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October 28, 2015

John Talvacchia, Esq.
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Re: Switzer v. Rezvina, et al.

Dear Mr. Talvacchia:

I have received the following documents in reference to the above-captioned litigation:

1. Plaintiff's first amended complaint
2. Affidavit if Merit of plaintiff's expert, Dr. Catherine Morrison
3. Letter to Board of Medical Examiners by Lindsay Switzer
4. Letter to Board of Medical Examiners by Dr. Natalia Rezvina
5. Medical records from Somers Manor Ob/Gyn
6. Audio transcript of conversation between Ms. Switzer and Dr. Rezvina on August 2, 2013
7. Patient's Bill of Rights
8. Witness statement from Jodi Green, plaintiff's doula
9. Letter from Giovana LoPresti, the labor and delivery nurse
10. Plaintiff's Answers to Interrogatories and attached records
11. Dr. Rezvina's Answers to Interrogatories with attachments
12. Plaintiff's Answers to Form A1 Interrogatories
13. Records from Michelle Richardson, MSW
14. Affidavit from Dr. Michael Bravoco
15. Records on disc from Shore Memorial Hospital for June 19, 2013 for Lindsay Switzer and Cole Switzer
16. Records from Horizons Counseling
17. Records from the delivery of Lindsay Switzer's first child in December 2010
18. Certification from Dr. Linda Stanley, plaintiff's subsequent treating physician
19. Part 1 of Lindsay Switzer's deposition with exhibits
20. Part 2 of Lindsay Switzer's deposition with exhibits

21. Deposition of plaintiff's husband, Joe Switzer
22. Deposition of Dr. Michael Bravoco
23. Email exchange between Lindsay Switzer and Dr. Katharine Morrison, plaintiff's liability expert
24. Color photograph of plaintiff's scar
25. Records from Beesley's Point Family Practice
26. New Jersey Civil Jury Charge on informed consent
27. Report of Michelle Richardson, MSW
28. Additional records from Beesley's Point Family Practice
29. Report and CV of plaintiff's expert, Dr. Katharine Morrison
30. Deposition of Dr. Natalia Rezvina
31. Answers to Form C Interrogatories on behalf of Somers Manor Obstetrics and Gynecology

Having now completed my review of these materials, I agree to serve as an expert on behalf of Dr. Rezvina. All my opinions are stated with a reasonable degree of medical probability. As a member of the American College of Obstetricians and Gynecologists, I abide by that organization's guidelines for expert witness testimony. In accordance with those guidelines, I affirm that while I expect to be compensated for the time spent in preparing this report and for any testimony that is necessary, I have no financial interest in the outcome of this matter, and will not accept compensation that is contingent upon the outcome of the litigation. I also affirm, consistent with the ACOG guidelines, that I am willing to have my testimony submitted for peer review.

In 2013, Lindsay Switzer was a 31-year-old G2P1 with a due date of 6/19/13. She had a previous 5 pound 15 ounce baby after a 10-hour labor, delivered by Dr. Rezvina in 2010. The 2013 pregnancy seems to have been uncomplicated. I note a phone call on 4/17 when the patient requested a referral for psychotherapy, as she was "feeling a bit overwhelmed." Ms. Switzer was also hospitalized the week prior to labor for a neurologic episode with a negative work-up for stroke.

She presented to Shore Medical Center at approximately 0900 on 6/19 with contractions that were 4 minutes apart. She was already 5.5 cm dilated, 80% effaced, and -3 station as documented by Lisa Lovett, a labor and delivery nurse. Ms. Switzer progressed to 7.5 cm and 100% effaced at noon. Shortly after noon Giovana LoPresti, the L&D nurse, documented an audible prolonged fetal heart deceleration into the "90-100's," leading to maternal repositioning and oxygen administration. Ms. Switzer was 8 cm according to CNM Jamie Sosa's exam at 1446, when membranes were artificially ruptured. The nurse documented full dilatation by the midwife's exam at 1516, but then wrote that Dr. Rezvina determined that she was actually 8 cm at 1534. Dr. Rezvina wrote that the patient was 9 cm in her note at 1537.

