68 - GREENFIELD
WILLIAMS -
On TUBBING.
70 - SNIDER &
MOSA

State of Ohio, )
) SS:
County of Cuyahoga. )

- - -

IN THE COURT OF COMMON PLEAS

- - -

ERIC HAWKINS, a minor, etc., et al.,

Plaintiffs,

vs.

BEDFORD MUNICIPAL HOSPITAL, et al.,

Defendants.

Case No. 957,170

Doc. 238

- - -

DEPOSITION OF STEVE?; M. KLEIN, M.D.

Saturday, September 13, 1386

- - -

The deposition of Steven M. Klein, M.D., called by the plaintiffs pursuant to the Ohio Rules of Civil Procedure, taken before me, Sidney Gantverg, Registered Professional Reporter and Notary Public in and: for the State of Ohio, by agreement of counsel and without notice or other legal formality, at the offices of Weisman, Goldberg, Weisman & Kaufman, 540 Leader Building, Cleveland, Ohio, beginning at 10:20 A.M., on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

Weisman, Goldberg, Weisman & Kaufnan
Fred Weisman, Esq.
Richard J. Berris, Esy.
540 Leader Building
Cleveland, Ohio

On behalf of Defendant Bedford Municipal Hospital:

Kitchner, Messner & Deery
Steven W. Albert, Esq.
Superior Building
Cleveland, Ohio

On behalf of Defendant Dr. Reyes:

McNeal, Schick & Archibald
Harley J. McNeal, Esq.
The Illuminating Building
Cleveland, Ohio

On behalf of Defendant Dr. Choi:

Gallagher, Sharp, Pulton & Norman
George W. Stuhldreher, Esq.
Sixth Floor-Bulkley Building
Cleveland, Ohio

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STEVEN M. KLEIN, M.D.

called by the plaintiffs pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, was examined and deposed as follows:

EXAMINATION

BY MR. WEISMAN:

Q. Give us *your* name and your address, please?

A. Dr. Steven M. Klein, 21125 Shelburne, Shaker Heights, Ohio, 44122.

Q. Your specialty is?

A. Obstetrics and gynecology.

Q. And do you have a CV?

A. I *do,* but I was not asked to produce it.

MR. ALBERT: I will be most happy to get a copy and send it over to you.

MR. WEISMAN: Tnat will be fine.

Q. Have you produced any writings, publications of any kind?

A. Yes, I have.

Q. And they are attacked to your CV, are they?

A. Yes, they are.

Q. Is it complete and up to date?

A. Yes, it is.

Q. Where did you attend medical school?

A. Ohio State.

Q. And you graduated when?

A. 1969.

Q. Give us your postgraduate training essentially.

A. I did a year of internship at the Ohio State University Hospital in medicine from 1969 to 1970, and I did four years of obstetrics and gynecology residency at the hospital of the University of Pennsylvania, in Philadelphia. So I finished in 1974, and then came to Cleveland in private practice.

Q. Have you Zone sone teaching?

A. Yes, I do, of medical students and residents, primarily at Mt. Sinai Hospital here in Cleveland.

Q. You have been affiliated with Mt. Sinai since when?

A. 1974.

Q. The matter of obstetrics is very much a tean! approach, correct?

A. Yes, it is.

Q. And your teaching, for example, of the nurses, is in what area? What have you taught the nurses about? What types of things have you touched on?

A. Patient care, innovative things as they come along in obstetrics and gynecology. I do a lot of infertility work, so we discussed a lot of that in service, in seminars, and so forth; discussions of fetal monitoring. Just in generai, the care of the patients.

Q. Who are the members of the team? When you speak of obstetrics as being a tean approach, who are in that tean

A. I would think that the physician, the obstetrician that is, and the patient, comprise the team.

Q. The patient?

A. Yes.

Q. Is that particularly during the pregnancy?

A. If the doctor and patient are fortunate enough to have a relationship, then it nay precede the pregnancy. It may anticipate a pregnancy. And certainly at the end of the pregnancy, and afterwards, the physician and patient still comprise the tean, as the patient may need additional help medically, psychologically, emotionally.

Q. And the nurses are on that team when it comes, I guess, to the labor and delivery aspect, is that correct?

A. If labor an6 delivery take place in a hospital, then the nurses are part of the team, yes.

Q. And also on the team would be others, conceivably, that are in place?

A. Conceivably.

Q. Sucn as an anesthesiologist, for example, sometimes?

A. Sometimes.

Q. You are knowledgeable, are you not, about the matters of labor and delivery? I know it's an obvious question, but your field is obstetrics, and you are

knowledgeable about labor and delivery matters

Yes.

Q. You are knowledgeable also about matte resuscitation of a newborn baby, where indicated'.

A. Yes.

Q. An6 there might be a difference between being knowledgeable about it and practicing it on a daily basis, isn't that true?

A. That is correct.

Q. Is it the fact that you don't resuscitate on a daily basis, yourself, or even on a weekly basis, yourself?

A. That is a fact. I do not do it on a daily, and sometimes not even on a weekly basis.

Q. When is the last time that you personally resuscitated a baby?

A. I can't give you an exact date, but it was within the year.

Q. Sometime within the year?

A. *Yes.*

Q. Can you think of any more than one time within the year that you personally were involved in resuscitation?

A. No, I cannot.

Q. Who usually does that, Doctor?

A. There are two people in my associations that generally do it where I practice most of ny obstetrics,

that is, at Mt. Sinai, and that is the pediatrician and anesthesiologist. Oft times a nurse will participate in some way, depending on the situation.

Q. it's basic medicine, isn't it, that when anyone assumes or undertakes a professional reponsibility in your field of medicine, that he is required, or she is required to bring to that task reasonable and sensible or prudent professional skill, knowledge and care, isn't that so?

A. That's so.

Q. And that's true whether it's any member of the team, the obstetrician, the anesthesiologist, the nurse, or whoever, is that correct?

A. Correct.

Q. Anything less than that you understand to be substandard care, do you not?

MR. McNEAL: Objection.

A. Not necessarily.

Q. Well --

A. You are creating or painting the picture of what would be ideal.

Q. Well, I asked you not for the ideal; what I asked you for was the question of, when you assume or undertake professional responsibility, you bring to it that degree of care which is reasonably prudent, not ideally prudent, but reasonably prudent or acceptably prudent, if you **would?**

A. I agree with that.

Q. So if you do less than that -- not the ideal -- but less than what is reasonable or acceptable, that would be unacceptable, would it not, medically?

MR. McNEAL: Objection.

A. I don't know if anything less would necessarily medically be -- what was the term you used?

MR. McNEAL: Unacceptable.

Q. Unacceptable.

A. Unacceptable. It night be substandard, perhaps, as far as that individual is concerned, or those individuals affected by that, but I don't know that necessarily, medically, it would be substandard all the time.

Q. Let's put it this way: If it is not substandard, it is less than standard, it is substandard; that you will agree on?

MR. McNEAL: Objection.

A. I will agree that there are certainly many degrees of standard. I don't know that, if it is not standard, it has to be substandard. It could be super-standard, and there could be variations in between.

Q. If something is less than standard, isn't it, by virtue of that fact, substandard?

MR. McNEAL: Objection.

A. *Yes,* it is.

Q. And if something is less than acceptable, that would be unacceptable, would it not?

MR. McNEAL: Show an objection.

A. You have to define "something," in my opinion.

Q. Is that right?

A. I would say that if that is true, in those terms, yes.

Q. Some of the functions that are taught to nurses relate to standard, safe and recognized care of the mother and the baby, isn't that so?

A. That's correct.

Q. And some of the things that are taught include the matter of monitoring the fetus during the time that the mother is about to deliver, isn't that so? Monitoring is one of the activities or functions of the nurse?

A. On the labor and delivery floor?

Q. Yes.

A. Yes.

Q. Do you teach about that? Do you teach them about monitoring, or have you in the past?

A. Yes, I have.

Q. Basically what is involved during labor? How frequently is, for example, the fetal heart rate to be checked, according to recognize6 standard practice in your obstetricial work?

A. You are talking about 1986, or are you talking about 1974?

Q. 1974, all of 1974.

MR. ALBERT: Just so that I am clear, everything that you are asking is in terms of 1974?

Q. Everything I have asked you about so far relates to 1974. You have no problems with that here on the past questions?

A. KO.

Q. And everything we are talking about in this case specifically relates to 1974. We are concerned with the standards and practices in 1974 or before.

A. I think that it would be a good standard of care if a nurse were to take a fetal heart tone approximately every thirty minutes in early labor, and would increase the frequency of that as the labor progressed.

Q. How frequently during the second stage, according to recognized standards in obstetrics?

A. I would think about every five to ten minutes.

Q. Is it reasonable to expect that if someone comes into a hospital to have a baby, that the nurse who is assigned the responsibility would understand the significance or importance of regular monitoring of the fetal heart rate?

A. Yes.

Q. That standard practice, just so that we are clear on it, isn't something that is relegated to the outstanding lead hospitals in a community, such as Mt. Sinai Hospital, or University Hospital, that's true in any hospital where a hospital has a maternity department to deliver babies, isn't that so?

A. Yes.

Q. You reviewed various things, I take it, before coming here today to testify?

A. Yes, I did.

Q. Tell us essentially what you reviewed up to date before coming here?

A. I reviewed the hospital chart on Baby Boy Hawkins, Eric Hawkins. I reviewed the hospital charts on Bettye Hawkins. One was for her labor and delivery, and the other was for an admission on October 23rd for false labor.

In addition, I reviewed the deposition of Dr. Kretchmer, Dr. Coker, Dr. Horwitz, and Dr. Edelberg. And I reviewed my report that I made to Mr. Albert, dated May 28th, 1986.

Q. I assume you reviewed the various records before writing your report, and some of them after, apparently, writing your report?

A. Some of the depositions weren't available to me. The hospital charts were available, as well as, I think, the

depositions of Dr. Horwitz and Dr. Edelberg.

Q. So the others, Dr. Coker and Dr. Kretchmer, came to you after you wrote your report?

A. Correct.

Q. Did those depositions that came afterwards, that is, Dr. Coker and Dr. Kretchmer, have any effect on changing any of your opinions with respect to findings made or observations made in your report?

A. No, sir.

Q. The first record at Bedford Hospital, the earliest one that you reviewed, was of what date, please?

A. That was October 23rd, 1974.

Q. And what did that show, essentially, that particula record?

A. That the mother had a viable pregnancy in a breech position, and that she was not in true labor.

Q. When you speak as an obstetrician about breech position, what does that mean?

A. Tnat the baby's presenting part in the lower uterine seqment was, in fact, breech, the buttocks of the baby, or the buttocks and feet of the baby, but not the vertex of the baby.

Q. Eave you had occasion to observe and handle breech position deliveries in your practice?

A. Yes, I have.

Q. And have you had a chance to observe breech position on many occasions?

A. Define "many," please?

Q. How frequently is this matter of breach, how rare, or how common is breech? What is the percentage, roughly, if there are studies on that?

A. I think about five or six percent of babies present as breeches.

Q. So five or six out of every hundred babies could reasonably be expected to be breech?

A. Yes.

Q. And there are different kinds of breech positions, as I understand it, is that correct?

A. Yes.

Q. But when you speak of a percentage, statistically, that five or six out of every hundred may be breech, you mean breech of one kind or another?

A. That's true.

Q. When you speak here about the position of Baby Eric Hawkins, he was what was described as frank breech. Does that have a special meaning, frank breech?

