THE STATE OF OHIO,)
) SS: DANIEL Θ. CORRIGAN, J.
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

Doc. 240

CYNTHIA WATSON, ADMINISTRATRIX, ETC.,

Plaintiff,

V.

COMMUNITY ,HOSPITAL OF BEDFORD, et al.,

Defendants.

Case No. 109808

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Deposition of STEVEN M. KLEIN, M.D., taken by the Plaintiff as if upon cross-examination before Nancy A. Nunes, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Kitchen, Messner & Deery, **1100** Illuminating Building, Cleveland, Ohio, on Wednesday, the 6th of April, **1988**, commencing at 2:05 p.m., pursuant to notice.

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APPEARANCES:

Charles Kampinski Co., L.P.A., by:
Christopher M. Mellino, Esq.,
and Charles Kampinski, Esq.,

On behalf of the Plaintiff

Kitchen, Messner & Deery, by:
Charles W. Kitchen, Esq.,

On behalf of Defendant Community Hospital of Bedford.

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., by:
Richard Ludgin, Esq.,
Susan Reinker, Esq., and
Michael M. Djordevic, Esq.,

On behalf of Defendant Dr Ahmed

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Nancy A. Nunes; and that her stenotype notes may be subsequently transcribed in the absence of the witness

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STEVEN M. MELLINO, M.D.

called by the Plaintiff for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. MELLINO:

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

A. Steven Michael Mellein.

Q And your address?

A. 26900 Cedar Road.

Q. I take it that's your office address?

A. That's correct

Q What's your home address?

A. 21125 Shelbourne Road.

Q. What city is that in?

A. That's in Shaker.

Q. Have you been deposed before, Doctor?

A. Yes. I have

Q. So I'd only ask two things of you; one's that you answer all my questions verbally because the court reporter can't take down a nod of the head, and the other thing is if at any time you don't understand any of my questions, or don't hear me, ask me to repeat or rephrase

the question. Do you understand each other?

A Yes.

Q What did you review in this case?

A I reviewed the hospital chart of Cynthia Watson, and that's from Bedford Community Hospital, as well as the hospital chart of Tanissa Nicole, Baby Girl Watson, also from Bedford, as well as the fetal monitoring strips, and an initial file review supplied to me by Mr. Kitchen.

Q. Okay. You reviewed those to prepare your report?

A. That's correct.

Q. Have you reviewed anything since preparing your report?

A. I saw briefly a report of a Dr. Titas, or --

MR. KITCHEN: Titan.

A. From New Jersey, I believe.

Q. (BY MR. MELLINO) Did you see the report of a Dr. Mann?

A No

Q Have you reviewed any depositions?

A No, sir.

Q Have you ever been a defendant in a lawsuit before?

A Yes, sir

Q When is that? First of all, how many times was it?

A. Defendant, as far as a deposition is concerned only.

Q. Well, were you sued, named in a lawsuit?

MR KITCHEN: Have you been a defendant where you have been sued by somebody?

A. Yes.

Q. (BY MR. MELLINO) Okay. How many times was that?

A. Well, twice, to my knowledge

Q. And when was it?

A. Well, both suits are ongoing, so one was initiated, I think, in 1984, and another one in 1987

Q. What were the facts underlying those suits?

A. One was a situation of a stillbirth and subsequent hemorrhage because of a retained placenta, and subsequent infertility due to the surgery that had to be done to stop the bleeding. The other case was that of a stillbirth, also requiring surgery to control an obstetrical hemorrhage, and those pretty much are the facts.

Q. What were the allegations in those cases, the allegations that you did wrong?

A. Which case?

Q Well, start with the one in '94

MR KITCHEN: I'm going to object to the line of questioning. I don't see the relevancy, but go ahead

A. The case of the stillbirth with the hemorrhage and subsequent infertility, the allegation was that the placenta should have been removed by me without the obstetrical hemorrhage

Q. Okay.

A. The other case was, that was a case of a post term breach, and the allegation was that I should have done a cesarean section before the baby died

Q You aid both of those cases are --

A Pending.

Q -- still pending Who represents you in those cases?

A PIE

Q What were the lawyers that represent you?

A. The PIE lawyers

Q. Do you know their names?

A Mr. Heschel Mano for Joseph Cases

Q. Okay. Are those pending in Cuyahoga County?

A. Yes

Q How many times have you acted as an expert witness in a malpractice case?

A. Perhaps a half a dozen.

Q. How many of those occasions were on behalf of plaintiffs?

A Two.

Q What did those cases involve? What were the facts?