The patient requested intermittent monitoring only throughout this labor. Dr. Rezvina was called to see Ms. Switzer due to changes in the fetal heart rate, and was at her bedside at 1534. According to the nurses' notes, Dr. Rezvina instructed the nurse to continuously monitor the baby at 1535. Dr. Rezvina wrote a long note at 1537, discussing

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her concern about "fetal distress" and that it was unclear to her (due to the intermittent nature of the monitoring) for what length of time this had been occurring. Dr. Rezvina wrote that the patient and her husband were refusing the cesarean, and that Dr. Rezvina counseled them that the fetus was "in jeopardy of lack of oxygen and brain damage" with this refusal. At 1551 the nurse documented a discussion about cesarean section due to "non-reassuring fetal heart rate." The patient and her husband were "visibly upset." In response to the patient's request for a second opinion, at 1609 both the patient and her husband spoke with Dr. Bravoco on the telephone. Dr. Rezvina was at the bedside again at 1611, when the cesarean section was explained. Dr. Rezvina wrote that the couple agreed to the cesarean at 1615. Ms. Switzer went to the operating room at 1624. The skin incision was at 1648, and the baby was born at 1654 with Apgars of 9 and 9 and weighing 8 pounds 3 ounces.

The fetal heart monitor strips showed a normal baseline, moderate variability, and occasional accelerations between admission and noon. There was a prolonged deceleration that began at 1204 and had a nadir of 80, and then returned to baseline at approximately 1208. There was documentation of a normal baseline and occasional accelerations intermittently from 1209 to 1454. After this, there was a brief (20 second) strip with what looks like minimal variability and normal baseline at 1509 and a few seconds of a normal rate at an unspecified time after this. There were 2 decelerations at about 1537, with one clearly being a late deceleration. Late decelerations recurred at 1541, 1545, 1548, and 1551. A pattern of decelerations continued after this, with decelerations apparent at 1555 and with essentially every contraction after this until the monitor is turned off. The timing of the decelerations appears "earlier" after 1600 until delivery. Although the variability was moderate in the early part of the labor, the variability deteriorated beginning at approximately from 1530, adding to concern about fetal wellbeing. Nurse LoPresti assessed that the strip was Category I at 1449 but Category III at 1540 and thereafter.

Prior to initiating litigation, Ms. Switzer wrote to the Board of Medical Examiners, alleging that she was bullied into an unnecessary cesarean, that Dr. Rezvina lied to her, and essentially that Dr. Rezvina's treatment of her was unprofessional. It is my understanding that the Board investigated her complaint and did not feel that action was indicated. Ms. Switzer also wrote that she requested a "double layer of stitches" to increase her chances of VBAC in future pregnancies. I see that the operative note by Dr. Rezvina does document closure of the uterine incision in two layers, consistent with this request.

The plaintiff's expert, Dr. Katharine Morrison, alleges that Dr. Rezvina violated "the standards of The American College of Obstetricians and Gynecologists" in obtaining consent from Ms. Switzer. As we analyze this allegation, it is first helpful to remember that all Committee Opinions are recommendations by the national organization, and specifically do not exclusively set a standard of care. There are indeed differences in opinion in the obstetric community about the relative rights of a mother and a fetus. Nevertheless, Dr. Morrison quotes sections of the Committee Opinion #439 to support her contention that Ms. Switzer was coerced, and that her own preference and choice

were not respected. She specifically criticizes, "By threatening to call a judge to mandate a Cesarean Section Mrs. Switzer had firmly said she did not want, Dr. Rezvina violated ACOG's clearly stated precepts on obtaining informed consent… nor is it voluntary if the patient cannot decline the proposed treatment- Cesarean Section." My understanding of what took place is quite different from Dr. Morrison's.