A. Yes.

Q. As opposed to sone other breech, or compared to some other breech?

A. Correct.

Q. Tell us what frank breech means?

A. It means that the legs are extended in front of the baby, and that the breech is in the pelvis. It just refers to the legs and how they are in relationship to the breech itself.

Q. And essentially what is happening there, if I understand -- and tell me if I am right on this -- that the buttocks present first, rather than in the more common way, the head would be presented first?

A. That's correct.

Q. What are the dangers, if any -- is this, by the way, what you would call -- withdraw the question.

Is this what you would call a high risk pregnancy when it's in a breech position, or a frank breech position?

A. I would call that a high risk pregnancy, yes.

Q. There are a whole myriad of things that are high risk classified in your field, are there not, Doctor?

A. That is correct.

Q. What are these high risk things? What are the high risk features or scenarios?

A. Situations in which I would anticipate a potentially bad outcome for either rnother or baby.

Q. All right. Certainly it doesn't mean that there is anything necessarily bad or diseased or injured about the particular fetus involved, or the mother involved, when

you have this high risk situation, isn't that so? It certainly doesn't necessarily indicate that?

A. Correct.

Q. And especially in breech, in at least five or six out of every hundred babies, you just have what you would call a red light, and you look out for the possibility of something going wrong with a breech; is that the idea, essentially?

A. Well, in the situation of a breech there might, in fact, be something wrong with the mother physically that would give rise to the position on the breech.

But you are right, that would just make a red light go off, and I would consider that a high risk situation.

Q. Are there any studies done, to your knowledge, in your field, on the percentage of breech births that have an entirely normal outcome3

A. I have seen various studies done on breeches, and problems with breeches, and I would think that most of them, at the time in 1974, I would think would be considered to have good outcomes.

Q. Yes, in 1974, I am glad you brought that up. I am talking about 1974.

A. Yes.

Q. When you say most, is there any significant percentage, with breech, that have complications?

A. I don't recall a particular percentage, I am sorry

Q. Now, if there were, that would be kind of a headline event that you experts would be familiar with, would you not?

In other words, if it represented significant mortality or morbidity to have a breech birth, that would be certainly something known well to obstetricians who are specialists in obstetrics?

A. I think, to be perfectly frank, within the last ten to twelve years that I have been in practice, it has subsequently come to pass that indeed many problems have been associated with breech deliveries, and we are looking much more carefully than we did look in 1974 at breeches, and we are delivering them by Cesarean section in a lot greater instances, because *of* what we have learned over the subsequent years.

But getting back to 1974, I think we weren't as concerned, as we are now in 1986. I don't think we were as smart in 1974, perhaps.

Q. When were you first called upon to review this case?

A. I don't have with me all of the letters between myself and Mr. Albert. I believe it was either March or April of 1986, if I an not mistaken.

Q. Who contacted you?

A. Mr. Albert.

Q. How do you know Mr. Albert?

A. We play golf.

MR. ALBERT: We play at golf.

THE WITNESS: We play at golf.

Q. Where?

A. At the Oakwood Country Club.

We have mutual friends.

Q. How long have you been a member of Oakwood?

A. Nine years, I believe.

Q. And Mr. Albert has been a member of that country club since when?

A. You would have to ask Mr. Albert.

Q. I will.

MR. WEISMAN: How long?

MR. ALBERT: I won't answer you on the record.

MR. WEISMAN: Off the record.

(Discussion had off the record.)

Q. The word is that Mr. Albert has been a member for nine years,

You both joined in the sane year?

A. I WES not aware of that.

Q. You were not aware of that?

A. No.

Q. Did you know each other before Oakwood Country Club?

A. No.

Q. Did you speak with Mr. Albert about this case before coming here today?

A. Yes. We spent a few minutes discussing it briefly.

MR. ALBERT: But not on the golf course.

THE WITNESS: No, in his office.

Q. At this office?

A. At his office.

Q. When you say a few minutes, how many minutes is that, your best estimate?

A. Less than an hour: more than ten.

Q. And when did that review take place?

A. Just prior to walking over here, at ten o'clock this morning.

Q. Bid you ever speak with him previously to that about this case?

A. I have communicated with him. I don't remember whether we had talked specifically on the phone, or just through letters and reports.

But, yes, I have communicated with him on this case prior to this morning.

Q. Well, did you review the details of it with him

on the phone, or in person, before this morning?

A. Yes.

Q. And where did those get-togethers take place, those reviews?

A. Either through the mails, or on the telephone.

Q. Are there any other writings, or any writings whatever, that Mr. Albert provided You with pertaining to this case?

A. None that I haven't already expounded upon.

Q. Did he write a letter to you about this case?

A. Oh, yes.

Q. *so* you have that letter?

A. I only have a letter, and that is concerning this morning's deposition. All other correspondence with Mr. Albert I have left at home.

MR. ALBERT: Would you like that?

THE WITNESS: It wasn't premeditated. I just left it at home.

MR. WEISMAN: Yes, I would like that.

Q. How many letters did he write to you?

A. I don't know exactly.

Q. Approximately?

A. Five, seven.

Q. And then how many letters or notes or memoranda did you write to him?

A. One.

MR. WEISMAN: Do you have those letters that he is talking about?

MR. ALBERT: Not with me. I have them at the office.

I will tell you this, that they are all enclosure letters, and one that is merely making an inquiry as to whether or not he would be willing to undertake a review of the documents, which were thereafter enclosed.

There was nothing detailing it, and as I said, when we are done, if you want them today, I will be glad to go and get them. But they are not adding anything to this case.

MR. WEISMAN: Yes, I would like to have copies of those letters.

MR. ALBERT: Sure.

You also understand that he is a partner of your partner's father-in-law. You were trying to get the background relationship.

BY MR. WEISMAN:

Q. Now, when Baby Eric Hawkins -- withdraw that.

Sou have outlined in your report what I gather represents substandard and unacceptable care on the part of Dr. Choi in his obstetrical care as it relates to this

particu1ar de1ivery, right?

MR. STUHLDREHER: Show an objection.

A. No, I don't agree with you. If you could point out specifically where I have said that it was substandard care, I would appreciate that.

Q. You said various things that should not have been done, for example?

A. Yes.

Q. I assume that you were providing us, or Mr. Albert, in that report, with your statement as to what ought to have been done, or what should have been done to comport with standards and recognized practices in your profession, isn't. that so?

A. I was relating it to the way I would have handled it, perhaps, as an obstetrician.

Q. Were a19 of these things that are stated by you the way you would have handled it as an obstetrician, or the way it ought to proceed from the standpoint of accepted standards and recognized standards in your profession?

A. I was making statements, I believe, in general about the way I would have handled the situation in 1974.

Q. Then I take it you are not addressing yourself to the standards or practices that you believe applied in 1974, is that right?

A. No, that is not right. I am simply saying that

statements that I have in my report concerning Dr. Choi's obstetricial decisions, were compared with those decisions that I would have made.

I am not refuting, denying, or anything else, anything about standards of care.

I feel that I practice according to proper standards of obstetrical care as defined by my college, and my colleagues.

Q. Do you have an opinion as to whether or not the care provided by Dr. Choi was consistent with tandards of reasonable obstetrical practice back in 1974, under the circumstances that you reviewed in this case?

A. Please repeat the question.

MR. WEISMAN: Sure.

Will you read the question back, please?

(Question read.)

A. I have an opinion, yes, I do.

Q. What is it?

A. I do not believe that the standards of care set forth in 1974 were met entirely by Dr. Choi in this particula case.

Q. Why not? Give us the particulars as to where there was substandard, or what we, I think, agreed before, would represent unacceptable or less than standard care?

A. I believe that the choice of -- can I say strike

that, when I say the wrong thing?

PIR. STUHLDREHER: Let me say that I want to strike it. I want to strike his opinion because he has testified here he didn't even read Dr. Choi's deposition, so I move that it all be stricken.

MR. ALBERT: You can say whatever *you* wish, as Mr. Stuhldreher will say whatever he wishes, and everybody else will say whatever they wish.

THE WITNESS: Let's go back.

I think that Dr. Choi should have used a different hospital or location in which to induce labor on Mrs. Hawkins.

MR. STUHLDREHER: I move that the answer be stricken.

Q. And on what basis do you say that?

A. She presented after rupturing membranes, not in labor. As a matter of fact, her cervix was somewhat not favorable as far as induction, as we would have considered it in 1974. The baby's presenting part, which was a breech, was very high in the pelvis.

Ey deposition of another person, there was mention that she had delivered her first child vaginally with some difficulty, and that baby cas six pounds eleven

ounces.

One might have anticipated, therefore, potentially that this was going to wind up as a Cesarean section, and that perhaps the induction might fail along any line and, therefore, I think that she should have been in a hospital which provided those things available to the obstetrician to make him manage the case with more ease.

Q. What hospital --

A. Then as far as the delivery process itself, I believe that I would have done it somewhat differently at that point in time, myself. I would have thought that a Cesarean section should have been performed prior to an attempt at breech delivery.

Q. And is it reasonable for me to conclude, or for us to conclude, that since you perform according to standards that are recognized, as being safe and acceptable and appropriate obstetricially in this country, and in this community here in Cleveland, that you would regard the failure to do a C-section as less than standard care?

A. Oh, heavens, no. I would just simply say that that is a judgment, and in no way would I say that what I do is, again, the standard. It is simply that there are several ways of handling situations, that we learn in medicine. And one way might be better for a particular condition than another method, or for a particular

practitioner, than another method, or for a particular patient, than another method.

And I am simply saying that my choice would have been different, that's all.

MR. ALBERT: Why don't you finish your answer to the other question, which originally was, your criticisms of Dr. Choi, and you had one criticism about where the delivery took place.

THE WITNESS: Yes.

MR. ALBERT: Then you digressed into the C-section.

Why don't you just make your criticisms, and then we can pursue it logically, if that's okay?

MR. WEISMAN: That is fine with me.

Q. Do you have any other opinions as to --

A. I think that breeches, as a group, are more subject to intrauterine difficulties, and difficulties with the birth process, i.e., hypoxia and asphyxia, that is a lack of oxygen and/or circulation. And therefore, I would have chosen a hospital where there were more expert hands and people surrounding me to deliver this situation, as the case may have warranted.

Q. Bedford Hospital, I take it, was ill equipped to handle this situation appropriately, is that right?

A. Beford Hospital, to the best of my knowledge -- and

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Q. Bedford Hospital, I take it, was ill equipped to handle this situation appropriately, is that right?

A. Beford Hospital, to the best **of** my knowledge -- and

I have never been there -- but from the depositions, and so forth, it was not equipped, and it did not purport to be able to handle high risk obstetrical cases.

This was a high risk obstetrical case, in my mind, that reverted to an obstetrical emergency.

I believe Bedford Hospital could handle obstretical emergencies, and I believe it did handle obstetrical emergency in this instance, but it would not be my primary basis.

Q. The word ill equipped is a word used by you in your report, is it not?

A. Can you point that out?

Q. Yes. On the second page of your report, I believe that you mention that no attempt at pitocin induction should have been made in this situation, especially at Bedford Hospital which was a low risk hospital ill equipped and unprepared for potentially catastrophic obstetrical occurrences.

Are those your words, sir?

A. Yes.

Q. Do you stand by them today?

A. Yes.

Q. Do you have an opinion as to whether or not a hospital that is ill equipped to handle high risk pregnancies can properly proceed to admit a frank breech case?