A. Which ones?

Q Well, all of them. Start one at a time

A. I can't remember

Q. How long ago was it?

A. It was in the past several years that I have been in practice.

Q. When would the first one have been?

A. I don't remember

Q. How long have you been in practice?

A Fourteen years

Q. When was the most recent one?

A. A case that I reviewed, must have been about three, four months ago.

Q Do you remember what the facts of that case were?

A I'm sorry I don't

Q. Are you Board-certified?

A. Yes, I am.

Q. When were you certified?

A In 1976.

Q What were you asked to do in this case?

A Review the records and prepare a report

Q Okay Now, in your report, it's dated November 24, 1986. Was that the only report you prepared in this case?

A That's correct.

Q Okay. You conclude in that report in the second to last paragraph that the treatment received by Cynthia Watson and the care given by the Community Hospital of Bedford met the standards of the American College of Obstetricians and Gynecologists. Can you tell me what the standards of ACOG were with regard to notifying a pediatrician?

A. No, I can't.

Q. Do you know if they were met in this case?

A. If I don't know the standards, then, I don't know whether they were met

Q. Okay In the sentence before that, you conclude that the eventual death of Baby Watson was a result of meconium aspiration and fetal acidosis that occurred prior to labor Can you tell me what evidence there is in the record that the aspiration occurred prior to labor?

A. Yes Upon rupturing the membranes, heavy

meconium was noted. When monitoring the baby, there was an elevated baseline, a lack of beat to beat variability, or at least diminished beat to beat variability with a lack of either prolonged or prolonged ominous accelerations.

Eventual outcome after the birth of the baby was a severely distressed fetus that was not very well resuscitated, and eventually a demise occurred, and that diagnosis of the demise was meconium aspiration.

However, I concur that the meconium aspiration occurred prior to the patient arrival at the hospital

Q. Can you be more specific for me as to when it occurred?

A No, sir.

Q Is there any evidence in the autopsy? You did review the autopsy?

A. I did not.

Q. Oh, you did not Okay All right The things you pointed out for me, heavy meconium, elevated baseline, lack of beat to beat variability, you indicate in your report that those things indicate to you that the meconium aspiration occurred prior to labor based on a study that you cite in here, is that correct?

A. Do I footnote that?

Q. Yes.

A What is the footnote? Where are we talking about in my report?

Q On page 3, the middle paragraph says, abnormal fetal heart rate patterns and conditions such as tried of thick meconium, elevated baseline, FHR, and the loss of best to best variability can indicate an injury that precedes labor At the end of that paragraph you cite recent medical literature offers evidence that meconium aspiration does occur prior to the onset of labor and delivery, and I cite No 3, an article on fetal meconium aspiration in utero, author Manning, F. A , et al, Journal, American Journal of Obstetrics and Gynecology, 1978, volume 132, pages 111 to 113

And you think that's a recent study, two years ago, a 1978 study?

A. It's ten years old

Q. Okay. And then you go on to say, read the next sentence there.

A. This is followed by elevated baseline as noted by t e in ake physical examination done by Dr Soto-Zabala, minimal variability and unanticipated decels acidosis and neonatal morbidity, and I cite article No. 4, Fetal Injury Prior To Labor; Does It Happen, authors Paul, R H , et al, American Journal, American Journal of Obstetrics and Gynecology, volume

154, No. 6, 1986, page 1187. That looks to be approximately two years old

Q Okay Well, I guess my question is that you told me this is what the evidence of the aspiration occurring prior to labor is, those factors you gave me, and my question is what is your basis for saying that these factors tell you that?

What tells you that these -- What tells you, by seeing these factors, that it occurred prior to labor?

A. Prior to the patient arriving at the hospital that's all I can -- that's all that my opinion is based on, that it occurred prior to the patient arriving at the hospital.

Q. Right. I understand that

A Yes

Q. And my question is, and I understand your opinion is based on these factors being present, the heavy meconium, the lack of beat to beat variability, elevated baseline?

A Yes.

Q My question is what tells you that these factors being present indicate that it occurred prior to her arriving at the hospital?

MR KITCHEN: Do you understand his

question?

THE WITNESS: I'm sorry

MR MELLINO: What's okay I just don't understand the question, so so he can rephrase it

A I don't understand your question.

Q. (BY MR. MELLINO) Okay. My question is, these studies that we just discussed, do they say that when these factors are present, hyaly meconium, elevated baseline, lack of beat to beat variability, when those are present, then the aspiration occurred before or?

