LINTON & HIRSHMAN

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ROBERT F. LINTON, JR.
ELLEN HOBBS HIRSHMAN
TOBIAS J. HIRSHMAN

STEPHEN T. KEEFE, JR.

October 16, 2003

David Paris, Esq.
Nurenberg, Plevin, Heller & McCarthy
The Standard Building - First Floor
1370 Ontario Street
Cleveland, OH 44113

RE: Steven Klein, M.D.

Dear Mr. Paris:

Enclosed please find copies of the following information our office has regarding Dr. Klein:

1. *Curriculum Vitae*;

2. Expert reports dated February 7, 1998 and June 24, 1998; and

3. Depositions dated May 22, 1996 and August 6, 1999.

Should you have any questions regarding this matter, please do not hesitate to contact me.

Very truly yours,

Molly A. Clifford

Molly A. Clifford
Legal Assistant to Tobias J. Hirshman

/mac

Enclosures

CURRICULUM VITAE

Steven M. Klein, M.D.

Personal Data

Born October 12, 1943 (New York, New York)

Professional Status

Private practice of Obstetrics, Gynecology, and Infertility
Beachwood OB/GYN, Inc.
29001 Cedar Road, Suite 518
Lyndhurst, Oh 44124

Education and Training

Resident, Hospital of the University of Pennsylvania Department of Obstetrics and Gynecology; Philadelphia, PA 1970-1974

Intern, Straight Internal Medicine, Ohio State University Hospitals; Columbus, Ohio 1969-1970

M.D., The Ohio State University College of Medicine; Columbus, Ohio 1965-1969

Bachelor of Arts, Cum Laude, Washington and Jefferson College; Washington, PA 1965

Additional Experience

Ten-month clinical elective in Infertility and Endocrinology, Hospital of the University of Pennsylvania Obstetrics and Gynecology's Department of Reproductive Biology; Philadelphia, PA, 1972-1973

Part-time Appointee, University of Pennsylvania Student Health Service; Philadelphia, PA, 1973-1974

Medical Licensures

Ohio #031831
Pennsylvania #MD012187E

Professional Societies

Fellow, American Association of Gynecologic Laparoscopists
Fellow, American College of Obstetricians and Gynecologists, District V
Fellow, American Fertility Society, 1975
Diplomate, American Board of Obstetrics and Gynecology, 1976
Fellow, American College of Obstetricians and Gynecologists, 1977
Blockley Obstetrical Society of Philadelphia
American Medical Association
Ohio State Medical Association
Cleveland Academy of Medicine
Advisory Board, Childbirth Education Association of Cleveland
Executive Committee, Mount Sinai Medical Society of Cleveland
President, Mount Sinai Medical Society, 1986-1988
American Association of Planned Parenthood Physicians
Cleveland Obstetrical Society
At-Large Member, Executive Committee, Cleveland Society of Obstetrics and Gynecology, 1988-1989
Advisory Board, RESOLVE, Cleveland Chapter Infertility Couples Support Encounter Group
Charter Member, Fallopius International Society for Fallopian Tube Infertility Investigation, 1985
Charter Member, Society of Reproductive Surgeons, 1984
Member, Board of Trustees, Mount Sinai Medical Center, 1986-1990
Member, Surgical Review Committee, Mount Sinai Medical Center
Member, Operating Room Committee, Mount Sinai Medical Center
Member, Human Ethics Committee, Meridia Hillcrest Hospital
Educational Chairman, Department of OB-GYN, Mt. Sinai Medical Center
Chairman, The Quality Assurance Committee of the Department of Obstestrics & Gynecology, Mt. Sinai Medical Center

Hospital Affiliations

Meridia Hillcrest Hospital
Meridia Suburban Hospital
Mount Sinai Medical Center
University Hospitals of Cleveland

Teaching Experience

Clinical Instructor, Case Western Reserve University Department of Reproductive Biology

Director, Mount Sinai Medical Center Endocrine-Infertility Clinic, 1974-1979

Professional Presentations and Community Contributions

Appearance on WEWS' "The Morning Exchange" Television Program on "Chlamydia," 3/1/85