Dr. Morrison writes, "nor is it voluntary if the patient cannot decline the proposed treatment." In Ms. Switzer's labor, she clearly did have the option of refusal, and Dr. Rezvina only proceeded to perform the surgery after the patient and her husband agreed to it. She did not, for example, take the patient down the hall for the cesarean against her wishes. Instead, Dr. Rezvina explained to the patient and her husband why she thought the baby was at risk if a cesarean was not performed and even got a second opinion from Dr. Bravoco, who independently reviewed the fetal monitoring and agreed that cesarean was appropriate. She then had the patient sign a consent form. Almost an hour elapsed between Dr. Rezvina's arrival and the patient's going to the operating room. The charting and the testimony reflect that a process occurred during that time period, culminating in the patient's consent.

The plaintiff apparently takes the point of view that she was "coerced" into the cesarean. My reading of all the materials is that Dr. Rezvina and the patient initially had a significant difference in opinion about what harm the fetus might suffer if cesarean were not done. The evidence clearly shows that after Dr. Rezvina gave her recommendations, the patient and her husband did not agree to the cesarean, and requested a second opinion. Dr. Rezvina then left the room, and Dr. Bravoco reviewed the strips remotely and spoke with Mr. Switzer. Mr. Switzer relayed this discussion to his wife. Dr. Bravoco, of course, agreed that the cesarean was indicated. After hearing his opinion, the Switzers consented to the cesarean and signed the consent form. There had been no further discussion about calling hospital administration. Over time, then, the patient agreed to accept Dr. Rezvina's determination that cesarean was safer for the baby than vaginal birth.

Dr. Morrison does not address in her opinions the concept that Dr. Rezvina had 2 patients that day (mother and baby), and had a responsibility to both. If Dr. Rezvina felt that the baby was at risk if he stayed in his mother's uterus, it surely was her responsibility to communicate to the parents why she was concerned, and what her recommendation was for remedying that problem. She did this. If Dr. Rezvina felt that the maternal refusal put the baby at risk of brain damage, it was also reasonable for her to try to figure out how she should deal with this. I would not expect her to know the law- about when a court might mandate intervention. Making a phone call to hospital administrators to find out what she could do, given her concern for the baby, would have been an ethical and thoughtful action.

Dr. Morrison claims that Dr. Rezvina "violated ACOG standards by not being current in her knowledge base," and goes on to describe that she interpreted the fetal monitor strip differently than Dr. Rezvina. She takes the position that further evaluation was needed because, in her interpretation, the strip was Category II, and that "ACOG states [a Category II strip] requires further evaluation to determine fetal well-being, not immediate

or emergency delivery." The interventions she recommends as standard of care are scalp stimulation and amnio-infusion. She then cites without reference a statistic that brain damage to a newborn is rare. She feels that Dr. Rezvina did not know this piece of information and that Dr. Rezvina did not know that cesarean sections haven't decreased the incidence of cerebral palsy.

Where do I begin? Dr. Morrison seems to have a political opposition to cesarean in general, and is confusing her personal beliefs with an obstetric standard of care. It may be true that the incidence of cerebral palsy has not changed in the United States, but this is a complicated issue that has to do with many factors, including poverty, lack of access to prenatal care, the rate of prematurity, multiple pregnancy rates, and advances in quality of neonatal care. It cannot be proven that fetal monitoring has affected the rate of brain damage, but it is nonetheless ubiquitous and standard for American obstetricians to use monitoring to assess fetal status. A problem with fetal monitoring is that it has poor positive predictive value- that is, the majority of abnormal tracings result in vigorous infants. Nonetheless, babies born after acute hypoxia and placcntal insufficiency commonly show fetal heart rate abnormalities like diminished variability and late decelerations- changes exhibited by Ms. Switzer's fetus during the end of the labor. Dr. Morrison may want the American obstetric community to abandon fetal monitoring, but that does not mean it was a violation of the standard of care for Dr. Rezvina to rely on the type of fetal monitoring information that almost all obstetricians utilize.