A. These studies indicate that these can be and often times are a result of meconium aspiration syndrome, and that it does precede labor in many instances

Q Okay And so is that what you're basing your opinion on then, that in this case it was prior to labor --

A. That's correct.

Q. -- those studies that are cited in there?

A. No I'm basing my opinion that the meconium aspiration occurred prior to the onset of the patient arriving at the hospital because the patient, when she arrived at the hospital had meconium in the fluid already, and because when they began to monitor the patient, there was, from the very first time they began to monitor the patient, those signs that I referred to previously, that is the elevated baseline, the loss of beat to beat

variability, the lack of profound or deep decelerations, and eventually we had a severely compromised infant, all of which to me means that the meconium aspiration took place prior to the patient arriving at the hospital.

Q. Okay. And I guess my question is why does that mean that to you, what's that based on?

A I think I have answered the question.

Q. Well, what's the answer?

MR. KITCHEN: He's just given you the items.

A. I'm sorry. I don't understand what you're driving at

Q. (BY MR. MELLINO) I'm asking you, these factors --

A. Yes.

Q. -- these signs --

A Yes.

Q -- indicate to yo that it occurred prior to labor?

A Yes, it does

Q. Okay What is that based on? Is it based on the medical literature, is it based on --

A. Yes. It's based on the medical literature that says that if these signs are present, that indeed meconium aspiration can be the cause, and in my opinion is

was in this instance

Q Okay And those studies are the ones we talked about that are cited in footnote three and four?

A I cited footnotes three and four.

Q Okay Right So you have a copy of the Paul study with you?

A No, sir

Q If there was meconium aspiration prior to labor, would that in any way influence what in an autopsy?

A That meconium aspiration occurred would be found at autopsy

Q Would you be able to tell when it occurred by the autopsy?

A. I wouldn't be Perhaps a pathologist might be able to

Q Okay Okay Your CV indicates that you were on a tissue committee at Mt. Sinai Hospital; what was that?

A. Correct

Q. What did you do as part of that committee?

A. Review surgical cases, their indications and diagnoses to make sure that there is good quality assurance

Q. Did you review tissue samples, or why is it called a tissue committee?

A Well, I think it's -- I don't know why it's called a tissue committee rather than the pathologist reviews the diagnosis and makes sure that it fits with his pathology report.

Q. Well, what was your role on the committee, now didn't actually --

A. I'm one of the physicians on the committee that helps to review the cases that may come up in which there is a discrepancy between the discharge diagnosis and the final tissue report, the pathologist report

Q. What does meconium tell you as an obstetrician when you see ruptured membranes?

A. That the baby has experienced some kind of distress, the fetus has experienced some kind of distress

Q What do you do when you see meconium?

A Monitor the pregnancy as best I can to determine whether the distress that the fetus has experienced is ongoing.

Q. Do you call a pediatrician?

A. That's not my first -- that's not the first thing I do.

Q. Well, you are done answering?

A I'm done If there s a pediatrician helping me manage the pregnancy.

Q. Well, is it important when you see meconium, to

have a pediatrician there at delivery?

A. It's important to have a person at the delivery who is capable of resuscitating a newborn that needs to be resuscitated; in some instances it is a pediatrician, and in some instances it's an anesthesiologist, and in some instances it's the obstetrician himself or his associate.

Q. Well, what would be your first choice to have present?

A My first choice would be pediatric residents where I deliver most of my babies, or the anesthesiologist.

Q. Are you aware of how their resuscitation took place in this case?

A. I'm aware only of what I read on the chart.

Q What did you read on the chart?

A. The operative note of Dr. Ahmed reads, after the head of the baby was delivered, DeLee suction cannuls was introduced and all the meconium in the throat was completely suctioned The baby was then handed to the anesthesiologist, which was standing by for immediate endotracheal intubation and suctioning.

In addition, the anesthesiology record states baby cyanotic I can't read the next line, but it says heavy mecon am, baby cyanotic, heavy meconium stained,

suctioned through endotracheal tube, excess endotracheal tube left.

That's how I interpret that writing on the anesthesia record. Those are the resuscitative efforts as far as I can determine.

Q. Did you look at the nurses' notes?

A. Where is that?

Q. It's in the chart of Baby Girl --

MR. KITCHEN: You are referring to Baby Girl's chart?

Q. (BY MR. MELLINO) Yeah. Baby Girl Watson's chart. Why don't you read that note, the one at the top of the page, out loud.

A. Delivered female via C section. Meconium stained fluid thick and tenacious. Dr. Ahmed suctioned infant with bulb syringe and DeLee. Handed to nurse to waiting anesthesiologist. Dr. Barsom suctioned with DeLee, thick, tenacious meconium fluid three CC, infant bagged -- Shall I go on?