Presentation at Mount Sinai Medical Center Grand Rounds on "Gynecological Endoscopy," 3/9/85

Appearance on WEWS' "Inner Circle" Television Program on "PMS," 3/17/85

Presentation for RESOLVE's Infertility Encounter Group on "Infertility 1985," 3/17/85

Presentation at Mount Sinai Medical Center's Women's Wellness Day at the Cleveland Play House on "PMS," 4/3/85

Presentation at Laurel School on "Adolescent Gynecology and Birth Control," 4/18/85

Heard on WCLV Radio's "The Jewish Scene," 7/21/85

Presentation at Mount Sinai Medical Center's Stork Club, 7/23/85

Presentation at Mount Sinai Medical Center's Microsurgery Work Shop on "The Female Workup for Infertility," 9/9/85

Presentation for Mount Sinai Medical Center's Department of Emergency Medicine on "Emergency Delivery in the Emergency Room," 10/8/85

Presentation at The Cleveland Clinic Foundation's Symposium on Infertility for RESOLVE, 10/19/85

Heard on WCLV Radio's "The Jewish Scene," on "Antenatal Diagnosis," 8/19/86

Presentation at RESOLVE on "Sex and Infertility," 6/19/87

Presentation at Jewish Community Center on "Aids in Our Society: An Understanding," 10/13/87

Presentation at Stork Club on "Your Baby's Birthday," 3/15/88

Presentation at Jewish Community Center on "Aids in Our Society: An Understanding," 4/11/88

Presentation at Beachwood High School on "Aids in Our Society: An Understanding," 4/15/88

Professional Presentations and Community Contributions (cont.)

Presentation for Shaw High School's Straight Talk Series on "Birth Control and Sexually Transmitted Diseases," 1/12/89

Appearance on WEWS' "The Morning Exchange" Television Program on "Diabetes in Pregnancy," 11/29/89

Appearance on WEWS' "The Morning Exchange" Television Program on "Vaginismus and Sexual Dysfunction," 2/14/92

Presentation for Progressive Insurance on "Infertility," 4/6/94

Radio program for the Academy of Medicine of Cleveland entitled "Health Lines," heard on WCLV, subject "Premenstral Syndrome," 5/16, 5/18, 5/20/94.

Presentation at Metrohealth Medical Center, to Cuyahoga County Chapter of Medical Assistants, on "INFERTILITY, " 11/16/95.

Research Projects

Comparison of Laparoscopy and Hysterosalpingogram at the University of Pennsylvania

Histologic Demarcation of the Fetal Zone of the Mouse Adrenal Gland

Postpartum Tuberculosis Endometritis -- A Study and Review of the Literature

Treatment of the Cervical Factor with Specific Dose Regimens of Estrogens

Publications

Klein, Steven M. "Asherman's Syndrome: A Critique and Current Review," in Fertility and Sterility 24: 9, 1973.

Shearman, Rodney P., ed. "Book Review: Human Reproductive Physiology," in Fertility and Sterility 24: 10, 1973.

Klein, Steven M. "Asherman's Syndrome: A Potential Iatrogenic Disaster," in Contemporary OB/GYN 4: 1974.

Sciarra, John J., ed. "Asherman's Syndrome," Chapter 24 in Gynecology and Obstetrics. New York: Harper and Row, 1981.

Garcia, et al, ed. "Asherman's Syndrome of Intrauterine Adhesions," in Current Therapy of Infertility -- 3. New York: B. C. Decker, Inc., 1988.

BEACHWOOD OB/GYN, INC.