I understand that Dr. Morrison has a different interpretation of the fetal monitoring, but this does not mean that Dr. Rezvina's evaluation was inconsistent with the standard of care. Obstetricians have varying thresholds for taking a chance on neonatal brain damage, and don't always agree about when a baby is at risk. ACOG Practice Bulletin #106 discusses the subjective nature of fetal monitoring interpretation. This publication describes research on fetal heart rate monitoring going back to the 1980's, showing tremendous inconsistency in the interpretation of fetal heart rate monitoring:

> There is high interobserver and intraobserver variability in the interpretation of FHR tracing. For example, when four obstetricians examined 50 cardiotocograms, they agreed in only 22% of the cases. Two months later, during the second review of the same 50 tracings, the clinicians interpreted 21% of the tracings differently than they did during the first evaluation. In another study, five obstetricians independently interpreted 150 cardiotocograms. The obstetricians interpreted the tracings similarly in 29% of the cases, suggesting poor interobserver reliability.
>
> The interpretation of cardiotocograms is more consistent when the tracing is normal. With retrospective reviews, the foreknowledge of neonatal outcome may alter the reviewer's impressions of the tracing. Given the same intrapartum tracing, a reviewer is more likely to find evidence of fetal hypoxia and criticize the obstetrician's management if the outcome was poor versus good. Therefore, reinterpretation of the FHR tracing, especially if neonatal outcome is known, may not be reliable.

We must recognize that interpretation of the fetal heart status is an art, not a science, and that retrospective analysis of strips may be unfairly biased. Dr. Morrison has the retrospective knowledge that the baby came out vigorous, contributing to her evaluation that the strips did not show fetal compromise. This does not mean that it was unreasonable for the nurse, Dr. Rezvina and Dr. Bravoco to have concern about the strips on a prospective basis.

Dr. Morrison says that a Category II strip requires further evaluation, but doesn't take into account the entire clinical picture. She appears to be referring to ACOG #116, which also says that expedited delivery must be considered for persistent late decelerations. The same publication says that accelerations and moderate variability with late decelerations decrease the chance of worrisome academia, and that lack of accelerations and minimal variability (as occurred here) increase the level of concern. In Ms. Switzer's labor, there was no information about fetal status from approximately 1500 until the lates began, increasing the physician's concern about the duration of potential fetal compromise.

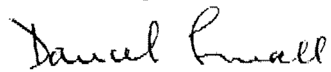
Fetal scalp stimulation accompanied by acceleration is an option, but not the standard of care. With minimal variability and lates, it is highly unlikely that scalp stimulation would have resulted in a positive response. Dr. Morrison's idea that amnioinfusion was indicated is just misinformed. Amnioinfusion can be considered for recurrent variable decelerations, and is aimed at reducing cord compression. There was no evidence in this labor of cord compression, and no indication for amnioinfusion.

It was also important that Ms. Switzer progressed rapidly to 7.5 cm at noon, but then labor progress slowed despite apparently adequate contractions. She progressed approximately 1 cm over the subsequent 3 to 4 hours, a labor abnormality known as a protraction of the active phase. Put in the most favorable light, one would have expected that vaginal delivery was not at all imminent at 1600- that even if a vaginal birth were possible, Dr. Rezvina had reason to believe that the fetus would be subject to considerably more labor stress before this could occur. Viewed statistically, though, it was quite possible that Ms. Switzer was exhibiting early signs of an obstructed labor, and would have gone on to cesarean section even without concern for the fetal heart monitor. The fact that Cole was over 2 pounds larger than his sibling no doubt contributed to the abnormal labor progress.

In sum, I find that Dr. Rezvina performed her duties in a manner consistent with the standard of care expected by our professional community. It is my opinion that Dr. Rezvina's recommendation for cesarean was specifically consistent with the standard of care. Dr. Rezvina was open to the concept of a second opinion, and Dr. Bravoco indicated at that time that he agreed with the decision for cesarean. One cannot fault Dr. Rezvina for feeling that cesarean was in the best interest of the baby, and communicating this to her patient. When met with the patient's refusal, she reiterated the rationale for her concern, and pursued an appropriate course involving a second opinion about this advice. The patient eventually gave consent, though she clearly was upset that she was not going to deliver vaginally. This is not uncommon despite consent for cesarean. I will be

available to testify in court should the need arise. I reserve the right to add to or amend my opinions should further information become available.

Respectfully submitted,



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