Q. No. That's fine. Does bagging or can bagging have the effect of pushing meconium further into the airways?

A. Yes.

Q. Was this an appropriate way to resuscitate this baby?

A I don't know that that, in fact, happened

Q Well, I will ask you to assume that it happened

A. I can't assume that it happened

MR. KITCHEN: For purposes of his question, he is asking you to assume that. So you can take that assumption and then ask the question. Go ahead.

Q (BY MR MELLINO) Assume that it happened the way that it is reflected in Nurse Dittmar's note that you have just read. Is that an appropriate way to resuscitate the baby?

A No

Q. When you have meconium present upon rupture of the membranes, doesn't that tell you, as an obstetrician, that it would be important to have appropriate resuscitative measures taken upon delivery as soon as the baby is delivered?

A. Yes.

Q. Because the first few breaths are the most important in terms of not having meconium aspiration, is that right?

A. I don't know that

Q. Well, why is it that you want to have appropriate resuscitation?

A Well, whatever caused the baby to have the

distress such that the baby passed the meconium, it may still be in distress and may need to be resuscitated.

Q If you assume that -- how does a baby or fetus, how does it aspirate meconium; fetus doesn't breathe through its nose and mouth, correct?

MR. KITCHEN: That's an in utero question when you're using the word fetus and inspiration.

Q. Right. In utero.

A. No, your statement was -

Q. How does meconium aspirate?

A. By breathing it in.

Q. Okay. A fetus in utero doesn't breathe, or does it breathe in utero, let me just --

A. By depressing the diaphragm, and using the muscles

Q How does it expend oxygen?

A Through the placenta

Q. So it doesn't normally breathe through its nose and mouth, does it?

A. I disagree with that statement.

Q. Okay. You believe --

A. The baby, fetus, does make breathing movements, and in fact, there is amniotic fluid going in and out of the brachial tree throughout fetal life.

Q Is there medical literature that supports that

belief?

A.

Q. o into the lungs under your --

A. Into the lungs.

Q. g amniotic fluid?

A. If the trachea and the brachia are part of the lungs, it goes into the lungs.

Q. it's taking amniotic fluid in its mouth and nose and goes down through the esophagus, trachea into the lungs and back out again; it passes amniotic fluid just like it would oxygen if it was out in the air?

A. Amniotic fluid going into the tracheal bronchial tree, and with aspiration efforts the amniotic fluid would pass back to the tracheal and bronchial tree

Q. When does it start and when does it stop?

A. I am not sure.

Q. Do you do a C section every time you see meconium fluid, meconium amniotic through --

A. Do I?

Q. Yes.

A. No, sir.

Q. Well, wouldn't it be important to do one when you believe the baby would be passing amniotic fluid in

and out through its lungs? Wouldn't that put the baby at risk for meconium aspiration?

A Yes It would put the baby at risk for meconium aspiration

Q So why is it that you don't do a C section?

A Because meconium aspiration occurs in only 2 to 5 percent of those babies that do pass meconium.

Q Why is it that there is no meconium aspiration if they're breathing in and out amniotic fluid, there isn't meconium aspiration; why isn't it a higher percentage than two percent?

A The amount of meconium aspiration is higher than two percent. Meconium aspiration syndrome is where you have persistent fetal circulation and pulmonary hypertension occurs in about two percent of the cases of meconium.

Q. Why does it only occur in two percent? What's the difference?

A. I don't know why

Q. Okay. Would resuscitation have anything to do with it?

A Would resuscitation have anything to do with?

Q With it?

A With what?

Q The difference in the amount that the babies

have that conium aspiration and those that are symptomatic?

A. No Resuscitation will not make a difference as to the development of meconium aspiration sydrome

Q It doesn't?

A It does not.

Q Okay. What makes the difference do you know?

A. No, I don't

Q. Okay. If there was meconium in the lungs, would there be macrophagus in the lungs or macrophagus containing meconium in the lungs?

A. I don't know.

Q. If you assume that the aspiration didn't occur in utero, and you assume that the resuscitation took place as reflected in Nurse Dittmar's note, would that have caused the meconium aspiration syndrome in this case?

A. Could you repeat the question, please?

Q. Sure. If you assume that the meconium aspiration occurred, didn't occur in utero, okay, and you assume that the resuscitation took place as reflected in that nursing note, would that have caused the meconium aspiration syndrome in this case?

