of July, 2006 upon the following parties:

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By: _____
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Attorneys for Defendant
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7/24

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. and KIMBERLY RHOADES, individually and as personal representatives of the Estate of MIKAYLA RHOADES,

Plaintiffs,

Vs.

MARY C. KRUSZEWSKI, DO and DuBOIS REGIONAL MEDICAL CENTER,

Defendants.

CIVIL DIVISION

No. 03-1268 CD

Issue No.

**BRIEF IN SUPPORT OF MOTION IN LIMINE TO PRECLUDE PLAINTIFFS' EXPERT DR. MOLLICK FROM OFFERING ANY OPINION AS TO THE NURSING STANDARD OF CARE**

Code: 007

Filed on behalf of DuBois Regional Medical Center, one of the defendants.

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JUL 10 2006

COURT ADMINISTRATOR'S OFFICE

BRIEF IN SUPPORT OF MOTION IN LIMINE TO PRECLUDE PLAINTIFFS' EXPERT DR. MOLLICK FROM OFFERING ANY OPINION AS TO THE NURSING STANDARD OF CARE

NOW COMES DuBois Regional Medical Center, one of the defendants, by its attorneys, Thomson, Rhodes & Cowie, P.C., and submits this brief in support of its motion in limine to preclude the opinions of plaintiffs' expert, Dr. Mollick.

## I. ARGUMENT

A motion in limine is a procedural mechanism for obtaining a ruling on admissibility of evidence prior to or during trial, before the evidence has been offered. Delpolo v. Nemetz, 710 A.2d 92 (Pa. Super. 1998); Gurevitz v. Piczon, 42 Pa. D & C 4th 308 (Lackawanna County, 1999). The motion in limine affords counsel an opportunity to petition the trial court for an order, outside the presence of the jury, precluding opposing counsel from referring to and/or offering into evidence matters prejudicial to the moving party where a curative instruction cannot alleviate an adverse effect on the jury. Commonwealth v. Noll, 662 A.2d 1123 (Pa. Super. 1995). Generally, trial courts should only admit relevant evidence that tends to establish or impact upon issues of genuine import to the claims at trial. Birth Center v. St. Paul Companies, Inc., 727 A.2d 1144 (Pa. Super. 1999). Evidence is deemed to be relevant if it tends to make the facts at issue more or less probable or intelligible. Shiner v. Moriaty, 706 A.2d 1128 (Pa. Super. 1997). A motion in limine should be granted if it appears in advance of trial that the evidence being offered would be incompetent.

In a case such as this one, expert medical testimony is required to establish the standard of care required under the circumstances, and to establish a breach of the applicable standard of care. Toogood v. Rogal, 824 A.2d 1140 (Pa. 2003). In the instant case, the subject matter

pertaining to DuBois Regional Medical Center involves the standard of care of the various nurses involved in the treatment of mother-plaintiff and her child on May 10, 2002.

### A. Dr. Mollick is not Qualified/Competent to Offer an Opinion on the Nursing Standard of Care

To support the professional liability claims so asserted against DuBois Regional Medical Center (as the *respondeat superior* for its nurses), plaintiffs offer the testimony of James L. Mollick, M.D., whose report is attached as exhibit "A," to this defendant's motion in limine. At several places in his report, Dr. Mollick opines that the nursing staff breached the applicable nursing standard of care. However, Dr. Mollick is not himself a nurse. He is totally incompetent and unqualified to present to the jury an opinion regarding nursing standards of care and whether they were or were not met in this case.

In order to qualify as an expert in a given field, a witness must possess more training than is within the ordinary range of training, knowledge, intelligence or experience. Flanagan v. Labe, 690 A.2d 183 (Pa. 1997). "The test to be applied when qualifying an expert witness is whether the witness has any reasonable pretension to specialized knowledge on the subject matter under investigation." Whittington v. Episcopal Hosp., 768 A.2d 1144 (Pa. Super. 2001) (quoting Miller v. Brass Rail Tavern Inc., 664 A.2d 525 (Pa. 1995)). If a witness possess neither experience nor education in the subject matter under investigation, the witness should be found not to qualify as an expert. Dierholf v. Slade, 581 A.2d 649, 651 (Pa. Super. 1990).

In Yacoub v. Lehigh Valley Medical Associates, 805 A.2d 579 (Pa. Super. 2002), the Superior Court applied the above established principles to address an issue almost identical to the one presently before this court. There, the plaintiffs sought to have their expert, a neurosurgeon, testify as to the Special Care Unit nursing care received by the decedent. After examining the credentials of the expert, the trial court observed that he had no experience in Special Care Unit

care nursing and, thus, even under the liberal rules governing admittance of expert testimony, was not competent to offer an opinion as to the standard of care against the nurses. Yacoub, 805 A.2d at 591. On appeal, the Superior Court affirmed the trial court's decision to exclude the neurosurgeon from criticizing the nurses, and it noted as follows.

> "While we recognize that experts in one field of medicine may be found qualified to address other areas of specialization where the specialties overlap in practice or the specialist has had experience in a related field of medicine ... we find that the Appellant failed to lay a proper foundation to qualify Dr. Romy based overlap or experience in ... Special Care Unit nursing. Accordingly, the trial judge did not abuse his discretion in precluding Dr. Romy from opining as to the applicable standards of care in [this] field[s] of medicine."

Yacoub, at 592.

Notably, Yacoub is the last word from the Pennsylvania Appellate Courts concerning the competency of a medical physician to testify against nurses in a professional liability case.

Dr. Mollick's curriculum vitae is attached as exhibit "C" to this defendant's motion in limine. Based upon the information contained therein, it is readily apparent that Dr. Mollick has neither the "experience" nor the "education" in the field of nursing to qualify him as an expert witness on the appropriate nursing standard of care. Dr. Mollick's curriculum vitae is an instruction in inclusiveness - leaving no stone of professional achievement unturned or any "Who's Who" listed un-remarked upon. Yet, what it does not contain is of penultimate significance for the matter before this court. There is no indication that Dr. Mollick has one iota of experience, education or training in the field of nursing - a specialized field of medicine for which individuals are awarded specific degrees and must follow unique licensure requirements. From Dr. Mollick's curriculum vitae, it appears that he has not trained as a nurse, trained others to be nurses or presented or published on nursing skills or techniques. How then is Dr. Mollick

competent to offer an opinion as the nursing standard of care in this case? The answer, as clearly enunciated by Yacoub and the cases cited by it, is that he is not, and that his testimony should be properly excluded.

Thus, there is no basis for any testimony by Dr. Mollick to the effect that the nurses at DuBois Regional Medical Center deviated from the standard of care. And, it follows, therefore, that Dr. Mollick's opinion cannot be used to establish that the acts or omissions of nurses at the DuBois Regional Medical Center were a legal or proximate cause of the injuries or damages at issue in this case.

**B. The Testimony Expected to Be Elicited from Dr. Mollick Is Cumulative**

In addition to Dr. Mollick, plaintiffs have identified Diane S. Moore, Ph.D., R.N. as an expert who will testify on their behalf at trial. (Nurse Moore's report is attached as exhibit "B" to this defendant's motion in limine). Both Dr. Mollick and Nurse Moore offer opinions that are critical of the nursing staff, and use as their bases identical aspects of the care and treatment rendered by nursing staff which they deem fell below the nursing standard of care. As a result, the expert testimony of Dr. Mollick is cumulative, in that he offers the same opinions as to the standard of care as those offered by Nurse Moore, who is actually qualified to do so. Under Rule of Evidence 403, even relevant evidence may be excluded is its probative value is outweighed by the danger of unfair prejudice, confusion of the issues, or undue delay, waste of time or needless presentation of cumulative evidence. In this regard, as to the treatment rendered by the nursing staff, plaintiffs should be precluded from offering testimony at trial, live or otherwise, from Dr. Mollick in the interest of judicial economy.

### C. Dr. Mollick's Testimony Critical of the Nurses Causes Undue Prejudice to This Defendant

Even if relevant, Dr. Mollick's testimony against the nursing staff should be excluded as unduly prejudicial, particularly in light of its scant relevance, in that Dr. Mollick possess no training, education or professional experience in the filed of nursing. Rule of Evidence 403 lists six negative characteristics that may justify exclusion of otherwise admissible evidence, including unfair prejudice, misleading the jury and confusion of the issues - all of which are applicable to the above. The "prejudice" requisite to the exclusion of evidence does not merely mean "detrimental" to a party's case, but rather connotes "an undue tendency to suggest a decision on an improper basis" by causing the jury to base its decision on "something other than the legal proposition relevant to the case." Commonwealth v. Peer, 454 Pa. Super. 109, 684 A.2d 1077 (1996).

Herein, should Dr. Mollick be permitted to testify in a manner critical of the nurses, such testimony carries with it the inherent potential for prejudice, in that a jury will accord it undue weight out of all proportion with Dr. Mollick's qualifications to opine as an expert upon this topic. Simply put, there exists a public perception that physicians, by virtue of their status as medical doctors, are superior to nurses in education and achievement. Because of this, a jury may be influenced to give improper credence to the opinion of a physician on the issue of whether a nurse erred. As a corollary to this argument, given the prejudice that will necessarily ensue to this defendant, the plaintiffs will suffer no prejudice if Dr. Mollick's opinion as to the nurses is excluded, since they will be able to offer the identical opinion of Nurse Moore on the same issue.

For all the above reasons, Dr. Mollick should be precluded from offering expert medical testimony at trial relative to the standard of care required of the nurses under the circumstances;

or, that the nurses breached such standard of care. And, all parties and witnesses should be precluded from referring to any portion of Dr. Mollick's report which includes criticisms of DuBois Regional Medical Center or its nurses.

Respectfully Submitted,

THOMSON, RHODES & COWIE, P.C.

David R. Johnson, Esquire
Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of defendants

CERTIFICATION OF SERVICE

I hereby certify that a true and correct copy of the within document has been served upon the following counsel of record and same placed in the U.S. Mails on this 7th day of July, 2006:

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Brad R. Korinski, Esquire
Attorneys for DuBois Regional Medical Center, one of the defendants.

7/24
Judge
Reilly

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

**MEDICAL PROFESSIONAL LIABILITY ACTION**

CASE NO. 03-1268-CD

RECEIVED
JUN 19 2006
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TYPE OF PLEADING:
**PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION TO EXCLUDE SCIENTIFIC TESTIMONY PURSUANT TO PA. R.C.P. 207.1 & A REQUEST FOR HEARING PURSUANT TO RULE 207.1(a)(3) PRIOR TO TRIAL**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

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**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | **MEDICAL PROFESSIONAL LIABILITY ACTION** |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**PLAINTIFFS' MEMORANDUM IN SUPPORT OF THE MOTION TO EXCLUDE SCIENTIFIC TESTIMONY PURSUANT TO PA. R.C.P. 207.1 & A REQUEST FOR HEARING PURSUANT TO RULE 207.1(a)(3) PRIOR TO TRIAL.**

AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and set forth the following Memorandum in support of the foregoing Motion.

**BACKGROUND**

This matter is before the Court on the Motion of the Plaintiffs challenging the hypotheses and conclusions of the Defendant's experts regarding the methodology used by the Defendant's experts in reaching their ultimate conclusions.

To the extent that the hypotheses and conclusions reached by the Defendant's experts are reached without the benefit of any facts in the medical records which support those conclusions and hypotheses, Plaintiffs believe that this case involves novel medical "science" and based on the report of Dr. Mollick the Plaintiffs' expert, that the methodologies used by the Defendant's physicians in reaching their conclusions and hypotheses are not methodologies generally accepted in the medical

community.

**THE METHODOLOGIES AND TECHNIQUES EMPLOYED BY THE DEFENDANT'S EXPERTS.**

Both Dr. Depp and Dr. Fox contend in their reports that they reviewed various medical records as set forth in the Plaintiffs' Motion. Despite having reviewed the medical records, the reports appear to be based on no underlying facts as found in the medical records.

Dr. Mollick prepared the report, attached to the Plaintiffs' Motion as Exhibit 6, as a medical doctor, and as a specialist in obstetrics and gynecology. Dr. Mollick reviewed the American College of Obstetrics & Gynecology Code of Professional Ethics which addresses what a specialist in that field must do before offering expert testimony. Article V, §5 of the Code of Professional Ethics provides:

> "The obstetrician-gynecologist testifying as an expert witness must have the knowledge and experience about the range of the standard of care and available scientific evidence for the condition in question during the relevant time and **must respond accurately about questions about the range of the standard of care in the available scientific evidence**."

Article V, §6 provides:

> "Before offering testimony, the obstetrician-gynecologist **must thoroughly review the medical facts of the case and all relevant information.**"

As can be seen from the report of Dr. Depp, he did not review many of the records that were reviewed by Dr. Fox, and thus failed to review all of the medical facts and all available relevant information.

Likewise, both Dr. Depp, an obstetrician-gynecologist, and Dr. Fox, a pediatrician, substituted their opinions for that of the pathologist who performed the autopsy, in essence going outside of their specialty, and offering contrary opinions to that found in the autopsy.

Their opinions, which are not based upon medical facts of the case and all available relevant information constitute "novel science", and the methodologies employed in reaching those opinions are not generally accepted in the medical community.

**ARGUMENT**

On February 11, 2003 the Superior Court of Pennsylvania, en banc, decided the case of *Trach vs. Fellin*, 817 A.2d 1102 (Pa. Super. 2003).

The Court discussed the circumstances under which a party may seek to exclude expert scientific testimony and may test the admissibility of that evidence pursuant to *Frye* vs. *United States,* 293 F. 1013 (D.C. Cir. 1923).

The Superior Court in *Trach* discussed the two lines of thought regarding the application of *Frye*, represented by the Court's decisions in *Blum vs. Merrell Dow,* 705 A.2d 1314 (Pa. Super. 1997, aff'd. 564 Pa. 3, 764 A.2d 1 (2000), and the second standard identified by the Superior Court as the "Frye/Topa standard". *Trach*, 817 A.2d. 1110.

Reconciling what appeared to be some inconsistency between the two standards the Superior Court concluded that the focus of a Rule 207.1 hearing must be solely on principals and methodologies of a scientific expert, not on the conclusions that they generate. *Frye* only applies to determine if the relevant scientific community has generally accepted the principals of the methodologies the scientist employees, before the Court may allow the expert to testify. *Trach,* 817

A.2d at 1112.

Subsequent to the decisions of the Superior Court in *Trach* and *Blum*, the Supreme Court of Pennsylvania decided *Grady vs. Frito Lay*, 839 A.2d. 1038 (2003).

The Supreme Court of Pennsylvania determined that the *Frye* rule continues to provide the rule for decisions in Pennsylvania regarding the admissibility of expert scientific evidence.

The Supreme Court indicated the Rule 702 of the Pennsylvania Rules of Evidence controls the admissibility of expert testimony and scientific knowledge. The *Frye* test was adopted in Pennsylvania in *Commonwealth vs. Topa*, 471 Pa. 223, 369 A.2d 1277, and is part of Rule 702 of the Pennsylvania Rules of Evidence at this time. Under *Frye* novel scientific evidence is admissible only if the methodology that underlies the evidence has general acceptance in the relevant scientific community. *Commonwealth vs. Blasiola*, 552 Pa. 149, 713 A.2d 1117, 1179 (Pa. 1998).

In setting forth the bright line standards for Frye's proper application the Supreme Court indicated that the first standard, consistent with the Court's traditional adherence to the general evidentiary tenet that the proponent of a proposition bears the burden of proving it, is that the proponent of expert scientific evidence bears the burden of establishing all of the elements for admission of evidence under Pa.R.E. 702 which includes a showing that the Frye Rule is satisfied.

In the instant case, it is the Plaintiffs' contention that the novel scientific evidence being advocated by the Defendant is found in the opinions of two physicians who reached their hypothesis without any substantial basis in the medical records, and no references to medical literature which support their contentions. For example, the Defendant's experts contend, contrary to every piece of medical evidence in the hospital records, and contrary to the treatment of Dr. Kruszewski, and all of the Plaintiff decedent's treating physicians, that Mikayla Rhoades died from sepsis and/or

infection. These hypotheses are not only inconsistent with the medical records, but also inconsistent with the medical literature in the field, and thus constitute novel science.

As indicated by Dr. Mollick, on page 18 of his report, Dr. Depp ignored the facts and deposition testimony that indicated that Mrs. Rhoades did not have chorioamnionitis, and that the baby was diagnosed having hypoxia and asphyxia and died not from sepsis, but from hypoxic ischemic encephalopathy as a result of birth asphyxia.

Dr. Mollick cited eleven factors ignored by Dr. Depp, i.e. the methodology used by Dr. Depp to reach his conclusions, those factors being: (1) the patient's Group B strep culture was negative, (2) Mrs. Rhoades was never febrile, (3) Mrs. Rhoades' temperature during and at delivery was normal, (4) Mrs. Rhoades did not have or complain of a file smelling discharge or amniotic fluid, (5) Mrs. Rhoades did not have uterine tenderness, (6) Mrs. Rhoades' white blood cell count was normal, (7) the placental pathology report showed no evidence of chorioamnionitis, (8) the patient was never diagnosed by any health care provider before, during and after delivery with corioamneonitus or infection, (9) the patient never received antibiotic treatment from Dr. Kruszewski or any other treating physician, (10) there was no evidence of sustained fetal tachycardia on the fetal tracings, (11) the epidural that was not providing adequate analgesia and that the patient's pulse rate fluctuations continued after delivery.

Dr. Depp ignored the hospital notes and records, the autopsy, the deposition testimony of the DuBois Regional Medical Center's neonatologist, and the pathologists who indicated that Mikayla died from hypoxia and perinatal asphyxia.

Thus, the methodology employed by Dr. Depp failed to review the medical facts of the case and relevant information, and failed to respond accurately to questions about the available scientific

evidence, contrary to the American College of Obstetrics & Gynecology Code of Professional Ethics.

The Supreme Court indicated that the second step that the Court must take in applying the Frye Rule was to require the proponent of the evidence to prove that the methodology of its experts is generally accepted by scientists in the relevant field as a method for arriving at the conclusion the expert will testify to at trial. The Plaintiffs contend that there is no school of medicine which allows physicians to reach conclusions and/or diagnoses, without being based on facts. The Plaintiffs contend that there is no methodology approved by the medical community which allows physicians to reach conclusions contrary to all of the medical information regarding the patient which was available to them at the time the opinions were reached.

Although the Superior Court ruled in *Folger vs. Dugan*, 876 A.2d 1049 (Pa. Super. 2005) that generally the methodology of an expert testifying to a patient's medical record which was used by the patient's doctors to treat the patient was not subject to challenge, the Court also ruled that the facts underlying an expert opinion must be of record, and expert opinion testimony is proper only if the facts upon which it is based are of record. Citing *Commonwealth vs. Rounds*, 518 Pa. 204, 542 A.2d 997 (Pa. 1988). Thus, although the opinions of medical experts based on facts are generally not considered to be novel science, the methodology used by the defense experts, reviewing the medical records and ignoring the facts set forth therein is not a methodology generally accepted in the medical community, nor is it a methodology approved by the standards of ethics for testifying physicians by the American College of Obstetrics & Gynecology.

Thus, Dr. Kruszewski as the proponent of the methodologies of Dr. Depp and Dr. Fox must show that the methodologies which they used to reach their conclusions were generally acceptable in the medical field, in order to comply with *Frye*.

The Supreme Court discussed the third criteria under Pa.R.E. 702 which must be considered as part of the Frye requirement. This third criteria is whether the scientific testimony is given by witness who is qualified as an expert by knowledge, skill, experience, training or education. Nevertheless the Court held that "whether a witness is qualified to render opinions and whether his testimony passes the Frye test are two distinct inquiries and therefore must be raised and developed separately by the parties and ruled upon separately by the trial courts". The Court is not being asked in this Motion to rule upon the qualifications of Defendant's experts.

Finally, the Supreme Court set the standard for the Court's discretion in ruling on evidentiary matters, and indicated that an abuse of discretion would be found only where there is "manifest unreasonableness, or partiality, prejudice, bias, or ill will, or such lack of support so as to be clearly erroneous".

Considering these factors for the Court's exercise of its own discretion, a ruling by this Court that the methodologies used by Drs. Depp and Fox were so flawed that they could not result in admissible evidence would not be an abuse of discretion.

The trial court's analysis in *Grady vs. Frito Lay* might well be applied to this case. The Supreme Court reviewed the analysis in the Memorandum Opinion authored by the trial court, finding that the plaintiff's expert in *Grady* did not use a methodology based on scientific data that was generally accepted in the community of scientists in that particular field, and rather that the methodology was akin to "junk science" and did not meet the test of Frye.

A similar finding could be made with respect to the reports of Dr. Depp and Dr. Fox.

Dr. Depp reviewed considerably more information than Dr. Fox, and cited as the only relevant literature which he reviewed in this matter an article on fetal heart rate monitoring, in the

American Journal of Obstetrics & Gynecology, and an article on fetal heart rate monitoring in the Journal of Gynecologic Nursing, on page 2 of his report.

Neither of these articles deals with sepsis, chorioamnionitis, or infection, and it appears that Dr. Depp's opinion is largely based on the result of a cord gas test which he identifies in a table at the bottom of page 5 of his report as being "arterial" cord gas. As indicated in Dr. Mollick's report, a review of all of the available information which Dr. Depp could have reviewed, and some of which he did review, shows that neither the technician who drew the cord gas sample, nor the neonatologist who attend Mikayla at the DuBois Regional Medical Center were able to determine whether the cord gas was taken from a vein or from an artery.

Thus, where the methodology underlying the opinion of Dr. Depp relies entirely on a fact not supported by the record, it is contradictory to the standards of the American College of Obstetrics & Gynecology, and not generally accepted in the medical community.

Although Dr. Fox is a pediatrician, and not an obstetrician, the same ethical standards for testifying as a physician and providing medical opinions would apply to Dr. Fox. That is, he would be required to review all of the medical facts of the case and all available relevant information, and to respond accurately to questions about the range of the standard of care and all available scientific evidence.

Initially, Dr. Fox failed to review all of the information available to him, but rather only reviewed four sets of records as listed on page 1 of his report.

In fact Dr. Fox goes to great lengths to point out in his report that his theories are not supported by the medical records, despite the fact that he reaches certain conclusions. For instance, Dr. Fox concedes that the neonatal blood cultures were negative. He concedes that the placental

slides do not show chorioamnionitis. (Fox Report, ¶¶2 & 3).

Dr. Fox did not consider any of the other available medical information, such as the deposition of the neonatologist who treated Mikayla at DuBois Regional Medical Center.

Additionally, although Dr. Fox is a professor of pediatrics, he reaches a conclusion totally inconsistent with the pathologist who performed the autopsy. Dr. Fox is not a pathologist, and does not explain anywhere in his report why his opinion is directly opposite that of the pathologist.

It is novel science for a physician who specializes in pediatrics to contradict the findings of the pathologist without any reason to do so, particularly when pathology is not part of his speciality. As indicated by Dr. Mollick, on page 19 of his report, Dr. Fox ignored the facts of this case including an autopsy report that confirmed that Mikalya died of hypoxic ischemic encephalopathy. According to the final autopsy report the final autopsy diagnoses were (1) acute ischemic encephalopathy, severe, and the microscopic neuro-pathology revealed severe acute ischemic damage in neurons in nearly all areas of the brain ... the most significant finding at the autopsy was "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor".

Dr. Fox, as did Dr. Depp, simply ignored the findings of the pathologist.

The rules for a testifying expert found in the Code of Ethics of the American College of Obstetrics & Gynecology are not inconsistent with Pennsylvania law. An expert witness is not permitted to guess or offer an opinion based on mere conjecture, no matter how skilled the witness may be. *Collins vs. Hand*, 431 Pa. 378, 390; 246 A.2d 398, 404 (1968). Although an expert opinion need not be based on absolute certainty, an opinion based on mere possibility is not competent evidence. *Niggel vs. Sears Roebuck & Co.,* 219 Pa. Super. 353; 281 A.2d 718.

The Defendant's experts simply made up the facts to support their hypotheses.

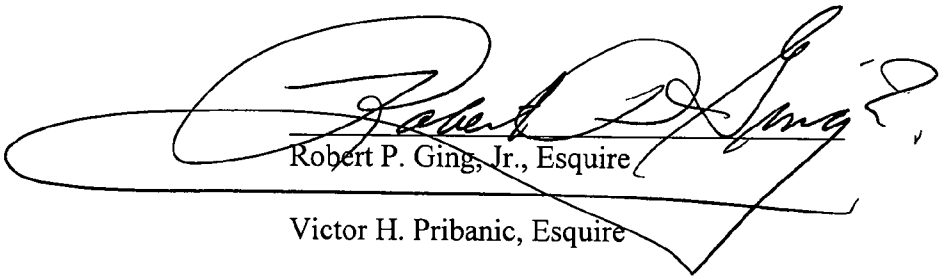
The Pennsylvania Superior Court has also ruled that for expert testimony to be deemed admissible, Frye requires proof that the relevant scientific community generally accepts the methods and principles used by the expert in reaching that conclusion. *Carroll vs. Avallone*, 869 A.2d 522, (Pa. Super. 2005).

In this case, Dr. Mollick has reviewed the reports of Dr. Depp, and Dr. Fox, and opined that the methods used to reach the hypotheses set forth therein would not be generally acceptable in the medical community.

Since the Supreme Court ruled in *Grady vs. Frito Lay* that the proponent of expert scientific evidence bears the burden of establishing all of the elements for admission which includes a showing that the Frye Rule has been satisfied, and since the methodology of the Defendant's experts have been challenged, the burden is on the Defendant to show that the methodology used by her experts is generally acceptable in the medical community.

WHEREFORE, the Court is respectfully requested to conduct an evidentiary hearing requiring the Defendant to demonstrate that the methodology of her experts in reaching the hypotheses set forth in their reports is generally accepted by the medical community.

Respectfully submitted,



Robert P. Ging, Jr., Esquire

Victor H. Pribanic, Esquire

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Brief in Support of the Motion to Exclude Expert Testimony was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail

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Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: June 16, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

3, 8, 11, 12, 14, 15

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. and KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | * | |
| vs. | * | NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, Defendants | * | |

**ORDER**

NOW, this 9th day of January, 2006, following argument of counsel, and, with the Court having received correspondence from each of the party's counsel setting forth a proposed schedule, it is the ORDER of this Court as follows:

1. By no later than March 15, 2006 the Defendants shall have provided all expert reports and discovery in the case shall be completed.

2. The case will be on the civil trial list for call on April 4, 2006.

3. The civil pre-trial conference will be held as per the Court's schedule on April 19, 20, or 21, 2006, as will be determined at civil call.

4. The jury selection will be on April 27, 2006.

5. Jury trial is hereby scheduled for eight (8) days being August 7th through 11th and August 14th, 15th and 16th, 2006, Courtroom No. 1, Clearfield County Courthouse, Clearfield, Pennsylvania.

6. Any mediation of the case shall be conducted at least thirty (30) days prior to the trial date.

7. Any party filing any motion or petition regarding limitation or exclusion of evidence or testimony to be presented at trial, including but not limited to motions in limine, shall be filed no more than thirty (30) days prior to the trial date.

1-5 6-17 18-22

8. The party's petition or motion shall be accompanied by an appropriate brief. The responding party thereto shall file an answer and submit an appropriate response no later than fifteen (15) days prior to trial.

9. All depositions which are to be used for trial purposes shall be completed no later than forty (40) days prior to the commencement of trial or the same will not be available for use at trial. A copy of the transcript of any such deposition shall be provided to opposing counsel within no more than ten (10) days following completion of the deposition.

10. Any party making objections relative to testimony provided by a witness in the form of a deposition at the time of trial shall submit the objections to the Court, in writing, no later than thirty (30) days prior to commencement of trial. All objections shall reference specific page and line numbers within the deposition in question along with party's brief relative to same. The opposing party shall submit a brief in opposition to the objections no later than fifteen (15) days prior to the commencement of trial.

11. At the time of jury selection, the Plaintiffs shall have four pre-emptory challenges, Dr. Kruszewski shall have two pre-emptory challenges and DRMC shall have two pre-emptory challenges.

12. Plaintiff's Motion to Preclude Filing of Additional Expert Reports to Preclude Expert Testimony of Dr. Mary Kruszewski is withdrawn.

BY THE COURT,

FREDRIC J. AMMERMAN
President Judge

2, 3, 4, 6, 8, 10, 11

13

3, 14, 20.

20, 22.

16.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03–1268–CD

TYPE OF PLEADING:
**PLAINTIFFS' PRETRIAL STATEMENT**

John Blasko
David Johnson

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

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**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03–1268–CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**PLAINTIFFS' PRE-TRIAL STATEMENT**

AND NOW come the Plaintiffs by their attorneys, Robert P. Ging, Jr. and Victor H. Pribanic and set forth the following Plaintiffs' Pre-Trial Statement pursuant to LRCP 212.

## I – NARRATIVE STATEMENT OF FACTS THAT WILL BE OFFERED BY ORAL AND DOCUMENTARY EVIDENCE AT TRIAL.

The Plaintiffs Dennis R. and Kimberly D. Rhoades were the parents and natural guardians of Mikayla Rhoades, and are the appointed personal representatives of the Estate of Mikayla Rhoades.

Dr. Mary C. Kruszewski is an osteopathic physician believed to be duly licensed and practicing as a specialist in obstetrics and gynecology, at the DuBois Regional Medical Center.