MR. ALBERT: Excuse me, is there going to be evidence that a hospital admits the patient? Physicians admit patients.

MR. WEISMAN: I would like to get the doctor's opinion on it.

Read the question back, please?

You car. object, if you wish.

A. Yes. My opinion is that in 1974 frank breech babies did not necessarily need -- I am confusing myself.

Would you please read the question again?

(Question re-rea6 by the reporter.)

A. Yes, I have an opinion. Yes, I believe a frank breech case can be admitted to a hospital such as Bedford.

Q. And what is the basis for that opinion?

A. Frank breeches are delivered vaginally many times without any problems whatsoever.

Q. That doesn't change your previous testimony in any way that they are nonetheless high risk, is that correct?

A. That the red light goes off?

Q. Yes.

A. No, it does not. They are high risk.

Q. Therefore, on admission of such a patient who has a frank breech position for the baby she is about to deliver, the potential is that one reasonably could expect an

episode of asphyxia or hypoxia to come about with the delivery of that frank breech baby, is that true?

A. True.

Q. And when that would happen, that hospital that was, as you have characterized it, ill equipped to handle what could have evolved into a catastrophe, that would have allowed a baby like that to be delivered in their hospital, when they are not equipped to deliver a baby with that potential problem -- is that what you are saying?

MR. McNEAL: Show an objection to the word "catastrophe."

A. No, I don't believe I am saying that.

What you asked me,. if I am correct, is should a hospital like that have admitted a frank breech, or allowed the admission of a frank breech.

And my answer is yes, I believe that Bedford could admit a frank breech.

I think then what happened, or what happens, could have altered whether or not the patient continued to stay.

But admitted at, delivery at Bedford, I think that in this particular instance -- babies can change position from breech to vertex. How would we have known that unless the patient was admitted?

It might very well be that the patient, being admitted after rupturing her membranes was, in fact, now

a vertex.

So she needs to be admitted to the hospital to find out whether that had taken place.

We might have also found out that when she arrives at the hospital, her cervix is fully dilated. The breech is now down deep into the pelvis, labor and delivery goes very quickly, and there are no problems.

That might have happened, as well.

Q. Why do you say the hospital was ill equipped to handle this?

A. To handle what?

Q. You said that this hospital is ill equipped and unprepared for potentially catastrophic obstetrical occurrences, are the words you used in your report.

Why?

A. Primarily, because it did not have a potential for resuscitation that would be necessitated by a potential catastrophic obstetrical problem, as I see it.

Q. What is needed for that purpose? What kind of resuscitative attention, care, equipment, is needed?

MR. ALBERT: Are you talking about equipment, or people, or both, or just in general?

MR. WEISMAN: I think the question is clear.

Please read the question back to the doctor

so that it's clear. If it is not clear to you, Doctor, ask me to clarify it.

A. I think that what would have beer, needed would be simply a person or persons who manage situations *of* this nature frequent enough to be comfortable ir, their management.

Q. Was Dr. Reyes -- do you know anything about Dr. Reyes, the anesthesiologist here?

A. I don't know much about Dr. Reyes, except from the deposition, I think, of Dr. Kretchner.

Q. Where you, as you have told us, are knowledgeable about resuscitation, but not practiced in it very much because you don't do it, with rare, rare exceptions -- am I right so far on that?

A. Yes.

Q. You look to such as the anesthesiologist, or other person who is placed in position by the hospital, do you not, to handle the resuscitation?

MR. ALBERT: He has never said anything such as "by the hospital."

MR. WEISMAN: I am asking. And will you stop interrupting me?

MR. ALBERT: No, I won't stop interrupting.

MR. WEISMAN: You stop, and you let me question the witness, and if you have an objection,

you can assert it. You have every right to any objections and all objections to the question, but let the man answer the question.

MR. ALBERT: I will allow him to answer questions which are not mischaracterizing the testimony.

MR. WEISMAN: I did not characterize any testimony, sir.

Read the question back to the doctor.

MR. ALBERT: Go ahead.

(Question read.)

A. Can you rephrase it? I don't understand the question.

Do I look to an anesthesiologist to --

Q. Or any other individual who is assigned the responsibility for the neonatal resuscitative care, newborn resuscitative care?

A. Yes, I do.

Q. Sure. And you don't do it yourself?

A. Generally speaking, I do not.

Q. And it is the standard and practice that the obstetrician generally does not, as a matter of custom, only with unique exceptions, isn't that true?

A. In community hospitals, and particularly in 1974, I think we, as obstetricians, were involved in the

resuscitation, or resuscitative measures, much more frequently than we are now.

I think we have been displaced by pediatricians and neonatologists, perinatologists and anesthesiologists in that role.

Q. Yes.

A. But in community hospitals, where there is just a doctor, a nurse, delivering babies, be they breech or by vertex, I think that, yes, indeed, the obstetrician was very much a part *of* the resuscitative measures at that point in time.

Q. Doctor, all you are telling us, really, is that he certainly could be a part *of* the resuscitative pattern?

A. That's right.

Q. And he could be today, correct?

A. That is correct.

Q. You could be today, is that correct?

A. That is correct.

Q. But you are not, is that correct?

A. As I choose.

Q. Back then in 1974 and indeed, specifically for Eric Hawkins, isn't the information within your knowledge, based on your review, that the undertaking and assumption of resuscitation was indeed by the anesthesiologist, Dr. Reyes?

A. That's correct.

Q. Also by the nurse?

A. That's correct.

Q. And in that case -- that is, this case that we are talking about, Eric Hawkins, back in 1974 -- the resuscitation was not done by the obstetrician either?

A. That's correct.

Q. Nothing unusual about that, based on your everyday practice today, is what you have told us?

A. Right.

Q. And it is not unusual from the standpoint of the custom and practice generally across the country today?

A. That's correct.

Q. And it was the same in 1974, essentially?

A. Yes.

Q. Now, respecting your knowledge about resuscitative matters, at the same time concentrating on the idea that you, as the obstetrician, don't do the resuscitation, necessarily, I want to ask you some questions about resuscitation and your knowledge about it.

MR. McNEAL: Show an objection to all questions about resuscitation, unless you qualify the doctor as an expert.

Q. You have studied the subject of resuscitation, in your background, in your schooling, and in your postgraduat

training, have you not?

A. Yes.

Q. You are familiar with articles and textbooks that deal with the matter of resuscitation of the newborn baby, are you not?

A. Yes.

Q. You discuss the matter of resuscitation of the newborn with your colleagues, and have done that in past years, since medical school and afterwards?

A. 'res.

Q. What does it mean to resuscitate, by definition?

A. It means to re-establish circulation and/or respiration, if either or both are not present in an individual.

Q. What was the picture of Eric medically when he was born?

A. All I know from the chart is that they assigned an Apgar score of one, and I don't know what that means. They never specifically mentioned what the Apgar score was for.

So you are asking me to assume something that I have absolutely no idea, except that I think he was very sick when he came out of the mother.

Q. When he would be designated an Apgar score of one, isn't it reasonable to conclude that all that he had was a

heart beat, and that under 100, if he had one point on the Apgar score?

A. I can't assume that. Although it is reasonable to assume that, nonetheless, I really can't, to be semantic about it.

Q. If he didn't have a heart beat, Doctor, wouldn't you expect that Eric would have been dead?

A. No, I don't know that he would have been dead. He would not have had a heart beat, and no breathing, perhaps but I don't know that he would have been dead.

Q. What is your definition of dead?

A. Dead, I think, is an EEG pattern consistent with flat waves.

I am not quite sure about that. But I know that people, and babies, and the like, even though they have no heart beat and no respirations, are able to be resuscitated. So that doesn't mean that they are dead.

Dead connotes to me forever. That didn't exist in this situation.

Q. All right. Was Eric at birth what you would call asphyxiated?

A. Yes, I believe he was.

Q. And was he what you designate -- and this is, I understand, a term of art -- a severely depressed newborn baby?

A. Yes, he was.

Q. And that's a special category of knowledge, is it not, published and recognized, written about, discussed, and known by all people dealing with this matter of newborn resuscitation: isn't that true?

A. Yes.

Q. And when you have a severely depressed newborn, certain steps are essentially mandatory for the appropriate care of the newborn baby, generally speaking, are they not?

A. Yes.

Q. What are they? Outline those for us.

A. Essentially, to assure that there is circulation, i.e., a heart beat, and to assure that oxygen is getting into the baby's lungs, artificial respiration of sorts. Those would be the two mandatory things, as far as I know, that would be necessary for proper resuscitation -- mandatory.

Q. And if you don't get an inflation of the lungs promptly -- a normal baby breathes, does he not, and does she not, within a matter of seconds after birth, right?

A. Yes.

Q. So if you don't get a proper reaction from the baby to indicate that the lungs are ventilating and the baby is breathing soundly, and all, what do you do if you have a severely depressed newborn baby, from the standpoint of the recognized practice, specifically as to intubation of

the baby?

MR. McNEAL: Objection.

MR. ALBERT: Do we have a time frame for that?

MR. WEISMAN: The doctor will answer the question.

If you have an objection, counselor, give us the objection.

MR. ALBERT: My objection is that there is no time frame.

MR. WEISMAN: Fine.

Read the question back to the doctor, if you would, please?

(Question read.)

MR. McNEAL: Show my objectior,.

A. Eventual17 it becomes necessary to intubate that baby.

If you are --

Q. Why -- go ahead, I didn't mean to interrupt you.

A. In 1974, most of the resuscitations were taking place manually, in attempting to bag breathe the baby, and getting good respirations in that manner, and you would bag breathe the baby as long as you were aerating the lungs, expanding them, and so forth, for as long as it took the baby to perk up, wake up and, in fact, have been resuscitated

If one were not adequately expanding the lungs in that fashion, then one, in 1974, would have placed a tube into the trachea and breathe for the baby in that way, as that would assure definitely expansion of the lungs and getting oxygen to the baby.

Q. Would it be fair to say that according to standards that should have been done within about a minute or so?

MR. McNEAL: Objection.

A. No, I don't think so, in 1974, I don't think that standards were as specific as they are today. But I think in 1974, that as long as there was good exchange, that the doctor or the nurse, or whoever was the resuscitator, was getting a good expansion of the lungs, they would do that until the baby then was revived.

I don't know that within a minute or so should be placed on when a tube should be put down, or if a tube ever should have been put down.

I think that as resuscitative techniques evolved, I think that most people would go with the tube very quickly. But that is a matter of preference, and a matter of ability, and a matter of feeling comfortable for the resuscitator. And I think that either one, from my point of view, would be just as satisfactory, as long as good air exchange was taking place.

Q. Do you think that good air exchange took place in

Baby Eric Hawkins, in this case?

MR. McNEAL: Objection.

A. I don't know, because nobody expressed in writing whether or not the lungs and the chest were moving, and so forth.

The fact that it took 15 minutes, by history, for the baby to have spontaneous respirations, does not necessarily mean that the baby wasn't getting good air exchange. Perhaps it means that the baby suffered quite a bit while still intrauterine, and perhaps that was the best that resuscitation could have expected the baby to have done, i.e., develop spontaneous respirations in 15 minutes.

So I have no way of knowing whether the baby was getting adequately aerated or not during that period of tine.

Q. Does a three Apgar score at five minutes have any significance, in your professional thinking?

A. I believe that it connotes that the baby has more of, or a greater chance of having suffered central nervous system damage if the Apgar score is below five, in my way of thinking, at five minutes. So an Apgar score of three means that the baby was still sick.