A. If I assumed that it had not occurred prior to the resuscitative efforts, is that what you're saying?

Q. Yeah, didn't occur in utero.
A. Did not occur in utero
Q. Yeah
A. And I assumed --
Q. That the resuscitation took place as reflected in that nursing note?
A. As described by this nurse?
Q. Right
A. Would then meconium aspiration syndrome have evolved, eventuated?
Q. Would it have been caused by either the method of resuscitation reflected in that note, or the lack of appropriate resuscitation?
A. I think that meconium aspiration syndrome could have been caused by the resuscitative efforts described, if the previous assumptions are made
Q. Okay. What about could it have been prevented by appropriate resuscitative measures under the same set of assumptions that I just gave you?
A. Yes.
Q. What are macrophagus?
A. Macrophagus are a type of tissue cell that is used to pick up tissue waste like a little garbage can
Q. Are those present in the lung?
A. Yes

Q And you don't know if there was meconium in the lung, whether these macrophagus would attempt to pick up -- to use your words -- meconium?

A. I think that they would probably be present I don't know.

Q. Okay.

A. They have been described as being present when meconium aspiration syndrome has occurred

Q If they are present, does that tell you how long the meconium had been in the lungs?

A. Probably 36 to 48 hours

Q And if they're not present, what does that tell you?

A That they may never have been there in the first place, they might not have picked up meconium in the first place. Doesn't tell me --

Q. Doesn't tell you anything?

A. That's correct.

Q. Okay. Whose responsibility is it to have a pediatrician present at the delivery?

A. I don't know that it's necessary to have a pediatrician present at the delivery

Q. Well, do you know what the standards were in this hospital for having a pediatrician present at delivery?

A. No.

Q. Do you have an opinion in this case of whether or not it was required to have a pediatrician present at the delivery? Let me rephrase --

A. I think a pediatrician should have been present at the delivery.

Q. Okay. Do you think it was within the standard of care to call a pediatrician prior to delivery?

A. Not necessarily

Q. If it was a standard of ACOG to have a pediatrician present under the circumstances present in this case, do you think it would be within the standard of care to call a pediatrician?

A. If the standards of ACOG said that in this type of situation a pediatrician should have been called, then that was clearly a breach of the standards of ACOG, but I think that people use standards as guidelines and need to make decisions for themselves concerning medical situations.

Q. So you don't think that doctor or hospital had any responsibility for having a pediatrician present at the delivery of this baby, anything independent of what may have been required by the hospital, which you are unaware of, correct?

A. No. I don't think that the doctor nor the

hospital was at fault for not having the pediatrician at the birth of this baby

Q. And you say that without knowing what the requirements of the hospital were to have a pediatrician present?

A. I say that knowing what I reviewed from the chart.

Q. But you didn't review the policy and procedure manual for that?

A. That's correct

Q. And you don't know what the standard of ACOG are regarding having a pediatrician present?

A. That's correct.

Q. And you haven't read Nurse Dittmar's deposition?

A. That's correct.

Q. I take it then your opinion wouldn't change regardless of what Nurse Dittmar said?

A. My opinion concerning what?

Q. This case

MR. KITCHEN That's a pretty open question. Are you still back on the pediatrician present at delivery issue, or have you gone on to something else?

Q. (BY MR. MELLINO) Well, let's start with the pediatrician being present. Would your opinion that you

just gave me that the nurse, or the hospital and the doctor were not responsible for having a pediatrician present, would that change -- I don't know if you were given further facts, are there any set of facts that --

MR. KITCHEN: Well, I'm going to object to that I don t see how he can possibly respond to th t If you want to put a set of facts before him and see if he can respond to that, he can do that, but not just an open question.

Q. You didn't think it was important to look at Nurse Dittmar's deposition?

MR. KITCHEN: I didn't send him the deposition.

MR. KAMPINSKI: Well, that's not the question. He can ask for it.

MR. KITCHEN: Sure. All right

Q. (BY MR. MELLINO) Did you ask for Nurse Dittmar's deposition?

A. I didn't know that Nurse Dittmar was deposed

Q. Would her testimony be important to you in terms of rendering an opinion in this case?

A. Rendering an opinion concerning what?

Q. Well, any of the issues in the case

MR. KITCHEN: I'm going to object to that I don't see how he can answer that question. If you can

answer the question in that form, Doctor, so ahead, and if you can't, say so.

A I don't know.

MR. MELLINO: All right. Why don't we take about a five-minute break?

(Short break taken)

Q. (BY MR. MELLINO) Doctor, have you talked to Dr. Ahmed about this case?

A. No, sir.

Q. Do you know Dr. Ahmed?

A. No, I don't

Q. Do you know who he is?

A. No.

Q. Did you talk to Nurse Dittmar about this case?

A. I did not

Q. When you reviewed the records, I take it you saw that note that we have been discussing today?

A. I probably read it. I don't remember having read it.

Q. Why wasn't that note important to you in terms of rendering an opinion in this case given the fact that you have told me that if you assume that note to be true, then the resuscitation was improper?