The DuBois Regional Medical Center is a Pennsylvania corporation having an address of 100 Hospital Avenue, DuBois, Pennsylvania, and at all times relevant hereto provided facilities,

staff and privileges to Dr. Kruszewski. The Plaintiffs Dennis and Kimberly Rhoades sought the professional medical assistance of Dr. Kruszewski on or about June 22, 2001. A patient/physician relationship was established, and Mrs. Rhoades subsequently became pregnant. Dr. Kruszewski agreed to perform gynecological and obstetric services including but not limited to monitoring and supervising Mrs. Rhoades' pregnancy and delivering her child at the DuBois Regional Medical Center. On or about April 18, 2002 Kimberly Rhoades commenced a course of weekly visits to Dr. Kruszewski for the monitoring and supervision of her pregnancy. During that time Kimberly Rhoades expressed concerns about the size of the baby to Dr. Kruszewski on several occasions.

On May 9, 2002 Dr. Kruszewski directed Mrs. Rhoades to present herself at the DuBois Regional Medical Center on May 10, 2002 for the purpose of inducing labor. Mrs. Rhoades presented herself at the DuBois Regional Medical Center on May 10, 2002 at 7:00 a.m. There was no determination made of the condition of the mother or child before drugs were administered to induce labor, nor was there a determination made as to whether or not labor had commenced. Induction of labor by administration of Pitocin at the DuBois Regional Medical Center commenced at 12:40 p.m. Mrs. Rhoades' labor progressed very slowly.

During the labor, monitors being used by nurses employed by and under the supervision and control of the DuBois Regional Medical Center and Dr. Kruszewski demonstrated fetal distress and fetal bradycardia as early as 3:37 p.m. Neither the hospital employees nor Dr. Kruszewski took any precautions to assure the health of the infant upon the occurrence of the fetal distress and bradycardia. As the induction of labor continued severe and progressive variable decelerations, signs of fetal distress were revealed by the monitors and noted by a hospital nurse employed by the DuBois Regional Medical Center.

As labor continued the decelerations continued and became progressively more severe. The decelerations were noted by an attending nurse, however the infant was not delivered by cesarean section despite the obvious distress.

The infant was ultimately born at 11:52 p.m. by vaginal delivery with vacuum assistance and the performance of an epesiotomy by Dr. Kruszewski. The vacuum assistance consisted of four (4) pulls and two (2) pop offs during the attempt to deliver. The vacuum extraction device was not available in the delivery room at the time of the delivery.

The infant Mikayla was born at 11:52 p.m. having been repetitively and progressively asphyxiated by Dr. Kruszewski and the nursing staff, resulting in profound central nervous system destruction and eventually the death of the baby. Thereafter she suffered seizures, temporal bleeding, swelling and other affects of the asphyxiation. Subsequent to the complications surrounding her delivery the infant was transferred to Children's Hospital in Pittsburgh on May 11, 2002. During the four days of her life, as a result of the asphyxia, the infant Mikayla suffered seizures, temporal bleeding, swelling and other effects of asphyxia all of which are described in the records of Children's Hospital of Pittsburgh.

The infant Mikayla was treated at Children's Hospital of Pittsburgh from May 11, 2002 until May 14, 2002. On May 14, 2002 after discussions with neonatologists, neurologists, and social workers at Children's Hospital of Pittsburgh, life support was withdrawn from Mikayla due to her condition and poor prognosis for a meaningful recovery.

The Plaintiffs have made a claim that as direct and proximate cause of the negligence of Dr. Kruszewski and employees of the DuBois Regional Medical Center, individually and on behalf of the Estate of Mikalya Rhoades, Mikayla died. The claim includes a claim for pain and suffering

for Mikayla between the time she came under the care of Dr. Kruszewski and the time of her death. There is a claim for economic loss including the infant's potential future earning power and other income, and a claim for pain, suffering and inconvenience to the extent recoverable under the law. There is a claim for negligent infliction of emotional distress, and a claim for potential losses suffered by the decedent's survivor by reason of her death and for reimbursement of medical bills, funeral expenses and other expenses incurred.

Plaintiffs will offer oral testimony on their own behalf, and may also offer the testimony of friends and family members who attended the Plaintiffs during the labor and birth of the infant, and the tragic days leading up to her death. These witnesses have all been deposed and are identified elsewhere in this Pre-Trial Statement.

Plaintiffs may also present the testimony of Dr. James Mollick, Dr. Frederick A. Gonzales, and Dr. Diane S. Moore, Ph.D., as expert witnesses. In addition, the Plaintiffs may present the testimony of Dr. Mary C. Kruszewski, the Defendant, Dr. Richard Grout, a neonatologist at DuBois Regional Medical Center, and the attending nurses and respiratory therapist who participated in the labor and delivery of Mrs. Rhoades at the DuBois Regional Medical Center, all of whom are identified elsewhere in this Pre-Trial Narrative.

Additionally, the Plaintiffs may present the testimony of Carol Gilmore, M.D., a neonatologist who attended Mikayla at Children's Hospital of Pittsburgh, Dr. Ronald L. Hamilton, a pathologist at Children's Hospital of Pittsburgh, and Dr. Sarangarajan Ranganathan, a pathologist at Children's Hospital of Pittsburgh.

The Plaintiffs may also present documentary evidence including the records of the DuBois Regional Medical Center, the records of Dr. Mary Kruszewski, and the records of Children's

Hospital of Pittsburgh. They may also admit policy and procedures provided by DuBois Regional Medical Center, and guidelines promulgated by the American College of Obstetrics and Gynecology.

Plaintiffs will also present the testimony of Dr. William Houston Reed, Ph.D., to testify with respect to economic losses. Plaintiffs do not anticipate that there are any unusual questions of evidence anticipated with respect to the proof of the foregoing facts.

## II – STATEMENT OF ANY UNUSUAL QUESTIONS OF LAW ANTICIPATED WITH RESPECT TO ISSUES IN THIS CASE.

Plaintiffs do not currently have any unusual questions of law anticipated with respect to the presentation of their evidence. Plaintiffs are reviewing the recently filed reports of Dr. Kruszewski's expert witnesses to determine whether or not the methodology used to reach the expert opinions is generally accepted in the medical community. Plaintiffs will object to the admission of panels and slides illustrating medical issues and damages, and charts, diagrams and anatomical drawings that have not been fully identified and have not been provided in discovery. Plaintiffs will object to the testimony of any physician not competent to testify pursuant to 40 Pa.C.S. 1303.512.

## III – LIST OF NAMES AND ADDRESSES OF ALL PERSONS WHO MAY BE CALLED AS WITNESSES.

1. Dennis R. Rhoades – liability & damages
   309 Belgiumtown Road
   Brookville, PA 15825

2. Kimberly Rhoades – liability & damages
   309 Belgiumtown Road
   Brookville, PA 15825

3. Dr. James Mollick – liability & damages
   2114 Countryview Lane
   Lansdale, PA 19446

4. Dr. Frederick A. Gonzales – liability & damages
   88 North Mountain Drive
   Dobbs Ferry, NY 10522

5. Dr. Dianne S. Moore – liability & damages
   20322 Carlsbad Lane
   Huntington Beach, CA 92646

6. Dr. William Houston Reed – damages
   P.O. Box 15145
   Pittsburgh, PA 15237

7. Dr. Bart Matson – damages
   Suite 203
   1008 S. 5th Avenue
   Clarion, PA 16214

8. Dr. Richard Grout – liability & damages
   c/o DuBois Regional Medical Center
   100 Hospital Avenue
   DuBois, Pennsylvania 15801

9. Dr. Carol Gilmore, MD – liability & damages
   Department of Neonatology
   Allegheny General Hospital
   6th Floor, South Tower
   320 E. North Avenue
   Pittsburgh, PA 15212

10. Dr. Sarangarajan Ranganathan – liability & damages
    3705 5th Avenue
    Pittsburgh, PA 15213

11. Dr. Ronald L. Hamilton – liability & damages
    3705 5th Avenue
    Pittsburgh, PA 15213

12. Dr. Brian Yuskevich
    c/o DuBois Regional Medical Center
    100 Hospital Avenue
    DuBois, Pennsylvania 15801

13. Gloria Bennett – liability & damages
    c/o DuBois Regional Medical Center
    100 Hospital Avenue
    DuBois, Pennsylvania 15801

14. Desiree Smith – liability & damages
    c/o DuBois Regional Medical Center
    100 Hospital Avenue
    DuBois, Pennsylvania 15801

15. Shawn Welsh – liability & damages
    c/o DuBois Regional Medical Center
    100 Hospital Avenue
    DuBois, Pennsylvania 15801

16. Karen Consentino – liability & damages
    c/o DuBois Regional Medical Center
    100 Hospital Avenue
    DuBois, Pennsylvania 15801

17. Suzanne McCullough, RN – liability & damages
c/o DuBois Regional Medical Center
100 Hospital Avenue
DuBois, Pennsylvania 15801

18. Sherry Kizina, RN – liability & damages
c/o DuBois Regional Medical Center
100 Hospital Avenue
DuBois, Pennsylvania 15801

19. Tina Newell, RN – liability & damages
c/o DuBois Regional Medical Center
100 Hospital Avenue
DuBois, Pennsylvania 15801

20. Tammy Shaffer – liability & damages
181 Aber Road
Punxsutawney, PA

21. Georgi Fitzgerald – liability & damages
Fitzgerald Road
Brookville, PA 15825

22. Shirley Painter – liability & damages
1707 Route 36
Brookville, PA 15825

23. Angela Snyder – liability & damages
210 Fitzgerald Avenue
Brookville, PA 15825

24. Priscilla Stahlman – liability & damages
c/o Dr. Mary Kruszewski
190 West Park Avenue
DuBois, PA 15801

25. Diane Assalone – liability & damages
c/o Dr. Mary Kruszewski
190 West Park Avenue
DuBois, PA 15801

26. Sheila Olsoky – liability & damages
c/o Dr. Mary Kruszewski
190 West Park Avenue
DuBois, PA 15801

27. Thea Richardson – liability & damages
c/o Dr. Mary Kruszewski
190 West Park Avenue
DuBois, PA 15801

28. The Minister Reverend Henry Scoff
158B Waterford Pike
Brookville, PA 15825

29. Any witness identified in the Pre-Trial Statements of the Defendants.

30. Plaintiffs specifically reserve the right to call rebuttal witnesses, pursuant to LRCP 212.4(f).

## IV – MEDICAL REPORTS OF TREATING, EXAMINING OR CONSULTING PHYSICIANS.

1. Discharge summary – Dr. Kruszewski

2. Final autopsy report – Children's Hospital of Pittsburgh

3. Discharge summary and report of Dr. Carol Gilmore.

4. Medical records obtained from the DuBois Regional Medical Center, Dr. Mary Kruszewski, and Children's Hospital of Pittsburgh, all of which have previously been provided to all parties to the litigation.

## V – REPORTS OF EXPERTS WHOSE OPINIONS WILL BE OFFERED IN EVIDENCE AT THE TIME OF TRIAL.

1. Dr. Frederick A. Gonzales – Report attached.

2. Dr. Dianne S. Moore (Ph.D.) – Report attached.

3. Dr. James Mollick – Report attached.

4. Dr. Carol Gilmore – Discharge summary attached.

5. Dr. Sarangarajan Ranganathan – Final autopsy report attached.

6. Dr. Ronald L. Hamilton – Final autopsy report attached.

7. Dr. William Houston Reed – Report attached.

8. The Plaintiffs reserve the right to call rebuttal witnesses, pursuant to LRCP 212.4(f).

9. Plaintiffs reserve the right to supplement the list of expert witnesses.

## VI – LIST OF SPECIAL DAMAGES

Damages set forth in the report of Dr. Reed.

Cost of headstone, $1,644.00.

Funeral Expenses, $1,033.30.

Burial Plot, $ 200.00.

**VII – LIST OF EXHIBITS WHICH PLAINTIFFS MAY USE AT TRIAL.**

Plaintiffs may use any of the documents, bills, and statements identified previously herein. Plaintiffs will also use photographs, copies of which are attached, Technical Bulletins Promulgated by the American College of Gynecology, and Policies & Procedures for the DuBois Regional Medical Center. Plaintiffs will also use the medical records as exhibits.

**VIII – PHOTOGRAPHS WHICH THEY WILL SEEK TO INTRODUCE AT THE TIME OF TRIAL.**

Attached

**IX** – Plaintiffs anticipate that the trial will take at least eight (8) days.

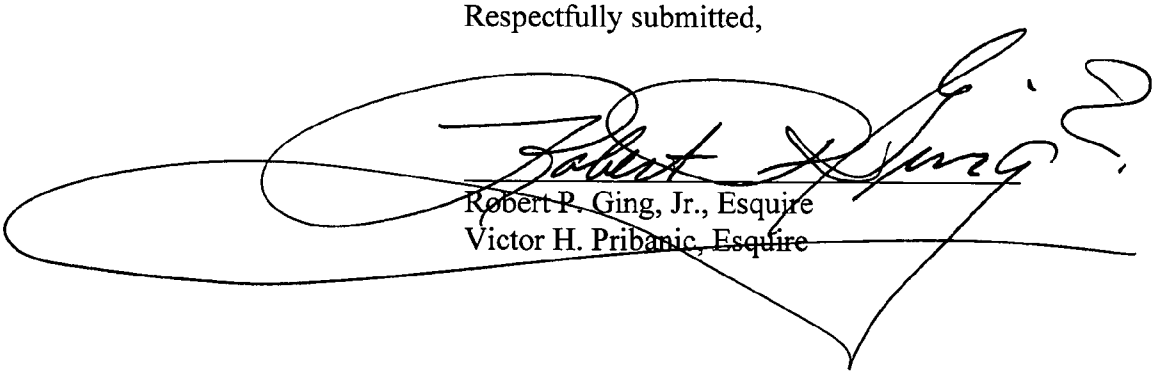
**XI – LIST OF PROPOSED STIPULATIONS.**

Plaintiffs propose to stipulate to the authenticity and admissibility of the records of the DuBois Regional Medical Center, Dr. Mary C. Kruszewski, and Children's Hospital of Pittsburgh. If a stipulation is not reached with respect to these records, Plaintiffs respectfully request this Honorable Court to allow the records to be subpoenaed pursuant to Rule 4009.21, and/or for the depositions of the records custodians at these facilities to be taken.

Plaintiffs would also propose a stipulation with respect to the amounts of the bills from

each of the physicians and facilities where Kimberly and Mikayla Rhoades were treated.

Respectfully submitted,



Robert P. Ging, Jr., Esquire
Victor H. Pribanic, Esquire

# APPENDIX
# OF
# ATTACHMENTS

1. Report of Frederick A. Gonzalez, M.D.
2. Report of Dianne S. Moore, R.N., Ph.D.
3. Report of James L. Mollick, M.D.
4. Discharge Summary, Children's Hospital
5. Final Autopsy Report
6. Report of Dr. William H. Reed, Ph.D.
7. Photos PT1 – PT40

**Frederick A. Gonzalez, MD**

88 North Mountain Drive
Dobbs Ferry, N.Y. 10522
usa

Phone 914-591-5644
Fax 914-591-6324

May 04, 2003

Dear Sirs,

I have reviewed the medical records regarding the pregnancy of Kimberly Rhoades. I have reviewed the records from:

1)Dubois Medical Center
2) Sundar Chandrasekhar, MD
3) Children's Hospital
4) Autopsy Report

At the time Mrs. Rhoades was a 34 year old G1P0 EDC 5/10/02. Prenatally her course was remarkable only for a 44 lb weight gain which is excessive. Her glucose challenge test was normal. She was admitted for induction of labor on 5/10/02. There is no estimated fetal weight either clinically or sonographically. There is no mention of informed consent regarding a macrosomic baby. The failure to evaluate fetal weight and to properly counsel a patient when she has a macrosomic baby regarding an induction of labor is a departure from good and accepted standards of medical care. At this point if the patient had opted for a cesarean section the baby's birth asphyxia could have been avoided.

Induction of labor was begun and the labor progressed slowly. There was a fetal bradycardia at around 15:37 hrs which recovered but pitocin was never discontinued and no precautions such as changing of position, administering oxygen, or scalp pH were performed. These are all departures from good and accepted standards of medical care. At around 22:46 hrs. severe and progressive variable decelerations occured. These decelerations were noted by the nurse and oxygen was started. However, pitocin was not discontinued and this represents a departure from good and accepted standards of medical care. The baby should have been delivered by cesarean section at this point. The failure to deliver by cesarean section represents a deviation from good and accepted medical care.

The decelerations continued and became progressively severe. Finally pitocin was discontinued at 23:42 hrs. A scalp pH was never done. Failure to properly evaluate the fetus by performing a scalp pH is a departure from good and accepted standards of medical care. The patient was delivered by vaccum extraction. There were four pulls with 2 pop offs. The pressure was not reduced between uterine contractions. This is an inappropiate use of the vaccum extraction and represents a departure from good and accepted standards of medical care.

As a result a severely asphyxiated baby was born with Apgars of 0,3,4,5 at 1,5,10, and 20 minutes. The cord pH was 7.13 with a base excess of -13 which represents metabolic acidosis. The baby suffered seizures, temporal bleeding, and swelling. These findings are all consistent with birth asphyxia and a traumatic delivery. As a result of the multiple departures on the part of Dr. Kruszwski and the nurses at DuBois Regional Medical Center, the baby suffered severe birth asphyxia and eventually died. My opinions are to a reasonable degree of medical certainty.

Sincerely,

Frederick A. Gonzalez, MD

Kimberly Rhodes

Expert Witness Report

Labor and Delivery Nursing Care of
Kimberly Rhoades and infant

This report is based on a review of the medical records for Kimberly Rhodes at Du Bois Medical Center including the fetal monitoring records, records from Dr. Kruszewski, and the records from Children's Hospital of Pittsburg. In addition the depositions of the attending RN's, and MD neonatologist as well as the deposition of Dr. Kruszewski attending obstetrician were reviewed. Furthermore the policy and procedure manual sections related to maternity and neonatal from Du Bois Medical Center were also reviewed.

Mrs. Kimberly Rhodes was a 33 year old G1P0 Caucasian female with a history of infertility, when she presented for her first obstetrical visit on November 1, 2001 with an LMP of 8/1/01 giving her a EDD of 5/10/02. This EDD was later confirmed by ultrasound. Mrs. Rhodes is 5'6" with a pre-pregnancy weight of 123 pounds and a BP of 108/72. She had a total of 13 prenatal visits which showed adequate fetal growth and movement, normal NST's, ultrasounds and BPP. Mrs. Rhodes developed edema of her hands, feet and face as well as a rise in her blood pressure along with a 47 pound weight gain. PIH laboratory work was ordered along with an ultrasound and NST and BPP, they were reported as normal but there is no evidence in the prenatal notes of any further care, teaching or advice. Since she is an "elderly primipara" there is a higher incidence of pre-eclampsia to be concerned about.

While the record shows the baby to have adequate FHT's and movement and to be in a vertex position it does not give the exact position of the head, the station or an estimated fetal weight even after the mother raised concerns on the size of the baby. There is a late ultrasound with an EFW of 3500 grams which translates to an slightly larger than average size baby of approximately 7 pounds 11.5 ounces but no follow-up clinically either prior to labor or when she was admitted to the hospital in labor. The labor examination does not include an evaluation of fetal size, engagement of the fetal head or position all of which are important in a primipara especially when the vaginal examination shows a – 3 station and the plan is induction/augmentation of labor.

An induction of labor was scheduled at DuBois Regional Medical Center on May 10, 2002. The admission report indicates Kimberly Rhoades was having contractions on her own and was 3-4 cm dilated, 50-75% effaced and -3 vertex at 740 a.m.. The membranes were artificially ruptured and clear fluid presented. Fetal Monitoring tracing indicate the FHT was baseline at 150 with good variability with some occasional small minor variable decelerations. Contraction pattern shows q 1.5 to 2 minutes and are reported to be of mild intensity based on manual palpation and maternal reporting. There is no report on a concern for prolapsed cord which is a strong possibility with a -3 station. In addition with the external electronic monitor on the uterus it is not possible to determine the actual strength or uterine baseline of the contractions or the accuracy of the FHT in response to contractions.

Furthermore, it is unusual to find a primipara with 50-75% effacement at 3-4 cm of dilation. It is also a warning sign of CPD (cephalopelvic disproportion) to have a primipara with a -3 station upon the start of active labor; the fetal head usually drops into the pelvis about 36 weeks of pregnancy. There is a higher incidence of cesarean section among primiparas who enter labor when the fetal head has not engaged in the pelvis by the active phase of labor; it is an indication of CPD and must be monitored closely. There is also no record of the fetal position which can influence CPD. This potential for CPD was the case with Mrs. Rhodes so that position, presentation and station are all important variables to be closely monitored.

Mrs. Rhoades was still 4 cm, 60% and -3, despite spontaneous contraction every 2-3 minutes, by 12:37 pm, five hours later. This constitutes arrest of cervical dilation and arrest of fetal decent. Induction/augmentation of labor was started with 2 mu. at 1237 p.m. and increased to 4 mu. at 1250 p.m. by nurse SK. The FHT baseline at the time of augmentation of labor was 130 with mild variability, variability increased with signs of accelerations and contraction pattern was every 2-3 minutes. Pitocin increased again at 1320 to 6 mu. and the FHT responded by baseline of 140 and decreased variability. By 1440 the BP has risen to 135/84 and a pulse of 93, contractions q1.5 to 2 minutes, FHT 140-150's and some variable decelerations. The nurse, SK, appropriately moves the patient to her left side.

Pitocin is increased again to 10 mu. by nurse SK, and contractions respond with increased baseline and frequency every minute. The FHT responds with decreased variability. At 1500 an epidural is placed and during that time there is no FHT picked up. The heart rate on the tracing is the maternal. Maternal BP is 133/79 and pulse is 105. By 1540 there is a 6 minute combination late/variable deceleration of the fetal heart rate. The nurse, GB, reduces the pitocin to 8 mu. Turns the mother on her right side, does a SVE finding the patient to be virtually unchanged at 4-5 cm, 70% and -2 with a the maternal BP is 185/161 with a pulse of 111 and there is another episode of fetal heart rate deceleration. The heart rate recovers but with minimal variability. This represents the first of several episodes that follow where there are decelerations followed by recovery but with minimal variability, showing there is not adequate fetal recovery. Nurse, GB, calls the DO to inform her of FHT pattern, results of SVE and pitocin induction status.

The nurse, GB, appropriately called the physician to report. However if she had reported the contraction pattern and FHT with the reminder of the definition of adequate contraction patters, i.e. 7 contractions in a 15 minute period and the patient had 9 contractions in a 15 minute period; there should have been an alternate plan to monitor this mother and fetus. The continued plan to increase the pitocin despite the fetal and uterine response does not follow safe practice in light of the initial and continued maternal-fetal condition. To provide an adequate safe trial of labor the continued increase in dosing of pitocin must be followed by an alternate plan such as the use of internal electronic monitoring to properly assess the patient's condition.

Despite nurse GB giving a 1000 cc bolus of fluids and turning the maternal position the FHT still had minimal variability for over 24 minutes. There is a repeated episode of uterine hyperstimulation which does not allow for fetal recovery. By 1620 the nurse, GB, again increases the pitocin to 10 mu. and the fetus responds with some minor variable

decelerations. At no time was there any attempt to place an internal fetal monitor to determine if the FHT and uterine tracing was accurate and to determine the true strength, baseline and frequency of contractions to properly adjust the pitocin dosage. The nursing intervention was to change the maternal position, provide fluids and adjust the Toco on the monitor.

By 1850, the cervix and fetal position are unchanged 11 hours later despite increasing the pitocin. She has prolonged arrest of dilation and decent and this should have been reported to the physician with a request for further medical evaluation, application of internal monitoring and preparation for a cesarean section particularly in light of the increasing pattern of decelerations, decreased beat to beat variability and an erratic contraction pattern and a maternal blood pressure that is erratic. Furthermore the absence of an FHT when placing an epidural should have also been a warning sign to place an internal fetal monitor in light of the other compounding factors

Overall there is a lack of safety precautions and following standard of care in relation to the use of pitocin induction or augmentation of labor in light of the initial maternal-fetal examination, arrest of decent and dilation, uterine contraction pattern and fetal heart rate response to the induction/augmentation process. A safer course of action would have been to use an internal fetal monitor to get a true picture of the fetal and uterine response and when there was an arrest despite an adequate contraction pattern to recommend consideration of a cesarean section. While the nurse does not make this decision the nurse can follow the hospital protocol by properly informing the physician of the facts and if there is not an adequate response based on the nurses professional judgment, to follow the required hospital protocol for further evaluation.

Therefore in light of the above evaluation of this case it is my professional opinion with a reasonable degree of certainty that the labor and delivery room nurses attending Mrs. Rhodes during her labor failed to act in accordance with a reasonable standard of nursing care in the provision of labor and delivery nursing services to Mrs. Kimberly Rhoades and her infant and this failure was the cause of the medical problems experienced by the infant at the time of birth.

Dianne S. Moore PhD, RN, CNM, MN, MPH

Dianne S Moore

1212 West Paul Ave
Fresno CA 93711
914 572 6879

PHONE (610) 279-6621

**NORRISTOWN OB-GYN ASSOCIATES, P.C.**
*WOMEN'S CENTER*
1437 MEDICAL ARTS BUILDING • SUITE 101
1437 DEKALB STREET
NORRISTOWN, PA 19401-3405

J. J. FITZGERALD, III, D.O.

J. L. MOLLICK, M.D.

February 15, 2005

Robert P. Ging
2095 Humbert Road
Confluence, PA 15424-2371

Re: Kim Rhoades

Dear Mr. Ging,

Thank you for allowing me to review the Rhoades case. I have reviewed the following medical records:

1. Amended Complaint,

2. Answer and New Matter to Plaintiffs' Amended Complaint filed on behalf of Mary C. Kruszewski, D.O.,

3. Answers and Objections to Interrogatories to Dr. Kruszewski and Request for Production of Documents,

4. Answers to interrogatories to the Dubois Regional Medical Center and request for production of documents,

5. Supplemental answers to interrogatories to the Dubois Regional Medical Center,

6. Amended answers to interrogatories to Dubois Regional Medical Center,

7. Objections and responses to interrogatories to the Dubois Regional Medical

8. Response to request for production of expert reports,

9. Medical records of Kimberly D. Rhoades (including prenatal records 2001-02), Mary C. Kruszewski D.O. and the Dubois Regional Medical Center (2002 admission),

10. Medical records of Mikayla Rhoades (birth to death 2002) including records of Sundar Chandrasekhar, M.D., Dubois Regional Medical Center (2002), Children's Hospital of Pittsburgh (2002) and the Final autopsy Report (2002),

11. Deposition's of Mary Kruszewski, D.O., Gloria Bennett, R.N., Tina Newell, R.N., Sheri Kizina, R.N., Suzanne McCullough, R.N., Shawn Welsh, R.N., Desiree Smith, R.N., Karen Consentino, Brian Yeskevich, M.D., Richard Grout, M.D.,

12. Expert Reports of Deborah Sommer, M.D., Diane Moore, PhD, RN, William Houston Reed, PhD, and Kimberly A. Comport RN.

After review of the records, depositions, an expert reports, I have reached the following opinions and conclusions to a reasonable degree of medical certainty:

Kim Rhoades was a 33-year-old white female G1P0000 with an LMP of 8/3/02, an EDC of 5/10/02 confirmed by a 13.5 week ultrasound done on 11/1/01. Prior to becoming pregnant she had a workup for infertility including hysterosalpingogram and semen analysis.

She was followed prenatally by Mary Kruszewski, D.O., and was seen for 13 prenatal visits. The patient was noted to have several elevated blood pressures during her pregnancy with negative workups.

The patient had several ultrasound examinations during her pregnancy. Dr. Kruszewski did not recognize that the reports failed to include a percentile weight for gestational age. The ultrasound done on 4/18/02 revealed a 38 week and five day fetus with an estimated fetal weight of 3382 grams. There was a normal amount of amniotic fluid present. A biophysical profile at that time was 8/8.

Her final prenatal visit was recorded on 5/9/02 at which time the patient was 39.6 weeks, had a blood pressure of 126/88, negative urine protein, and a cervical exam which was posterior and soft with no indication of cervical dilatation. Induction was scheduled for the A. M. of 5/10/02. I could not find documentation indicating the reason for the induction, and/or any documentation of a conversation explaining the indications for and risks of induction of labor with the patient. These deviations were below the accepted standard of care.

The patient was admitted Dubois Regional Medical Center on 5/9/02 for induction of labor (see orders for protocol for induction of labor using IV pitocin and routine labor/delivery). A verbal order was given by Dr. Kruszewski at 1200 on 5/10/02 to start pitocin per protocol.

According to the admission note by Dr. Kruszewski dated 5/10/02 at 7:40 a.m.:

"Prenatal course was unremarkable except blood pressure has been increasing slowly the past couple of weeks. Preeclampsia labs, BPP, and NST were done 4/18 and were all normal." "Monitor shows good FHT variability. Mild contractions q 1 -- 2 minutes." "Cx exam was performed and membranes ruptured during exam. Cx 3-4/75%/-3/Vertex."

According to the Dubois Regional Medical Center's Maternity Department Policy and Procedure Manual (hereafter "Hospital's Policy and Procedure"), Policy and Procedure, No. 76.1, entitled Active Management of Labor in Primipara:

"In patients admitted in spontaneous labor make a definitive diagnosis as soon as possible.

A. Diagnosis based on the following criteria:
   1. Contractions: At least 1 in 7 minutes.
   2. Show.
   3. Rupture of membranes.
   4. State of Cervix:
      a. If effacement at least 70%-80%
      b. Cervical dilation of 3 cm or greater.
      c. Contractions as above, then in labor."

These criteria support that this patient was in labor on admission.

According to Dr. Kruszewski's admission note, "Hook was used to rupture membranes further and large amount of clear fluid was obtained."