Q. Does that indicate to you that you would reasonably expect that this baby is ventilating well at five minutes?

A. I don't know that it would have been possible to have had this baby any better at all at five minutes, or at

15 minutes. I don't have any way of knowing, as I say, because of what may have occurred intrauterine just prior to the actual delivery, and the delivery itself.

Q. Doctor, you are speculating about what may have occurred intrauterine, I take it?

MR. McNEAL: Objection.

A. I think we are all speculating here as to what actually occurred. I don't know what happened intrauterine.

Q. All right, fine.

So therefore, instead of determining what everybody is doing, let's just talk about what you are doing.

You agree that you are speculating as to what occurred intrauterice, is that correct?

A. No, I think it's a little more than speculation. It is my expert opinion, as an obstetrician, that that baby suffered from oxygen deprivation while still intrauterine, or else it wouldn't have been born with an Apgar score of one.

Q. Doctor, your opinion apparently changed from speculating to one of an opinion -- withdraw that.

MR. McNEAL: Show an objection to the argument.

Q. Let me ask you this:

Where resuscitation is provided, why is it provided? What is the purpose of it?

A. To re-establish those things that are not there, that is, good circulation, potentially, and good aeration. It's an attempt to metabolically recreate normalcy in a situation that is abnormal metabolically.

Q. What is the purpose of intubation?

A. The purpose of intubation is to achieve aeration of the lungs and deliver oxygen to the lungs.

Q. Any special way?

A. By placing an endotracheal tube into the trachea, and then breathing through that, instead of the mouth and nose, as would be done by mask.

Q. Why not do it by mouth and nose, which is done by mask?

A. I don't know why not.

Q. Then what is the purpose of using a tube? Isn't it true that the tube would give you direct communication without a waste or falloff of the oxygen to other areas?

MR. McNEAL: Objection.

A, You have answered your own question.

Q. I asked you, but you didn't answer it for me, Doctor, that is the point. You are not answering my question. You are trying to fence.

A. I don't mean to fence, I am sorry.

I apologize.

MR. ALBERT: You don't have to apologize.

He is only trying to characterize your testimony, which he is not entitled to do either.

THE WITNESS: I am sorry.

Q. What is the reason for tubing, as against ordinary bag and mask?

A. Some resuscitators feel more confortable with a bag and mask. Some feel more comfortable by placing a tube immediately. If the bag and mask, however, is not doing the job adequately, then I believe the tube should be introduced.

I don't at all fault your reasons for saying that there is wasted space in the nasal passages and mouth passages, and so forth, that may interfere, perhaps, but if the job is being done adequately by mask, then it wouldn't be necessary to do the tube, even though the tube would be perhaps more -- I can't think of the word.

Q. Efficient?

A. Efficient. Thank you.

Q. Is a baby reasonably entitled to resuscitation that is done according to reasonably skilled, prudent, knowledgeable people, when a baby is born in a hospital, any hospital, in 1974?

MR. McNEAL: Objection.

A. Yes.

Q. Doctor, when you talk of circulation, there is a

matter of acidosis that's been discussed and referred to in this case. Are you familiar with that term?

A. Yes.

Q. What does it mean?

A. It is a situatior, metabolically that exists when an anerobic metabolism has occurred due to the lack of oxygen. The anerobic metabolic, therefore, creates certain substances that need to be buffered. These are acid substances that need to be buffered by bases, These either make the pH stay normal if it is adequately buffered, or go down. And if the pH goes down, this, in the circulation in the blood, is felt by the various organ systems in the body, and they do not function properly.

That's what acidosis means to me.

Q. When you have a severely depressed, asphyxiated newborn like Eric Hawkins, is it that standard and practice as a part of the resuscitative effort to provide sodium bicarbonate or some similar product, to counteract the acidosis?

MR. McNEAL: I object to the characterization.

A. You are asking me a specific, and then a general question in the same question, I believe, if I am not mistaken.

I don't mean to fence.

Yes, it certainly would be reasonable to give bicarbonate as a help, to be able to better buffer the acids that are being built up if, in fact, the baby is not responding quickly enough to the other resuscitative measures.

So if the resuscitation is taking a long time, one would then anticipate that the acidosis is not being corrected by the baby itself, and that the baby needs the help of a buffer, such as bicarbonate.

Q. Is that the standard and practice to do that?

A. That is the standard and practice to do that,

Q. And that was not done for the baby in this case, was it?

A. Not to my knowledge.

Q. At the same time that sodium bicarbonate should have been administered to Baby Eric Hawkins, blood gases likewise should have been obtained on Baby Eric Hawkins, according to standards, isn't that true?

MR. ALBERT: Objection. He doesn't say that it should have been administered to Eaby Eric Hawkins, the sodium bicarbonate.

Q. Is it your testimony that under the circumstances that were shown here, sodium bicarbonate was not necessarily indicated?

A. No. I believe that Baby Eric Hawkins should have

received sodium bicarbonate.

MR. WEISMAN: Then that clears up that problem for you, Mr. Albert.

MR. ALBERT: Thank you.

MR. WEISMAN: Read the question that I asked of the doctor, again, if you would, please?

(Question read.)

A. Again, blood gases should have been obtained if the resuscitation was seeming to be inadequate and/or the bicarbonate did not have the response that one was looking for. Blood gases most certainly could have helped. I don't know that they have to, or should have been done necessarily in this instance.

It would have been, perhaps, done by those who deal with resuscitation in catastrophic obstetrical occurrenc '%hosethat deal with it commonly, would have done that, if it was available to them to do it.

By available, I mean the laboratory capabilitie

Q. And you are not aware whether or not the hospital had such laboratory capability, is that the idea?

A. That's correct. I don't know.

Q. Well, if indeed there were any such question about the hospital having adequate laboratory facilities, properly manned, properly equipped, to provide blood gases,

wouldn't you agree that that would be woefully substandard care for a maternity hospital, or a hospital that has a maternity department?

A. No, I would not. I would think that, as I have stated, that in hospitals that deal routinely with the high risk patient, with the patient who would be about to deliver a potentially compromised baby, those hospitals would be equipped to handle, with laboratory facilities, things such as blood: gases.

I *bo* not think that every community hospital, or hospital that allows maternity, that is, obstetrics to be done on its premises, does necessarily have to have a blood gas laboratory available, as well.

Q. Where were you in 1974?

A. I was in two places, in Philadelphia until June, and in July here in Cleveland.

Q. Do you have any knowledge of the standards of the Joint Commission on Accreditation of Hospitals in 1974 and before, as to whether or not lab facilities were required at any hospital that delivered babies?

a. No, I do not.

Q. Do you have any knowledge of the administrative regulations of the State of Ohio governing maternity hospitals in 1974 and before?

A. I do not.

Q. Would it come as a surprise to you that it was a matter of law that any maternity hospital was required to have laboratory facilities?

A. For the purposes of blood gases in 1974?

Q. I believe so.

A. It would come as a surprise to me.

Q. It would.

Blood gases were not commonly studied, are you telling us, in 1974?

A. No, I am not telling you that at all.

Q. You are telling us that babies, where asphyxia of the newborn was present in a baby born at local hospitals, or suburban hospitals, around our locality, or anywhere, they couldn't reasonably be expected to give appropriate laboratory care for blood gases, for example, is that right?

A. No, I think that those hospitals probably had blood gas capabilities. The personnel to run them, and the availabi1ity of those facilities on a 24 hour basis perhaps would not have beer, there.

Most hospitals certainly have the capability of doing blood gases.

Q. And yet babies are borr,, of course, at any time around the clock?

A. Yes, they are.

Q. That has been going on for quite a while, right?

A. Yes, sir.

Q. And if a hospital holds itself out to deliver babies --

A. The hospital doesn't deliver babies.

Q. If a hospital holds itself out to accept patients who are going to deliver babies, then obviously the hospital must be equipped to provide 24 hour, around the clock service for delivery of babies, isn't that so?

A. Yes.

Q. And when the hospital does that, they know that a given baby could come in, or a mother with a fetus could enter the hospital, and at any given moment a baby that is born through an entirely normal pregnancy, in every way normal, position and everything else, could suddenly become an asphyxiated baby, or a depressed baby at birth, isn't that so?

A. Yes, that's correct;

Q. That could happen in any given birth, in any given birth, in any given suburban hospital., on any day or nignt, right?

A. That's correct.

Q. And if hospitals are not equipped to handle, maternity hospitals, that is, are not equipped to handle asphyxiated babies, wouldn't you think, Doctor, that it would be the responsibility of the hospitals so to advise

every mother who cones in pregnant to deliver her baby -- and like if it was going to be your wife coning in, that they would say to her, "If we have asphyxiation of the newborn, severe depression of the newborn, we are not qualified to handle it"?

A. I think that would be reasonable.

Q. You expect them to do that?

A. Yes.

Q. Yes. Is there any evidence, or any understanding on your part that the hospital here, Bedford Hospital in this case, so advised any of their patients3 Do you have any information that suggests to you, or indicates to you that the hospital said to these people, "We are not equipped to handle asphyxiated, severely depressed newborns"

A. No.

Q. Do you have any evidence or any indication to you, that the hospital here, Bedford Hospital, said to Dr. Choi, the obstetrician here, that the hospital did not have personnel or equipment or labs, or anything else sufficient to treat or care for severely depressed or asphyxiated newborn children, babies?

A. No.

Q. Tne nursing staff that we adverted to briefly before, obstetrical nursing people, the nurse is the one that has the responsibility for monitoring the fetal heart

rate. You pointed that out to us before, did you not?

A. As a general rule in a hospital setting, yes.

Q. In this case, in reviewing the hospital records, you noticed there was a nurse, Gerhardstein, that was referred to, or doesn't that name come to mind?

A. Yes, it does.

Q. That's right, you mentioned that it was she and Dr. Reyes that handled the subsequent resuscitation work.

A. Yes.

Q. Now, according to the standards of obstetrics in 1974, the monitoring by her was not done according to standards, was it?

A. When was that?

Q. As to frequency, the 30 minute pre-birth period, where there was no fetal heart rete even noted in the record, is that correct?

A. Well --

Q. First, is it correct that there was not one note of the fetal heart rate of Baby Eric Hawkins in the record at Bedford Hospital?

A. Thirty minutes prior to birth?

Q. Yes, that is true, isn't it?

A. That is true.

Q. That duty to do that monitoring was upon Nurse Gerhardstein in this case, since she was the only

nurse that was there?

A. But I think this was a situation where the nurse generally takes a heart beat just prior to the delivery, and then delivery generally occurs.

I think Nurse Gerhardstein did, in fact, take a fetal heart rate prior to delivery. Then Dr. Choi, I believe, attempted to deliver the baby. And it took, I believe, two attempts, two anesthetics. And I don't know whether it was possible, or I don't know whether it was done and not recorded.

But this was an unusual situation, and certainly not a problem as far as Nurse Gerhardstein is concerned. We are trying to get the baby out at this point, Dr. Choi is. E don't know what it would serve to say, for example, for Nurse Gerhardstein to say, "Step aside. It's five minutes now. I have to take fetal heart tones. You have to stop trying to deliver the baby."

*So* my point is that there was an active attempt to try to get the baby out, and I don't think, as this point in time, taking or not taking the fetal heart tones enters into the situation.

So I don't know how Nurse Gerhardstein can be faulted for not taking fetal heart tones after the last one that she did record.

Q. Well, if it is the responsibility of the

obstetrical nurse to check fetal heart rate at least every five minutes -- is that what you indicated, Doctor, at second stage of labor?