A. I read the operative note of the physician doing the C section, I read the anesthesia note of the

physician doing the resuscitation, and felt that those were all I needed to render an opinion as far as the resuscitative efforts were concerned

Q Well, the operative note really only concerns how Ahmed did the initial resuscitation?

A. Yes It also asserts how he handed the baby off to the waiting anesthesiologist who was waiting to intubate the baby and suction through the endotracheal tube, and that's corroborated by the anesthesia record. I have no reason to believe otherwise.

Q. What about Nurse Dittmar's notes?

MR. KITCHEN: I'm going to object at this time This doctor was not now asked, or at trial asked to resolve fact questions. You have asked him his opinion on both sides of the issue, and obviously the issue is going to be to have to decide what the facts are

MR. KAMPINSKI: He apparently resolved the fact, the question rendering the opinion.

MR. KITCHEN: And you have asked the question both ways, and obviously at trial he is not going to resolve fact questions.

Q. (BY MR. MELLINO) In the other case that you acted as an expert witness, were you deposed in any of those cases?

A. Some of them.

Q. How many of them?
A. I don't remember.
Q. You don't know if it was -- was it less than three?
A. I don't remember
Q. You have absolutely no idea out of the six cases how many depositions you gave?
A. I don't remember
Q. How many cases did you render a report in?
A. I don't remember
Q. You have absolutely no idea if it was less than three, more than three?
A. Correct. I have absolutely no idea
Q. How many cases went to trial?
A. I have testified at one trial
Q. When was that?
A. I don't remember.
Q. Do you keep records of the cases you act as an expert witness in?
A. Not if the case has already been resolved
Q. You don't have any records?
A. No, sir
Q. Would you report your income from those cases on your income tax return?
A. Certainly do

Q. And you said that would have commenced in 1975 that you started reviewing cases?

A. I don't remember when I started to review cases.

Q. Well, can you give me an idea?

A. Sometime after I arrived in Cleveland in July of 1974.

Q. How is it that you were retained by Mr. Kitchen in this case?

A. You'd have to ask Mr. Kitchen.

MR. KITCHEN: I think that would be a question appropriately asked of me, and I don't think I'm going to answer the question if you intend to present it to me, Mr. Mellino.

Q. (BY MR. MELLINO) Did you know Mr. Kitchen before this case?

A. Yes.

Q. How did you know him?

A. Through work that I had done for him prior to this case.

Q. As an expert witness?

A. Yes.

Q. When did you act as an expert?

A. I don't remember.

Q. Well, was it 14 years ago, was it last year?

MR. KITCHEN: To simplify the process, there was a trial that he testified in that was Steve Albert's case I don't remember the name of the plaintiff. I can get that information for you, if you wish.

MR KAMPINSKI: Well, if you want to go off?

(Discussion had off the record)

MR. KITCHEN: Let me just make the statement for the record. Off the record we have determined that the doctor will go back and search out whatever records he has to produce the names of any cases that those records from any source reflect that he has reviewed and rendered reports in and/or presented depositions and/or testified in. We have also recalled that he did testify in the Lukins case. I think that you can, if you want to know the case number, I can get that for you, too

MR KAMPINSKI: That's not necessary.

Q. (BY MR. MELLINO) Why wouldn't the autopsy be important in determining the cause of the meconium aspiration syndrome in this case?

A. I don't know that it wouldn't

Q. Well, why didn't you review it then?

A. I wasn't given that material to review

Q Did you ask for it?

A No, sir.

Q Well, if it would have been important, why didn't you ask for it?

A. Well, I didn't think it was important to determine those things that I was asked to determine

Q Well, what are those things you were asked to determine?

A To review the material that was sent to me, and to write a report based on the review of those materials.

Q. And so you limited yourself to those materials?

A. Yes

Q. Isn't there medical literature that reflects meconium is not always due to -- I will strike that question. What does a finding of disseminating intervascular coagulation mean?

A. That there is evidence of coagulation disseminated through the baby s vascular --

Q. Would that mean anything to you in terms of when the asphyxia occurred?

A No, sir.

Q No, it doesn't, or doesn't mean anything to you?

A It does not.

MR. MELLINO: Okay. I don't have any other questions. Some of the other attorneys may have questions for you.

MR. DJORDEVIC: Nothing

MR. KITCHEN: We would not waive signature. If you have it typed, you can send it to me, and I will send it out to him.

MR. KAMPINSKI: Before we go off the record, can we have some type of time estimate when we can expect the information from the other cases?

MR. KITCHEN: You can get that back to me within a week, can't you?

THE WITNESS: Yes

MR. KAMPINSKI: Okay. Thank you very much.

- - -

I have read the foregoing transcript from page 1 to page 34 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

STEVEN M. KLEIN, M.D.