Dr. Kruszewski deviated from the Hospital's Policy and Procedures, P/PR No. 79, entitled Protocol for Amniotomy which states:

"The artificial rupture of membranes may only be carried out by a physician. The fetal head must be fully engaged in the pelvis prior to amniotomy."

According to the progress record authored by Dr. Kruszewski on 5/10/02 at 9:30 p.m.:

"The patient was noted to be 8 to 9 cm/100%/minus 1-0/vertex.... FHT's have been good throughout."

This was the only progress note written by Dr. Kruszewski from the time of admission until delivery.

According to Dr. Kruszewski's Delivery Note on 5/11/02 at to 12:55 a.m.:

"Patient was complete approximately 10:00 p.m... She pushed well and vertex came down to plus 1 to plus 2 station. Baby had a sustained bradycardia and vacuum was applied. Delivery was accomplished in one to two minutes after vacuum applied. Baby was suctioned and NICU personnel were called for resuscitation. Baby was delivered from OA positioned with vacuum over a midline episiotomy. Birth time was 11:52 p.m... Placenta delivered intact at 11:54 p.m. A cord pH was 7.13."

In review of the Vacuum Assisted Delivery Sheet dated 5/11/02 at 12:50 a.m., the fetal station was noted to be +1-+2, consistent with a midpelvic delivery. There were 4 pulls recorded, 2 pop offs and a duration of cup application of 3 minutes. The pressure was not reduced between contractions.

According to progress record the patient was discharged at 5:00 p.m. on 5/11/02.

According to the nursing progress record:

The patient was admitted at the 0653.
An IV was started at 0700.
The patient's vital signs on admission were normal with a blood pressure of 110/76.
The nurse documents a cervical exam at 0725 of 3-4 centimeters/50%/minus three station.
The pelvic exam documented by Dr. Kruszewski in her note of 7:40 a.m. was noted to be 3-- 4 cm/75%/minus 3/vertex.
The nurse documents contractions from between two to six minutes apart.
She documents AROM large amount of clear fluid at 0725.
The patient was started on pitocin at 12:40 p.m. on 5/10/02. According to the Hospital's Policy and Procedure, P/PR No. 76 entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

There was no indication for induction and or augmentation with pitocin. There was no notation by Dr. Kruszewski as to why the pitocin was started. She failed to discuss the risks of and indications for induction and or augmentation with the patient. She did not evaluate the baby for fetal size and failed to perform clinical pelvimetry. These deviations were below the accepted standard of care.

The pitocin was steadily increased to a maximum level of 28 milliunits per minute.
On 5/10/02 and 1500 the patient received an epidural anesthetic.

According to the nursing patient progress note dated 5/10/02:

5:30p.m. - Dr. Kruszewski was notified of coupling and tripling pattern with pitocin and of the average fetal heart rate variability. The nurse was instructed to continue gradual increase of pitocin per protocol.
8:30p.m. - Dr. Kruszewski was advised of the uterine contraction pattern with extended periods out of duration increased, and fetal heart rate variability after reviewing the prior 2 hours of the fetal heart rate tracing. The nurse received an order to continue increasing the pitocin. A late entry indicates that Dr. Kruszewski was informed of an increased temperature on the patient.

According to the nursing patient progress notes dated 5/11/02;

1:00 a.m. late entry narrative - Dr. Kruszewski in attendance assisting. Patient with pushing from 2212. Fetal heart rate baseline 150s with average long term variability onset of pushing. The epidural was discontinued by anesthesia.

The fetal heart tracing demonstrated variable deceleration pattern increasing with progressive pushing. Occasionally variable with late onset.

IV bolus 1000 and LR with 800 cc.

At 2244, 02 increased to 5 L per minute via nasal cannula at 2246 as nursing a measure.

At 2300 depth of variable decelerations reached a fetal heart rate level of 60s returned to baseline 130 – 140's after less than 1 minute. Dr. Kruszewski questioned re. patient resting through a few contractions. Instructed to proceed with pushing.

800 CC fluid bolus infused by 2312 and 02 at 10 L per minute.

As of 2330 variable decelerations to 58 -- 72 bpm lasting 30 -- 80 seconds noted with UC.

Patient proceeding to push vertex to +2 station. Fetal heart rate return to normal parameters. Fetal heart rate with scalp stimulation by Dr. Kruszewski with variables.

2342 Fetal heart rate capture lost on external fetal monitor. Pitocin discontinued per nursing measure at 2343.

2344 Fetal heart rate audible 60 – 70s. Fetal scalp stimulation by Dr. Kruszewski.

2346 Fetal heart rate audible at 50bpm and dropping.

2347 Order received verbally for vacuum.

2349 Vacuum extractor applied by Dr. Kruszewski with continuous effort made until vacuum assisted the vaginal delivery a female infant over median episiotomy by Dr. Kruszewski.

2354 spontaneous vaginal delivery of placenta by Dr. Kruszewski.

In review of the fetal heart tracing and notations, I note:

The patient was having contractions with a notation on the tracing of "AROM large clear fluid with the patient at 3 -- 4 cm/50%." (Tracing #55105)

As seen on fetal tracing number 55109 the patient was contracting almost every minute.

Beginning on 55133 the contraction baseline was elevated after up to 17 attempts to calibrate the external monitor to this point.

Pitocin was started at 2 milliunits per minute at approximately 1239.

The patient was noted to have hyperstimulation with bradycardia. The fetal heart rate was below 110 from 1502 through 1521 at which point the standard of care required placement of a scalp electrode, intrauterine pressure device, discontinuing the pitocin, and to notify Dr. Kruszewski. Not doing so was below the accepted standard of care.

The patient was noted to have a prolonged deceleration beginning at approximately 1536 through 1541 associated with uterine hyperstimulation requiring that the nurses place a scalp electrode, an intrauterine pressure device, discontinue the pitocin and notify Dr. Kruszewski. Not doing so was below the accepted standard of care. Shortly after this episode, the fetal heart variability was decreased requiring placement of a scalp electrode and testing for fetal well being. Not doing so was below the accepted standard of care.

At 1845, a pelvic exam revealed the cervix to be unchanged and the patient was noted to have at least seven contractions in 10 minutes.

At 1849, the patient was positioned in the knee chest position and the pitocin increased to 22 milliunits per minute. The fetal heart tracing was inadequate and uninterpretable from 1848 through 1914. The notation on the fetal strip was "UA INOP CARDIO INOP."

At 1855, the nurse notes on the tracing, "poor fetal and uterine toco capture while in knee chest against BB."

At 20:32, Dr. Kruszewski was notified by phone of the last two pelvic exams, pitocin level, the periods of hypertonic appearing contractions, fetal heart rate with average variability and IV fluid bolus at 2031. The pitocin was then increased to 26 milliunits/min.

The pitocin finally reached its maximum level of 28 mu/min at 2050.

The patient had an episode of fetal bradycardia beginning at 2057 associated with an increased contraction baseline and hyperstimulation with contractions less than a minute apart. The bradycardia terminated at 2116. The nurse documents on the fetal tracing "maternal heart rate". Dr. Kruszewski was not made aware of this finding. An internal fetal scalp electrode was not placed. These deviations were below the accepted standard of care. The only way to accurately determine the difference between the fetal and maternal heart rate was by placement of a scalp electrode or by ultrasound. According to the Hospital's Policy/Procedures, P/PR No. 61.3 entitled, Fetal Scalp Electrode:

"Application of Fetal Scalp Electrode by nursing personnel is permitted by order of the Physician after documented education, training and supervised practice." "In emergency situations, nursing may apply fetal scalp electrodes before notifying Physicians."

At 2120, the patient was having variable decelerations requiring placement of a scalp electrode. Not doing so was below the accepted standard of care.

Dr. Kruszewski performed a pelvic exam at 2123 and the cervix was found to be 8 to 9 cm and 100% effaced. A note by the nurse at that time revealed that the electronic fetal monitoring strip to present was reviewed by Dr. Kruszewski. A scalp lead was not placed during the pelvic exam. This was below the accepted standard of care.

The pitocin was decreased to 20 milliunits per minute at 2131.

The fetal heart rate variability was decreased from 2138 through 2158 associated with uterine hyperstimulation. Dr. Kruszewski failed to place a fetal scalp electrode and/or intrauterine pressure device. Not doing so was below the accepted standard of care.

At 2146 the pitocin was decreased to 18 milliunits per minute. The variability was still decreased.

At 2200, the nurse notes that the electronic fetal monitoring tracing was reviewed to present by Dr. Kruszewski. Dr. Kruszewski also performed a pelvic exam, and the patient was found to be completely dilated. The pitocin was decreased to 16 milliunits per minute.

The patient began pushing at approximately 2213.

The epidural was stopped at approximately 2226.

The fetal tracing was suboptimal beginning at 2230 with episodes of drop out and decelerations noted. Not placing a fetal scalp electrode was below the accepted standard of care.

The patient was having repetitive decelerations beginning at 2243. The IV fluid was increased at 2244 and oxygen was placed at 2246. These findings mandated placement of a scalp electrode, an intrauterine device, discontinuing the pitocin and taking the patient to cesarean section. Not doing so was below the accepted standard of care.

Beginning at 2250 the patient was noted to be hyperstimulated associated with multiple repetitive severe variable decelerations, with loss of variability, mandating discontinuing the pitocin, placement of a scalp electrode and intrauterine pressure device, and performing an emergency cesarean section. Not doing so was below the accepted standard of care. According to the Hospital Policy and Procedure Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreasurring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.
4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent or correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

The pitocin was continued, a scalp electrode was not placed, and the patient was not taken to cesarean section. These deviations were below the accepted standard of care.

The severe variable decelerations became more pronounced after 2310, associated with late recovery and total loss of variability consistent with hypoxia and asphyxia. (SEE P/PR No. 61.2 above under "ominous fetal heart rate pattern") Not stopping the pitocin and performing an emergency cesarean section was negligent and below the accepted standard of care.

At 2306, oxygen via face mask at 10 L per minute was started.

At 2311, intravenous fluids were increased.

The severe variable decelerations were repetitive, more severe and associated with loss of variability and late components.

At 2338, an episode of terminal bradycardia occurred requiring emergent delivery. Not doing so was below the accepted standard of care.

At 2340, the fetal heart rate was essentially lost.

The pitocin was discontinued at 2343 and the nurse notes that the fetal heart rate was audible at 60 -- 70.

Again the nurse notes on the strip at 2346 that the fetal heart rate was audible at 50 beats per minute and dropping at which time an order was received for the vacuum extractor which was applied. A second RN was called to the room.

At 2348 the nurse notes on the strip that the vacuum was applied by Dr. Kruszewski.

At 2350 the nurse notes on the fetal tracing that she was unable to capture the fetal heart rate.

At 2350 the nurse notes that the NICU was notified to come stat upon delivery of the infant's head.

At 2351 the nurse notes delivery time, vacuum assisted vaginal delivery female infant over media lateral episiotomy.

Dr. Kruszewski took infant to warmer, NICU staff present.

According to the obstetric discharge summary, completed by Dr. Kruszewski, the discharge diagnosis was term pregnancy delivered. None of antenatal risk factors including any that could be added were checked off.

According to history and physical examination done by Sundar Chandrasekhar, M.D.;

"Mikayla Rhoades was born by a spontaneous vaginal delivery assisted with the vacuum at 11:42 p.m. 15/10/02. The baby was noted to have a fetal bradycardia during the second stage of labor and delivery was assisted by vacuum, as mentioned. Cord pH was noted to be 7.13; loose cord around the neck was noted. The baby was limp at birth with no heart rate or respirations. Apgar at 1 minute was 0, at 5 minutes was 3, at 10 minutes was 4, at 20 minutes was 5. Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds, after which the heart rate went up to over 100 per minute. The baby was then transferred right away to the NICU for further management. First gas in the NICU showed a pH of 6.60, a second gas done at 12:30 a.m. showed a pH of 6.90, CO2 of 49, PO2 of 1021 vent settings of 100% oxygen."

Excerpts from the physical exam revealed that the central nervous system examination shows anterior fontanel open, pupils were small but did not appear to react to light. The baby did not have any response to painful stimuli. Deep tendon reflexes were not elicitable.

The impression was "large for gestational age female term baby with perinatal depression."

The plan was to provide prophylactic phenobarbital to prevent seizures.

According to the Pediatric Discharge Summary by Dr. Richard Grout, M.D.:

"This patient was transferred to Children's Hospital because of birth asphyxia with Apgar scores at 0 at 1 minute, 3 at 5 minutes, 4 at 10 minutes, 5 at 20 minutes."

Excerpts from the physical examination revealed a birth weight of 4400 g. "The patient was noted to be minimally responsive to external stimuli with some withdrawal to noxious stimuli only. The patient had some tremors and was given to boluses of Phenobarbital 10mg/kg for a total of20 mg/kg. The patient was catheterized and there was a small urine output which was sent for urine analysis."

The transferred diagnosis was: "severe birth asphyxia, term birth."

Reason for transfer was: "need for supervisory care of the pediatric neurologist and in conjunction with the familial request for transfer."

Excerpts from the Children's Hospital of Pittsburgh inpatient discharge summary dated 6/28/02 by Carol Gilmour M.D. indicate that;

"She did have chest compressions for less than 30 seconds for low heart rate."

"Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace.

The baby was evaluated for sepsis.

We also had neurology evaluate her. Her EEG times two showed no baseline activity, just intermittent focal sharp waves. She had a CT scan times two that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had lost a spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of severe hypoxic ischemic encephalopathy.

Over the next several days there was no change in Mikayla exam. There continued to be fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with neonatology, neurology, social work in the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life-support. The etiology is suspected to be acute perinatal total asphyxia. -- This was discussed thoroughly with the parents so the family did continue support of this infant."

According to the FINAL AUTOPSY REPORT dated 5/15/02, the final autopsy diagnoses were:

"A five day old female with hypoxic ischemic encephalopathy",
Brain – "Acute ischemic encephalopathy, severe."
Edematous and congested lungs,
Biventricular hypertrophy of the heart,
Congested hepatomegaly,
Congested spleen,
Thymic depletion,
Hemorrhagic adrenal glands,
Congested kidneys,
Pericardial fluid,
Generalized pitting edema.

Special Procedures:
CHP – Neuropathology – Final Neuropathological diagnosis of Brain and Spinal Cord;

1. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE

Microscopic Neuropathology revealed – "sections show widespread, severe acute ischemic damage in neurons in nearly all areas of the brain with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord."

Summary/Discussion – "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." -----"the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

To a reasonable degree of medical certainty I have reached the following conclusions and opinions in addition to those are ready mentioned;

1. The induction of labor was not indicated and conducted below the accepted standard of care.

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only."

According to ACOG, the indications for induction are;

"Abruptio Placenta
Chorioamnionitis
Fetal demise
Pregnancy induced hypertension
Premature rupture of membranes
Post term pregnancy

Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension)

Fetal compromise (e.g., severe fetal growth restriction, isoimmunization) preeclampsia, eclampsia."[1]

"Labor also may be induced for logistical reasons, for example, risk of rapid labor, distance from hospital, or psychosocial indications."[2]

There was no indication for the induction. There is no documentation as to the indication for the induction.

The patient was not at risk for rapid labor and there were no logistical indications for labor induction.

The patient was never diagnosed with pregnancy induced hypertension or chronic hypertension. During the patient's last prenatal visit with Dr. Kruszewski, on 5/9/02, the patient's blood pressure was 126/88 and she had no protein in the urine. She had already had a negative workup for preeclampsia including blood work, an NST and a biophysical profile of 8/8. The last ultrasound performed on the patient was interpreted as normal. Even defense expert Dr. Sommer agreed that the pregnancy was "uncomplicated", noting that "preeclampsia was appropriately ruled out with normal lab studies, a normal biophysical profile, and an ultrasound that showed a baby that was slightly larger than average size." Dr. Sommer fails to note that the only way to accurately determine this was by noting the percentile weight for gestational age and that the fetal weight on ultrasound bordered on macrosomia or fetal weight >90%.

There was no medical indication for induction of labor.

According to ACOG, "assessment of gestational age and consideration of any potential risks to the mother or fetus are of paramount importance for appropriate evaluation and counseling before initiating cervical ripening or labor induction. The patient should be counseled regarding the indications for induction, the agents and methods of labor stimulation, and the possible need for repeat induction or cesarean delivery."[3]

Dr. Kruszewski never documented an indication for the induction in either the prenatal chart or hospital record. There is no documentation that Dr. Kruszewski ever discussed the reason for the induction with the patient. There is no documentation indicating that Dr. Kruszewski ever explained the risks associated with induction with Mrs. Rhoades and there was never a discussion about the possibility of a repeat induction or cesarean section with the patient. These deviations were below the accepted standard of care.

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[1] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.
[2] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

[3] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to ACOG, "Additional requirements for cervical ripening and induction of labor include cervical assessment, pelvic assessment, assessment of fetal size and presentation, and personnel familiar with the effects of uterine stimulants on the mother and fetus because uterine hyperstimulation may occur with induction of labor. Monitoring the fetal heart rate and uterine contractions is recommended as for any high risk patient in active labor. Although trained nursing personnel can monitor labor induction, a physician capable of performing a cesarean delivery should be readily available."[4]

There was nothing in the record to support that the maternal pelvis and fetal size were evaluated prior to induction. Dr. Kruszewski admitted that she never evaluated the baby's weight and thus failed to recognize that the baby was macrosomic as evidenced by a birth weight of approximately 4400 g. The nurses and Dr. Kruszewski were not familiar with the effects of uterine stimulants on the mother and fetus and failed to recognize and act on the hyperstimulation caused by the pitocin which resulted in severe periodic changes with loss of variability indicating asphyxia. They failed to monitor the patient appropriately by utilizing internal fetal monitoring with a scalp electrode and intrauterine pressure device. These deviations were below the accepted standard of care and lead to progressive and severe perinatal asphyxia.

2. The management of the induction, augmentation and labor were below the accepted standard of care;

A. Dr. Kruszewski failed to recognize that the patient was at risk for and had a labor abnormality. This was below the accepted standard of care:

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

[4] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

According to Williams Obstetrics, "Pelvic contraction and fetal malposition are common causes of uterine dysfunction. That moderate degrees of pelvic contraction and fetal malposition may cause hypotonic uterine dysfunction is of great clinical importance."[5]

The patient had no medical indications for induction. Ultrasound examinations during the pregnancy were consistent with a larger than normal baby and bordered on fetal macrosomia. On exam, the patient was noted to have an unengaged fetal head. In a primagravida patient this finding is associated with a poor prognosis for vaginal delivery and indicated cephalopelvic disproportion. Dr. Kruszewski admitted that she failed to evaluate the pelvis and fetal size. The baby's birth weight was approximately 4400 grams or nearly 9 pounds indicating fetal macrosomia which also placed the mother and fetus at risk for labor abnormalities that would not justify the aggressive pitocin induction and or augmentation.

The patient presented to the hospital on 5/10/02, for induction of labor in active labor with contractions at a frequency of 2-6 minutes apart. According to the nurses notes on admission the pelvic exam was 3-4cm/50%/-3 station. According To Dr. Kruszewski's exam the cervix was 3-4/75%/-3. According to the Hospital's Policy and Procedures, P/PR No. 76.1 entitled Active Management of Labor in Primipara, the diagnosis of labor is made as follows,

a. Diagnosis based on the following criteria:
    1. Contractions: At least 1 in 7 minutes.
    2. Show.
    3. Rupture of membranes.
    4. State of Cervix:
        a. If effacement at least 70%-80%
        b. Cervical dilation of 3 cm or greater.
        c. Contractions as above, then in labor."

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[6] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[7]

The patient presented to the hospital in the active phase of labor.

There is no notation as to why the pitocin was started. There is no notation that there was a discussion with the patient about the risks associated with induction and or augmentation of labor with pitocin, especially in light of the fact that the patient was already in active labor. These deviations were below the accepted standard of care.

The patient's membranes were ruptured by Dr. Kruszewski.

The patient was noted to be 3 to 4 cm at that time with an unengaged fetal head, and at 0740 the patient was having contractions almost every minute. From the time of admission until the pitocin was started at 12:39 p.m., the tocometer was readjusted and or zeroed on multiple occasions indicating the need for an intrauterine pressure device to accurately evaluate and

[5] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 343.
[6] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[7] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

monitor the contraction pattern prior to administering pitocin. Not doing so was below the accepted standard of care. The cervix was unchanged from the time of admission until the pitocin was started consistent with active phase arrest.

According to Williams Obstetrics, "Uterine dysfunction in any phase of cervical dilatation is characterized by lack of progress, for one of the prime characteristics of normal labor is its progression."[8] The patient had no cervical change for over four hours prior to starting pitocin.

According to Williams, "Uterine dysfunction is often a protection against some degree of pelvic contraction or abnormalities of fetal size or presentation. Fortunately, the uterus does not typically persist in spontaneous activity that would lead to rupture. Instead the usual forces of labor are replaced by hypotonic uterine dysfunction. Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[9]

Dr. Kruszewski failed to place an intrauterine pressure catheter and fetal scalp electrode. She failed to determine that the baby was macrosomic, that the patient was arrested in the active phase of labor, and failed to perform a cesarean section after two hours of labor with no cervical change. These deviations were below the accepted standard of care.

According to Williams Obstetrics, "There have been three significant advances in the treatment of uterine dysfunction:

(1) The realization that undue prolongation of labor may contribute to perinatal morbidity and mortality;

(2) The use of very dilute intravenous infusion of oxytocin in the treatment of certain types of uterine dysfunction; and

(3) The more frequent use of cesarean section to affect delivery rather than difficult midforceps delivery or if oxytocin fails or its use is inappropriate."[10]

B. Dr. Kruszewski and the nurses failed to recognize that this patient was arrested in the active phase in labor which was a contraindication to the use of intravenous pitocin. This was below the accepted standard of care.

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[8] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 341.

[9] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 343.

[10] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 342.

A summary of the patient's pelvic exams are as follows;

| TIME | DILATION | EFFACEMENT | STATION |
|---|---|---|---|
| 7:25 a.m. | 3-4cm | 50%-75% | -3 |
| 8:25 a.m. | 4cm | 60% | -3 |
| 9:30 a.m. | 4cm | 70% | -3 |
| 12:50 p.m. | 4cm | 70% | -2 |
| 3:40 p.m. | 4-5cm | 70% | -2 |
| 5:10 p.m. | 5cm | 75% | -2 |
| 6:50 p.m. | sve unchanged | | |
| 8:10 p.m. | 4-5cm | 80% | 0/-1 |
| 8:30 p.m. | 4-5cm | 80% | 0/-1 |
| 9:20 p.m | 8-9cm | 100% | 0/-1 |
| 10:00 p.m. | complete | | |

The chart indicates that the patient's cervical exam remained unchanged for approximately 12 hours.

The patient presented to the hospital actively contracting and was found to be 4 cm dilated on admission. The patient was re-examined over 4 hours later and her cervical exam was unchanged despite having contractions as often as 1 minute apart consistent with arrest in the active phase of labor. The standard treatment for arrest in the active phase of labor with evidence of cephalopelvic disproportion was and is a cesarean section. Not doing so was below the accepted standard of care.

According to ACOG, "labor commences when uterine contractions of sufficient frequency, intensity, and duration resulting effacement and dilation of the cervix."[11] The active phase of labor generally occurs "when the cervix reaches 3-4 cm of dilatation."[12]

The patient presented to the hospital in the active phase of labor.

According to ACOG, arrest disorders constitute no cervical dilatation in a nullipara for more than two hours. This requires that the patient to have entered the active phase of labor to make a diagnosis.

Protraction Disorders:

1a. Multiparous - dilatation less than 1.5 centimeters per hour;
b. Multiparous - descent less than 2.0 centimeters per hour;

[11] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[12] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

2 a. Nulliparous - dilatation less than 1.2 centimeters per hour; and
b. Nulliparous - descent less than 1.0 centimeter per hour

Arrest disorders are defined as follows:

1a. Multiparous- No cervical dilatation for greater than two hours;
b. Multiparous - No descent of the presenting part for greater than one hour;

2a. Nulliparous - No cervical dilatation for greater than two hours;
b. Nulliparous - No descent of the presenting part for greater than one hour.[13]

According to ACOG, "It has been suggested that before the arrest disorder can be diagnosed in the first stage of labor, the following criteria should be met:

1. The latent phase is completed (*i.e.*, cervical dilatation is a minimum of 4 centimeters), and

2. A uterine contraction pattern exceeds 200 Montevideo Units for two hours without cervical change. "Assessment of powers during the active phase of the first stage of labor involves the investigation of uterine contractility. The minimal contraction pattern of 95 percent in spontaneous labor consists of three to five contractions in a ten minute window."[14] The patient was having in excess of 5 contractions in 10 minute windows.

"Several methods of quantifying uterine activity with internal monitors have been described."[15] "In a retrospective report an induction of labor with Oxytocin, 91% of women achieved at least 200 to 224 Montevideo Units and 40% achieved at least 300 Montevideo Units."[16] The only way to diagnose an active phase arrest associated with a hypotonic labor dysfunction was by placing an intrauterine pressure device.

According to Parer, with reference to the Tokodynamometer or external contraction monitor "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experience hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This

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[13] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[14] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[15] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

[16] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.

requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[17] An intrauterine pressure device was not placed by Dr. Kruszewski to assess the powers of labor. This was below the accepted standard of care.

At 0725, the cervical exam was 3-4 cm. Her cervical exam was unchanged at the time pitocin was started at 12:39 p.m., 4 1/2 hours later. If an intrauterine pressure device had been placed prior to starting pitocin and indicated that the contractions were adequate, a cesarean section would have been indicated and pitocin unnecessary.

Starting pitocin, while the patient was actively contracting, in active labor, with no cervical change for over 4 hours, without first placing an intrauterine pressure device to document contraction adequacy was below the accepted standard of care.

According to Williams Obstetrics, "failure of the cervix to dilate or of the presenting part to descend is cause for concern. Prolongation of either the first or second stage of labor may result in increased perinatal and maternal morbidity. Any delay in cervical dilatation during the first stage or prolongation of the second stage of labor should alert the obstetrician to possible danger."[18]

There was no indication for the pitocin augmentation.

C. Aggressive pitocin augmentation was not indicated and below the accepted standard of care.

The patient was arrested in the active phase of labor for up to 12 hours. According to Williams Obstetrics, "oxytocin is a powerful drug, and it has killed or maimed mothers due to rupture of the uterus and even more babies through hypoxia from markedly hypertonic uterine contractions."[19]

According to Williams, oxytocin stimulation is appropriate if the following criteria for pelvic adequacy are met;

1. The diagonal conjugate is normal,
2. The pelvic sidewalls are nearly parallel,
3. The issue spines are not prominent,
4. The sacrum is not flat,
5. The suprapubic angle is not narrow,
6. The occiput is known to be the presenting part,
7. The fetal head is engaged or descends through the pelvic inlet with fundle pressure. ( the patient presented with an unengaged, floating head, at -3 station)

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[17] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[18] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia-–, 1989, pg 341.
[19] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 345.

If these criteria are not met, the alternatives are cesarean delivery or possibly oxytocin stimulation. If oxytocin is used, it is mandatory that the fetal heart rate and the contraction pattern frequency, intensity, duration, and timing in relation to fetal heart rate be observed closely."[20]

According to the Hospital's Policy and Procedures, P/PR No. 76, entitled Administration of Oxytocic Agents for the Induction or Stimulation of Labor:

"POLICY:

Intravenous induction will be used for medical indications only. The following criteria must be met:

a. Patient will be at or near term with ripe, soft cervix.
b. No evidence of pelvic disproportion by physical examination and/or x-ray pelvimetry.
c. Patient willing to be induced.
d. Vertex presentation.

"Use of an IUPC is to be considered for these patients."

"It is recommended that patients receiving oxytocics be monitored continuously with an electronic fetal monitor."

Dr. Kruszewski failed to perform clinical pelvimetry on this patient who presented with a macrosomic infant, and an unengaged floating head indicating cephalopelvic disproportion. Dr. Kruszewski failed to place an intrauterine pressure device to document contraction adequacy, and to accurately monitor the contraction pattern. Dr. Kruszewski started the pitocin augmentation without precise knowledge of contraction adequacy and after the patient was arrested in the active phase of labor for over 4 hours with contractions as close as 1 minute apart. She aggressively augmented this patient without first discussing and documenting the indications for its use. These deviations were below the accepted standard of care.

According to Williams, "the arrest disorders are considered to be present when there is no cervical dilatation for two hours, when the deceleration phase is prolonged, or when there is failure of the presenting part to descend for greater than one hour or longer. Friedman (1978) maintains that approximately one half of these patients have "insurmountable obstruction" and recommends the judicious use of intravenous oxytocin but cautions that such efforts, while effective in dilating the cervix and ultimately resulting in vaginal delivery, may subject the fetus to substantial risks of hypoxic injury as well as birth trauma[21]."

According to Williams Obstetrics, "one characteristic of intravenous oxytocin is that when successful, it acts promptly, leading to noticeable progress with little delay. For any given rate of infusion the plasma level reaches a plateau after about 30 to 40 minutes as the rate of infusion and rate of destruction by oxytocinase achieve equilibrium. Therefore, the drug need not be used for an indefinite period of time to stimulate labor. It should be employed for no more than a few hours; if, by then, the cervix is not changed appreciably and if predictably easy vaginal

[20] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 344
[21] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 346

delivery is not imminent, cesarean delivery should be performed."[22]"Ready resort to cesarean section in cases where oxytocin fails or in which there are contraindications to its use has served to diminish perinatal mortality and morbidity appreciably."[23]

D. The patient was exposed to unrecognized, iatrogenic uterine hyperstimulation secondary to aggressive pitocin augmentation, resulting in progressive hypoxia, asphyxia and permanent central nervous system damage. This was below the accepted standard of care.