A. Yes.

Q. And more frequently if there appears to be a problem, isn't that the standard?

A. Yes, sir.

Q. And if she didn't do it, she, at least, did not comply with that standard; we can agree with that, can't we?

I am not talking about what effect it would have. I am saying the standard is that you are expected to check fetal heart rates every five minutes, and that is the obstetrical nurse's requirement, according to standards, and she didn't do that?

A. She did not record it.

Q. She did not record it?

A. Yes.

Q. Therefore, there is no indication, if it isn't written, chances are it wasn't done; that is the presumption at least, isn't it, that you doctors engage in, and you insist on when you teach your courses to the nurses as to recording data, that if it is not recorded, you presume that it wasn't done; isn't that right?

A. I can only attest to the fact that it is not recorded.

Q. Therefore, let's put it this way, you certainly can't tell us it was done?

A. Correct.

Q. And what you do know is that it was not recorded?

A. Correct.

Q. And it was supposed to be recorded, according to standards?

A. Correct.

Q. So whether or not that failure did or did not make any material difference in the ultimate brain damage to this child, certainly you can't necessarily say that it did or didn't, the fact that the fetal heart rate wasn't taken, or wasn't recorded, isn't that true? You are not going to say that made any particular difference in the brain damage to the child, is that correct?

A. Correct.

Q. But what it does do, it does not give you the basis for knowing precisely what the status of the baby was during that 30 minute time, does it?

A. No, sir.

Q. And if you don't know that, then obviously, if you don't know it from a careful, detailed review of the records, assumedly the people in charge, this obstetrical team over at Bedford Hospital, didn't know it either, if it

wasn't indeed taken?

MR. ALBERT: Or recorded. You have been using recorded, now you switched to taken.

A. If indeed it wasn't recorded.

Q. If indeed it wasn't recorded or communicated to them, let's say.

A. Yes. I don't disagree.

Q. Xurse Gerhardstein, concentrating on her for a moment, apparently in her assistance, my understanding is that she gave hot and cold soaks to the baby immediately after the baby was handed over to her, or during this resuscitative effort. Eo you endorse hot and cold soaks for a severely depressed, asphyxiated newborn baby?

A. No. Personally, I don't.

Q. As a matter of fact, are you familiar with the literature on it, and the fact that this hot and cold soaks idea went out -- maybe this is an exaggeration -- maybe with the Middle Ages?

A. I am not familiar with the literature on it, but I don't endorse hot and cold soaks.

Q. It is not acceptable or safe, according to standards and practices in obstetrics, is it?

A. No, sir.

Q. It is substandard in the practice of obstetrics, isn't it, to do it?

A. As a sole attempt at resuscitation, yes.

Q. As a matter of fact, it produces, according to th standards of the learned people in your obstetrical field who have written on the subject, it produces hypothermia, cold soaks, obviously, particularly, isn't that right?

A. I don't know. I am not familiar with the literature.

Q. And this baby indeed was hypothermic, isn't that true, Baby Eric Hawkins was hypothermic?

A. Was hypothermic, yes.

Q. It's fair and reasonable, isn't it, to conclude that the cold soaks by Nurse Gerhardstein probably contributed to the hypothermia, isn't it?

A. It's reasonable to assume that.

Q. The reason hot and cold soaks are not endorsed by you folks in the obstetrical field is because it is harmful potentially to the baby?

A. I don't know. If it went out in the Middle Ages, I was not exposed to it as a resident, and I have had no dealings with hot and cold soaks.

Q. It has nothing to do with the body of knowledge that is there to care for the newborn asphyxiated baby, does it?

A. Correct.

Q. The last 30 minutes before Eric's birth, you

noted in your review, did you not, that there was apparently some confusion on the matter of the administering of anesthesia to the mother; did you note that?

A. I didn't note confusion.

Could you point that out?

Q. You had said that Dr. Choi, thinking delivery was imminent, had Dr. Reyes give her a general anesthetic.

A. That was my assumption,

Q. Yes.

Who decides on when an anesthetic should be given?

A. The obstetrician:

Q. Yes. And when he decides on that he has to communicate that to the anesthesiologist, correct?

A. Yes.

Q. And when the anesthesiologist participates as a member of this team, he has certain responsibilities on his part, basically, does he not?

A. Yes, certainly.

Q. One of them is, he is supposed to do a pre-anesthesia physical of the mother?

A. If there is time.

Q. And here there would be time, certainly?

A. There was tine to transfer the baby and mother to another hospital, as well.

Q. There was lots of time for things here, right?

A. Yes.

Q. And the anesthesiologist certainly had the time to do a pre-anesthesia physical, didn't he?

A. I don't know when the anesthesiologist was brought into the picture, when Dr. Choi advised the anesthesiologist when he might need him, so I don't know if there was adequate time.

Q. In any event, there was no pre-anesthesia evaluation of this patient, was there?

A. Not from what I could glean.

Q. In the form provided by the hospital, if my recoilection is correct on this, I think there was a form that said something about pre-anesthesia evaluation or examination, and that was totally blank. That is my recollection.

Do you want to check that, Doctor?

MR. ALBERT: Is it important? I mean, the record will speak for itself.

You are asking him to find a pre-anesthesia form?

MR. WEISMAN: Yes. I think there was a form on that.

A. I only see the anesthesia record.

Q. In any event, pre-anesthesia evaluation is the

standard throughout the country in evaluating parturient or expectant mothers?

MR. McNEAL: At what time?

Q. Prior to the delivery; isn't that right, Doctor?

A. Yes, sir.

Q. That page, pre-anesthetic evaluation, immediately follows, I believe, the anesthesia chart or charts.

A. Yes. I found it.

P And it's empty on pre-anesthetic evaluation, is it not?

A. Yes.

Q. Not a word written in there by Dr. Reyes, is that correct?

A. Or anyone else.

Q. Or anyone else, right.

And also you noticed before that there were two charts, two anesthesia charts in the fi e?

A. Yes.

Q. That is peculiar, is it not?

A. Yes, it is.

e. How many charts do you find in every file that you have ever reviewed, anesthesia charts? How many are there?

A. Generally a single one.

Q. Do you have any explanation, in your review of

this, why there are two charts in there?

A. No, sir.

Q. That is not according to the standards, obviously

MR. McNEAL: Show an objection.

A. I don't know that it is not according to the standards. There should be an anesthesia chart and, in fact, there is more than one. I don't know that more than one makes it substandard, or according to standard. Maybe more than one is better.

There are two anesthetics involved, and maybe one dealt with one anesthetic, an6 the other dealt with the other anesthetic.

Q. Do you want to look at them?

A. I only see one. I am sorry. I find one here, and I don't find a second one.

Q. All right. We will bring that to your attention maybe at a later time.

Now, in your review of this case, did you ascertain that there was an essentially uneventful prenatal course that took place throughout the pregnancy of Mrs. Hawkins?

A. I am sorry, I was looking at the anesthetic record and not paying attention.

MR. WEISMAN: Will you read the question back, please?

MR. ALBERT: Read the question back.

(Question read.)

A. With the exception of her having been admitted in false labor, yes.

Q. Did you have the opportunity to look at the prenatal records as to the growth of the fundus, and the checking of her at the prenatal examinations and all? Those would be records of Dr. Luczek.

A. Yes, I did. Those records that were provided to the hospital by Dr. Luczek. I don't have his office records.

Q. And in those, everything was just copacetic, normal, everything going along just fine, nothing to indicate any alarm whatsoever, is that correct?

A. Correct.

Q. A good, healthy pregnancy, you would say, if you were talking to another doctor about it, is that correct:

A, Correct.

Q. With respect to the breech position of the baby, it can happen in a breech delivery that a cord compression can take place; that is the typical situation that occurs, is it not, that could prevent flowing of oxygen, for example, to the fetus; isn't that true?

A. Yes, it is.

Q. That is the thing that one is concerned about

happening?

A. That is one of the things of concern in breeches, yes.

Q. Did that happen in this case, in your opinion, Doctor?

A. Yes, it did, in my opinion.

Q. It did.

Doctor, is there one word in the record about cord compression on this baby?

A. I don't recollect..

Q. You didn't see anything that you can tell us about, I take it?

A. Fight.

Q. Now, in your review of the deposition of Dr. -- wait a minute, you didn't review the deposition of Dr. Choi, I take it, the obstetrician here?

A. Correct. I have not reviewed his deposition.

Q. So you can't tell us what he said or did not say about cord compression, obviously?

A. That's right.

MR. ALBERT: But you can.

Q. Yes, I can tell you that he said not one word about cord compression, the obstetrician himself that was in place in this case, I will tell you that.

MR. McNEAL: You mean that that proves

there was none?

THE WITNESS: No, he says there was none.

MR. WEISMAN: He would be the best one to know whether there was tangling of the cord, or cornpression, I would think.

MR. ALBERT: In your opinion.

Q. With respect to narcotics, sometimes narcotics can cause cord compression?

A. Is what you said about his being the best one to know, did that go into the record, as well?

MR. ALBERT: Yes. It is just Mr. Weisman talking. That is all right, he can talk.

Q. 30 you disagree with the comment?

A. Unfortunately, the best one to know would be the baby.

It's very difficult sometimes to ascertain what is going on, even at the time.

MR. ALBERT: I would like to just take a two minute recess.

MR. WEISMAN: Sure.

(Short recess had.)

MR. WEISMAN: Will you read back the last few questions and answers, please?

(Record read by reporter.)

BY MR. WEISMAN:

Q. And that is the reason that you are not ab e to tell us with any degree of medical certainty just where the lack of oxygen problem occurred, is that the point?

A. No, I have an opinion, that I believe, with my relative medical certainty, that I think I know where the lack of oxygen to the baby occurred.

9 You think you know that?

A. Yes.

Q. And where did that occur?

A. I think that occurred intrauterine, during the delivery process.

Q. Intrauterine during the delivery process, all of it?

A. I believe a significant amount of it.

Q. Can you tell us when durinq the delivery process this occurred?

A. No, sir, except that it occurred sometime in the thirty minutes, this severe lack of oxygen to the baby, sometine during the 30 minutes prior to the actual delivery of the baby.

Q. And whether it occurred within the last few minutes, or whether it occurred within the last 30 minutes, you have no kind of measurement device or basis for telling

us when the lack of oxygen occurred, is that right?

A. That's right.

Q. And how much of it occurred extrauterine, secondary to inadequate resuscitative efforts, you can't measure that precisely for us, either, is that right?

MR. McNEAL: Objection.

A. I don't know how much, if any, lack of oxygen to the baby occurred extrauterine.

Q. And I added, secondary to inadequate resuscitativ efforts, because that is what you wrote in your report.

MR. McNEAL: Show an objection.

Q. Do you agree, or do you want to withdraw those words?

A. No, sir, I agree.

Q. So the resuscitative efforts obviously, in your opinion, were inadequate, right?

MR. McNEAL: Show an objection.

A. I would like to change that from inadequate. I don't know that they were inadequate. I must say, after reviewing that statement that I did make in my report, I now question whether inadequate is the appropriate term.

Q. You would like to change that now?

A. Yes, I would like to change that.

Q. Don't you think that your colleagues in the profession who write about the standards and appropriate

resuscitative care rather agree with you that these resuscitative efforts here were inadequate?

MR. McNEAL: Show an objection.

A. I think they were non-expert. But inadequate, I think, pertains to results, rather than it pertains to the sequence of the efforts being made.