Subscribed and sworn to before me this day of , 1988.

Notary Public

My Commission Expires:

THE STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Nancy A. Nunes, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that STEVEN M. KLEIN, M.D was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice; and that I am not a relative or attorney of either party or otherwise interested in the event of this action

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 4th day of May, 1988.

Nancy A. Nunes RPR/CM, Notary Public
Within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: February 14, 1989

Steven M. Klein, M.D.
21125 Shelburne Road
Shaker Hts., Ohio 44122

November 24, 1986

Mr. Charles W. Kitchen
Kitchen, Messner & Deery
1305 The Superior Building
815 Superior Avenue, N.E.
Cleveland, Ohio 44114

Re: Your File No. 3480 A 2910
Cynthia Watson, etc. v. Community Hospital of Bedford et al

Dear Mr. Kitchen:

As per your instructions, I have prepared the following report after reviewing the March 1, 1985 admission of Cynthia and Tanisa Nicola Watson as well as the fetal monitor strips and your initial file review.

Cynthia Watson was a divorced, 28 year old black female when she entered Bedford Hospital on Friday, March 1, 1985 at 6:27 A.M.. Her attending obstetrician was Dr. Azzam Ahmed, and her EDC of March 10, 1985 placed her at 38-½ weeks at that time. She also weighed in excess of 200 lbs.. Historically she had previously delivered a 7 lb. 3 oz. male and an 8 lb. 9 oz. male both vaginally and apparently without problems. A family history of diabetes was noted on her prenatal evaluation history sheet.

The patient presented at approximately 6:00 A.M. on March 1, 1985 in early labor. Pelvic examination revealed that she was 2 cm. dilated, the vertex was at a minus 2 station and her blood pressure was 120/70. She was allowed to ambulate but was monitored at 6:30 A.M. for a 147 FHR, at 6:45 A.M. for a 147 FHR and again at 7:00 A.M. for a 155 FHR before she was allowed to walk.

Dr. Ahmed was notified at 6:30 A.M. of her arrival. At 8:30 A.M. he artificially ruptured the amniotic sac and found thick, tenacious meconium. An internal monitor was applied to the fetal scalp. Contractions were every **1** to 2 minutes of moderate, one to two plus, intensity. FHR ranged from 130-175 with a tendency toward an elevated baseline tachycardia of 155-165.

At 10:30 A.M. Dr. Ahmed was called to check the patient because of a decrease in variability. A review of the monitoring strip from 8:35 A.M. to 11:14 A.M. demonstrates possible intermittent late decelerations, scattered, but not profound, variable decelerations, possible early, head compression, decelerations and a diminished beat to beat variability at times but not profound since the variability intermittently returned. There were no persistent late or severe prolonged variable decelerations. There was evidence of an elevated baseline with intermittent tachycardia.

Dr. Ahmed examined the patient at 11:00 A.M. and found her to have dilated **to** 4 cm. with a rather thick, edematous cervix and the vertex at a minus 1 station. Probably considering that vaginal delivery was not going to occur within a relatively short period of time, Dr. Ahmed gave the patient nasal oxygen and prepared for a Cesarean section. She was taken to the operating room at 11:14 A.M. after surgery, anesthesia and the nursing supervisor had all been notified at 10:50 A.M. and after the patient electively signed for sterilization as well as for the Cesarean section. At 11:30 A.M. general anesthesia was begun and at 11:28 A.M. the baby was born.

At birth the baby was suctioned with a bulb and catheter then handed to the anesthesiologist. The baby was laryngoscoped with an endotracheal tube and suctioned through the tube and the tube was left as part of a resuscitative effort since the baby had **a** 1 minute Apgar of 3 (HR less than 100, minimal respiratory effort and occasional spontaneous muscle reflex was noted). An Apgar 4 (tone) was obtained at 5 minutes.

At 11:55 A.M. the baby had a tachycardia of 160, was hypothermic at 95.9 degrees and tachypneic at 88 with decreased activity, abnormal cry, diminished tone, plethoria and cyanosis. Vitamin K was given and Dr. Kahill, a pediatrician was notified.

At 12:45 P.M. the baby experienced a cardio-respiratory arrest and was successfully resuscitated. At 12:55 P.M. the perinatology team from Rainbow Babies and Childrens Hospital arrived and inserted umbilical catheters through which bicarbonate was given. The blood gases obtained reveal an acidosis at one point of 6.89 but the pH recovered to 7.29 at 3:05 P.M.. The baby was then transfered to Rainbow Babies and Childrens. An x-ray study showed that an umbilical catheter may have been inserted arterially and maneuvered through the descending thoracic aorta and through the baby's heart. Whether this, along with the meconium aspiration helped to allow for persistent fetal circulation is conjectural.