According ACOG, "the goal of oxytocin administration is to effect uterine activity that is sufficient to produce cervical change and fetal descent while avoiding uterine hyperstimulation and fetal compromise. Minimally effective uterine activity has been defined as 3 contractions per 10 minutes averaging greater than 25 mmhg above baseline."[24] "Typically, a goal of a maximum of five contractions in a 10 minute period with resultant cervical change is considered adequate."[25]

According to Dr. Kruszewski's deposition testimony,

Question – "What do you consider to be significant hyperstimulation of the uterus?" (pg. 28)

Answer – "If the uterus is staying contracted for more than two or three minutes and not relaxing."

Question – "Did you have any concerns about the administration of oxytocin or pitocin causing uterine hyperstimulation during the labor?"(96)

Answer – "No."

Question – "Did you make any observations which would indicate that Mrs. Rhodes was suffering from uterine hyperstimulation at any time during her labor?"(96)

Answer – "No."

Question - "Can hyperstimulation cause fetal stress?"(96)

Answer – "Yes."

Question – "Would this discontinuance of oxytocin be an intrauterine resuscitation procedure that could mitigate a worrisome fetal heart rate patterns?"(97)

Answer – "Possibly."

Question – "Do you believe that the administration of pitocin over the course of Kim's labor caused any complications of her pregnancy?"(97)

Answer – "No."

According to the deposition testimony of Gloria Bennett (referencing 3:26 when the pitocin was decreased),

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[22] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 345

[23] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia---, 1989, pg 345

[24] ACOG Technical Bulletin, Dystocia---, No.218, December 1995

[25] ACOG Technical Bulletin, Dystocia---, No.218, December 1995

Question – "Okay. Now, why did you reduce the pitocin at that point that you've just described?"(29)

Answer - "Just to see the fetal response to a pitocin decrease."

Question - "Why would you do that, I mean what medical reason would you have for reducing the pitocin and how would that affect the infant response?" (29)

Answer - "If the contractions are close together which at that point they were very close together." "It can be over stimulating the fetus."

Question - "And when you say it's over stimulating the fetus, what do you mean? (29-30)

Answer - "Just means that it's not giving the baby a chance to recover between contractions."

According to the Hospital's Policy and Procedures Manual, P/PR No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinues oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.

According to ACOG, hyperstimulation is defined as "a persistent pattern of more than five contractions in 10 minutes, contractions lasting 2 minutes or more, or contractions of normal duration occurring within 1 minute of each other."[26]

According to Williams Obstetrics, "Uterine contractions must be evaluated continually and oxytocin shut off immediately if contractions exceed 5 in a 10 minute period or last longer than 1 minute or if the fetal heart rate decelerates significantly."[27]

The pitocin was started at 12:39 p.m. on 5/10/02, and progressively increased, without an intrauterine pressure device, to a maximum level of 28 milliunits per minute resulting in unrecognized iatrogenic hyperstimulation causing severe periodic changes, loss of variability, terminal bradycardia, profound hypoxia, asphyxia, and irreversible brain damage. The aggressive use of pitocin and the failure to recognize the uterine hyperstimulation and the repetitive periodic changes were below the accepted standard of care.

There were multiple episodes of hyperstimulation on pitocin throughout the fetal tracing beginning as early as 1431. Because of the difficulty the nurses were having maintaining a tracing with the tokometer, the poor tracing quality, elevated baseline, and uterine

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[26] ACOG Technical Bulletin, Dystocia and the Augmentation of Labor, No. 218, December 1995.
[27] Williams Obstetrics, 20th Edition, Cunningham et al., Dystocia—, 1997, pg 426.

hyperstimulation, placement of an intrauterine pressure device was mandatory. Not doing so was below the accepted standard of care.

According to Parer, with reference to the Tokodynamometer or external contraction monitor, "the tokodynamometer detects frequency and often duration of uterine contractions but ordinarily cannot be calibrated for intensity and direct pressure measurements. Use of the experienced hand for determining intensity of a contraction may be more accurate than this device." "A potential additional disadvantage of the external device results from the fact that it works best with the woman in the supine position and with minimal maternal movement. This requirement may not be optimal for maternal comfort, fetal well-being, or progress in labor."[28]

According to Williams, "Most often, once the diagnosis of active labor followed by hypotonic uterine dysfunction has been made and the head is well fixed in the pelvis, the membranes, if intact, should be ruptured and ideally an intrauterine pressure catheter and fetal scalp electrode placed."[29]

The nurses and Dr. Kruszewski failed to recognize and act on the inadequate tracing of uterine contractions, uterine hypertonus, and failed to recognize the multiple episodes of uterine hyperstimulation. These deviations were below the accepted standard of care.

The nurse and Dr. Kruszewski failed to recognize and act on the repetitive severe fetal heart rate decelerations caused by the iatrogenic uterine hyperstimulation with pitocin. They failed to place an intrauterine pressure device and fetal scalp electrode to monitor fetal well-being and short term variability. They failed to realize that the repetitive severe decelerations associated with loss of variability signaled hypoxia, asphyxia and fetal compromise. They failed to discontinue the pitocin which was causing the hyperstimulation and the decelerations. Dr. Kruszewski failed to take this patient to cesarean section. These deviations were below the accepted standard of care and lead to the delivery of a profoundly asphyxiated and neurologically damaged infant.

According to ACOG, "if hyperstimulation with a non-reassuring fetal heart rate occurs, intravenous infusion of oxytocin should be decreased or discontinued to correct the pattern. Additional measures may include turning the woman on her side and administering oxygen or more intravenous fluid. If hyperstimulation persists, use of terbutaline or other tocolytics may be considered."[30]

According to the Hospital's Policy and Procedures Manual, No. 61.2, entitled Fetal Monitoring, Nonreassuring Patterns:

A nonreasurring fetal heart pattern includes,

1. Repetitive late decelerations with poor/decreased variability.
2. Variable decelerations lasting longer than 45 seconds, with poor/decreased fetal heart rate variability and rising baseline.
3. Loss of fetal heart rate variability with deceleration.

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[28] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 117-18.

[29] Williams Obstetrics, 18th Edition, Cunningham et al., Dystocia—, 1989, pg 343.
[30] ACOG Practice Bulletin, Induction of Labor, No. 10, November 1999.

4. Prolonged deceleration due to paracervical block, epidural block, supine hypotension, vaginal examination or manipulation.

An ominous fetal heart rate pattern includes:

1. Persistent, on correctable late decelerations with loss of fetal heart rate variability.
2. Variable decelerations with any of the following observation: loss of fetal heart rate variability, fetal tachycardia, prolonged overshoot.
3. Sinusoidal patterns.
4. Fetal heart rate variability is assessed through the use of a spiral electrode.

Abnormal uterine activity patterns include:

1. Uterine resting tone greater than 15mmhg.
2. Contraction frequency greater than every two minutes.
3. Contraction duration of greater than 90 seconds.
4. Contraction intensity of greater than 75mmhg.

Discontinue oxytocin infusion if in use.

1. Assist the patient the left lateral position.
2. Administer oxygen via mask eight to 10 L per minute.
3. Initiate IV line of LR with 16/18 gauge angiocath.
4. Perform a vaginal exam to assess dilatation, effacement, station, presentation, position and the presence of the fetal cord.
5. Apply fetal scalp electrode if ordered/indicated.
6. Notify physician immediately of fetal heart rate pattern, interventions and fetal response.

E. The nurses and Dr. Kruszewski failed to identify and act upon the severe periodic changes and loss of variability. This led to progressive and profound fetal hypoxia, asphyxia and permanent neurological damage. These actions were below the accepted standard of care.

1. The nurses and Dr. Kruszewski were unfamiliar with the basic concepts and principles of fetal monitoring resulting in the unrecognized progressive iatrogenic fetal asphyxia.

Dr. Kruszewski admitted that she failed to review the entire fetal monitoring strip when she arrived at the hospital at 9:30 p.m. (deposition pg. 47). This was below the accepted standard of care.

Dr. Kruszewski demonstrated a lack of understanding of basic fetal monitoring as evidenced by her deposition testimony.

Question – "What do you mean when you say prolonged decelerations?" (pg. 25)

Answer – "Again, that varies from case to case. There is no strict definition of what a prolonged deceleration is."

According to a Parer, the definition of a prolonged deceleration is, "an abrupt decreased (defined as onset of deceleration to beginning of Nader of less than 30 seconds) in FHR from the baseline. The decrease in FHR below the baseline is at least 15 beats per minute, lasting (from baseline to baseline) at least 15 seconds and is greater than two minutes, but less than 10 minutes."[31]

Question – "What is a sustained bradycardia?" (pg. 49)

Answer – "That the heart rate went down below 100 beats per minute and stayed that way for more than two or three minutes."

According to Parer, "a bradycardia is considered to represent a decrease in heart rate below 110 beats per minute for 10 minutes or longer."[32]

Dr. Kruszewski also demonstrated a lack of understanding of the fetal scalp stimulation test by noting in her deposition (pg. 57),

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

When Gloria Bennett was asked about fetal scalp stimulation on page 42 of her deposition she responded,

Question - "What is fetal scalp stimulation?"

Answer - "Where you just rubbed the baby's head and watch how the heart rate responds."

Question - "Did the heart rate respond to that?"

Answer - "Yes, it would come up to baseline."

According to Parer, with reference to scalp stimulation, "in the case of suspected fetal acidosis the scalp is digitally stimulated during vaginal examination and a FHR monitor observed for acceleration of 15 seconds duration, peaking 15 beats per minute above the baseline FHR.[33]

2. The nurses and Dr. Kruszewski were unfamiliar with the pathophysiology and clinical presentation of fetal asphyxia.

When Dr. Kruszewski was asked in her deposition, pg.49, whether or not the baby was asphyxiated she responded as follows,

Question – "Okay. Was the baby asphyxiated?" (pg. 50)

Answer – "No"

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[31] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg148.
[32] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg152.
[33] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 120

Question – "Do you know what the term asphyxiated means?" (50)
Answer – "Yes."
Question – "What does it mean to you, Doctor?"(50)
Answer – "Significant deprivation of oxygen causing metabolic abnormalities."
Question – "How did you determine the baby was not asphyxiated when it was delivered?"(51)
Answer – "By the cord pH."
Question – "You weren't able to make an observation?"(51)
Answer – "No."
Question - "And make that determination?"(51)
Answer – "No."
Question – "Is there any way that you could have determined whether or not the infant was experiencing asphyxia if she was prior to her delivery?"(66)
Answer – "No"
According to the Hospital Policy and Procedure, P/PR No. 76.1, entitled Active Management of labor in Primipara:
"Consider check scalp PH if suspicious of fetal distress."

Dr. Kruszewski was contradicted by the deposition testimony of Richard Grout, pg. 39, when he states,
Question – "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that as evidence of acidosis?"
Answer – "Correct."

This patient had a prolonged period of repetitive severe variable decelerations and fetal bradycardia with complete loss of short term variability. Dr. Kruszewski and the nurse failed to recognize the progressive fetal asphyxiation. Dr. Kruszewski failed to place an internal scalp electrode, failed to place an intrauterine pressure device, failed to stop the pitocin and failed to perform a cesarean section. These deviations were below the accepted standard of care.

According to Parer, "there is also general agreement that the fetus with absent FHR variability, a heart rate within or outside the normal range, and deep variable or late decelerations, is presumed to be asphyxiated, and expeditious delivery is indicated."[34]

According to Parer, "fetal asphyxia almost always occurs as a result of insufficient umbilical or insufficient uterine blood flow."[35] This can be seen with umbilical cord compression and with uterine hyperstimulation.

According to Parer, "In the presence of normal FHR variability, no matter what other FHR patterns may be present, the fetus is not suffering cerebral tissue asphyxia, because it has been able to successfully centralize the available oxygen and is thus is physiologically compensated. In the presence of excessive asphyxial stress, however, as evidenced by severe periodic changes or prolonged bradycardia, this compensation may break down, and the fetus

[34] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 201
[35] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg198.

may have progressive central tissue asphyxia (i.e., hypoxia in cerebral and myocardial tissues). In this case, it is theorized that fetal heart rate variability decreases and eventually is lost."[36]

According to Parer, "the presence of FHR variability indicates central (nervous system and or myocardial) normoxia, while its decrease in the presence of distress patterns indicates a decrease in the oxygenation of these organs."[37] A decrease in oxygenation leads to hypoxia, acidemia, and asphyxia.

According to ACOG, "the term asphyxia should be reserved for the clinical context of damaging acidemia, hypoxia, and metabolic acidosis. The committee strongly supports the concept that a neonate who has had hypoxia proximate to delivery severe enough to result in hypoxic encephalopathy will show other signs of hypoxic damage, including all of the following:

1. Profound metabolic or mixed acidemia (pH less than 7.00) on an umbilical cord arterial blood sample, if obtained.
2. Persistent Apgar scores of 0-3 for longer than five minutes.
3. Evidence of neonatal neurological sequelae (e.g., seizures, coma, hypotonia, and one or more of the following: cardiovascular, gastrointestinal, and the to logical, pulmonary, or renal system dysfunction)."[38]

According to the deposition testimony of Karen Constantino, she was called Stat close to midnight to the delivery room.

Question - "Did you perform a blood gas or did you extract the blood to submit to the lab for a blood gas test from the cord?"(7)

Answer - "We don't submit them to the lab. We run them and draw and them, it's a respiratory function."

Question - "So you do both testing and the obtaining of the blood sample to be tested?"(7)

Answer - "Right"

Question - "Did you do that in this case? (7)

Answer - "Yes I did."

Question - "How did you obtain the blood gas sample in this case?"(7)

Answer - "I used they -- we have pre-Heparinized syringes for drawing blood and just insert the needle in either the vein or the artery of the cord and draw sufficient amount to which each usually around 3 cc and then we put them in the blood gas machine which reads the values.

Question - "Do you keep a record of whether you put the needle in the vein or the artery?"(7)

Answer - "No, because sometimes depending on the twist in the cord, it's hard to know exactly which value you're getting and sometime the blood's mixed."

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[36] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 157.

[37] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 202.

[38] ACOG Committee Opinion, No. 197, February 1998.

Question - "OK. In this case would the chart show or would you have any record of where the sample actually came from?"

Answer - "No, it's just I would have marked it a cord gas."

According to the deposition of Richard Grout,

Question - "Dr. Chandrasrasekar also noted a cord pH of 7.13. What was the significance of that finding to you when you took over Mikayla's care?"(15)

Answer - "That indicates the infant had acidosis at the time of birth. The accuracy of that finding is difficult to assess sometimes because it's not always known whether that sample comes from the cord artery or the cord vein."

"Or it can be a mixture of the two together."

"And it's difficult to know for sure when they obtain that sample whether it's a pure vein, pure artery or a mixture of the two."(16)

Question - "When you stated on the cord gas which I think was around midnight was taken, you indicated that was not reliable because you didn't know what vessel it came from?" (38)

Answer - "Correct"

Question - "And is that because of the person taking the sample, could you explain that a little more, I know you explained there were a vessel and an artery?"(38)

Answer - "I believe it has to do with the technique that's used to do it."

Question - "Do you know what technique was used here" (38)

Answer - "They still do it the same way. It is basically, the sample of the cord is isolated between two clamps, and a needle attached or syringe is inserted in the cord and they attempt to aspirate back blood and hopefully -- usually they try to go to the vein.

Question - "We have no evidence here, other than the fact there was the cord gas, we don't know whether they were in the vein or an artery, is that what you're saying?"(38)

Answer - "Correct, you don't know for absolute certainty which one."

Question - "So indeed it could be a valid test too?"(39)

Answer - "Well, its validity is, it certainly couldn't be any better than it was. I mean the best -- the sample coming from the vein with the blood going to the baby, and hopefully that would be the best that he could be."

Question - "Would you consider 7.13 cord gas, I think it was reported at 1210 or thereabout, could you consider that is evidence of acidosis?(39)

Answer - "Correct."

According to the history and physical exam of Dr. Chandrasekhar, "the baby was limp at birth and with no heart rate or respirations. Apgar at one minute was 0/10, at five minutes was 3/10, at 10 minutes was 4/10 and at 20 minutes was 5/10." "Chest compressions were provided for less than 30 seconds for low heart rate of 60 per minute for less than 30 seconds." The first gas in the NICU showed a pH of 6.60.

Dr. Grout admitted in his deposition that the cord pH obtained at delivery indicated fetal acidosis.

The baby's neurological exam was markedly abnormal and the baby was placed on prophylactic phenobarbital for seizures.

According to the discharge summary dictated by Dr. Richard Grout, the transferred diagnosis was, "severe birth asphyxia, term birth."

After evaluation at the Children's Hospital of Pittsburgh revealed no baseline brain activity, the baby was withdrawn from life support and died.

The final autopsy report indicated, "A five day old female with hypoxic encephalopathy (clinical)" and a brain with "acute ischemic encephalopathy, severe."

According to the Autopsy Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

In my opinion to a reasonable degree of medical certainty this baby was repetitively and progressively iatrogenically asphyxiated by the nursing staff and Dr. Kruszewski resulting in profound central nervous system destruction, and eventually the death of the baby.

3. The patient had multiple episodes of unrecognized iatrogenic asphyxial stress which required intervention by cesarean section. Not performing a cesarean section in this situation resulted in fetal asphyxia and permanent brain damage. This was below accepted standard of care.

The fetal monitor revealed episodes of prolonged decelerations, severe variable decelerations with and without late components, fetal bradycardia, and loss of variability.

In review of the fetal tracing the patient had a reassuring fetal tracing on admission which correlates highly with fetal well being.

The pitocin was started at approximately 12:39 p.m. after over 4 hours of no cervical change and active phase arrest. The patient was noted to have fetal bradycardia from 15:02 to 15:21 associated with uterine hyperstimulation. A scalp electrode and intrauterine pressure device should have been placed, the pitocin stopped, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

The tracing revealed a prolonged deceleration from 15:37 to 15:41 associated with uterine hyperstimulation. The variability was decreased after the prolonged deceleration mandating placement of a scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care. The hyperstimulation mandated placement of an intrauterine pressure device to accurately monitor the contraction pattern and the pitocin should have been discontinued. Not doing so was below the accepted standard of care. According to Dr. Kruszewski's deposition testimony,

Question - "what kind of things would you be looking for to determine whether intervention was an option during labor?" (pg. 25)

Answer – "prolonged decelerations or decelerations that were occurring very frequently with the mother remote from delivery, decreased in fetal heart rate variability." She defines

intervention as, "can be any number of things, it can be a C-section, it can be a vacuum assisted delivery." (pg. 24).

The nurse notes on the strip at 15:38, "SVE 4-5cm 70% -2.", "Dr. Kruszewski called in, report given of recent variable decels and pitocin changes." The pitocin should have been discontinued, and the patient taken to cesarean section for arrest in the active phase of labor. Not doing so was below the accepted standard of care.

The Toco revealed an increased baseline from 17:10 to 17:20, requiring the reference to be readjusted again. The nurse also noted on the fetal tracing that there were multiple maternal position changes making interpretation of the uterine contraction pattern even more difficult. Not placing an intrauterine pressure device was below the acceptable standard of care.

The nursing staff continued to increase the pitocin in the face of arrest in the active phase of labor associated with uterine hyperstimulation from 16:40 on. They did not inform Dr. Kruszewski that the patient was being iatrogenically hyperstimulated, they failed to stop the pitocin and to insist that Dr. Kruszewski come in to evaluate the patient. These deviations were below the accepted standard of care.

The hyperstimulation with pitocin continued and the nurse noted on the tracing that the patient was placed in the knee chest position at approximately 18:49. The tracing indicated at this point that the "UA INOP, CARDIO INOP". The fetal heart tracing from 18:50 to 19:11 was inadequate and unreliable. The nurse notes on the fetal tracing that, "poor fetal and uterine toco capture while pt in knee chest against BB." At this time the patient was hyperstimulated with contractions almost every minute. Dr. Kruszewski should have been notified, a fetal scalp electrode and intrauterine pressure device should have been placed, the pitocin should have been discontinued, and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 20:08, the cervical exam was unchanged. The patient was arrested in the active phase of labor for over 12 hours, associated with uterine hyperstimulation. A cesarean section was indicated. Not performing one was below the accepted standard of care.

At 20:31, the nurse again documents a note indicating that "Dr. Kruszewski on phone aware of last 2 exams, Pit level, periods of hypertonic appearing FHR average variability, IV fluid bolus. The nurse should have insisted that Dr. Kruszewski come in to evaluate the patient and discontinue the pitocin. The nurse should have insisted that Dr. Kruszewski be present to manage the patient. She should have discontinued the pitocin augmentation because of the arrest in the active phase of labor and because of the uterine hyperstimulation. These deviations were below the accepted standard of care.

Instead, the nurse increased the pitocin to 26 mu/min. If Dr. Kruszewski failed to respond, the nurse should have involved the nursing supervisor, Chief of Obstetrics and or the Hospital Administrator. According to the Hospital Policy and Procedures, No. 82, entitled Physician Notification in Maternal/Fetal Distress:

"When patients demonstrate maternal or fetal distress, the attending Physician will be notified immediately and his specific orders carried out."

"The hospital Supervisor should be notified."

"In the event the attending Physician fails to respond, the Labor Room Nurse will notify the Manager or Supervisor. The Chief of Service may be notified for advice."

Other procedures noted are to "See Medical Staff Chain of command."

The nurse documents that Dr. Kruszewski was notified of the last 2 pelvic exams, periods of hypertonic appearing UC, fetal heart rate with average variability, and that an IV fluid bolus was given. The pelvic exam at that time was 4-5 cms. The patient's cervical exam was unchanged despite aggressive pitocin augmentation. A cesarean section was indicated. Not performing a cesarean section and proceeding with the aggressive pitocin augmentation was below the accepted standard of care and lead to iatrogenic hyperstimulation, severe periodic changes, loss of variability, end stage bradycardia and eventually profound and irreversible brain damage.

At 2057, the patient had an episode of bradycardia lasting approximately 16 minutes associated with hyperstimulation, and an increased contraction baseline requiring placement of a scalp electrode, intrauterine pressure device, and discontinuing the pitocin. Not doing so was below the accepted standard of care. Although the nurse notes on the strip that the fetal heart rate was consistent with "maternal" heart rate, the only way to differentiate maternal from fetal heart rate was by placement of a scalp electrode.

The nurse failed to make Dr. Kruszewski aware of the fetal bradycardia, abnormal uterine activity pattern, uterine hyperstimulation, and increased baseline tone. She failed to insist that Dr. Kruszewski evaluate the patient. She failed to place a scalp electrode and intrauterine pressure device. She failed to discontinue the pitocin. These deviations were below the accepted standard of care.

At around 2120, the fetal strip revealed variable decelerations.

At 2131 the pitocin was decreased to 20mu and maternal position was changed.

The variability was decreased to absent from 2138 and through 2200. The nurse notes the EFM tracing "to present" reviewed by Dr. Kruszewski. At that time a pelvic exam was done by Dr. Kruszewski and the pitocin was decreased to 16mu.

The patient began pushing at approximately 2213. The patient had an abnormal uterine activity pattern. The strip revealed areas of drop out and difficulty monitoring the contraction pattern with multiple recalibrations of the UA reference mandating placement of a fetal scalp electrode and intrauterine pressure device. Not doing so was below the accepted standard of care.

The fetal heart tracing demonstrates that the patient was having decelerations at approximately 22:37.

In reference to the fetal tracing at 10:54 (22:54), Nurse Bennett states in her deposition,
Question – "Did the decelerations at this point concern you in any manner?"(36-37).
Answer - "I'd like to see the patient delivered."

The fetal tracing from 22:40 forward was suboptimal with areas of drop out, severe periodic changes and loss of variability.

There are multiple references by the nurses regarding difficulty tracing the fetal heart rate during labor. According to the deposition testimony of Gloria Bennett when asked about the variable decelerations at 1037,

Question - "You lost the heart rate on the monitor?"(34)

Answer - "Right, when they're doing this, baby's usually moving to get off the cord so you don't always keep capture the whole way through."

With reference to a variable at 1039,

Question – "Ok. And how long would that have lasted?"(35)

Answer – "That's indeterminate because of inadequate capture."

When referring to a variable at 1052 she states,

Answer - "At 52, there was shown a returning to baseline of 120's but there is not an accurate measure of whether it was maternal heart rate were capturing or fetal, so I can't determine that."(36-37)

Answer – "54, same scenario, 90s -- returning from the 90s after inadequate capture."(36-37)

Answer - "When the mother is pushing to, they're often in the position, where they're bumping the monitor she can't keep in the fetal heart rate all in the entire time."(36-37)

When referring to a deceleration at 2331 she states,

Answer - "At which time capture was lost for seconds, and when it recaptured was 120's."(40)

According to the deposition testimony of Sherry Kizina,

When asked about a variable deceleration at approximate 8:45 a.m. (on page 88 of the transcript),

Answer – "that's not clear; it's not captured the whole way."

According to Parer, with reference to the external heart monitor, "although this device is simple to apply and can be used before rupture of the membranes, it sometimes is unreliable during labor because of maternal and fetal movement. A greater disadvantage is that it may not always give a valid indication of beat to beat variability, because the Doppler signal is broad and slurred, and the machine is not always able to select accurately and consistently a point on this slurred curve to represent the exact time of a cardiac event. Hence, an artificial short term variability can be portrayed by the apparatus. Long term variability, however may be displayed reasonably accurately."[39] According to Parer, with reference to a fetal scalp electrode, "this mode gives the most valid FHR tracing because of the discreteness of the signal; therefore, it best depicts beat to beat variability."[40]

An IV fluid bolus was given at 2244; oxygen was started at 2247 via nasal cannula. A scalp electrode and intrauterine pressure catheter were mandatory in this situation. Not utilizing these modalities was below the accepted standard of care.

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[39] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 103

[40] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 102.

At and after 2250 the patient was hyperstimulated, was having repetitive severe periodic changes and loss of variability consistent with fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care

At 2306, 02 via facemask was applied at 10 L per minute, the patient had an abnormal uterine activity pattern and was having decelerations which were more severe associated with loss of variability signaling fetal asphyxia. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

At 2312 an IV fluid bolus was given and continued.

From 2310 forward the patient continued to have an abnormal uterine activity pattern, with severe periodic changes now with late components and loss of variability signaling fetal asphyxia and central nervous system compromise. The pitocin should have been discontinued and the patient taken to cesarean section. Not doing so was below the accepted standard of care.

Dr. Kruszewski stated in her deposition testimony (pg. 23) that "fetal stress can be some heart rate decelerations, changes in the variability of a heart rate pattern."

Question – "what do you consider to be non-reassuring fetal monitoring tracing?"(pg.28).

Answer – "frequent decelerations, decelerations with each contraction or almost every contraction that don't respond spontaneously to the end of the contraction, significant decrease in fetal heart rate variability." Allowing the patient to continue to labor in the face of progressive repetitive severe variable decelerations with loss of variability, resulted in fetal asphyxia and central nervous system damage. This was below the accepted standard of care.

According to Parer, severe variable decelerations are described as,

"A. Below 60 beats per minute and

B. Longer than 60 seconds in duration."[41]

Other practitioners use the "rule of 60s" as a guideline.

"When severe variable decelerations are present, vigorous efforts should be made to abolish them, because it is likely that even the normally grown fetus with normal placental function eventually will decompensate, although usually not before 30 minutes."[42]

According to Parer, "during severe variable decelerations the heart rate pattern must be observed for an intermittent reduction in FHR variability during and following the variable deceleration. Should this begin to occur and still abolition of the decelerations can not be achieved by the means outlined above (resuscitation maneuvers), then delivery is recommended. Delivery is recommended before the total loss of variability because this may signify asphyxial decompensation, and indeed must be present to do so unless asphyxia can be ruled out by ancillary methods."[43]

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[41] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[42]Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 170.

[43] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

"Severe variable decelerations in the presence of frequent uterine activity may become confluent and form a prolonged deceleration, and eventually a bradycardia. Therefore in the presence of persistent severe variable decelerations it is prudent to attempt to maintain uterine contractions more than two minutes apart."[44] At 2330, the tracing revealed multiple severe variable decelerations with loss of variability associated with uterine hyperstimulation consistent with fetal asphyxia and central nervous system damage. This pattern finally terminated in severe bradycardia at 2338. The fetal tracing at this point was not traceable and unreliable.

The nurse notes that the pitocin was discontinued at 2343 and that the fetal heart rate was audible from 60 to 70. Emergent delivery was mandatory.

Dr. Kruszewski admits in her deposition that,

Question - "What can happen in a situation where the heart rate is that low and stays down?"(49)

Answer - "The baby's deprived of oxygen."

Question - "What happened in this case?"

Answer - "The baby was acidotic."

If Dr. Kruszewski contends that the startup time for her cesarean section was excessive, then this knowledge should have been applied to the management of the asphyxial stress due to the severe periodic changes by earlier delivery. Not doing so was below the accepted standard of care.

It is my opinion that the progressive, repetitive, severe variable decelerations with total loss of variability associated with uterine hyperstimulation, resulted in irreversible fetal asphyxia and neurological injury which had already occurred prior to the terminal bradycardia, rendering mode of delivery at this point irrelevant.

The nurse notes on the fetal tracing that the heart rate was audible at 50 beats per minute and dropping.

At 2346, the orders are received for vacuum. A second RN was called to the room.

According to the notation on the fetal tracing;

The vacuum was applied by Dr. Kruszewski at 2348 and at 2350 nurses are unable to capture the fetal heart rate.

At 2351, the time of delivery, the NICU was notifying to come stat upon delivery of the infant. The baby was delivered by Dr. Kruszewski.