I don't have any way of measuring as to whether or not the results of the resuscitation in this instance were effective or ineffective, because I am quite uncertain as to the product that they had to deal with, that is, the resuscitative team of Dr. Reyes and Nurse Gerhardstein.

Q. Your colleagues that write on the matter, especially those in the obstetrical field that refer to resuscitation, there are some good books and recognized authorities that you certainly are conversant with as a specialist in your field, are you not?

A. Yes.

Q. And those books would be what, for example?

A. On resuscitation?

I don't know the --

Q. Resuscitation, or the others that deal with obstetrics and make reference to resuscitation.

A. Dr. Gertie Marks; Dr. Bret Gutche.

Q. You have to give us the titles.

A. I don't know. These are all articles I have read

by then. But they are all experts in resuscitation.

Q. Give us those names again.

A. Gertie Marks and Dr. Bret Gutche, these are two names of anesthesiologists that do specialize in obstetrical anesthesia, and who have written on the subject of newborn resuscitation.

Q. Where are they located, if you know?

A. Dr. Gutche was located in Philadelphia at the hospital *of* the University of Pennsylvania at one time, and Dr. Gertie Narks, I don't know.

Q. Did you know Dr. Gutche personally?

A. Yes.

Q. G-u-t-c-h-i-e?

A. G-u-t-c-h-e, I think.

Q. How many articles did you read of theirs?

A. I don't recollect.

Q. Do you have copies of them at home?

A. I imagine I do.

Q. How many?

A. I don't know.

Q. Are there a half dozen or so? Is it a textbook, or just isolated articles?

A. Articles.

Q. Will you get those together for counsel so that we can have a look at those, and all the articles on that?

MR. WEISMAN: Is it agreeable to do that, if the doctor sends them to you, we will be glad to pay for the copies.

MR. ALBERT: If they exist, we will send copies to you gratis.

MR. WEISMAN: We know! according to the doctor's testimony, that they exist.

Q. Do you know the number?

A. I don't know the number.

Q. Is it three or four, six or eight? You must have some idea of tine number.

A. It has been a while since I referred to them. I don't know the number.

MR. McNEAL: I would like to have a copy also.

MR. ALBERT: Sure.

Q. What textbooks do you think are sound and very good on this matter of the resuscitation of the newborn, especially the severely depressed: newborn?

A. I use textbooks for reference purposes, and Williams Obstetrics is the obstetrical textbook that I refer to. But I must say that I rely more upon knowledge that I read in the literature, than upon textbooks per se.

Q. You certainly have the right to disagree with any part of any article or textbook, or anything else.

But the question I am asking you is, these are reliable, authoritative works, are they not, the things you are telling us about?

A. Yes, sir.

see 69, L.4; on Heveles Williams

Q. Like Williams Obstetrics, for example?

A. Yes.

Q. And there are other books that are top flight or highly regarded in your profession besides Williams; you rely on Danforth from time to tine, or make reference to it from tine to time?

A. Not Danforth.

Q. Greenhill; do you know the book, Greenhill?

A. I know it.

Q. It's a good: one, highly regarded. Who was it, Friedman and Greenhill; Emanuel Friedman was a recognized authority in obstetrics?

A. Yes. He still writes.

Q. He is still living?

A. Yes. He just wrote an article in the New England Journal of Medicine.

Q. Where is he located?

A. He is still in Boston, I believe. I don't know what hospital. He is associated with Harvard, I believe.

Q. That's a great book that you have had occasion

to make reference to yourself, to study yourself, from time to time, I take it?

A. Yes.

Q. What other ones? Give us other textbooks that are sound, reliable, and that you refer to and rely on, such as Williams and Greenhill?

A. There are textbooks on genetics, on infertility, on gynecology, but I don't know of any others off the top of my head that I rely upon for obstetrics.

Q. By the way, a big part of your work is dealing with genetics and chromosomal disorders and that type of thing?

A. No.

Q. But as an obstetrician you do allude to that area from time to time, is that correct?

A. That's correct.

Q. Did you check out Eric Hawkins to determine whether there was any chromosomal or inborn or genetic defect of any kind that appeared in his records?

A. I didn't note any.

Q. It would be fair, based on the evidence, if there is no evidence of any, we can say that there probably is no genetic defect, can we not?

MR. McNEAL: Show an objection.

A. I am not privy to that information. I have not

seen anything in the depositions, or any information I have gone over.

Q. Just so that I know what you are going to testify to when we get down to the courthouse. You are not going to suggest that there is any inborn defect or genetic difficulty, or chromosomal problems in Eric Hawkins that would be attributable to his impairment and disabilitie today; is that correct?

A. That's correct.

Q. I don't know if you are familiar with any other anesthesia writers on obstetrical anesthesia, for example.

A. Sol Snider.

Q. Sol Snider. He is on the West Coast, isn't he?

A. I believe so.

Q. Then you are familiar with him; you have read

A. Yes.

Q. And Frank Moya?

A. Yes.

Q. Have you read an of his stuff on obstetrical anesthesia?

A. Probably in reference to his works, but I can't say that I have read a specific article.

Q. What about John Bonica's two volume work?

A. Yes.

Q. That is the most exhaustive study on obstetrical anesthesia that was ever published, I have been told.

A. I think you are right.

Q. And for the record, you are willing to acknowledge these people as authoritative writers and medical experts in the field of obstetrical anesthesia, the ones just mentioned?

A. Yes.

Q. And further it's clear, there is nothing. to suggest anything by way of infection of the mother or baby that occurred throughout the pregnancy that was evident in any of the records, or suggested, or indicated, or implied in any of the records, is that correct?

A. That is correct.

Q. And that there was no chronic hypoxia, certainly, suggested here by any condition, illness or injury that predated the birth of this baby, isn't that so?

A. Not to my knowledge, that is correct.

Q. So that what we had was an acute episode of hypoxia that occurred just before Eric was born at Bedford Hospital?

MR. McNEAL: I object to that. I don't think that is the testimony, Mr. Weisman.

MR. WEISMAN: Well, I am asking the question of him. You can clear it up if I

have it wrong some way.

Read the question back to the doctor, please.

(Question read.)

MR. McNEAL: I think his testimony was that somewhere within this 30 minute period, to which he could not affix any particular time.

MR. ALBERT: I think that is what he said.

MR. McNEAL: I think. that is what he said.

MR. ALBERT: Off the record.

(Discussion had off the record.)

BY MR. WEISMAN:

Q. Can you answer the question?

A. I believe that the lack of oxygen to this baby occurred prior to the delivery, in that 30 minute time frame, somewhere in that 30 minute time frame, and that it was acute.

Q. At least that's your contention?

A. That is my contention.

Q. And this is your contention notwithstanding that there is not one note of cord conpression in the file or record on the baby, is that correct?

MR. McNEAL: Show an objection.

A. Yes.

Q. And further, that on the matter of narcotics, are you aware that there was a substance called Narcan that was administered here?

A. I did not note that.

Q. It was a small detail in the record, rather obscurely placed, as a matter of fact, in the record, so I can understand your possibly missing that.

Let's assume, though, that the truth is that Narcan was administered.

A. Yes. To the baby?

Q. To the baby, and it had no effect in reversing the situation.

MR. McNEAL: He is nodding his head.

THE WITNESS: I am sorry. Yes.

Q. Would it be fair and reasonable, then, to conclude that with probability, it was probably not a narcotic depression?

A. Then that would be fair to conclude, that the lack, after a time -- that if the Narcan had been given, it would: be proper to conclude, therefore, that when the baby didn't respond, that it wasn't due to narcosis, yes.

That is not to say that the narcotics didn't, along with the other events, didn't compound the baby's problems.

Q. What is the physiological progression that takes place medically from the point of oxygen lack to the end point of brain damage? Are you aware of that?

MR. ALBERT: In the fetus?

Q. In the fetus, or the newborn?

A. Once oxygen fails to be delivered in adequate amounts to the brain, then the brain cells are not able to continue to live. They then become irreparably damaged, becauss they can't utilize oxygen in their metabolism and in their respirations and they die. And I think that's what causes brain damage.

Q. Is this the area that you are an expert in particularly?

A. This is not an area in which I am an expert.

Q. The area of expertise that should be called upon, really, for careful explanation of it would more than likely be the pediatric neurologist, isn't that so?

A. I would think that a pediatric neurologist would understand the scheme of anoxic brain damage better than I.

Q. And that is not to diminish your knowledge about the subject. I recognize you certainly have general knowledge about the medicine that's involved in this obstetrical phenomenon of brain damage to the newborn, do you not?

A. Yes, I think I do.

Q. You are familiar, in fact, with studies that indicate that 80 percent of the babies with Apgar scores of one at one minute, if properly resuscitated, come out with no brain damage whatever, and are entirely normal children, are you not?

MR. McNEAL: Show an objection.

A. No, as a matter of fact, I think that that was from the testimony of Dr. Edelberg that I obtained that 80 percent from. I am not familiar, myself, with the literature that says that.

Q. Do you disagree with it?

A. I have no basis on which to agree to disagree.

Q. You, I take it, have not checked that out since being asked to handle this assignment, is that correct?

A. I did not check that out.

Q. Now, if there is any disagreement on that point, based upon your study or research that may take place between now and Vovember 10th, when this trial starts, will you call that to the attention of counsel for the hospital, Mr. Albert?

A. Yes.

MR. WEISMAN: And Mr. Albert, do I have your agreement and understanding that in the event there is any basis upon which that statistical study is to be contradicted, that

you will call it to my attention and let me know that before trial?

MR. ALBERT: Yes.

BY MR. WEISMAN:

Q. Do you have an opinion as to whether or not the resuscitative team -- withdraw that.

Thank you very much. That's all I have. You may examine.

MR. ALBERT: Both of these fine gentlemen have the right to ask you questions. In which order, it makes no difference.

- - -

EXAMINATION

BY MR. STUHLDREHER:

Q. Dr. Klein, I am going to be very brief.

I believe you stated when you answered questions of Mr. Weisman, that one criticism you had of Dr. Choi's performance was that he should have used a different hospital in this particular case; is that right? Is that what you said?

A. Yes, I believe so.

Q. You indicated that the Bedford Community Hospital was ill-equipped to handle this particular case; isn't that what you testified to?

A. Yes.

Q. Are you aware, Doctor, that Dr. Choi never saw this patient until the day of the delivery? Are you aware of that, Doctor?

A. Yes.

Q. She was a patient of Dr. Luczek, isn't that a fact?

A. Yes.

Q. And Dr. Luczek, then, probably chose Bedford Community Hospital as the hospital to deliver this child, isn't that true?

A. Yes.

Q. Do the records reflect, insofar as you know, that Dr. Choi was called to cone to the hospital after the patient arrived at the hospital, to deliver the baby?

A. Yes, the records reflect that Dr. Choi indeed was called, and indeed came to the hospital.

Q. In your experience as an obstetrician, have you ever seen a case where a mother was transferred to another hospital after she was in labor, because it was found that the particular hospital where she was, wasn't equipped to handle the delivery?

A. Yes.

Q. Have you seen that situation?

A. Yes.

Q. How many times have you seen that happen?

A. Several.

Q. Are you telling us that the mother was transferre after she was in labor, stage one, by anbulance, to another hospital?

A. Yes.

Q. Could you te 1 us about that, when that occurred?

A. *i* could refer you to a case that happened this week at Mt. Sinai Hospital, where a lady entered the hospita at 26 weeks gestation with permature rupture of the membrane in early labor. She was later transferred to University Hospital because of the availability of Rainbow Babies and Children's. Should this woman deliver, the baby would then be in the confines of an expert neonatologist.