By the time of transfer, a diagnosis of meconium aspiration syndrome had been made along with a secondary diagnosis of disseminated, intravascular coagulation, persistent fetal circulation, cardio-respiratory arrest and persistent cyanosis.

Aside from meconium, there was no evidence of severe fetal distress in labor. The criteria for fetal heart tracings indicating an intrapartum ominous pattern are the occurrences of persistent late or pronounced variable delecerations of greater than 40 seconds duration and/or greater than 60 beats loss with a lack of reactive fetal tachycardia and persistent loss (flat line or sinusoidal wave form) of beat to beat variability.[1] Continuous fetal heart rate monitoring throughout labor is only a rough screening technique for detection of possible fetal hypoxia and is associated with a high false-positive rate. Fetal scalp sampling of suspected cases of fetal hypoxia is necessary to confirm a diagnosis of fetal distress in most instances.[2]

Abnormal fetal heart rate patterns and conditions such as the triad of thick meconium, elevated baseline FHR and the loss of beat to beat variability can indicate an injury that preceded labor. Recent medical literature offers evidence that meconium aspiration does occur prior to the onset of labor or delivery.[3] This is followed by an elevated baseline, as noted even by the intake physical examination done by Dr. Soto-Zabala, minimal variability, and unanticipated severe fetal acidosis and neonatal morbidity.[4]

Thus even without acidosis or hypoxia in labor, meconium may cause persistent fetal circulation and be responsible for central nervous system injry. Aspiration of meconium is probably the reason why baby Watson did not establish regular respirations at birth. In addition, the baby was cyanotic. Skin color can be used as a guide to the baby's state, but it is not a realiable indicator of the degree of asphyxia. If, however, in addition there is no respiration, muscle tone or reflex activity, then preceding cerebral damage may have occurred.[5]

To pass meconium, the baby must have experienced antenatal asphyxia. While prolonged labor and traumatic delivery can be prevented or modified by the obstetrician, most of the other causes of fetal asphyxia and acidosis (antenatal hemorrhage; sepsis; prematurity; IUFER; placental insufficiency; congenital anomoly; isoimmunization; maternal diabetes; hypertensive complications) are predetermined in the antenatal course.[6]

Meconium aspiration has been documented to have occurred hours or days before delivery.[7] It is the number one contributor to death in infants and autopsy studies showing macrophage invasion of alveoli indicate aspiration 36-48 hours earlier.[8] Also cases showing a baseline FHR in excess of 160 BPM, minimum variability, and unanticipated severe fetal acidosis and neonatal morbidity and mortality with fetal heart rate patterns often lacking episodes of accelerations or dramatic decelerations are not uncommon with meconium aspiration.[4]

Persistent fetal circulation, or pulmonary hypertension, is often the result of meconium aspiration.[9] Its major feature is hypoxemia unresponsive to conventional mechanical ventilation. Some die but most who live do so with neurologic impairment. Since not all cases of meconium aspiration can be avoided, and because meconium was present in this case in early labor, one must assume that fetal aspiration took place prior to labor and hence, the timing of the Cesarean section made no difference as to the eventual result. The asphyxia response of the Watson baby occurred in an already damaged fetus.[10]

In summary, the eventual death of baby Watson was as a result of meconium aspiration and persistent fetal circulation that occurred prior to labor as evidenced by loss of variability, no significant decelerations, heavy meconium an elevated baseline and tachycardia. The treatment received by Cynthia Watson and the care given by the Community Hospital of Bedford met the standards of the American College of Obstetricians and Gynecologists which are: 1) identification of high risk mother and fetus; 2) continuous electronic fetal monitoring; 3) Cesarean section capability within 30 minutes; 4) anesthesia on a 24 hour basis; 5) neonatal resuscitation; 6) laboratory services; 7) consultation and transfer agreements.[11] The hospital properly notified Dr. Ahmed, properly monitored the patient and permitted a problem to be identified and resolved.

There was never established an acute medical emergency. The death of baby Watson was not preventable.

Sincerely yours,

Steven M. Klein, M.D.

SMK:eh

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4. "Fetal Injury Prior to Labor: Does it Happen?" Author Paul, RH et al., Journal American Journal of Obstetrics & Gynecology Vol. 154 No. 6 1986 pg. 1187.

5. Hypoxemia author R.J. Harris, M.D.

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9. Persistent Fetal Circulation: Neuro-Development Outcome Author Sell, EJ et al., Journal American Journal Disease of Childhood Vol. 139: 25, 1985 also Survey Vol 40 No. 11 Nov. 1985 pg. 685.

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