On page 49 of her deposition when asked about her recollections of labor and delivery Dr. Kruszewski notes, "she was complete about 10 p.m. and started to push, and the progress of pushing was going relatively well, and then towards the end, just before the baby delivered, she began having decels, that didn't respond to scalp stimulation and other interventions, and the baby was crowning at that time so I asked for a vacuum to facilitate the delivery. Dr. Kruszewski's deposition testimony was contradicted by the fetal tracing and her own deposition testimony. The fetal tracing revealed multiple repetitive severe variable decelerations with loss of variability and bradycardia for up to one hour prior to delivery of Mikayla. The baby was not crowning but was noted to be at the +1 to +2 station at the time of the vacuum application. Dr. Kruszewski in her deposition (pg. 57) states,

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[44] Handbook of FHR Monitoring, Second edition, Parer et. Al, 1997, pg 216-17.

Question - "Were you aware that Kim Rhoades was having multiple variable decelerations?"

Answer - "Yes".

Question - "And did that cause you any concern?'

Answer - "No, because they responded back to baseline with scalp stimulation, and the beat to beat variability was generally good through out."

Dr. Kruszewski chose to perform a midpelvic vacuum extraction without first performing clinical pelvimetry, and chose to do so on a baby that was macrosomic. The decision to employ vacuum extraction at this time was futile since the baby was already asphyxiated and neurologically compromised.

Severe repetitive periodic changes were present as early as 2237 which became more severe and atypical until they resulted in the end stage bradycardia documented by the nurse prior to delivery. A scalp electrode was not placed to evaluate variability and fetal well being. An intrauterine pressure device was not placed in light of the uterine hyperstimulation and difficulty maintaining the external toco. The pitocin was not discontinued when the iatrogenic pitocin augmentation resulted in repetitive severe periodic changes terminating in fetal bradycardia. A cesarean section was not performed when the severe periodic changes became repetitive and resulted in loss of variability. These deviations were below the accepted standard of care.

When Dr. Kruszewski was asked whether there is a time when bradycardia becomes significant in whether the child will be delivered healthy, she answered "not that I'm aware of."(pg. 55)

In review of the report of Dr. Sommers, there were numerous inaccuracies and omissions:

She notes that the baby was transferred to Children's Hospital of Pittsburgh and that "over the next few days her condition deteriorated." According to the inpatient discharge summary authored by Carol Gilmour on 6/28/02, "Neurology's impression was that of a severe hypoxic ischemic encephalopathy." "Over the next several days there was no change in Mikayla's exam".

Dr. Sommers notes that, "An autopsy was performed and the clinical diagnosis was acute total asphyxia of unknown etiology and subsequent perinatal hypoxic/ischemic encephalopathy."

According to the Final Autopsy Report: The final autopsy diagnosis was "a five day old female with hypoxic encephalopathy (clinical)."

According to the Summary/Discussion: "At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to perinatal asphyxia." ---- "the cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor."

Dr. Sommers did not address the lack of an indication for the induction, the failure to discuss the reason for and risks associated with induction and or augmentation with the patient, the fact that the patient had evidence of fetal macrosomia, cephalopelvic disproportion, and that

the Mrs. Rhoades was not examined by Dr. Kruszewski for fetal size or clinical pelvimetry prior to the induction and or augmentation.

Dr. Sommers failed to question the lack of documentation indicating the reason for the pitocin augmentation. She did not address the management of this patient who was arrested in the active phase of labor for up to 12 hours. She did not question why the pitocin augmentation was started after 4 hours of no cervical change and why the patient was not taken to cesarean section after 2 hours with no cervical change.

Dr. Sommers did not note that the nurses and Dr. Kruszewski failed to recognize and properly manage the prolonged episodes of uterine hyperstimulation.

Dr. Sommers failed to question why an intrauterine pressure device wasn't placed after the nurses were having difficulty maintaining the external tracing, after the multiple attempts at recalibration by the nurses were noted, after the baseline tone was increased and because of the uterine hyperstimulation.

Dr. Sommers did not address the inability of the nurses and Dr. Kruszewski to recognize asphyxial stress and to appropriately manage it. Dr. Sommers failed to question why a fetal scalp electrode was not placed with fetal bradycardia, prolonged decelerations, with extensive fetal dropout (while in knee chest), with decreased variability, and with repetitive decelerations.

Dr. Sommers failed to address why the pitocin was continued and the patient not taken to Cesarean section despite the recurrent severe periodic changes, uterine hyperstimulation, and the ominous fetal heart pattern with loss of variability indicating fetal asphyxia.

Nurse Comport's report contained numerous inaccuracies:

She notes that "an ultrasound done on 4/13/02, just 22 days prior to delivery, revealed a fetus at 3383 grams or 7#7oz confirming an average sized infant." She than goes on to mention that "the hospital staff did not make a determination of fetal weight either clinically or sonographically. However, this is refuted by the fact that ultrasound assessment had just been recently done revealing a normal sized infant."

The ultrasound examination was done more than 3 weeks prior to delivery and was not done "recently." Nurse Comport fails to substantiate how she concluded that the baby was "average size" since there was no percentile weight for gestational age given in the ultrasound report. Using standard tables, the percentile weight for gestational age approached the 90$^{th}$ percentile. What actually did happen was that Dr. Kruszewski failed to evaluate the fetal weight and pelvis on admission, failed to recognize that this baby was macrosomic, and failed to realize that an unengaged fetal head at -3 station indicated cephalopelvic disproportion. These deviations were below the accepted standard of care.

Nurse Comport opines that "a second issue addressed is the lack of appropriate nursing, assessments and responsiveness to the fetal heart rate changes." As illustrated in my report, the nurses were unfamiliar with the basic concepts of fetal monitoring, and principles of labor and delivery. They failed to recognize that this patient was arrested in the active phase of labor. They failed to insist that an intrauterine pressure device was placed after numerous attempts at recalibration, after abnormal uterine activity patterns were noted, and because of the iatrogenic

uterine hyperstimulation with pitocin (see P/PR No. 61.2). They failed to place or have Dr. Kruszewski place a fetal scalp electrode when the tracing revealed dropout, prolonged decelerations, bradycardia, repetitive decelerations and loss of variability (see P/PR No. 61.3). They failed to discontinue pitocin with the presence of nonreasurring and or ominous fetal heart rate patterns and when abnormal uterine activity patterns were present as per the Hospital's Policy and Procedures, P/PR No. 61.2.

Nurse Comport than goes on to note that, "Criticism has been raised that the pitocin was only decreased and not discontinued, but this is an appropriate course of action. You want to decrease the pitocin to decrease the contraction frequency, which in turn facilitates more oxygenated blood to the fetus." Even more of a reason to discontinue the pitocin optimizing blood flow and oxygenation to the baby. Nurse Comport failed to review the Hospital's Policy and Procedures P/PR, No. 61.2, which states that the procedure indicated for nonreasurring, ominous and abnormal uterine activity patterns is to "Discontinue oxytocin if in use."

She than mentions that "However, you also want to expedite the delivery especially if there are any signs of a change in the fetal heart rate pattern such as variable deceleration." Another way to expedite delivery, without exposing the baby to the asphyxial stress caused by variable decelerations, is by performing a Cesarean Section. Not doing so was below the accepted standard of care.

Nurse Comport finally goes on to note that, "During the second stage or the time the patient was pushing there were times when the fetal heart rate pattern was concerning. This is a relatively common occurrence with pushing as the uteroplacental blood flow is diminished during the pushing effort." Nurse Comport admits that there were times that the fetal heart rate pattern was concerning but fails question why a fetal scalp electrode was not placed, why the pitocin was not discontinued, and why the nurses did not insist that Dr. Kruszewski stop the pitocin augmentation and take this patient to cesarean section.

Nurse Comport recognizes that uteroplacental blood flow is diminished during the pushing effort. She failed to recognize that, in this case, the aggressive pitocin augmentation with uterine hyperstimulation and pushing resulted in decreased blood flow resulting in repetitive severe variable decelerations associated with loss of variability indicated hypoxia and asphyxia. The nurses did not stop the pitocin. They did not recognize that Mrs Rhoades was hyperstimulated and was having decelerations requiring placement of a fetal scalp electrode, intrauterine pressure device, discontinuing the pitocin and insisting that Dr. Kruszewski take this patient to cesarean section. These deviations were below the accepted standard of care.

If the nurses had truly recognized the significance of the fetal tracing, the nurses could have followed Hospital Policy and Procedure P/PR No. 82, entitled Physician Notification in Maternal/Fetal Distress. They chose not to. They did not recognize and act on the progressive iatrogenic fetal asphyxia caused by the aggressive pitocin augmentation and uterine hyperstimulation.

I reserve the right to amend this report if and when any further information becomes available to me.

Sincerely,

James L. Mollick, M.D., FACOG

Children's Hospital of Pittsburgh

3705 Fifth Avenue
Pittsburgh, PA 15213-2583

INPATIENT DISCHARGE SUMMARY

RHOADES, MIKAYLA
MRN 979701
DOB 05/10/2002
ADMISSION 05/11/2002
DISCHARGE 05/14/2002
**Attending Physician Carol Gilmour MD**

## BIRTH WEIGHT
4.42 kg

## WEIGHT AT DEATH
4.46 kg

## ADMISSION DIAGNOSIS
1. Term female
2. Seizures
3. Rule out sepsis
4. Rule out metabolic disease

## DIAGNOSIS AT THE TIME OF DEATH
1. Term female at 4 days of age
2. Hypoxic ischemic encephalopathy

## BIRTH HISTORY
Mikayla was the 40-week, 4.42 kg female infant delivered to her 34-year-old G-1 P-0 AB+, serology negative, GBS negative mother. The baby was born by spontaneous vag assisted delivery with a vacuum extraction. She was noted to have fetal bradycardia during the second stage of labor. The antenatal course was reportedly unremarkable and uncomplicated. The mother took no medications during her pregnancy. The baby was born at Dubois Hospital. She was limp at birth with no heart rate or spontaneous respiration. Apgar at one minute was 0, Apgar at five minutes was 3 with 1 for color and 2 for heart rate. Apgar at ten minutes was 4 with 2 for color and 2 for heart rate. At twenty minutes of age, the Apgar was listed as 5 with 2 for color, 2 for heart rate and 1 for grimace. She did have chest compressions for <30 seconds for a low heart rate. The baby was then transferred to Dubois NICU for further management. The first blood gas in the NICU when the baby was being put on the ventilator showed a pH of 6.6, pCO2 of 95, pO2 73, bicarb 8.6. Within an hour on the ventilator the pH was 7.3 wit a CO2 of 23 and a pO2 of 197 with a bicarb of 11 and a base deficit of –14. The infant was started on prophylactic phenobarb to prevent seizures and was transferred to Children's for further management and neuro-evaluation. Upon arrival at approximately 12 hours of life, she did have quivering of her diaphragm, bilateral ankle clonus, she had no spontaneous movement, she did not have a gag, she had some spontaneous breathing. In response to suctioning she had an inconsistent grimace. The baby was evaluated for sepsis. We also had Neurology evaluate her. Her EEG x 2 showed no baseline activity, just intermittent focal sharp waves. She had a CT scan x 2 that showed a slight increase in the density of the cortex, small temporal bleeds and minimal soft tissue swelling. On exam, she continually had loss of spontaneous eye opening and spontaneous movement. She had no gag, no corneal reflexes. Neurology's impression was that of severe hypoxic ischemic encephalopathy. Over the next several days there was no change in Mikayla's exam. There was continued fixed pupils to 4 mm, no spontaneous eye movement, no grimace or gag. After discussion with Neonatology, Neurology, Social Work and the parents concerning Mikayla's condition and poor prognosis for a meaningful recovery, it was decided to withdraw life support. The etiology is suspected to be acute perinatal total asphyxia. However, metabolic and karyotype tests are pending but the results will not change the outcome for the child. This was discussed thoroughly with the parents so the family did discontinue support of this infant.

CHILDREN'S HOSPITAL OF PITTSBURGH
INPATIENT DISCHARGE SUMMARY
**Attending Physician** Carol Gilmour MD

**RHOADES, MIKAYLA**
**MRN** 979701
**DOB** 05/10/2002
**ADMISSION** 05/11/2002
**DISCHARGE** 05/14/2002

Dictated By:

Susan Ziders CRNP

Carol Gilmour MD

D: 06/28/2002 14:10:09/sz
T: 06/28/2002 15:16:28/ras
R *

pc Carol Gilmour MD, Attending Physician

Children's Hospital of Pittsburgh

Department of Pathology
3705 Fifth Ave. (412) 692-5650
Pittsburgh, PA 15213 (412) 692-6550 FAX

# Final Autopsy Report

| | | | |
|---|---|---|---|
| *Accession #:* | **CHA02-15** | *Patient Name:* | **RHOADES, MIKAYLA** |
| *Accession Date:* | **05/15/2002 10:12** | *MRN:* | **000979701** |
| *Date of Death:* | | *Location:* | **NICU (CHP)** |
| *Date of Autopsy:* | **05/15/2002** | *DOB/Age/Sex:* | **05/10/2002 (Age: 5 d) F** |
| *Post-Mortem Time:* | | *Account #:* | **8001213175** |
| *Service of:* | **Carol Gilmour, M.D.** | *Billing Type:* | **Children's Hospital** |
| *Restrictions:* | **None** | *Date of Admission:* | **05/11/2002 06:15** |
| *Procedure Physician/Copies To:* | | *Specimen Class/Bench:* | **CHAAN, CHP Autopsy Anatomic/Neuro** |

## FINAL AUTOPSY DIAGNOSIS:

RECEIVED
JUN 13 2002
MEDICAL RECORD SERVICES

A 5-DAY-OLD FEMALE WITH HYPOXIC ENCEPHALOPATHY (CLINICAL)

BRAIN (473.0 GRAMS, EXPECTED 355.0 GRAMS)
ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE.

EDEMATOUS AND CONGESTED LUNGS

BIVENTRICULAR HYPERTROPHY OF HEART (0.5 CM EACH)
VACUOLATION OF MYOCYTES.

CONGESTED HEPATOMEGALY (228.0 GRAMS, EXPECTED 78.0 GRAMS)
PARENCHYMAL HEMATOMA (2.5 CM IN GREATEST DIMENSION) RIGHT LOBE OF LIVER

CONGESTED SPLEEN (12.7 GRAMS, EXPECTED 8.0 GRAMS)

THYMIC DEPLETION

HEMORRHAGIC ADRENAL GLANDS

CONGESTED KIDNEYS (COMBINED WEIGHT 58.5 GRAMS, EXPECTED 27.0 GRAMS)

PERICARDIAL FLUID 3 ML

GENERALIZED PITTING EDEMA

WAD/WAD

Pathologist: Sarangarajan Ranganathan, MD
**Report Electronically Signed Out**
By Pathologist: Sarangarajan Ranganathan, MD
06/12/2002 16:49

**My signature is attestation that I have personally reviewed the submitted material(s) and the final diagnosis reflects that evaluation.**

## SUMMARY/DISCUSSION:

This 5-day old female child, a product of a full-term pregnancy, was born by vaginal delivery. Due to fetal heart decelerations during second-stage of labor, vacuum assistance was used for delivery. At birth the child had poor APGARS of 0, 3, 4 and 5 at 1, 5, 10 and 20 minutes respectively. She had a very low pH and was immediately intubated. She was subsequently transferred to Children's Hospital and had no spontaneous movements and inefficient respiration on admission. Her peripheral pulses and

reflexes were present. Her respiration improved but she could not be weaned from ventilatory support. Due to the degree of brain damage, she was taken off ventilatory support with the consent of the parents.

At autopsy the most significant finding of a severe hypoxic encephalopathy, most likely due to the perinatal asphyxia. There was congestion of all the organs with hypoxic changes in the cardiac muscle in the form of vacuolation and in the liver in the form of congestion with ballooning of hepatocytes. The only other significant finding was the presence of bilateral adrenal hematomas, which are probably due to the severe brain injury. There were no significant infections or congenital anomalies noted at autopsy. There was no evidence to suggest a metabolic or viral etiology. The placenta did not reveal any significant findings. The cause of death is acute ischemic and hypoxic encephalopathy due to severe perinatal asphyxia and may have been precipitated by hypoxia during labor.

**CLINICAL SUMMARY:**

Mikayla Rhoades was born at term by spontaneous vaginal delivery 5/10/2002 at 11:42PM to a 34yo mother who was G1P1Ab0, blood group AB+, with no medications, no past medical history, and normal serologies for Group B strep, Hep B, rubella (immune), and RPR. The baby had bradycardia during second stage labor, and was therefore delivered with vacuum-assistance. A loose nuchal cord was noted at delivery; cord pH was 7.13. Weight was 4.4 kg (large for gestational age). The placenta (558 grams) was remarkable for partial velamentous three-vessel cord insertion, amnion nodosum with focal squamous metaplasia (as seen in oligohydramnios), mild subchorionic and intervillous fibrin deposition, and areas of calcification, but had no evidence of chorioamnionitis or funisitis (ref: Dubois Regional Medical Center surgical report # S02-2629, 5/12/02).

The baby had no spontaneous respiration or heart rate at delivery. Chest compressions were provided for less than 30 seconds. APGAR scores were 0 at 1 minute, 3 at five minutes (1 color, 2 heart rate), 4 at ten minutes (2 color, 2 heart rate), and 5 at twenty minutes (2 color, 2 heart rate, 1 grimace). She was transferred to the NICU. Just prior to intubation, ABG showed pH 6.6, CO2 95, pO2 73, HCO3 8.6. Within 1 hour of intubation (ventilator peak pressures 24/4) and 2 mEq/kg bicarbonate administration, ABG improved to pH 7.3, CO2 23, pO2 197, HCO3 11, base deficit –14.
Laboratories drawn 5/11/02 @12:45AM were remarkable for AST 403 (nl 24-95), ALT 272 (nl 7-40), alkaline phosphatase 259 (nl 65-270), conjugated bilirubin 0.95 (nl <0.6 mg/dl), total bilirubin 1.3 (nl <5.8 mg/dl). Anion gap was 27.6. CBC showed Hct 53.5%; platelets 185000, WBC 32000 with 5% bands, 34% polys, 49% lymphs, 8% monos, 2% eosinophils, and 5 nucleated RBCs. Blood cultures were negative at +48 hrs.

On 5/11/02, the baby was dosed with phenobarbital for seizure prophylaxis and transferred to Children's Hospital of Pittsburgh. At +12 hours of life, the baby had chin and diaphragm quivering suspicious for seizure activity (treated with phenobarbital), bilateral ankle clonus, no spontaneous movements, inconsistent grimace to suctioning, and ineffective spontaneous respiration with low total volume. The baby did have spontaneous eye openings, light-reactive pupils, positive corneal and grasp reflexes. Pulses were equal with good cutaneous perfusion.
Repeat CBC showed platelet count of 193000 with WBC 42200 (55% polys, 13% bands, 9% lymphs, 8% monos, 10 nucleated RBCs). Ampicillin, cefotaxime, and acyclovir were initiated. Blood, CSF, & urine cultures were negative for organisms (+48 hrs); rectal, conjunctival & oral cultures were negative for HSV (preliminary). EEG showed no baseline activity other than intermittent muscle twitch patterns and focal sharp waves consistent with seizure activity. CT scan showed slight increase in cortex density, minimal soft tissue swelling and small subarachnoid hemorrhages over the posterior convexities, tentorium, and falx cerebri, with possible clot in dural venous sinuses. Neurology impression was severe perinatal acute total asphyxia.

On 5/12/02, she had improved spontaneous respiratory functions, but problems with handling large airway secretions prevented extubation. Heart rate and blood pressure increased overnight. Repeat neural exam showed deterioration with no grasp, no spontaneous eye opening, and no gag reflex, and non-reactive pupils. Physical exam showed small subgaleal occipital swelling and conjunctival erythema. Lung exam showed upper airway mucus but no rales. During the evening, she had decreased perfusion that responded to additional phenobarbital and fluids. A repeat CT showed no changes from the 5/11 study.
Laboratory studies from 12:00 showed improved liver function tests with AST 322, ALT 260, gamma GGT 118, alkaline phosphatase 112, LDH 1810, conjugated bilirubin less than 0.1.

On 5/13, she was noted to have further deterioration with no spontaneous breathing over the ventilator, fixed pupils, diffuse hypotonia, and spontaneous clonus of all extremities. EEG showed complete background suppression with two short epileptiform episodes originating from the left hemi-cortex.
Repeat laboratory studies showed continued improvement with AST 281, ALT 221, gamma GGT 81, alkaline phosphatase 112, LDH 1734, total bilirubin 4.3, conjugated bilirubin less than 0.1.

# Children's Hospital of Pittsburgh

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## Final Autopsy Report

**CHA02-15** **RHOADES, MIKAYLA**

On 5/14, in face of a poor prognosis for meaningful recovery, the family consented to removal of respiratory support. Mikayla Rhoades died at 4:31 PM. The family requested complete autopsy; organ donation was declined.
The clinician's principal diagnosis was a full-term infant with acute total asphyxia of unknown etiology and subsequent perinatal hypoxic/ischemic encephalopathy.

**GROSS DESCRIPTION:**

EXTERNAL DESCRIPTION: The body is that of a 5-day-old, adequately nourished, light–skinned baby girl with generalized pitting edema. The body measurements are as follows: Weight 4.54 kg (birth weight 4.4 kg), length 54.0 cm/expected 49 grams, crown-to-rump length 38.0 cm, head circumference 35.5 cm, chest circumference 35.0 cm, and abdominal circumference 34.0 cm. There is marked edema of the vertex and right side of the head. The scalp is covered by short fine, dark hair. The anterior fontanelle is small, measures 1.0 x 1.0 cm and is slightly depressed and firm. The posterior fontanelle is not palpable. The ears are unremarkable. The bridge of nose is broad. The sclerae are white, and the conjunctivas are edematous. The irides are slate-gray. Each pupil measures 0.4 cm in diameter. The inner canthal measurement is 2.6 cm/expected 2.0 cm, and the outer canthal distance is 9.0 cm. The interpupillary distance is 4.2 cm. Each palpebral fissure measures 2.1 cm. The nares are unremarkable. The lips are pink and slightly light purple. The tongue protrudes between the gums and is not enlarged. The hard and soft palates are intact. The chin is slightly small. The neck shows redundant skin. No cervical, axillary, or inguinal lymph nodes are palpable. The chest appears symmetrical, and the costal angle measures approximately 90 degrees. A small amount of breast tissue is palpable. The internipple distance is 9.5 cm. The abdomen is soft and flares slightly at the sides. The ventral edge of the liver is palpable 5 cm below the right costal margin in the midclavicular line. A catheter exits from the umbilicus. The genitalia appear normal for a child of this age. The legs are in a frog-like position. The skin over the extremities is slightly redundant. The toenail beds are slightly dusky. Both feet show a slight medial deviation. A puncture wound is seen over the lateral aspect of the right foot, near the ankle. A puncture wound is located on the medial-anterior aspect of the left foot, just below the ankle. The fingers and fingernail beds are very cyanotic; the left hand more than the right. A puncture wound is seen on the dorsal aspect of the left hand. Two puncture wounds are seen on the dorsal aspect of the right hand. Dorsally livor mortis is developed in dependent areas. A shallow sacral dimple with a few hairs is seen. Brown and green, soft material exits from the anus. Rigor mortis is mild in the extremities and in the muscles of mastication. The temperature of the body is that of the refrigerator. A tag on the shroud and on the left great toe identifies the body. The Autopsy Permit is signed. Permission for a complete autopsy is granted. The autopsy is begun at 10 AM on May 15, 2002, 15.5 hours after death.

INITIAL INCISION: The usual Y-shaped incision shows pink skeletal muscles and pale yellow panniculus adiposis measuring up to 0.9 cm in thickness over the abdomen.

ABDOMINAL CONTENTS IN SITU: Two umbilical arteries are identified, and a catheter lies in the right umbilical artery. The peritoneal cavity contains about 3 ml of yellow, clear fluid. The serosal surfaces are smooth and glistening. The abdominal situs is normal. The liver is diffusely congested and enlarged. The ventral edge of the liver extends 5.5 cm below the right costal margin in the midclavicular line, 5.0 cm below the xiphoid process, and 5.0 cm below the left costal margin in the midclavicular line. The gallbladder lies in the usual location. The spleen does not extend below the costal margin. The diaphragm is located at the fourth rib on the right and at the fifth rib on the left. The bowel is normally fixed and rotated. The large bowel is moderately distended from the proximal part of the transverse colon to the distal sigmoid colon. The fundus of the urinary bladder is located 3.0 cm superior to the synthesis pubis. The ureters are not dilated. The ovaries are enlarged, cystic appearing and edematous.

THORACIC CONTENTS IN SITU: The pleural cavities are free of fluid. The thoracic situs is normal. The lungs are overdistended, edematous and each lung fills approximately two-thirds of its pleural cavity. The pleural surfaces are pink, smooth and shiny. The secondary lobulations are slightly to moderately prominent. A few scattered, faint petechiae are seen over the pleural surfaces. The thymus is pink and lies in the usual location. The C/T ratio is 5.9/9.9. The pericardial sac contains 3 ml of light yellow, clear fluid. The heart sits mainly in the left chest with the apex pointing to the left. The ventricular mass sits in a slightly more horizontal position than expected. The right atrial appendage is distended with blood. Thoracic arteries and veins lie in the usual anatomical position.

CENTRAL NERVOUS SYSTEM IN SITU: The cerebrospinal fluid is pale, straw yellow, and slightly cloudy. Mild-moderate galea aponeurotica hemorrhage is seen over the right posterior parietal plate and occiput. The parietal plates are movable. The fresh brain weighs 473 grams/expected 355 grams and is diffusely swollen. The gyri are flattened, and the sulci are very shallow. A few scattered areas of mild subarachnoid hemorrhage are seen tracking over a few of the vessels. The pituitary gland is unremarkable. The dural sinuses at the base of the skull are free of thrombosis.

RESPIRATORY SYSTEM: The trachea and bronchi contain frothy fluid. No tracheobronchial exudate or inflammation is seen. The lungs are overdistended and edematous. The lower lobes are slightly congested. The combined weight of the heart and lungs

is 118 grams/expected 64 grams. The lungs are inflated through their main bronchi with 10% buffered formalin. After fixation, incisions show brown, uniformed cut surfaces.

HEART, AORTA AND CAVAL VEINS: The apex of the heart is slightly rounded. The epicardial surface of the heart is red and shiny. A scant amount of epicardial adipose tissue is seen. The atrial situs is normal. The superior and inferior caval veins connect to the right atrium in the usual fashion. The oval fossa is probe patent. The coronary sinus is normally sized. The tricuspid valve measures 4.1 cm in circumference. The commissure between the septal and ventral leaflets of the tricuspid valve extends to the annulus. The free edges of the leaflets of the tricuspid valve forming this commissure have a slightly scalloped appearance. A few pinpoint sized blood cysts are seen on the tricuspid valve. The right ventricle is not dilated. The myocardium of the right ventricle is hypertrophied and averages 0.5 cm in thickness. The pulmonary valve consists of three normally formed cusps and measures 2.7 cm in circumference. The pulmonary trunk and right and left main pulmonary arteries are free of thrombus and show no evidence of an embolus. The lumen of the arterial duct averages about 0.2 cm in diameter. Its intima is wrinkled. The pulmonary veins connect to the left atrium of the heart in the usual fashion. The mitral valve measures 3.2 cm in circumference. The mitral valve appears normal, and a few pinpoint sized, scattered blood cysts are seen near its free edge. The left ventricle is not dilated. The myocardium of the left ventricle is hypertrophied and averages 0.5 cm in thickness. The aortic valve consists of two normally formed coronary cusps and one normally formed noncoronary cusp. The aortic valve measures 2.1 cm in circumference. The coronary artery orifices are patent. The coronary arteries course over the epicardial surface of the heart in the usual fashion. The aortic arch courses to the left, and the great thoracic arteries arise from the aortic arch in the usual fashion. The tip of an umbilical catheter lies in the thoracic aorta, and it is free of thrombus. The intima of the aorta is light tan, almost white, smooth and glistening.

GASTROINTESTINAL TRACT: The esophagus is free of material and lined by focally congested mucosa. The stomach is not distended and is partly filled with tan mucus. The gastric mucosa is pink-tan and mildly congested in the fundus. The small bowel is mildly congested. The mesentery is congested. The small bowel contains a small amount of green and dark green, soft material. The small bowel mucosa is tan and focally mildly congested. The lumen of the large bowel, from the proximal transverse colon to the distal sigmoid colon is distended and filled with dark green meconium. The large bowel mucosa varies from tan to dark green. The solitary lymphoid follicles of the large bowel, and the Peyer's patches in the small bowel are not prominent.

LIVER, GALLBLADDER, PORTAL SYSTEM: The liver is enlarged, diffusely congested and weighs 228 grams/expected 78 grams. The liver has a normal configuration, and the gallbladder is normally positioned. The capsular surface is deep red and smooth. Incisions show deeply congested homogeneous parenchyma except for a 2.0 x 1.5 cm parenchymal, dark red, friable hematoma on the cut surface of the posterior aspect of the right lobe of the liver. The border of the hematoma is irregular. A portion of this hematoma extends to the hepatic capsule on the visceral surface of the liver. The capsular surface over the hematoma shows a 2.0 x 0.3 cm area of congestion that lies next to a mild subcapsular hemorrhage measuring 1.8 x 0.6 cm. The capsule appears to be intact, and no lacerations are identified grossly. The hepatic veins are patent. The gallbladder is filled with dark green, thick bile. No stones are seen. The portal vein is unremarkable and free of thrombus. The venous duct is patent. The extrahepatic bile ducts and extrahepatic hepatic arteries appear to be unremarkable.

PANCREAS: The pancreas has a normal consistency and weighs 6.1 grams. The tail of the pancreas is slightly congested.