Q. That was for purposes of having the baby have treatment by the experts at University Hospital, rather thar the mother, isn't that true?

A. Yes. Also the mother, should the baby not deliver at this point in time.

Q. You are not suggesting that the transfer was made because University Hospitals was better equipped to handle the delivery than Mt. Sinai was, are you?

A. That is correct,I am not assuming that at all.

Q. The reason for that transfer was so that the Rainbow Babies and Children's Hospital would be available after the delivery of the baby?

A. That is correct.

Q. So that example really doesn't fit in with what we are talking about. It isn't a good example of the point I an trying to make, isn't that true?

A. I thought that Dr. Choi ought to be transferring this patient for the sake of the baby. 1 think that is the point I was trying to make.

Q. I thought You were saying that the hospital wasn't equipped and didn't have the facilities and tne equipment to handle the delivery of the baby.

A. Oh, no. He did. Dr. Choi delivered the baby there.

Q. It also has to do with the care of the baby after the delivery?

A. Dr. Choi delivered the baby at Bedford Hospital. That is a fact. I don't know that any other hospital would have made any difference, as far as Dr. Choi's being able to deliver the baby as he did, as he chose to.

Q. You are talking about the care of the baby after Dr. Choi has delivered the baby?

A. That's correct.

Q. As being the significant factor?

A. That's right.

MR. STUHLDREHER: That's all I nave.

MR. ALBERT: Mr. McNeal, who represent

the anesthesiologist, has a right to ask you questions.

MR. McNEAL: I have two or three.

- - -

EXAMINATION

BY MR. McNEAL:

Q. In 1974, Doctor, what was the procedure of choice, involving a newborn baby who demonstrated there were problems insofar as oxygen was concerned? What would be the facility of choice to be used in that delivery, whether it be endotracheal intubation, or mask and bag?

A. By and large, I believe that most people who were involved in resuscitation were mask bagging back in 1974 initially. And then did do endotracheal intubation shortly thereafter if no response occurred.

Today I believe that they would take a baby as depressed as this, and probably initially do endotracheal intubation.

Q. What are the problems that are involved with the use of endotracheal intubation?

A. There can be trauma involved with attempting to intubate anybody, particularly a newborn. There can be hemorrhage, a pneumothorax because of attempting intubation, or because of intubation.

So it is not necessarily a totally benign thing

to do.

Q. Can you describe what endotracheal intubation concerns itself with, what are the procedures, what is used?

A. One takes a laryngoscope, in this case it would be a pediatric laryngoscope, small, so that it could fit into the baby's mouth. The vocal chords are visualized, and the endotracheal tube is then passed between the chords as gently as possible. And then the end of the endotracheal tube is attached to a bag, usually with a valve, so that an excess amount of oxygenated air cannot be instilled, such that only a small amount that the baby can handle, and the artificial breathing then occurs.

Q. What is the endotracheal tube composed of, what type of material?

A. It is a rubberized or siliconized type of material, soft and pliable.

Q. Is that inserted within the tube?

A. No, that is the tube that is actually inserted,

Q. And that is approximately what length?

A. Nine inches, seven inches.

Q. And that is --

A. Most of it is outside the mouth. Only a small amount is into the throat and into the trachea of the child.

Q. That is inserted past the vocal chords?

A. Oh, yes.

Q. And clown into the larynx?

A. Down into the trachea past the larynx.

Q. What happens when the larynx is penetrated? Does that sometimes occur with the use of the endotracheal tube?

A. Blood vessels can be injured, and one can see hemorrhage; the wall of the air cavity can be penetrated, and one car, get emphysema or air passing into the passage-ways. And the trauma can make things more difficult with the infant.

Q. With the bag and mask is there anything that penetrates the throat?

A. No. But with the bag and mask things such as pneumothorax can still occur, and inadequate breathing can occur perhaps more frequently with the bag and mask than with the endotracheal tube. And that is perhaps why anesthesiologists more often today are using the endotracheal tube immediately.

It depends upon what the resuscitator is used to, what they feel confident with.

Certainly expert resuscitation can be accomplished I believe, in my opinion, with either method.

MR. McNEAL: That is all I have.

Thank you very much.

MR. WEISMAN: I would like the record to show that the doctor was appearing here pursua to Rule 26(B)(4)(b). I didn't note any statements, to the nature of the examination at the beginning.

I would like to finalize the deposition, if I may. Can I get a waiver of signature?

MR. ALBERT: No. The doctor would like to read the deposition, and whatever arrangements he wants to make as far as doing so is satisfactory to me.

MR. WEISMAN: Can we waive as to filing?

MR. ALBERT: Certainly.

MR. McNEAL: Yes.

MR. STUHLDREHER: Yes.

MR. WEISMAN: As to the signa ure, Mr. Gantverg will promptly transcribe the deposition and submit it to counsel or to the witness directly, if counsel wishes.

MR. ALBERT: I think that's best, If that is okay with the doctor, you can send it out to the doctor.

The doctor will read it, and he will make any corrections which he believes were

inaccuracies in what were taken down, not re-thoughts, but inaccuracies that were taken down, in the space provided for that. And we will send it back to the court reporter as the original, and I would like a copy of it.

- - -

(DEPOSITION CONCLUDED)

(corrections noted on "lawyer notes")

Steven M. Klein, M.D.

- - -

CERTIFICATE

State of Ohio, )
§§:
County of Cuyahoga. )

I, Sidney Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, STEVEN M. KLEIN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to shorthand in the presence of said witness, afterwards transcribed upon a typewriter, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certifv that I am not an attorney, employee or relative of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office in Cleveland, Ohio, on this 19th day of September, 1986.

Sidney Gantverg

Sidney Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter?

My commission expires:
September 12, 1988.

# LAWYER'S NOTES

| Page | Line | |
|---|---|---|
| 29 | 5 | Strikes handling - substitutes fully |
| 37 | 21 | strikes machines - substitutes manually |

**MORSE, GANTVERG & HODGE**
SHORTHAND AND STENOTYPE REPORTERS
750 LEADER BUILDING
CLEVELAND, OHIO 44114

PHONE 216-771-3350

WILLIAM L. MORSE

SIDNEY GANNERG
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DEPOSITIONS
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MEMBERS
NSRA
OSRA

September 19, 1986

Dr. Steven M. Klein
21125 Shelburne
Shaker Heights, Ohio 40122

Re: Eric Hawkins, a minor, etc.
et al.,
vs.
Bedford Municipal Hospital,
et al.,
Case No.957,170

Dear Mr. Klein:

Enclosed is a copy of your deposition given in the above matter on September 13, 1986. It is sent to you so that you may read and sign it in order that it may be filed with the Court.

If you find an error in a word, a name, a number, etc., please indicate the correction by page and line number on the blue "Lawyer's Notes" sheet at the end of the transcript. However, please avoid "editorial" or "second-thought" changes in the transcript, since the record should accurately reflect the actual testimony.

After you have finished, please sign at the indicated place on page 84 and return to me as soon as possible.

Very truly yours,

Sidney Gantverg

Sidney Gantverg
Registered Proffesional
Reporter & Notary Public

cc: Fred Weisman, Esq.,
Steven W. Albert, Esq.,
Harley J. McNeal, Esq.,
George W. Stuhldreher, Esq.,

MORSE, GANTVERG & HODGE
SHORTHAND AND STENOTYPE REPORTERS
750 LEADER BUILDING
CLEVELAND, OHIO 44114

PHONE 216-771-3350

WILLIAM L. MORSE

SIDNEY GANTVERG
RALPH L. HODGE



September 26, 1936

Fred Weisman, Esq.
Weisman, Goldberg, Weisman & Kaufman
540 Leader Building
Cleveland, Ohio 44114

Re: Eric Hawkins, a minor, etc.
et al.
vs.
Bedford Municipal Hospital,
et al.
Case No. 957,170

Dear Mr. Weisnan:

Doctor Klein has signed and returned his deposition taken on September 13, 1936. He has made two corrections, which are as follows:

Page 29 Line 5 Strike hardly; Substitute full;.
Page 37 Line 21 Strike machines; Substitue manually

These corrections are being made in the transcript of the deposition.

Very truly yours,

Sidney Gantverg
Registered Professional
Reporter & Notary Public

cc: Steven W. Albert, Esq.
Harley J. McNeal, Esq.
George W. Stuhldreher, Esq.

## SUMMARY OF KLEIN'S DEPOSITION

| PAGE | LINE | |
|---|---|---|
| 5 | 1 | Members of the team (as far as pregnancy, labor and delivery) are the obstetrician, the patient, the nurse and the anesthesiologist. |
| 6 | 3 | I am knowledgeable about matters involving resuscitation of the new born baby. |
| 6 | 20 | The two people who generally are involved in resuscitation of the new born baby are the pediatrician and the anesthesiologist. Often the nurse will participate in resuscitation. |
| 9 | 12 | Monitoring is one of the functions of the nurse on the labor and delivery floor. |
| 10 | 14 | Standard care for the nurse requires taking the fetal heart rate every 30 minutes in early labor and every five to ten minutes during the second stage of labor. |
| 11 | 1 | That standard applies to any hospital where babies are delivered. |
| 11 | 13 | Dr. Klein reviewed the following in preparation for the deposition:<br>1. Bedford Hospital chart on baby boy Hawkins<br>2. Bedford Hospital chart on Betty Hawkins (October 23rd admission for false labor as well as labor and delivery record)<br>3. Deposition of Dr. Kretchmer<br>4, Deposition of Dr. Coker<br>5. Deposition of Dr. Horwitz<br>6. Deposition of Dr. Edelberg<br>7. My report to Mr. Albert dated May 28, 1986 |
| 13 | 7 | Five to six percent of babies present as breeches. |
| 14 | 13 | Frank breech position is a high risk pregnancy. |
| 14 | 23 | Simply because there is a high risk situation doesn't necessarily mean that anything is bad or diseased or injured about the particular fetus involved. |
| 15 | 14 | Most breech births in 1974 resulted in good outcomes (as far as health of the baby). |
| 17 | 2 | I know Mr. Albert because we play golf together at Oakwood Country Club. We have mutual friends. |
| 22 | 19 | I do not believe that the care provided by Dr. Choi was consistent with acceptable standard of care in 1974. |
| 23 | 12 | Dr. Choi should have used a different hospital in which to induce labor on Mrs. Hawkins. |
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| 33 | 4 | The obstetrician did not resuscitate baby Eric Hawkins. |
| 33 | 8 | There was nothing unusual about the resuscitation being done by Dr. Reyes and nurse Gerharstein rather than Dr. Choi, |
| 34 | 11 | Resuscitation means to re-establish cerculation and/or respiration, if either or both are not present in an individual. |
| 34 | 21 | Eric Hawkins was very sick when he was born. |
| 35 | 20 | Eric Hawkins was asphyxiated at the time of his birth. |
| 36 | 23 | Eric Hawkins was severely depressed at the time of his birth. |
| 36 | 7 | With a severely depressed newborn, certain steps are essential and mandatory for the appropriate care of the newborn. |
| 39 | 13 | I have no way of knowing whether or not baby Eric Hawkins was being adequately oxygenated during the 15 minutes it took to establish respirations. |
| 39 | 17 | An Apgar score of three at five minutes indicates that the baby was still sick, |
| 40 | 7 | I think we are all speculating here as to what actually occurred. I don't know what happened intrauterine. |
| 42 | 6 | If a bag and mask is not doing the job adequately, then an endotracheal tube should be placed. |
| 42 | 11 | There is wasted space in the nasal passage and mouth that may interfere when using the bag and mask. |
| 42 | 14 | An endotracheal tube is more efficient than bag and mask. |
| 44 | 6 | If resuscitation is taking a long time, acidosis is not being corrected and the baby needs sodium bicarbonate according to standard practice. |
| 44 | 12 | Baby Hawkins did not receive sodium bicarbonate, |
| 44 | 25 | Baby Hawkins should have received sodium bicarbonate. |
| 45 | 8 | Blood gases should have been obtained if the resuscitation seemed inadequate or there was no response to the bicarbonate. |
| 48 | 6 | If the hospital holds itself out to accept patients who are going to deliver babies, then obviously the hospital must be equipped to provide 24 hours service. |
| 48 | 11 | A hospital knows that a given baby of an entirely normal pregnancy in every way, position and everything else, could suddenly become an asphyxiated baby or depressed baby at birth. |
| 48 | 18 | That could happen in any given birth, at any given suburban |

hospital on any day or night.