SPLEEN: The spleen is enlarged, slightly soft and congested. It weighs 12.7 grams/expected 8.0 grams. The capsular surface is shiny. The splenic vein is patent. Incisions show soft, slightly friable, deep red cut surfaces.

GENITOURINARY SYSTEM: The kidneys are diffusely congested and enlarged. The right kidney weighs 29.0 grams and the left kidney 29.5 grams (combined weight 58.5 grams/expected 27 grams). The capsules are easily stripped, and the cortical surfaces show multiple fetal lobulations. Coronal incisions show congested renal parenchyma. On the cut surfaces, areas of each kidney bulge slightly. The calices, pelves and ureters are not dilated and are patent. The urinary bladder is not overdistended, and its mucosa is pink-tan with a few focal, small mucosal hemorrhages over the posterior wall near the fundus. The mucosa of the proximal urethra is slightly congested. The ovaries are enlarged, edematous, pink and cystic. The right ovary measures 2.8 x 1.2 x 1.0 cm, and the left ovary measures 3.3 x 1.3 x 1.1 cm. An incision through each ovary shows multiple cystic spaces containing straw yellow, clear fluid. The largest cystic space is seen in the left ovary. It measures 1.3 cm in greatest dimension, and its inner wall is finely trabeculated. The fundus of the uterus, uterine tubes and fimbriae is very congested. The endometrium at the uterus shows a couple mild mucosal hemorrhages. The lip of the cervix is slightly congested.

ADRENAL GLANDS: The adrenal glands are diffusely, markedly hemorrhagic and distended with dark red, liquid blood. The combined weight of the adrenal glands, without the blood, is 22.2 grams. Incisions through both adrenal glands show diffusely hemorrhagic cut surfaces with almost all of the adrenal architecture lost.

RETICULOENDOTHELIAL SYSTEM: The thymus is mildly congested and weighs 9.7 grams. Incisions show congested cut surfaces with coarse lobulations. The mesenteric lymph nodes measure up to 0.3 cm in greatest dimensions and are congested. The vertebral bone marrow is red and hard.

THYROID GLAND: The thyroid gland appears unremarkable. Incisions show red, homogeneous parenchyma.

SPECIAL STUDIES: Skin is sent for growing fibroblasts for possible studies. Liver, psoas muscle, urine and serum are frozen for possible studies. Photographs are taken of the liver (hematoma) and adrenal glands.

BLOCK LIST:

1A – Right upper lung lobe
1B – Right middle lung lobe
1C – Right lower lung lobe
1D – Left upper lung lobe
1E – Left lower lung lobe -hilum
1F – Left lower lung lobe -periphery
1G – Right ventricle of heart
1H – Left ventricle of heart
1I – Esophageal-gastric junction
1J – Representative colon
1K – Representative small bowel
1L – Right lobe of liver with hematoma
1M – Right lobe of liver with hematoma
1N – Capsular surface associated with hematoma
1O – Capsular surface associated with hematoma
1P – Capsular surface associated with hematoma
1Q – Left lobe of liver
1R – Right lobe of liver
1S – Gallbladder
1T – Pancreas
1U – Spleen
1V – Kidney
1W – Kidney
1X – Ovary
1Y – Adrenal gland
1Z – Adrenal gland
1AA – Thymus
1AB – Mesenteric lymph nodes
1AC – Psoas muscle
1AD – Diaphragm
1AE – Thyroid gland
1AF – Urinary bladder
1AG – Vertebral body and rib
1AH – Skin with breast tissue

WAD//JRD/JRD

### MICROSCOPIC DESCRIPTION:

LUNGS (1A – 1F): Multiple sections through the lung parenchyma show congestion of the alveolar capillaries. There is no significant inflammatory infiltrate in the parenchyma. Scattered alveolar macrophages are present with some squames. A few secondary emphysematous changes are noted focally. The blood vessels appear relatively normal.

HEART (1G, 1H): Sections through the heart show some vacuolation of myocytes. There is no significant interstitial fibrosis or active necrosis. Focal endocardial thickening with some fibrosis is noted.

GASTROINTESTINAL TRACT (1I – 1K): Sections through the esophagus show a normal mucosa and wall. The stomach appears relatively unremarkable. Sections through the colon show normal mucosa with some focal increase in eosinophils. The wall appears normal. Ganglion cells are present in the myenteric and submucosal plexus. Sections through the small intestine show no significant pathology.

LIVER (1L – 1S): Sections through the liver show some ballooning of hepatocytes with marked sinusoidal congestion. The portal tracts appear relatively normally sized with the presence of bile ducts. There is extensive extramedullary hematopoiesis. A single focus of intraparenchymal hemorrhage is noted. Sections through the gallbladder show some autolytic changes of the wall.

SPLEEN (1U): Sections of the spleen show marked congestion of the red pulp with the presence of many pigment-laden macrophages. The white pulp appears relatively normal and preserved.

KIDNEYS (1V, 1W): Sections through the kidney show a cortex with relatively immature glomeruli along with the presence of tubules. Some of the tubules appear dilated and show the presence of Tamm-Horsfall protein. The interstitium shows congestion. Some of the vessels appear to be thick-walled.

OVARIES (1X): Sections through the ovaries show many cystically dilated follicles. The cortex shows the presence of numerous primordial follicles.

ADRENALS (1Y, 1Z): The adrenals show marked hemorrhages in the medulla and cortex. The hemorrhagic areas show necrotic-appearing adrenal tissue with numerous cholesterol clefts and pigment-laden macrophages. One of the large vessels adjacent to the adrenals shows the presence of fibrin, platelet and cellular thrombus in the lumen.

THYMUS (1AA): Sections through the thymus shows depletion of the cortex with the presence of lymphoid cells along with Hassall's corpuscles in the medulla.

LYMPH NODES (1AB): Sections through the lymph node show normal appearance.

SKELETAL MUSCLE (1AC, 1AD): Sections through the skeletal muscle show no significant pathology.

THYROID (1AE): Sections through the thyroid show normal appearance with varying sized follicles containing abundant colloid. A parathyroid gland is also identified. A paratracheal portion of thymus is also identified in the section. The trachea shows a normal epithelium with no significant inflammatory changes.

URINARY BLADDER (1AF): Sections through the urinary bladder show no significant pathology.

BONE WITH BONE MARROW (1AG): Sections through bone show normal marrow tissue. There is evidence of trilineage hematopoiesis with adequate megakaryocytes.

SKIN WITH BREAST TISSUE (1AH): Sections show skin with no significant pathology. The underlying breast tissue appears nodular with the presence of numerous ductular structures. There is no significant pathology in the breast tissue.

PANCREAS (1T): Sections through the pancreas show normal acinar structures. Numerous islets of Langerhans are present which do not show any significant inflammation. An occasional islet appears to be hypertrophied. Peripancreatic lymph nodes show no significant pathology. A portion of duodenal mucosa shows no significant pathology.

PLACENTA: The slides of the placenta and cord were requested from Dubois Regional Medical Center and reviewed. The cord is trivascular. The membranes do not show any inflammation. The placenta shows mature villi with some intervillous and villous fibrinoid material. There is no evidence of inflammation. No viral organisms present.

**SPECIAL PROCEDURES:**

**CHP Autopsy - Neuropathology**

# Children's Hospital of Pittsburgh

*Department of Pathology*
*3705 Fifth Ave.*
*Pittsburgh, PA 15213*

*(412) 692-5650*
*(412) 692-6550 FAX*


## Final Autopsy Report

**CHA02-15** **RHOADES, MIKAYLA**

### Final Neuropathological Diagnosis

BRAIN AND SPINAL CORD, TERM INFANT

I. ACUTE ISCHEMIC ENCEPHALOPATHY, SEVERE

Pathologist: Ronald L. Hamilton, M.D.
** Report Electronically Signed Out **
By Pathologist: Ronald L. Hamilton, M.D.
06/11/2002 16:08

### Gross Neuropathology

The weight of the fixed brain is 503 g (expected for term newborn: 389 grams). The cerebellum and brainstem weigh 40.1 g and the cerebellum alone weighs 30 g. The dura is smooth and glistening and the superior sagittal sinus is patent. The leptomeninges are translucent and glistening. The circle of Willis shows no vascular anomalies or aneurysms. The cranial nerves are unremarkable. Examination of the convexities shows no asymmetry, atrophy or softening. The morphologic appearance is consistent with estimated gestational age. There is moderate edema and notching of the unci, but no obvious herniation. The cerebellum and brainstem are unremarkable. The spinal cord with attached dura is received from upper thoracic to cauda equina and is grossly normal.

Coronal sections of the cerebral hemispheres reveal little distinction between the gray and white matter. The ventricles are compressed and their lining is smooth and glistening. The caudate, putamen, globus pallidus, thalamus and hippocampus are unremarkable. Myelination is consistent with estimated gestational age. Transverse sections of the brainstem and sagittal sections of the cerebellum show no lesions or other abnormalities. Serial sections of the spinal cord are unremarkable.

### Microscopic Neuropathology

Sections show widespread, severe acute ischemic damage in neurons in nearly all areas of the brain with relative sparing of the medullary tegmentum, pontine tegmentum and spinal cord. All other areas show eosinophilic shrunken neurons with nuclear pyknosis or karyorrhexis and cerebral edema. Nearly all neurons in the basal ganglia, thalamus, hippocampus, cerebellar cortex, dentate nucleus, midbrain, and basis pontis are affected. In the cerebral cortex, most neurons are affected. There are no other abnormalities.

### Other Neuropathology Gross

a - frontal cortex, left
b - caudate and cingulate gyrus, left
c – putamen and globus pallidus, left
d - thalamus, left
e - hippocampus, left
f - cerebellum
g - midbrain
h - pons
i - medulla
j - spinal cord and pituitary

### CHP Fibroblast Culture

### Interpretation

Tissue is sent to the Biomedical Genetics Laboratory, CLSI, for fibroblast culture and freezing of cells. The cell line number is 968.

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## Final Autopsy Report

**CHA02-15** **RHOADES, MIKAYLA**

Pathologist: Sarangarajan Ranganathan, MD
** Report Electronically Signed Out **
By Pathologist: Sarangarajan Ranganathan, MD
06/12/2002 16:51

**ICD-9 Diagnosis Codes:**{None Entered}

May 11, 2004

Robert P. Ging, Jr. Esquire
2095 Humbert Road
Confluence, PA 15424-2371

# Vocational/Economic Analysis of Earning Capacity Of Decedent, Mikayla Rhoades

## Introduction

Portions of the case file on the above stated plaintiff were given to this evaluator by your office. My assignment was to evaluate the earnings loss of the decedent and/or her estate, and to provide an economic projection of the results of my findings. Case records for review included the following documents: Amended Complaint signed 10/14/03; Resume of Kim Rhoades; Resume of Rich Rhoades; Income summary sheet for Kim and Rich Rhoades; Children's Hospital of Pittsburgh Inpatient Discharge Summary dated 5/14/02; Children's Hospital of Pittsburgh Final Autopsy Report.

## Vital Statistics:

| | |
|---|---|
| Plaintiff: | Mikayla Rhoades |
| DOB: | 5/10/02 |
| DOD: | 5/14/02 |
| Age at Death: | 4 days old |
| Time Elapsed: | 96 weeks; or @ 1.85 years |
| Pre-Death Life Expectancy*: | 79.92 years |
| Pre-Death Worklife Expectancy**: | 34 |
| Estimated Beginning Earning Capacity: (Based on age 22 College Grad. with $30,347 starting salary in 2002 dollars)*** | $76,175 |
| Wage Growth****: | 4.76% |
| Interest Rate (Discount Rate) | 5.54% (as of 5/10/04, U.S Treasury) |

* U.S. National Center for Health Statistics, Vital Statistics of the United States, Department of Health & Human Services. Also see "Statistical Abstract of the United States" and "Determining Economic Damages" (reference cited below).
**Median Years to Retirement and Worklife Expectancy for the Civilian U.S. Population," Tamorah Hunt, Joyce Pickersgill, and Herbert Rutemiller, *Journal of Forensic Economics*, Vol. X, no, 2, Summer, 1997. Also see, "Determining Economic Damages," Gerald D. Martin and Ted Vavoulis, James Publishing Incorporated, Costa Mesa, CA., 6/02.
U.S. Census Bureau, *Current Population Survey* p20-538.
**** See "Determining Economic Damages," Gerald Martin, James Publishing Incorporated, Table 40.

**ASSIGNMENT INFORMATION**
This wage earning capacity evaluation on Mikayla Rhoades, deceased child, was requested by Attorney Robert Ging, Jr... The report follows the discounting to present value method require by MCARE reforms, and deducts for personal maintenance as allowed or required by Pennsylvania law.

**BACKGROUND INFORMATION**
Mikayla was born on 5/10/02 to Dennis and Kimberly Rhoades. Both parents are college graduates[1] and make a middle class living in professional level work. They have had combined incomes of approximately $50,000 a year for full time work.

Unfortunately, Mikayla, due to alleged medical malpractice, died 4 days after her birth.

**OVERVIEW OF PROBABLE EARNING CAPACITY**
Studies have found that the educational attainment, work ethic, and earnings of the parents have a positive influence on the child. In fact, the child of parents who have both graduated from college has a high probability of doing so also. Typically, in the U.S., it may be said, the higher the education, the higher the earnings. Hence, Mikayla probably would have enjoyed the earning capacity of a college graduate.

**HER PROBABLE AVERAGE EARNINGS:**
Based upon Mikayla's probable educational attainment, given in part to the educational attainment of her parents and the increasing level of education for the average American, she could have had, for example, an average yearly wage of approximately $29,985 (the sum of the means for Political Science/Government and English Major Graduates in 2003 dollars)[2]. Furthermore, as was noted above, the average female college graduate in what would have been her age cohort earned $30,347 in 2002. Naturally, there are many majors that she could have chosen, and each would have a different starting salary offer level. However, these two examples are very close in earning capacity and hence representative of what she could have earned as a college graduate in the last couple of years dollars.

Therefore, it is assumed that Mikayla could have had, but for the wrongful death, a first year annual average earnings of $76,175 (in 2024 dollars). Multiplying that average yearly wage for the 34 years of her worklife expectancy, with a 4.76% growth factor compounded annually, and discounted back to present value with a 5.54% interest rate, we see that she could have earned total non-discounted wages of $6,177,403, but $1,414,265 when discounted to present value.

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1 Hence, she had a 70% probability of being a college graduate also. See, "Determining Economic Damages," 321.3.

2 Fall 2003 *Salary Survey*, National Association of Colleges and Employers, $28,786 for English Majors and $31,183 for Political Science/Government Major graduates.

**BENEFITS:**
The average college graduate worker receives fringe benefits as part of their compensation. The average percentage of wage paid in benefits is 27.1%[3]. Mikayla could have earned $1,414,265 in discounted wages. Therefore, she could have earned benefits with a discounted value of $383,266.

**PERSONAL MAINTENANCE (PM) CONSUMPTION**
It is common practice to deduct an amount that the decedent would have spent to maintain her own life, at a level commensurate with her station in life, in order to determine the amount of loss to her estate. The amount varies depending on marital status, the number of children she might have had, and her earnings. For example, as a single woman she would have consumed almost all of her income. However, as a married woman it would have dropped to approximately 30%. With each child, her personal consumption percentage rate would have lessened while the child was a dependent. Finally, it would go back to 30% when she and her husband would have been "empty nesters."

It is difficult to state with absolute certainty what her PM consumption would have been at any given time. Therefore, based within the known parameters, it is assumed that she would have had an overall yearly consumption rate of approximately 30%.

Therefore, with a personal consumption rate of approximately 30%[4] , she would have consumed approximately $424,280 leaving approximately $989,985 for her estate.

William Houston Reed

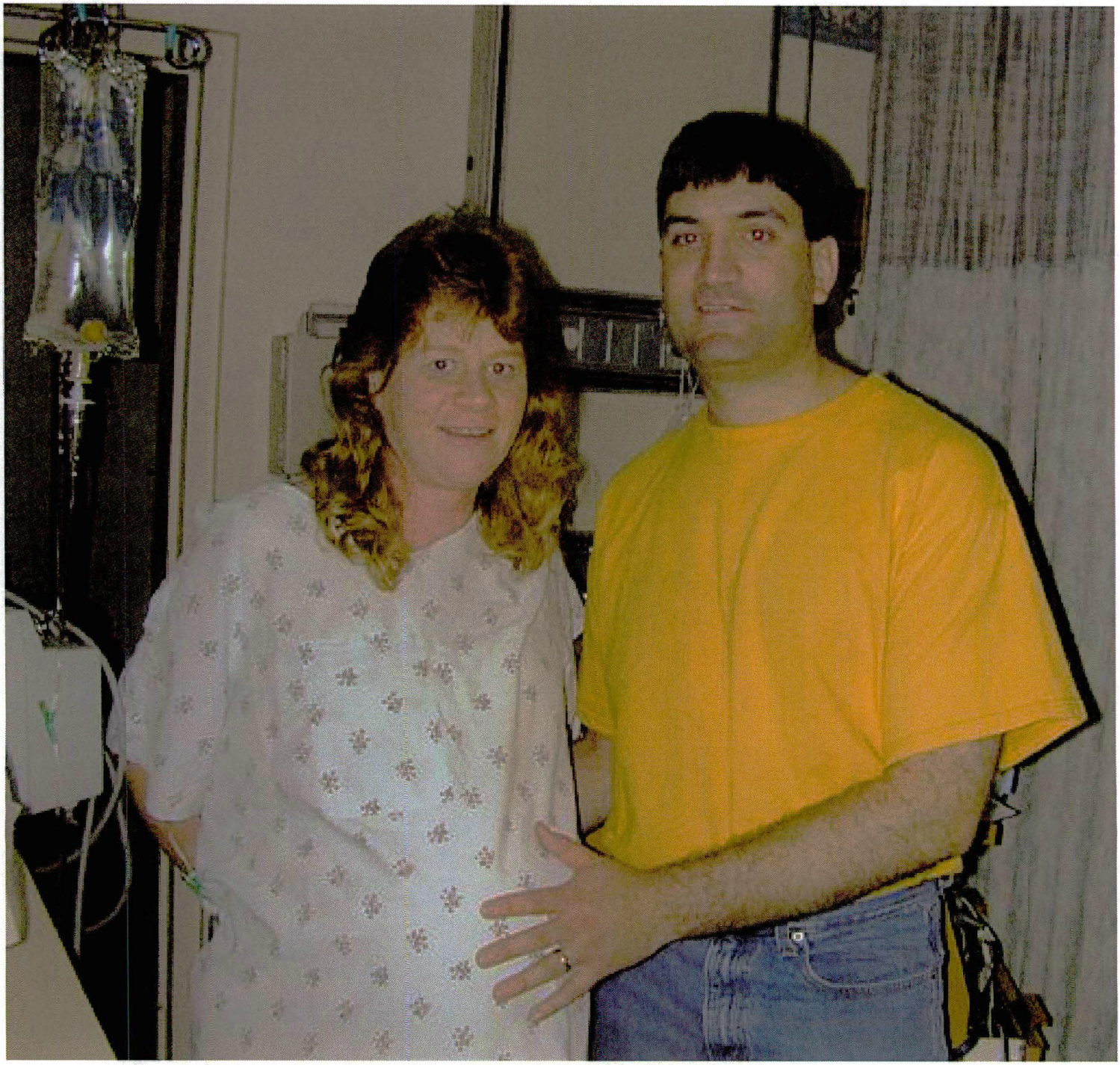
William Houston Reed, Ph.D.
Vocational Expert

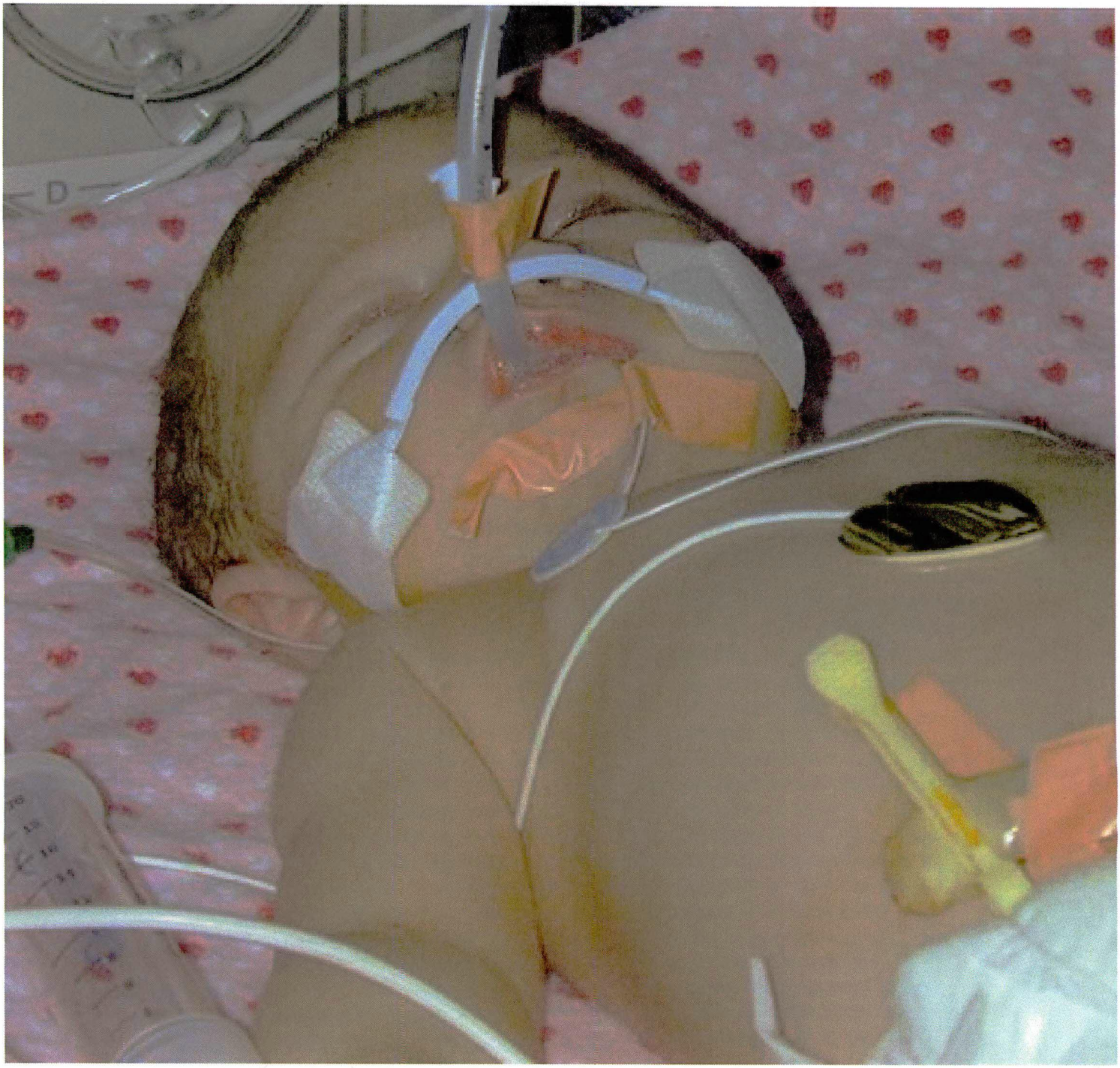
3 See, Determining Economic Damages, Gerald Martin, Ford Publishing Inc.
[4] See, "Determining Economic Damages," Gerald Martin, Ford Publishing, Inc.

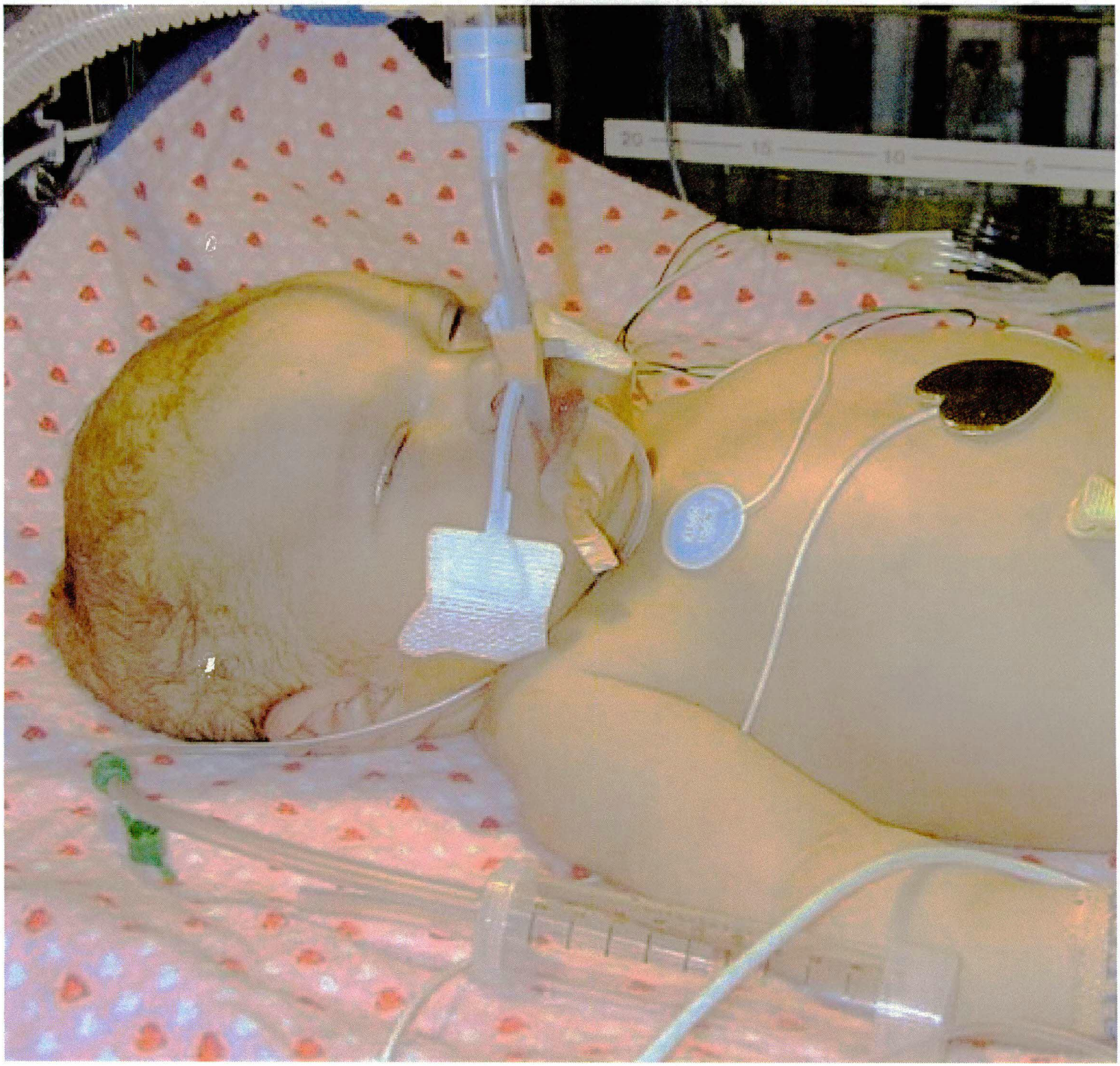
PT1

PT2

PT3







PT7

PT11

PT15

dren's
Pittsburgh

PT32

PT35

Mikayla Mary Rhoades
"like God"
May 10 - 14, 2002

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Plaintiffs' Pre-Trial Statement was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: April 11, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

**McQUAIDE BLASKO** ATTORNEYS AT LAW

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Additional offices in Hershey and Hollidaysburg

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May 31, 2006

*Federal Express, Overnight*
David S. Meholick, Court Administrator
Clearfield County Courthouse
230 East Market Street
Clearfield, PA 16830

**In Re: Rhoades vs. Kruszewski, et al.**
**Docket No: 03-1268-CD**

Dear Mr. Meholick:

Enclosed herewith please find the Brief of Defendant Mary C. Kruszewski, D.O. in Opposition to Plaintiffs' Motion to Reopen Discovery and to Compel Answers to Interrogatories and Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21, along with a Certificate of Service of the same. Would you please forward the Brief to Judge Ammerman for the argument scheduled for June 7, 2006.

Thank you for your attention to this matter.

Sincerely,

McQUAIDE, BLASKO

By: JOHN W. BLASKO

JWB:nls
Enclosures
cc: Robert P. Ging, Jr., Esquire (w/enc.)
cc: Victor H. Pribanic, Esquire (w/enc.)
cc: David R. Johnson, Esquire (w/enc.)

COURT ADMINISTRATOR'S OFFICE

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES )
individually and as personal representatives )
of the ESTATE OF MIKAYLA RHOADES,)
)
Plaintiffs, )
)
vs. )
)
MARY C. KRUSZEWSKI, D.O. and )
DUBOIS REGIONAL MEDICAL )
CENTER, )
)
)
Defendants. )
)
)
)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br><br>Plaintiffs,<br><br>vs.<br><br>MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER,<br><br>Defendants. | ) | Civil Action-Medical Professional Liability Action<br><br>NO. 03-1268 CD<br><br>JURY TRIAL DEMANDED |

**BRIEF OF DEFENDANT MARY C. KRUSZEWSKI, D.O. IN OPPOSITION TO PLAINTIFFS' MOTION TO REOPEN DISCOVERY AND COMPEL ANSWERS TO INTERROGATORIES AND PLAINTIFFS' MOTION TO STRIKE THE OBJECTIONS TO THE SUBPOENA PURSUANT TO RULE 4009.21**

AND NOW, comes Defendant Mary C. Kruszewski, D.O. by and through her undersigned attorneys, McQuaide, Blasko, Fleming & Faulkner, Inc., and files the following Brief in Opposition Plaintiffs' Motion to Reopen Discovery and Compel Answers to Interrogatories and Motion to Strike the Subpoena Pursuant to Rule 4009.21, and in support thereof avers as follows:

*I. Procedural and Factual History of the Case*

This is a medical malpractice alleging negligence against the Responding Defendant and Dubois Regional Medical Center. The allegations concern care that Defendants rendered to Mikayla Rhoades, who was born on May 10, 2002 to the Plaintiffs, Dennis and Kimberly Rhoades. Subsequently. Mikayla expired on May 14, 2002.

The case was initiated by Complaint on August 26, 2003 and is subject to a negotiated scheduling Order issued on January 9, 2006 by the Honorable Fredric J. Ammerman. Pursuant to the Court's January 9, 2006 Order, jury selection occurred on Thursday April 27, 2006 and trial is

set to begin on August 7, 2006. The Order also sets a discovery deadline, stating that "[b]y no later than March 15, 2006 ... discovery in the case shall be completed."

The scheduling Order in this matter was the subject of negotiation between the parties and ultimately ordered by the Court. By way of brief history, on December 7, 2005, all counsel appeared before the Court. At that time, the Court requested correspondence concerning each counsel's position regarding a scheduling order to set deadlines for the instant case. Pursuant to the Court's request, the parties exchanged correspondence and negotiated proposed deadlines. Each party ultimately submitted their preferences to the Court. On December 8, 2005 Plaintiffs suggested that Defendants should file all expert reports by January 15, 2006. In response, Defendant Kruszewski proposed, *inter alia*, that Defendants provide all expert reports by February 28, 2006 and discovery in the case would be closed on the same date. In subsequent correspondence, Plaintiffs' counsel did not object to identical deadlines for the completion of discovery and defense reports, nor did Plaintiffs' counsel request leave to file rebuttal reports. The Court issued an Order on January 9, 2006 setting March 15, 2006 as the time for Defendants to file expert reports and also the time for the completion of discovery. A central issue in the instant dispute is whether Plaintiffs should be bound by the Court's January 9, 2006 Order, which was negotiated among the parties. The Plaintiffs did not object to the Court's Order of January 9, 2006..

The instant dispute centers on the Court Ordered discovery deadline and discovery requests served by Plaintiffs almost two weeks after the discovery deadline on or about March 27, 2006. On that date, Plaintiffs served Defendant Kruszewski with Interrogatories, Requests for Production of Documents and a Notice of Intent to Serve a Subpoena to Produce Documents & Things for Discovery Pursuant to Rule 4009.21. Defendant Kruszewski filed Answers, Responses and Objections to Plaintiffs' Interrogatories and Request for Production on Documents and Objections

to the proposed Subpoena on April 6, 2006. On April 20, 2006 Plaintiffs filed a Motion to Strike the Objections to the Subpoenas and a Motion to Reopen Discovery and Compel Answers to Interrogatories to which Defendant filed timely responses. Each of the objected to requests seeks personal and professional information regarding Defendant Kruszewski's trial experts, Drs. O. Richard Depp, III and William W. Fox.

Accordingly, there are two issues currently before the Court. First, whether the Court should permit Plaintiffs to obtain additional discovery after the expiration of the Court Ordered discovery deadline based on the parties' negotiations. In the alternative, if the Court's discovery deadline is ignored, whether Plaintiffs' discovery requests regarding the following three categories of information are beyond the scope of discovery permissible under Pennsylvania law: 1) all 1099 tax forms of defense experts related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years, along with the identity of the professionals/entities involved; 2) any and all reports prepared by defense experts related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases; and, 3) any and all letters, documents, or articles authored by defense experts related to medical malpractice.

II. *Statement of the Questions Involved*

A. Whether Plaintiffs' Motion to Reopen Discovery Should Be Denied Where Plaintiffs Exhibited a Lack of Diligence By Unilaterally Failing to Pursue Discovery During the Time Permitted By the Court's Scheduling Order, which Order was negotiated by the parties, and, no objections thereto were filed by the Plaintiffs.

*(Suggested Answer: Yes)*

B. In the Alternative, if the Court's imposed Discovery Deadline is ignored, whether Plaintiffs' Motions Seeking to Compel Answers to Interrogatories and Requests for Production and Seeking Leave of Court to Serve Subpoenas Should Be Denied Where Defendants' Objections Are Fully Supported By Pennsylvania Law and Condoned by The Rules Of Civil Procedure

*(Suggested Answer: Yes)*

III. *Legal Argument*

A. Discovery Should Not Be Reopened After the Expiration of the Court Ordered Discovery Deadline Because The Sole Reason Plaintiffs Seek An Extension of the Deadline Is Their Own Unwarranted and Unilateral Failure to Timely Serve Discovery Requests

This Court should employ its vested power over the sequence and timing of discovery and enforce the Court Order of March 15, 2006 discovery deadline. Specifically, the Court should deny Plaintiffs' request to reopen discovery and preclude the additional discovery sought in this case. See, e.g., Yang, et al. v. Milton Hershey Medical Center, et al., 122 Dauph. 282 (2005) attached hereto as Exhibit "A" (holding the defendants were not required to respond to an additional set of interrogatories, additional requests for production, and requests for admissions served by Plaintiffs on the exact date of a court-imposed deadline for the completion of discovery). The Court, having entered a scheduling order after argument and correspondence with all counsel, should confirm its order and deny Plaintiffs' request to reopen discovery because the proposed Interrogatories could have been filed any time between filing the Complaint in August of 2003 and the March 15, 2006

discovery deadline. As Plaintiffs offered no legitimate cause as to why the discovery deadline in this case should be lifted, the Motion to Reopen Discovery should be denied in full.

Pennsylvania Rules of Civil Procedure allow a Court to strike or prohibit discovery which is unreasonable, overly burdensome, or in violation of court order. For example, Pennsylvania Rule of Civil Procedure 4012 provides:

> (a) Upon motion by a party or by the person from whom discovery or deposition is sought, and for good cause shown, the court may make any order which justice requires to protect a party or person from unreasonable annoyance, embarrassment, oppression, burden or expense, including one or more of the following:
>
> (1) that the discovery or deposition shall be prohibited;
>
> (2) that the discovery or deposition shall be only on specified terms and conditions, including a designation of the time and place; ...

See, Pa.R.C.P. 4012. Accordingly, Plaintiffs' discovery requests should be stricken because they are unreasonable, untimely, and in violation of a previously established Court Ordered discovery deadline.

In supervising discovery, the trial court has broad discretion to as it deems appropriate to ensure prompt discovery. See, e.g., Kerns v. Methodist Hosp., 393 Pa. Super. 533, 574 A.2d 1068 (1990). Plaintiffs contend that it was impossible to timely file the disputed discovery because they did not know the specific names of defense experts until immediately before the discovery deadline expired. However, this argument is specious at best. Plaintiffs could have crafted the requested discovery without the specific names of the defense experts. As a matter of practice, attorneys routinely request discovery about experts whose identities they do not know. Plaintiffs served such discovery requests in this very case. Specifically, two and a half years ago on or about October 1, 2003 Plaintiffs served Interrogatories on Dr. Kruszewski requesting the following:

(a) "41. Please identify each person who you intend to call as expert witness at the time of trial and state the subject matter on which the expert is expected to testify."

**(b) "42. Please have each expert identified in the previous answer state the substance of the facts and opinions to which the expert is expected to testify and provide a summary of the grounds for each opinion."**

The Plaintiffs filed the above Interrogatory without knowing the identity of any defense experts and through the request sought information specific to each expert. The Plaintiffs at any time from the filing of this case in August of 2003 through the discovery deadline could have framed the discovery requests they now seek in a similar "generic" fashion. For instance, the Plaintiffs could have filed interrogatories requesting that defense experts identify the times that they testified on behalf of defense counsel. Simply, Plaintiffs could have, and indeed should have, proposed the discovery at issue prior to March 15, 2006, the deadline for discovery. Plaintiffs unilaterally ignored the Court ordered deadlines and failed to engage in prompt discovery.

If the Court reopens discovery as to the experts the Defendants are in danger of substantial prejudice. The information sought from the experts is highly personal. The defense experts could potentially refuse to provide the information sought, including the details of their finances, expert reports related to third parties, and/or any and all letter, documents, or articles related to medical malpractice, finding that the degree of invasion into their personal lives outweighs their resolve to offer expert testimony. If that is the case, Defendants will be without experts to offer testimony at trial, after the discovery deadline has expired. At the very least this could cause delay in the trial of this matter.

In this case, during negotiations to set discovery deadlines, Plaintiffs did not object to Defendant's suggestion that discovery be closed on the same date the defense expert reports were due. Nor did Plaintiffs object to a Court Order to that affect until after the Court Ordered deadline

expired. The discovery deadline was negotiated, reasonable, and all parties were bound thereto. By failing to serve the discovery requests prior to March 15, 2006, Plaintiffs waived the right to now seek such discovery. Unilateral inaction, such as the Plaintiffs' blatant failure to timely serve discovery requests does not provide a party with a legitimate cause to ignore a standing Court ordered deadline. See, e.g., Yang, et al. v. Milton Hershey Medical Center, et al., 122 Dauph. 282 (2005). Therefore, this Honorable Court should deny Plaintiffs' Motions, enforce the March 15, 2006 deadline, and strike all discovery requests served by Plaintiffs on or about March 27, 2006. Otherwise, any Court Order establishing deadlines for the orderly processing of the case would be meaningless.

B. Plaintiffs' Motion to Strike Objections Must Be Denied Because the Requests Are Unreasonable, Exceptionally Overly Broad, Do Not Seek Relevant Information, and Are Simply Beyond the Scope of Discovery Permitted by Pennsylvania Law

In the alternative, Defendant's objections pertaining to three exceptionally broad categories of documents and information should be sustained and Plaintiffs' Motions which seek to strike the Objections should be denied in full. Specifically, Defendants should not be required to produce 1) any and all reports prepared by defense experts related to professional services to defense counsel insurance companies, and/or attorneys in personal injury cases; and, 2) any and all letters, documents, or articles authored by defense experts related to medical malpractice. See, Defendant Kruszewski's Answers, Responses and Objections to Plaintiffs' Interrogatories and Request for Production attached hereto as Exhibit "B"; see also, Plaintiffs' Notices of Intent to Serve Subpoenas on Dr. Depp and Dr. Fox attached hereto as Exhibit "C". Plaintiffs' requests related to 1099 forms and the identity of the entities/individuals for whom the experts have offered opinions in personal injury cases should also be denied. Plaintiffs' requests are untimely, beyond permissible bounds of discovery, and must not be condoned by the Court.

Defendant objected to the above requests on several bases including: 1) the requests are overly broad and compliance therewith would be unduly burdensome; 2) the requests are not reasonably calculated to lead to the discovery of relevant evidence; 3) the requests would potentially require the disclosure of confidential and protected medical information from other cases; and 4) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5. See, Exhibit "B" and Defendant Kruszewski's Objections to Subpoena per Rule 4009.21 attached hereto as Exhibit "D". For the reasons set forth below Plaintiffs' requests must be denied.

1. Plaintiffs' Requests and Proposed Subpoenas are Overly Broad and Compliance Therewith Would be Unduly Burdensome and Would Cause Unreasonable Annoyance, Oppression, Burden, and Expense

Viewed as a whole, Plaintiffs' discovery requests violate both the letter and spirit of the discovery rules, including Pa.R.C.P. No. 4011. The sheer scope of the interrogatories, document requests, and subpoenas demonstrates that these discovery requests are filed, not for legitimate discovery purposes, but to harass and annoy Defendant and her experts by requiring the making of an unreasonable, burdensome, and expensive investigation which would ultimately force the experts to violate the privacy rights of other litigants. Specifically, after the expiration of the discovery deadline the Plaintiff served the following:

Plaintiffs' Requests for Production of Documents:

> 1. Any and all reports prepared by Dr. O. Richard Depp, III in the last five years, related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases.
>
> ***
>
> 3. Any and all letters, documents, or articles authored by O. Richard Depp, III related to medical malpractice.
>
> ***
>
> 4. Any and all reports prepared by Dr. William W. Fox in the last five years, related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases.

***

6. Any and all letters, documents, or articles authored by William W. Fox related to medical malpractice.

Plaintiffs' proposed Subpoenas to Be Served on Defendant Mary C. Kruszewski's, expert witnesses, Dr. O. Richard Depp, III and William W. Fox:

".....

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letter, memos, or articles which you have authored on the subject of medical malpractice within the last five years."

See, Exhibits "B" and "C" attached hereto. The Plaintiffs' intended discovery is overly broad and compliance therewith would be unduly burdensome.

"[T]he aim of [the]discovery process is to expedite and facilitate rather than to burden and delay litigation." Cosner v. Ricci, 45 D&C2d 286, 287 (Washington Co. 1968). In furtherance of this goal, Pennsylvania Rule of Civil Procedure 4011 prohibits discovery that: (i) is sought in bad faith, (ii) would cause unreasonable annoyance, oppression, burden or expense, (iii) is beyond the scope of permissible discovery under the rules, (iv) or would require that an unreasonable investigation be made. See Pa.R.C.P. 4011. Rule 4012 authorizes the Court to enter an order limiting or even prohibiting discovery in order to protect a party or other person from unreasonable annoyance, embarrassment, oppression, burden or expense. Pa.R.C.P. 4012. Pennsylvania has traditionally asserted tight control over the scope and means of discovery concerning an opponent's expert. Unlike many other states, discovery depositions of expert witnesses are not permitted unless good cause is shown, and this virtually never happens. See, Pa.R.C.P. 4003.5.

In this case, Plaintiffs seek any and all "reports" and "letters, documents, or articles" authored by defense experts which relate to personal injury or malpractice cases, respectively. See, e.g. Exhibit "B", Requests for Production 1, 3, 4, and 6. The discovery sought would require

defense experts to search and review practically every written communication they have drafted over the past five (5) years including personal letters, emails, and notes for any reference to malpractice. As described by Plaintiffs, they seek this information to prove an "industry wide bias" against malpractice litigants and to prove "strong feelings about malpractice litigation." Plaintiffs' request is the epitome of expert harassment, is unreasonable, and merely seeks to bring national headlines into this case.

Moreover, Plaintiffs request that defense experts produce any and all reports related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases is unduly burdensome. Notably, as written Plaintiffs are requesting any and all reports from the past five years. The request includes reports for cases in which the experts did not testify and/or ignores the applicability of any confidentiality agreements. Further, Plaintiffs' request for reports and notice of subpoena of reports exceeds the manner of discovery permissible under Pennsylvania Rule of Civil Procedure 4003.5. Rule 4003.5 provides the sole mechanism by which a party can discover "facts known and opinions held" by an expert--the mechanism provide is via Interrogatories. The Court may order additional means of discovery upon cause shown. See, Pa.R.C.P. 4003.5(a)(2). Plaintiffs have offered no legitimate reason whatsoever as to why they should be permitted to serve subpoenas on defense experts. Plaintiffs' requests do not follow established limits on discovery and are designed to harass the defense experts. Thus, should the Court require the defense experts to produce the potentially voluminous information requested by the Plaintiffs, the defense requests that the Plaintiffs bear the compete financial burden of such an extensive search.

2. Plaintiffs' Requests Do Not Seek Relevant Information and Are Not Reasonably Calculated to the Lead to the Discovery of Relevant Evidence

Relevance is considered to be the most basic criterion in determining the admissibility of evidence. See Pa.R.E. 402; Henery v. Shadle, 443 Pa. Super 331, 340, 661 A.2d 439, 444 (1995). Evidence is relevant if it has "any tendency to make the existence of any **fact that is of consequence to the determination of the action** more probable or less probable than it would be without the evidence." Pa.R.E. 401 (emphasis added). Based on the language of Rule 401, there obviously must be some relationship between the evidence offered and the facts at issue. The burden of establishing the relevance and demonstrating that the evidence at issue should be admissible is upon the party introducing the challenged evidence. Valentine v. Acme Markets, Inc., 455 Pa.Super. 256, 261, 687 A.2d 1157, 1160 (1997).

In this case, Plaintiffs seek all "reports" prepared by defense experts for "defense counsel, insurance companies, and/or attorneys" in personal injury cases in the last five (5) years. Plaintiffs further seek "letters, documents, or article" written by the experts which relate to medical malpractice. The issue in this case is whether or not Dr. Kruszewski was in compliance with the standard of care with respect to Mikayla's delivery. Expert reports produced for other cases, relating to other patients--whose privacy is at issue, or personal letters which mention malpractice will not make it more or less probable that Dr. Kruszewski committed malpractice. Plaintiffs are simply on a fishing expedition which is impermissible under Pennsylvania law. Moreover, under Pennsylvania law, parties are generally not permitted to obtain expert reports unless the reports provide the basis for testimony to be provided at trial. See, e.g. Pa. R.C.P. 4003.5 (a)(3). The Rules recognize that reports and opinions which are not offered at trial are not relevant and should not be permitted to influence the case at bar.

Plaintiffs contend that "the very information objected to is discoverable" under Superior Court precedent. However, the language, reasoning, and holding of J.S. and C.S. do not support Plaintiffs' overreaching attempts to obtain expert reports in other cases and defense experts' personal writings. 2004 PA Super 406, 860 A.2d 1112 (Pa.Super. Oct 20, 2004). Rather the case was limited to the discovery of certain tax forms to show bias. In this case, Plaintiffs' requests seek evidence which is irrelevant and Defendants' objections must be sustained.

3. Plaintiffs' Request Would Require the Disclosure of Private, Confidential, and Protected Medical Information Pertaining to Uninvolved Third Parties

Plaintiffs' discovery requests blatantly seek to violate the privacy and confidentially rights of uninvolved third parties by requesting any and all "reports" and "letters, documents, or articles" related to medical malpractice and personal injury cases from the past five years. Individuals are entitled to privacy under common and statutory law. Pennsylvania law recognizes a constitutionally based privacy privilege. See, e.g., In re June 1979 Allegheny County Investigating Grand Jury, 490 Pa. 143, 415 A.2d 73 (1980) (recognizing a constitutionally -based right to privacy regarding the disclosure of medical records). An individual's right to privacy with regarding to their medical information is also recognized under federal and state statutory law. For example, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 prohibits the use or disclosure of "protected health information" unless authorized by patients. Under Pennsylvania law, physicians are not permitted in civil matters, to disclose any information which he acquired in attending to a patient in a professional capacity, except in civil matters 'brought by such patient', for damages on account of personal injuries. 42 Pa.C.S.A. § 5929.

While patients may have a reduced expectation of privacy as result of filing a civil suit for personal injuries their rights are not waived for all purposes. See e.g., 42 Pa. C.S.A. §5929. Should Plaintiffs seek unfettered access to expert reports detailing the private medical history of litigants in

other personal injury cases. This result would cause a chilling effect on individual rights. The decision to redress harm would be hampered by the knowledge that medical information would be produced not only in your own case but would also be spread limitlessly throughout the country during third parties' litigation cases. The degree of disclosure required by Plaintiffs' discovery requests and proposed subpoenas, would not only violate the rights of third parties, but also leaves the defense experts open to harsh criticism for disclosing the information, particularly in cases where the reports or other documents were not part of the public record.

Plaintiffs' Interrogatories, Requests for Production, and Subpoenas as drafted would require the production of documents detailing private medical issues. Plaintiffs simply have no right to private medical information regarding third parties and production of such would be a great injustice to uninvolved individuals and in violation of state and federal law. Therefore, Plaintiffs' request for all reports, letters, memos, and other documents related to medical malpractice and/or personal injury cases must be denied.

C. Plaintiffs' Request For Financial Information Seeks Records Beyond Those Which Are Related To The Case At Issue, Which Are Not Probative Of Bias, And The Prejudicial Effect On A Fair Trial (Potential Loss Of A Party's Expert) Outweighs Any Probative Value

In the instant case, the information sought is beyond that which is discoverable under Pennsylvania law. Plaintiffs in the instant case seek 1099 forms related to any professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years and the identify of such employers. Plaintiffs also seek the identity of all individuals and companies for whom the experts provided services. Specifically, Plaintiffs served the following requests:

Plaintiffs' Interrogatories:

1. Has Dr. O. Richard Depp, III testified or consulted for any defense counsel, insurance companies and/or attorneys in personal injury cases in the last five [5] years?

2. Please identify each and every attorney, insurance company, or defense counsel for whom O. Richard Depp, III has testified within the last five [5] years?

3. Has Dr. William W. Fox testified or consulted for any defense counsel, insurance companies and/or attorneys in personal injury cases in the last five [5] years?

4. Please identify each and every attorney, insurance company, or defense counsel for whom William W. Fox has testified within the last five [5] years.

Plaintiffs' Requests for Production of Documents:

2. Copies of the IRS 1099 Form issued to Dr Depp for professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years.

5. Copies of IRS 1099 Form issued to Dr. Fox for professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years.

Plaintiffs' Proposed Subpoena to Defendant Mary C. Kruszewski, D.O.'s expert witnesses, Dr. O. Richard Depp. III and William W. Fox:

"1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

Defendant objected to the above Requests for Production and Interrogatories on the bases that the information sought was in beyond the scope of permissible expert discovery under Pa.R.C.P. 4003.5, was overly broad and not reasonably calculated to lead to the discovery of admissible evidence. See, e.g., Mohn v. Hahnemann Medical College and Hosp., 357 Pa.Super. 173, 515 A.2d 920 (1986)(holding evidence, which was brought out on cross-examination of defendant's expert witness in medical malpractice action and which consisted of expert's receipt of

fees for medical-legal cases other than the one being tried, was inadmissible) as discussed in Section B, supra., Defendant Kruszewski also objected to the proposed subpoenas on following bases: 1) The proposed subpoenas violate Pa.R.C.P. 4003.5 in that same would include discovery of expert reports in cases where the physicians were consulted but were not anticipated to testify at trial; 2) The proposed subpoenas would potentially require the physicians to reveal confidential and protected medical information from other cases; and 3) The proposed subpoenas violate Pa.R.C.P. 4011 in that same would cause unreasonable annoyance, oppression, burden and expense to the expert witness.

Plaintiffs contend that the Defendant's objections were improper pursuant to the Superior Court's decision in J.S.and C.S. v Whetzel. However, as demonstrated by Mohn and J.S and C.S. the Superior Court precedent is divided on the issue of whether financial information from other cases is relevant to this issue of bias. Even if this Court were to decide that J.S. and C.S. rather than Mohn is controlling Answering Defendant disputes Plaintiffs' contention that J.S and C.S. stands for the proposition that a Plaintiff in a medical malpractice case may seek all 1099 forms from work done on any personal injury case regardless of the nature of the current or previous lawsuit. 2004 PA Super 406, 860 A.2d 1112 (Pa.Super. Oct 20, 2004). At best J.S. and C.S. stands for the proposition that under certain circumstances 1099 forms may be relevant and the production of such is not specifically precluded under all circumstances by Rule 4003.5. Under J.S. and C.S., the 1099 forms sought must be related to the case at hand and not overly broad. While J.S. and C.S. v. Whetzel did allow limited discovery of expert financial information that information was tailored to 1099 forms from a similar class of cases. The 1099 forms sought must be directly and closely related to the case at hand, such as 1099 forms in similar medical malpractice cases. In fact, another case cited by the Plaintiffs further illustrates this issue. See, Coward v. Owens-Corning Fiberglass

Corporation, 1999 Pa. Super. 82, 729 A.2d 614. The Court in Coward limited cross-examination of fees for testifying on behalf of other asbestos defendants the exact type of litigation at issue. Specifically, the Superior in J.S. and C.S. held:

> "...We hold a party may impeach an expert witness by examining his relationship with the counsel calling him and any previous participation in certain types of litigation, so long as this inquiry is relevant to the main issue before a court. Because the trial court permitted production of 1099 forms that are unrelated to this litigation, we vacate the order denying Dr. Eagle's motion for a protective order. We remand to the trial court to enter an order protecting from discovery those 1099 forms that are unrelated to this case. We note the court may need to conduct additional inquiry to determine which 1099 forms are relevant."

J.S. and C.S. v. Whetzel, 2004 Pa. Super. 406, 860 A.2d 1112, 1121 (2004). Plaintiffs' request is not limited to similar cases but would include work on workers compensation, automobile accident, slip and fall, and any other tort where the physician is evaluating personal injury.

Moreover, the Court in J.S. and C.S. did not clearly address whether the specific financial records of medical expert witnesses are actually probative of bias or whether the prejudicial effect on a fair trial (loss of a party's expert who refused to supply his tax information) outweighs any probative value. At this late stage of litigation the potential bias as a result of losing an expert is significant. Moreover, it is specifically denied that J.S. and C.S. allows for discovery of "[a]ny and all reports which [the expert has] prepared for defense counsel, insurance companies and/or attorney in personal injury cases over the past five years" or "[a]ny and all letter, memo, or article which [the expert has] authored on the subject of medical malpractice within the last five years." Rather, the Superior Court decision was limited to 1099 tax forms and whether past expert work was probative of bias. Plaintiffs' over-reaching attempt to bypass the law of this Commonwealth is improper and should not be countenanced by this Court.

D. Plaintiffs' "Motion to Dismiss Objections to Subpoenas" Fails to Comply with Pa.R.C.P. 208.2 and Clearfield County Rule of Civil Procedure 208.3

Finally, Plaintiffs' "Motion to Strike the Objections to Subpoena Pursuant to Rule 4009.21" does not comply with the procedural and substantive requirements for Motions set forth in the Pennsylvania and Clearfield County law. Pennsylvania Rule of Civil Procedure requires that at a minimum all Motions contain the material facts constituting grounds for relief and are written in a manner which allows for a precise coherent response. Specifically, Rule 208.2 provides:

> Rule 208.2. Motion. Form. Content
>
> (a) A motion shall
>
> (1) contain a caption setting forth the name of the court, the number of the action, the name of the motion, and the name of the moving party,
>
> **(2) be divided into paragraphs numbered consecutively,**
>
> **(3) set forth material facts constituting grounds for the relief sought,** specify the relief sought and include a proposed order,
>
> (4) include a certificate of service which sets forth the manner of service including the name of an attorney of record for each party that is represented by counsel, the party whom the attorney represents, a "pro se" designation for each party that is unrepresented, and the address at which service was made, and
>
> (5) be signed and endorsed.

See, Pa.R.C.P 208.2.

Moreover, the Court of Common Pleas of Clearfield County, 46th Judicial District, Commonwealth of Pennsylvania, Rules of Civil Procedure require that all Motions be divided into paragraphs numbered consecutively and set forth with particularity material facts constituting grounds on which they are based. See, Clearfield County Civil Rule of Court 208.3(a))1)(C)-(D). Plaintiffs' purported "Motion" utterly fails to comply by the above state and local Rules of Civil

Procedure. Therefore, all requests within the "Motion to Dismiss Objections to Subpoenas" should be denied.

The Plaintiffs' "Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21" does not set forth the grounds for relief but rather references a supporting brief to a separately filed Motion. Specifically, the Plaintiffs reference that the "Motion" is based on arguments in "their Brief in Support of their Motion for Sanctions". Defendant Kruszewski believes this is a reference to Plaintiffs' "Brief in Support of Motion to Reopen Discovery and Compel Answers to Interrogatories." In addition, the Plaintiffs' "Motion" is not divided into consecutively numbered paragraphs. In whole, the Plaintiffs' Motion states:

> "The Plaintiffs incorporate herein by reference the argument made in their Brief in Support of their Motion for Sanctions. Additionally Rule 4003.5(a)(2) indicated that "upon cause shown the Court may order further discovery by other means, subject to such restriction as to the scope and such provisions as the Court may deem appropriate. (sic)
>
> As indicated in the Plaintiffs' Brief in Support of the Motion for Sanction the Superior Court has ruled that the very information objected to is discoverable, and if the Defendant continues to refuse to respond to Interrogatories and Request for Production of Documents, the Court may allow service of a Subpoena pursuant to Rule 4009.21. Additionally, Plaintiffs could not have propounded companion Interrogatories and Requests for Production prior to close of discovery since the identity of Defendant's experts were not disclosed until March 14, 2006"

See, Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21. t "A".

Plaintiffs' Motion is vague and unintelligible and cannot stand as an appropriate request for relief to the Court. Plaintiffs fail to clearly set forth "with particularity material facts constituting grounds on which [the motion is] based..." See, J.D.R.C.P. 208.3(a)(1)(C)-(D). Accordingly, the "Motion to Strike the Objection to Subpoena Pursuant to Rule 4009.21" should be denied for its failure to comply with the Rules of Civil Procedure. See, e.g., Edward M. v. O'Neill, 291 Pa. Super. 531, 436 A.2d 628 Pa.Super., 1981 (stating "[t]his denial was proper in view of appellees' failure to

comply with the Rules of Civil Procedure...."; addressing the failure to comply with requirement that documents must be field with prothonotary not with the Judge in question in order to establish a class action.)

*IV.* *Conclusion*

In sum, Plaintiffs' discovery requests were served after the Court Ordered discovery deadline and seek information which is outside the scope of permissible discovery, and therefore, Plaintiffs' Motion to Strike the Objections to the Subpoena and Motion to Reopen Discovery and Compel Answers to Interrogatories should be denied.

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.

Date: June 1, 2006

By: _____
JOHN W. BLASKO
BRITT RUSSELL
Attorneys for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
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Exhibit A

Yang, et al. v. Milton Hershey Medical Center, et al.

Practice Discovery Protective order Reconsideration.

After four (4) years of ongoing discovery in this defamation case, the Court entered a protective order requested by the Defense, relieving them of any obligation to respond to an additional set of interrogatories, additional requests for production, and requests for admissions. The Plaintiffs then sent a letter via telefax to the Court opposing the entry of the protective order. The Court reviewed Plaintiffs' submissions and reconsidered the matter, but declined to vacate, amend or otherwise modify the protective order.