48 23 It would be reasonable that if a hospital was not equipped to handle asphyxiated babies that it would be the responsibility of the hospital to advise the patient that if asphyxia or severe depression occurs that they are not qualified to handle it. I would expect the hospital to do that.

49 9 I have no evidence to suggest that Bedford Hospital told the Hawkin's family that they were not equipped to handle asphyxiated, severely depressed newborns.

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53 22 If fetal heart rates were not recorded and communicated to Dr. Choi, then he too did not know what the status of the baby was during that final 30 minutes.

54 a I do not endorse hot and cold soaks for a severely depressed and asphyxiated newborn baby.

54 21 Hot and cold soaks is not considered safe or acceptable according to standards and practices in obstetrics.

54 24 Hot and cold soaks would be substandard as a sole attempt at resuscitation.

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| | | it occurred within the last 30 minutes prior to delivery. |
| 64 | 7 | I don't know how much lack of oxygen to this baby occurred extrauterine. |
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| 65 | 12 | Authoritative authors on the field of resuscitation are Dr. Gertie Marks and Dr. Bret Gutche. Both Dr. Marks and Gutche are anesthesiologists who specialize in obstetrical anesthesia and have written on the subject of newborn resuscitation, |
| 67 | 17 | Authoritative and reliable text books on the matter of resuscitation of the newborn include Williams Obstetrics and Greenhill. |
| 69 | 17 | I did not note any chromosomal or inborn or genetic defect of any kind that appeared in the records with respect to Eric Hawkins. |
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| 70 | 10 | Sol Snider, Frank Moya and John Bonica are authoritative writers and medical experts in the field of obstetrical anesthesia. |
| 71 | 9 | There is no evidence of infection of Mrs. Hawkins or baby Hawkins that occurred throughout the pregnancy. |
| 71 | 15 | There was no chronic hypoxia here created by any condition, illness or injury that predated the birth of Eric Hawkins. |
| 72 | 16 | The lack of oxygen to baby Eric Hawkins was acute. |
| 74 | 1 | I am not an expert in the physiology of brain damage. |
| 74 | 18 | A pediatric neurologist would understand the scheme of anoxic brain damage better than I. |

# SUMMARY OF KLEIN'S DEPOSITION

| PAGE | LINE | |
|---|---|---|
| 5 | 1 | Members of the team (as far as pregnancy, labor and delivery) are the obstetrician, the patient, the nurse and the anesthesiologist. |
| 6 | 3 | I am knowledgeable about matters involving resuscitation of the new born baby. |
| 6 | 20 | The two people who generally are involved in resuscitation of the new born baby are the pediatrician and the anesthesiologist. Often the nurse will participate in resuscitation. |
| 9 | 12 | Monitoring is one of the functions of the nurse on the labor and delivery floor. |
| 10 | 14 | Standard care for the nurse requires taking the fetal heart rate every 30 minutes in early labor and every five to ten minutes during the second stage of labor. |
| 11 | 1 | That standard applies to any hospital where babies are delivered. |
| 11 | 13 | Dr. Klein reviewed the following in preparation for the deposition:<br>1. Bedford Hospital chart on baby boy Hawkins<br>2. Bedford Hospital chart on Betty Hawkins (October 23rd admission for false labor as well as labor and delivery record)<br>3. Deposition of Dr. Kretchmer<br>4. Deposition of Dr. Coker<br>5. Deposition of Dr. Horwitz<br>6. Deposition of Dr. Edelberg<br>7. My report to Mr. Albert dated May 28, 1986 |
| 13 | 7 | Five to six percent of babies present as breeches. |
| 14 | 13 | Frank breech position is a high risk pregnancy. |
| 14 | 23 | Simply because there is a high risk situation doesn't necessarily mean that anything is bad or diseased or injured about the particular fetus involved. |
| 15 | 14 | Most breech births in 1974 resulted in good outcomes (as far as health of the baby). |
| 17 | 2 | I know Mr. Albert because we play golf together at Oakwood Country Club. We have mutual friends. |
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BRAIN DAMAGE EXPERT

No letterhead?
Why out of Home?
Member of Oakwood? - Assoc with L

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

May 28, 1986

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

Re: Your File # 3480 A 2345
Eric Hawkins, ecc., et al, v. Bedford Municipal Hospital, et al.

Dear Mr. Albert:

RECORDS & REPORTS reviewed.

In accordance with your letter of May 22, 1986 I have reviewed the testimony of Dr. Edelberg, Dr. Horwitz and the hospital. records of Bedford Municipal Hospital. The following are my report and opinions.

2 WKS. before BREECH.

Bettye Hawkins presented to Bedford Municipal Hospital at 2:30 P.M. on November 8, 1974 having spontaneously ruptured membranes 3-½ hours before at 11:00 A.M.. She and the fetus were doing well. She was not in labor. Pelvic exam revealed 1 cm. cervical dilatation and a floating presenting part that was a breech. Two weeks prior, she had presented in false labor and a pelvic x-ray revealed a breech position. According to testimony, she had delivered vaginally, with difficulty, her first baby. Dr. Choi obtained pelvimetry and found her midpelvis and outlet to be "borderline normal." According to the chart, Dr. Choi ordered Pitocin induction which was begun around 4:00 P.M. to avoid infection. The patient apparently agreed to this and to an anesthetic, when it became necessary, with the single exception of spinal.

7 Hrs Normal

Stage I of labor (until she became completely dilated) lasted approximately 9 hours during which she received Demerol analgesia. Monitoring of the fetus and mother was normal during this time and no mention of meconium was made despite the breech presentation. Dr. Choi slrrived according to the hospital records at approximately 1:20 A.M. on Kovember 9, 1974.

CHOI SUB-STANDARD

Stage II of labor (the time from complete cervical dilatation to delivery) lasted 1 hour and 50 minutes which is extremely long for a secundagravida *and particularly dangerous for a breech. This most certainly connoted fetal-pelvic disproportion and the pregnancy should hsve been terminated before this point by Cesarean section.

During her second stage of labor, she was taken to the delivery room and at approximately 3:20 A.M. was given a general anesthesia after having been premedicated with more Demerol and Vistaril. According to the chart, she was put to sleep a little early, so she was awakened so she could push. No mention was made whether Dr. Choi attempted delivery with this first anesthetic nor what the descent of the breech was at this point. At approximately 3:47 A.M. a second anesthetic was administered and the baby was delivered with forceps for the after corning head. No mention was made as to the method of the breech delivery except that it was difficult.

Up to the time of the first anesthetic, fetal heart tones were noted to have been 130 or greater and were obtained frequently. From 3:20 A.M. to 3:50 A.M., the actual time of birth, no fetal heart tones were recorded. The baby was born approximately 16 hours and 50 minutes after spontaneous rupture of membranes occurred. It was a male, 7 Pbs. 12 oz. with Apgar scores of 1 at 1 minute and 3 at 5 minutes but no breakdown was given as to what the scores were for. The baby was resuscitated by Dr. Reyes, the anesthesiologist and nurse Gerhardstein. According to testimony, no intubation was done, no bicarbonate was given? no blood. gases were obtained yet the baby did begin to spontaneously support its own respirations at 15 minutes. In addition the baby was hypothermic and had ecchymoses secondary to trauma from the delivery? Dr. Shapiro, the pediatrician, was apparently not notified for sometime after the birth. When he saw that-the baby was still having difficulties he arranged transfer to Rainbows Babies & Children's Hospital.

Because of the breech, the patient was high risk. Because she was not in labor, had an undilated cervix and a very high breech presenting part and borderline pelvimetry she and the fetus were even greater risk. No attempt at Pitocin induction should have been made in this situation, especially at Bedford Hospital-which was a low risk hospital illequiped and unprepared for potentially catastrophic obstetrical occurrences. At best the patient should have been transferred to a high level institution where facilities and equipment can handle obstetrical emergencies or at least neonatal pediatricians should have been alerted and should have' been in attendance if needed for resuscitative measures and evaluation of any trauma. This was the direct responsibility of the obstetrician, Dr. Choi.

There was at least a 30 minute period in the delivery room where the mother was given narcotics and a general anesthetic, then was awakened, asked to push and then given a second general anesthetic until a breech delivery was finally accomplished with difficulty. During this 30 minute episode, no fetal heart rate was recorded. It was entirely possible that with the breech deep in the pelvis (for Dr. Choi, thinking delivery was imminent, had Dr. Reyes give her a general anesthetic) cord compression occurred. This, in addition to narcotic and anesthetic depression x 2,

could have caused asphyxia in the fetus lasting from 1 to 30 minutes. That is, circulation and oxygen may not have reached the fetus for an undetermined yet significant period of time. Certainly long enough to cause irreparable brain damage. Hence, it is entirely possible that even with expert resuscitation at a high risk institution, brain damage would have been present before the moment of birth.

One cannot say with any medical certainty whether the lack of oxygen that caused the brain damage occurred intrauterine (secondary to cord compression, narcotics and anesthesia) or extrauterine (secondary to inadequate resuscitative efforts).

The anesthesiologist and nurse did not utilize what today many would consider the best of resuscitative techniques, yet, the baby did not die and in fact within 15 minutes began to breathe spontaneously. Therefore, the resuscitative efforts were not all that bad. Moreover, in a community hospital where only low risk, normal obstetrics is done, the anesthesiologist should not be expected to perform expert neonatal resuscitation when only one or two babies out of a thousand might require it. In this case, the obstetrician should have recognized and diagnosed the high risk situation and ensured either a transfer of the mother or the presence of a skilled resuscitative team. With over 9 hours of labor, there was certainly time.

As was stated in testimony, 80% of babies with Apgar scores of 1 at 1 minute are fully resuscitated without residual brain damage. If 20% of babies with Apgar scores of 1 at 1 minute go on to have permanent brain damage, even with expert resuscitation, why cannot Eric Hawkins have sustained his brain damage prior to delivery? I contend he did secondary to the prolonged second stage, cord compression, narcotic and anesthetic depression, and delayed, difficult, traumatic breech delivery. Because he did not suffer from chronic hypoxia due to intrauterine problems prior to the second stage of this labor is no reason to believe that the problems outlined above were not enough to cause asphyxia and brain damage during the 30 minutes prior to delivery.

Sincerely yours,

Steven M. Klein, M.D.

SMK:cb