Motion for Protective order. C.P., Dau. Co., No. 5193 S 2000. Granted.

Terry M. Henry, for Plaintiffs

Maureen Gallagher and Grant Fleming, for Defendants

Evans, J., March 22, 2005. - On March 8, 2005, defendants' filed a motion for protective order pursuant to Pa.R.C.P. 4012(a), wherein they request an order that they are not required to respond to an additional set of interrogatories, additional requests for production and requests for admissions that were served by plaintiffs on the date of a court-imposed deadline for the completion of discovery in this protracted case. On March 10, 2005, the Court granted defendants' motion for a protective order noting that the deadline for completionof discovery was February 16, 2005. On March 17, 2005, the Court received plaintiffs' response in opposition to defendants' motion for a protective order.[1] In light of plaintiffs' recent submission, the Court will reconsider the order entered March 10, 2005.

Plaintiffs raise a number of issues in opposition to the entry of a pro-tective order. First, plaintiffs allege that they have an outstanding motion to compel production of certain information, which was filed on February 22, 2005. Plaintiffs' contention in this regard is erroneous, as the motion was decided on February 28, 2005.[2] Moreover, we fail to see its relevance in the context of defendants' motion for a protective order.

Second, plaintiffs allege that defendants have pursued discovery beyond the deadline via document requests, the issuance of deposition notices and motions practice, all of which would require responses being served after the February 16 end date for discovery. Plaintiffs maintain that by virtue of the defendants conduct, they should be estopped from arguing that discovery responses must be served by the discovery end date.

By way of background, on January 14, 2005, the Court held a lengthy discovery conference with the parties. On January 21, 2005, four (4) orders were entered addressing a multitude of outstanding discovery issues. In addition, a revised scheduling order was issued which specif-ically provided that "[a]ll discovery shall be completed on or before February 16, 2005." This deadline was set after discussion and agree-ment by the parties.

Since January 21, 2005, in response to additional discovery motions, the Court has entered orders (a) permitting defendants' one (1) addi-tional day to depose each of plaintiffs; (b) permitting plaintiffs to serve limited punitive damages discovery upon each of the defendants; (c) permitting defendants to serve non-party subpoenas for the production of documents outside the discovery deadline, but imposed limitations on the documents to be requested in response to plaintiffs' objections; (d) denying defendants' requests for plaintiffs to produce certain documents prior to their depositions; (e) granting plaintiffs' request for an extension to produce certain documents; and (f) denying plaintiffs' motion to extend the deadline for production of expert reports.

Based upon the foregoing, we reject plaintiffs' assertion that defend-ants should be estopped from seeking a protective order, by virtue of their conduct in serving discovery requests prior to expiration of the deadline, when the responses were due after the deadline. In each instance where defendants sought to serve such discovery, they requested permission from the Court. With respect to the scheduling of depositions beyond the discovery deadline, we note that this was done by agreement of the parties, presumably to accommodate witnesses' schedules, and without objection/intervention by the Court.

Thus, in reviewing the record, it does not appear that defendants served any discovery requests which would have required responses beyond the discovery deadline, without an agreement of the parties or by order of Court. We acknowledge that defendants sent additional requests for production to plaintiffs on February 16, 2005. According to defend-ants, these requests were prompted by their receipt of plaintiffs' addi-tional discovery requests on February 16, 2005. During

a telephone conference with the parties on February 24, 2005, defense counsel advised the Court's law clerk and opposing counsel that these requests have been withdrawn. Moreover, unlike defendants, plaintiffs did not request the entry of a protective order relieving them of any obligation to respond to additional requests served on the date for completion of discovery. Had they done so, their motion would have been granted.

Next, while acknowledging that discovery must eventually end, plain-tiffs assert that the "end date should not be set by an arbitrarily selected calendar date tenuously tied to a 'provisional' trial listing. Rather, dis-covery should end when both parties have had a fair opportunity to obtain the information necessary for determining the truth of the parties' allegations, which is the ultimate goal of any good dispute resolution system, including litigation." Plaintiffs allege that although pending for over four (4) years, the case has not yet reached that point. We disagree.

This case, sounding in defamation, false light invasion of privacy and tortious interference with present and prospective business relationships arises from allegedly false and improper statements made by the defend-ants about the plaintiffs, after plaintiffs' departure from the Hershey Medical Center in February, 2000. Plaintiffs commenced this action by Writ of Summons on November 21, 2000. In December, 2000, plaintiffs served pre-complaint discovery. Defendants provided responses on January 4, 2001 and supplemented those responses on March 27, 2001. Plaintiffs served interrogatories and a request for production upon defendants in October, 2001 and defendants responded in November, 2001. Additional written discovery requests were served upon defend-ants in January, 2003 and responses were provided in February, 2003. Thereafter, plaintiffs served a third request for production, to which defendants responded in August, 2004. In addition, plaintiffs served expert and trial interrogatories as well as expert and trial requests for documents. The Court also permitted plaintiff to serve limited punitive damages discovery upon all defendants.

Despite the fact that discovery has been ongoing for over four (4) years, plaintiffs contend that they have been unable to obtain "meaning-ful" discovery. They attribute this to (a) defendants repeated attempts to manipulate the discovery process to avoid their obligations to produce information; and (b) the Court's allegedly inexplicable delay in deciding plaintiffs' initial motion to compel more complete answers to interroga-tories and requests for production, which purportedly prohibited the par-ties from engaging in further discovery and mandated readjustment of the pre-trial discovery schedule.

We disagree with plaintiffs' assertion that the entire discovery process has been hampered by the conduct of the defendants and the conduct of the Court. While the Court acknowledges that there was a delay in responding to plaintiffs' initial motion to compel, we note that the motion was filed on June 17, 2003 and related, in part, to the adequacy of responses to discovery provided by defendants in December, 2001.[3]

Since March, 2003, each party has filed no less then ten (10) discov-ery motions, including motions to compel more complete answers to written discovery; motions to rule on objections to subpoenas; motions to compel depositions; motions for sanctions and motions for protective orders. To date, multiple sets of interrogatories have been served and answered on behalf of all parties; voluminous amounts of documents have been produced in response to subpoenas and requests for produc-tion; and the parties and virtually all potential witnesses have been deposed. Contrary to plaintiffs' assertion, the discovery deadline of February 16, 2005 was in no way designed to impede any parties' abil-ity to ascertain relevant facts, but to bring an end to the protracted dis-covery process.[4] Along these lines, we note that the first discovery deadline in this case was set in April, 2003 mandating that discovery be completed by November 20,2003. The deadline was later extended four (4) more times, with a final end date of February 16, 2005. Each order set the date on which "all discovery shall be completed."

In ignoring the clear language of the orders, plaintiffs assert that the service of additional interrogatories, additional requests for production and over 130 requests for admissions on the afternoon of February 16, 2005 was permissible because "the Court could have expressly stated in either its August or January scheduling orders that discovery requests must be served so that responses are received by the discovery end date. It did not do so, and in the absence of such language or law to the con-trary, it is the common practice to serve discovery requests up to the dis-covery deadline." Plaintiffs' assertion calls to mind the phrase: "There are none so blind as those who will not see." We do not believe the phrase "all discovery shall be completed by February 16, 2005" is vague, ambiguous or susceptible to multiple interpretations. Not only did plaintiffs choose to ignore the discovery deadline, but they also chose to ignore Dauphin County Local Rule 4014 which provides that "[r]equests for admissions to a party, as a matter of right, shall not exceed forty (40) in number...." Here, plaintiffs' eleventh hour requests were more than three (3) times that amount. Accordingly, upon recon-sideration, the Court declines to vacate, amend or otherwise modify the protective order entered on March 10,2005. Defendants are not required to respond to the additional interrogatories, requests for production and requests for admissions

served on February 16, 2005.

---

[1] In a letter sent via telefax to the Court on March 15,2005, plaintiffs took issue with the timing of the order, noting that they were not permitted to file a response to defend- ants' motion. Plaintiffs asserted that the order was entered in violation of Pa.R.C.P. 208.3 and essentially demanded that the order be withdrawn, stating: "... the Court could have provided plaintiffs the courtesy of advising that the Court intended to rule on defendants' motion in an expedited fashion. Had the Court done so, it would not be necessary to now withdraw its Order to fully consider the matter." While we question the propriety of rais- ing such issues solely by written communication directly with the Court, and we dispute plaintiffs' contention that the order was entered in contravention to the Pennsylvania Civil Rules of Procedure, we have reviewed plaintiffs' submissions and given the matter due reconsideration.

[2] This motion was a renewed motion to compel production of information related to transplantation statistics and transplantation section finances from defendant Milton S. Hershey Medical Center which motion was previously denied on May 19,2004. Plaintiffs' most recent motion to compel was denied by order dated February 28, 2005.

[3] Plaintiffs allege that their motion to compel "inexplicably" sat for eleven (11) months. We would note that on April 29, 2003, due to the anticipated length of this case, the Honorable Jeannine Turgeon was appointed to oversee the matter, provide case man- agement including all discovery issues as well as preside at the trial of this case. Plaintiffs' motion to compel more complete answers to written discovery was filed on June 17,2003. Subsequently, on August 14, 2003, Judge Turgeon recused and the matter was reassigned to Judge Evans. Thereafter, additional discovery motions were filed and the Court held a status conference on October 13, 2003. Upon consideration of plaintiffs' motion to com- pel (filed June 17, 2003), this Court construed the motion as one for reconsideration of an order previously issued by the Honorable Richard A. Lewis and therefore, the pleading was transferred to Judge Lewis for further disposition. On March 12, 2004, Judge Lewis issued an order addressing one (1) issue and referred the remaining issues to Judge Evans for decision. An order addressing all outstanding discovery issues was entered on March 19, 2004.

[4] As demonstrated by the various filings, the parties have been unable to agree on vir- tually anything relating to the discovery issues. In response to defendants' motion for pro- tective order, plaintiffs even deny defendants' characterization of the quantity of the discovery requests recently served. In response to defendants' contention that they sought plaintiffs' concurrence in the pending motion, plaintiffs deny that defendants sought con- currence "on anything other than whether plaintiffs would concur in waiving their right to relevant information responsive to the requests plaintiffs reasonably calculated would lead to the discovery of admissible evidence."

Exhibit B

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
Answers and Objections to Interrogatories
Responses and Objections to Request for Production of Documents

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for
Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

***ANSWERS AND OBJECTIONS TO INTERROGATORIES DIRECTED TO DEFENDANT***

1. Has Dr. O. Richard Depp, III testified or consulted for any defense counsel, insurance companies and/or attorneys in personal injury cases in the last five [5] years?

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome;
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

2. Please identify each and every attorney, insurance company, or defense counsel for whom O. Richard Depp, III has testified within the last five [5] years?

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

3. Has Dr. William W. Fox testified or consulted for any defense counsel, insurance companies and/or attorneys in personal injury cases in the last five [5] years?

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

4. Please identify each and every attorney, insurance company, or defense counsel for whom William W. Fox has testified within the last five [5] years.

***ANSWER:*** Objection. An objection is raised to this Interrogatory on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

McQUAIDE, BLASKO
FLEMING & FAULKNER, INC.

BY _____
JOHN W. BLASKO
ALLEN P. NEELY
Counsel for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814)238-4926

Dated: 4/6/04

***RESPONSES AND OBJECTIONS TO REQUEST FOR PRODUCTION OF DOCUMENTS OF DEFENDANT, MARY C. KRUSZEWSKI, D.O.***

Pursuant to Pa.R.C.P. 4009.11 you are hereby requested to produce for inspection and copying the documents set forth below:

1. Any and all reports prepared by Dr. O. Richard Depp, III in the last five years, related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome;
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence; and
(4) This Interrogatory would potentially require the disclosure of confidential and protected medical information from other cases.

ALLEN P. NEELY

2. Copies of the IRS 1099 Form issued to Dr Depp for professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

3. Any and all letters, documents, or articles authored by O. Richard Depp, III related to medical malpractice.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

4. Any and all reports prepared by Dr. William W. Fox in the last five years, related to professional services to defense counsel, insurance companies, and/or attorneys in personal injury cases.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome;
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence; and
(4) This Interrogatory would potentially require the disclosure of confidential and protected medical information from other cases.

ALLEN P. NEELY

5. Copies of IRS 1099 Form issued to Dr. Fox for professional services for defense counsel, insurance companies, and/or attorneys in personal injury cases in the last five years.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

6. Any and all letters, documents, or articles authored by William W. Fox related to medical malpractice.

***RESPONSE:***

Objection. An objection is raised to this Request on the following bases:

(1) The information sought exceeds the scope of permissible expert discovery pursuant to Pa.R.C.P. 4003.5;
(2) The Interrogatory is overly broad and compliance therewith would be unduly burdensome; and
(3) This Interrogatory is not reasonably calculated to lead to the discovery of relevant evidence.

ALLEN P. NEELY

McQUAIDE, BLASKO
FLEMING & FAULKNER, INC.

BY _____
JOHN W. BLASKO
ALLEN P. NEELY
Counsel for Defendant
Mary C. Kruszewski, D.O.
811 University Drive
State College, PA 16801
(814)238-4926

Dated: 4-6-06

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

CERTIFICATE OF SERVICE

I hereby certify that the Answers and Objections to Interrogatories and Responses and Objections to Request for Production of Documents directed to Defendant Mary C. Kruszewski, D.O., in the above-referenced matter were mailed by regular mail, first class, at the Post Office, State College, Pennsylvania, postage prepaid, this 6th day of April, 2006 to:

***Original***
Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

***Copy***
David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

***Copy***
Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | |
|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,<br>Plaintiffs | |
| VS. | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,<br>Defendants | |
| | TYPE OF PLEADING:<br>**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21** |
| | FILED ON BEHALF OF:<br>Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades |
| | COUNSEL OF RECORD:<br>ROBERT P. GING, JR., ESQUIRE<br>SUPREME CT. No. 25459<br>2095 Humbert Road<br>Confluence, PA 15424-2371<br>(814) 395-3661 |

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

Plaintiffs intend to serve a subpoena identical to the one that is attached to this Notice. You have twenty (20) days from the date listed below in which to file a record and serve upon the undersigned an objection to the subpoena. If no objection is made the subpoena may be served.

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

COMMONWEALTH OF PENNSYLVANIA
CLEARFIELD COUNTY

Dennis R. Rhoades
Kimberly Rhoades
Mikayla Rhoades, Estate
Plaintiff(s)
Vs.
Mary C. Kruszewski
DuBois Regional Medical Center
Defendant(s)

No. 2003-01268-CD

SUBPOENA TO ATTEND AND TESTIFY

TO: O. Richard Depp, III
1280 Clubhouse Road
Gladwin, PA 19025

1. You are ordered by the Court to come to (See attached Addendum to Subpoena)

(Specify Courtroom or other place)
at _____ County, Pennsylvania, on _____ at _____
o'clock, __ M., to testify on behalf of _____
_____ in the
above case, and to remain until excused.

2. And bring with you the following: See attached Addendum to Subpoena.

If you fail to attend or to produce the documents or things required by this subpoena, you may be subject to the sanctions authorized by Rule 234.5 of the Pennsylvania Rules of Civil Procedure, including but not limited to costs, attorney fees and imprisonment.

ISSUED BY A PARTY/COUNSEL IN COMPLIANCE WITH PA.R.C.P. No. 234.2(a)

NAME: Robert P. Ging, Jr., Esquire
ADDRESS: 2095 Humbert Road
Confluence, PA 15424-2371
TELEPHONE: (814) 395-3661
SUPREME COURT ID # 25459

BY THE COURT:

William A. Shaw
Prothonotary/Clerk, Civil Division

Deputy

DATE: Wednesday, December 10, 2003
Seal of the Court

OFFICIAL NOTE: This form of subpoena shall be used whenever a subpoena is issuable, including hearings in connection with depositions and before arbitrators, masters, commissioners, etc. in compliance with PA.R.C.P. No. 234.1 . If a subpoena for production of documents, records or things is desired, complete Paragraph 2.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ADDENDUM TO SUBPOENA**

TO: RICHARD DEPP, M.D.

Within twenty (20) days after the service of the attached Subpoena you are Ordered by the Court to produce the following documents or things:

1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

These documents shall be produced at the Law Office of Robert P. Ging, Jr., 2095 Humbert Road, Confluence, Pennsylvania 15424.

You may deliver or mail legible copies of the documents or produce things requested by this Subpoena, together with the Certificate of Compliance to the party making this request at the address listed above. You have the right to seek in advance the reasonable costs of preparing the copies or

producing the things sought. If you fail to produce the documents or things required by this Subpoena within twenty (20) days after its service, the party serving the Subpoena may seek a Court Order compelling you to comply with it. The Subpoena was issued at the request of the following person: Robert P. Ging, Jr., Pa. Supreme Court Id. 25459, 2095 Humbert Road, Confluence, Pennsylvania 15424, (814) 395-3661, attorney for the Plaintiffs.

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Notice of Intent was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 27, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,
Plaintiffs

VS.

MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER,
Defendants

CASE NO. 03-1268-CD

TYPE OF PLEADING:
**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

FILED ON BEHALF OF:
Dennis R. and Kimberly Rhoades, and the Estate of Mikayla Rhoades

COUNSEL OF RECORD:

ROBERT P. GING, JR., ESQUIRE
SUPREME CT. No. 25459
2095 Humbert Road
Confluence, PA 15424-2371
(814) 395-3661

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**NOTICE OF INTENT TO SERVE A SUBPOENA TO PRODUCE DOCUMENTS & THINGS FOR DISCOVERY PURSUANT TO RULE 4009.21**

Plaintiffs intend to serve a subpoena identical to the one that is attached to this Notice. You have twenty (20) days from the date listed below in which to file a record and serve upon the undersigned an objection to the subpoena. If no objection is made the subpoena may be served.

DATED: March 31, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

COMMONWEALTH OF PENNSYLVANIA
CLEARFIELD COUNTY

Dennis R. Rhoades
Kimberly Rhoades
Mikayla Rhoades, Estate
Plaintiff(s)
Vs.
Mary C. Kruszewski
DuBois Regional Medical Center
Defendant(s)

No. 2003-01268-CD

SUBPOENA TO ATTEND AND TESTIFY

TO: William W. Fox, M.D.
411 Penn Valley Road
Narberth, PA 19072

1. You are ordered by the Court to come to (See attached Addendum to Subpoena.)
(Specify Courtroom or other place)
at _____ County, Pennsylvania, on _____ at _____
o'clock, __ M., to testify on behalf of _____
in the above case, and to remain until excused.

2. And bring with you the following: See attached Addendum to Subpoena.

If you fail to attend or to produce the documents or things required by this subpoena, you may be subject to the sanctions authorized by Rule 234.5 of the Pennsylvania Rules of Civil Procedure, including but not limited to costs, attorney fees and imprisonment.

ISSUED BY A PARTY/COUNSEL IN COMPLIANCE WITH PA.R.C.P. No. 234.2(a)

NAME: Robert P. Ging, Jr., Esquire
ADDRESS: 2095 Humbert Road
Confluence, PA 15424-2371
TELEPHONE: (814) 395-3661
SUPREME COURT ID # 25459

BY THE COURT:

William A. Shaw
Prothonotary/Clerk, Civil Division

Deputy

DATE: Wednesday, December 10, 2003
Seal of the Court

OFFICIAL NOTE: This form of subpoena shall be used whenever a subpoena is issuable, including hearings in connection with depositions and before arbitrators, masters, commissioners, etc. in compliance with PA.R.C.P. No. 234.1. If a subpoena for production of documents, records or things is desired, complete Paragraph 2.

**IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA**

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, Plaintiffs | ) | |
| VS. | ) | CASE NO. 03-1268-CD |
| MARY C. KRUSZEWSKI, D.O., and DuBOIS REGIONAL MEDICAL CENTER, Defendants | ) | |

**ADDENDUM TO SUBPOENA**

TO: WILLIAM W. FOX, M.D.

Within twenty (20) days after the service of the attached Subpoena you are Ordered by the Court to produce the following documents or things:

1. Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

2. Any and all reports which you have prepared for defense counsel, insurance companies, and/or attorneys in personal injury cases over the past five years.

3. Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

These documents shall be produced at the Law Office of Robert P. Ging, Jr., 2095 Humbert Road, Confluence, Pennsylvania 15424.

You may deliver or mail legible copies of the documents or produce things requested by this Subpoena, together with the Certificate of Compliance to the party making this request at the address listed above. You have the right to seek in advance the reasonable costs of preparing the copies or

producing the things sought. If you fail to produce the documents or things required by this Subpoena within twenty (20) days after its service, the party serving the Subpoena may seek a Court Order compelling you to comply with it. The Subpoena was issued at the request of the following person: Robert P. Ging, Jr., Pa. Supreme Court Id. 25459, 2095 Humbert Road, Confluence, Pennsylvania 15424, (814) 395-3661, attorney for the Plaintiffs.

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Intent was served on the following parties at their respective addresses on this date via U. S. First Class, Postage Pre-Paid Mail.

John W. Blasko, Esquire
811 University Drive
State College, PA 16801-6699

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

DATED: March 31, 2006

Respectfully submitted,

Robert P. Ging, Jr., Esquire

ALL-STATE® LEGAL 800-222-0510 ED11 RECYCLED

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DENNIS R. AND KIMBERLY RHOADES individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES,

Plaintiffs,

vs.

MARY C. KRUSZEWSKI, D.O. and DUBOIS REGIONAL MEDICAL CENTER,

Defendants.

Civil Action-
Medical Professional Liability Action

No: 03-1268 CD

Type of Case: Civil Action

JURY TRIAL DEMANDED

Type of Pleading:
Objections to Subpoena Per Rule 4009.21

Filed on Behalf of Defendant:
MARY C. KRUSZEWSKI, D.O.

Counsel of Record for this
Party: JOHN W. BLASKO
Court I.D. No.: 06787
ALLEN P. NEELY
Court I.D. No.: 65302

McQUAIDE, BLASKO, FLEMING
& FAULKNER, INC.
811 University Drive
State College, PA 16801
(814) 238-4926

Counsel of Record for
Adverse Party:
Robert P. Ging, Jr.
Victor H. Pribanic, Esquire

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
CIVIL DIVISION

| | | |
|---|---|---|
| DENNIS R. AND KIMBERLY RHOADES, individually and as personal representatives of the ESTATE OF MIKAYLA RHOADES, | ) | Civil Action-Medical Professional Liability Action |
| Plaintiffs, | ) | NO. 03-1268 CD |
| vs. | ) | JURY TRIAL DEMANDED |
| MARY C. KRUSZEWSKI, D.O. and DuBOIS REGIONAL MEDICAL CENTER, | ) | |
| Defendants. | ) | |

**OBJECTIONS TO SUBPOENA, PER RULE 4009.21, FILED BY DEFENDANT, MARY C. KRUSZEWSKI, D.O.**

Defendant, Mary C. Kruszewski, D.O. by and through her attorneys, McQuaide, Blasko objects to Plaintiffs' proposed subpoenas to this Defendant's expert witnesses. In support of her objections, Defendant avers as follows:

1. This is a medical malpractice action wherein Plaintiffs allege that the negligence of the Defendants caused the death of the baby, Mikayla Rhoades.

2. On March 27, 2006, Plaintiffs' counsel served a Notice of Intent to Serve Subpoenas and proposed subpoenas upon the Defendant's expert witnesses: Richard Depp, M.D., and William W. Fox, M.D.

3. Plaintiffs are proposing to serve subpoenas directly upon the Defendant's expert witnesses.

4. Attached to the proposed subpoenas is an addendum, demanding that Doctors Depp and Fox each produce the following items:

(1) Any and all 1099 Forms related to your professional services to defense counsel, insurance companies and/or attorneys in personal injury cases over the last five years.

(2) Any and all reports which you have prepared for defense counsel, insurance companies and/or attorneys in personal injury cases over the past five years.

(3) Any and all letters, memos, or articles which you have authored on the subject of medical malpractice within the last five years.

5. The Defendant objects to the proposed subpoenas on several bases:

- The proposed subpoenas violate Pa.R.C.P. 4003.5 in terms of the scope of information sought and the means by which the information is sought (by subpoena);

- The proposed subpoenas violate Pa.R.C.P. 4003.5 in that same would include discovery of expert reports in cases where the physicians were consulted but were not anticipated to testify at trial;

- The proposed subpoenas are overly broad and compliance therewith would be unduly burdensome;

- The proposed subpoenas are not reasonably calculated to lead to the discovery of relevant evidence;

- The proposed subpoenas would potentially require the physicians to reveal confidential and protected medical information from other cases;

- The proposed subpoenas violate Pa.R.C.P. 4011 in that same would cause unreasonable annoyance, oppression, burden and expense to the expert witnesses.

6. All of the information sought exceeds the scope of permissible expert discovery as delineated by Pa.R.C.P. 4003.5. Pursuant to this rule, a party may inquire through interrogatories about the identity of a trial expert, as well as the substance of the facts and opinions to which he is expected to testify. Pa.R.C.P. 4003.5(a)(1).

7. Reports of these experts have already been provided and therefore, Plaintiffs have been apprized of their identities and the substance of their anticipated trial testimony.

8. Plaintiffs' attempt to obtain any and all 1099 forms related to personal injury litigation and reports to counsel or insurance companies is beyond the scope of this rule. The request for "all letters, memos, or articles" about medical malpractice is likewise outside the scope of Rule 4003.5.

9. The subpoenas to expert witnesses is *per se* in violation of Rule 4003.5. This Rule does not provide for discovery of information about an expert by way of subpoena served directly upon the expert witness. The Rule provides for expert discovery only through interrogatories. Pa.R.C.P. 4003.5(a)(1).

10. Only by way of an order of court, issued upon good cause shown, may a party obtain further expert discovery through other means. Pa.R.C.P. 4003.5(a)(2). Plaintiffs have not sought an order of court seeking further discovery by other means, i.e., a subpoena served directly upon an expert. Furthermore, any such effort would be fruitless, given that there can be no good cause shown in support of disclosure to the extent sought by the proposed subpoenas.

11. Rule 4003.5(a) applies only to experts who are anticipated to testify at trial. Pa.R.C.P. 4003.5(a)(3). The request for any and all reports which these physicians prepared in personal injury cases over the last five years is so broad as to include cases where the doctors may have been retained as consultants only and who were not trial witnesses.

12. The proposed subpoenas are overly broad. Plaintiffs seek all 1099 forms from and reports to any insurance companies or attorneys within the past five years. The requests are not limited to this case, nor are the requests limited to work done for defendants in litigation.

13. The request for "any and all letters, memos, or articles" on the subject of medical malpractice is likewise overly broad. As stated, an informal e-mail to a colleague about the malpractice crisis in this state would be included, as would any writings by these doctors to their own malpractice carriers on the subject of their own insurance coverage.

14. The proposed subpoenas are not reasonably calculated to lead to the discovery of admissible evidence. Expert reports to attorneys (for the plaintiff or the defense) in other cases and tax forms related to involvement in personal injury cases (for the plaintiff or the defense) are not relevant. A letter or memo by an expert "on the subject of medical malpractice" is likewise irrelevant to this case.

15. Disclosure of reports from other cases could also potentially lead to the disclosure of confidential medical information about patients involved in cases which are totally collateral to the instant case.

16. Finally, the Defendant submits that these proposed subpoenas violate Rule 4011's prohibition of discovery which would cause unreasonable annoyance, oppression, burden or expense.

17. Pennsylvania has traditionally asserted tight control over the scope and means of discovery concerning an opponent's expert. Unlike many other states, discovery depositions of expert witnesses are not permitted unless good cause is shown, and this virtually never happens.

18. Plaintiffs' attempt to bypass the Rules of Civil Procedure by directly subpoenaing information from the Defendant's expert is improper and should not be countenanced by this Court.

WHEREFORE, Defendant, Mary C. Kruszewski, D.O., objects to Plaintiffs' subpoenas to Richard Depp, M.D., and William W. Fox, M.D., and demands that Plaintiffs refrain from attempting to serve the aforementioned subpoenas consistent with Pennsylvania Rule of Civil Procedure 4009.21(d)(1).

McQUAIDE BLASKO

By: _____

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JOHN W. BLASKO
Attorneys for Defendant
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811 University Drive
State College, PA 16801
(814) 238-4926

Dated: 4-6-06

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA
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| Defendants. | ) | |

CERTIFICATE OF SERVICE

I hereby certify that the Objections to Subpoena Per Rule 4009.21 of Defendant Mary C. Kruszewski, D.O., in the above-referenced matter were mailed by regular mail, first class, at the Post Office, State College, Pennsylvania, postage prepaid, this 6th day of April, 2006 to:

***Regular Mail and Via Facsimile***
Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

***Copy***
David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

***Copy***
Victor H. Pribanic, Esquire
1735 Lincoln Way
White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
Attorneys for Defendant
Mary C. Kruszewski, D.O.

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| Defendants. | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify that the Brief of Defendant Mary C. Kruszewski, D.O. In Opposition to Plaintiffs' Motion to Reopen Discovery and Compel Answers to Interrogatories and Plaintiffs' Motion to Strike the Objections to the Subpoena Pursuant to Rule 4009.21 in the above-referenced matter was served by Regular Mail at State College, Pennsylvania, this 1st day of June, 2006 upon the following parties:

Robert P. Ging, Jr., Esquire
2095 Humbert Road
Confluence, PA 15424-2371

David R. Johnson, Esquire
Two Chatham Center, Tenth Floor
Pittsburgh, PA 15219-3499

Victor H. Pribanic, Esquire
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White Oak, PA 15131

McQUAIDE, BLASKO, FLEMING & FAULKNER, INC.

By: _____
JOHN W. BLASKO
ALLEN P. NEELY
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Mary C. Kruszewski, D.O.