Sandra L. Bellin, M.D.
Steven M. Klein, M.D.
Irwin Kornbluth, M.D.
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Steven M. Klein, M.D.
SS# 282-36-0644

February 7, 1996

Mr. Murray K. Lenson
Ulmer & Berne
Bond Court Building
1300 East Ninth Street, Suite 900
Cleveland, Ohio 44114-1583

RE: CINDY BRYANT VS. DRS. HILL & CHAPNICK, INC.
(DRS. CHAPNICK & STALLWORTH)

Dear Mr. Lenson:

I have, at your request, reviewed the following:

1. PAP smear request of Dr. Rutenbergs on Cindy Bryant of 6/23/90.
2. PAP smear report of Dr. Chapnick on Cindy Bryant of 6/23/90 request of 7/2/90.
3. PAP smear request of Dr. Basquinez on Cindy Bryant of 3/14/91.
4. PAP smear report of Dr. Chapnick on Cindy Bryant of 3/14/91 request of 3/27/91.
5. PAP smear request of Dr. Basquinez on Cindy Bryant of 7/11/91.
6. PAP smear report of Dr. Stallworth on Cindy Bryant of 7/11/91 request of 7/23/91.
7. PAP smear request of Dr. Quinn on Cindy Bryant of 4/24/92.
8. PAP smear report of Dr. Stallworth on Cindy Bryant of 4/24/92 request of 4/30/92.
9. Office records of Lake Obstetrics & Gynecology, Inc. on Cindy Bryant 2/18/88 to 5/21/92.
10. Ashtabula County Medical Center discharge summary of Cindy Bryant. Admission 7/9/92-7/11/92 for fetal demise at 18 weeks and retained placenta.
11. PAP smear report of Dr. Ronald Huhn on Cindy Bryant requested by Dr. S. Huang of 1/7/93.
12. Dr. Huang's office chart on Cindy Bryant 1/5/93 to 12/13/94.
13. Pathology report of Dr. Huhn on Cindy Bryant's Cone biopsy of 1/22/93.
14. Dr. Huang's operative note of Cindy Bryant's Cone biopsy of 1/20/93.

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15. Dr. Huang's history and physical examination and laboratory data of Cindy Bryant's admission of 1/20/93.
16. Dr. Huang's operative note of Cindy Bryant's abdominal hysterectomy and appendectomy of 3/22/93.
17. Dr. Huhn's pathology report of Cindy Bryant's operation of 3/24/93.
18. Dr. Huang's history, physical examination, discharge summary and laboratory data of 3/22/93 admission. Discharged 3/25/93.
19. Dr. Huang's PAP smear of Cindy Bryant's vaginal cuff of 6/21/93 read by Smith Kline Beecham in Lexington, Kentucky.
20. Dr. Huang's PAP smear of Cindy Bryant's vaginal cuff of 9/1/94 read by Dr. Huhn.
21. Ashtabula County Medical Center's emergency department report of 10/26/94 on Cindy Bryant.
22. Pathology report of Dr. Huang's vaginal cuff biopsy of Cindy Bryant on 12/8/94 of Dr. Huhn.
23. Consultation report of Dr. Stachelek to Dr. Huang of Cindy Bryant 12/20/94 including:
    - Bone Scan
    - IVP
    - Chest X-ray
    - Laboratory Data
24. Ashtabula County Medical Center emergency department report on Cindy Bryant of 1/4/95 "probable cysto-vaginal fistula with cystitis".
25. Dr. Bruce Sebek's (Cleveland Clinic) interpretation of 1/22/93 Cone biopsy.
26. Cleveland Clinic's Dr. Charles Biscotti's interpretation of Dr. Huang's PAP smear of Cindy Bryant done 1/5/93 (C93-44) read by Dr. Huhn as "high grade lesion" and read by Dr. Biscotti as ASCUS-probable dysplasia.
27. Jan C. Seski, M.D.-12/19/95 report.
28. Melvyn J. Ravitz, M.D.-12/11/95 report.

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29. Edward B. Sussman, M.D.-11/3/95 report.
30. Dorothy L. Rosenthal, M.D.-10/31/95 report.
31. Michael P. Hopkins, M.D.-11/17/95-unsigned report.
32. Brigette M. Ronnett, M.D.-10/25/95 report.
33. Depositions of: V. Rutenbergs, M.D. 6/14/95.
Aida Basquinez, M.D. 6/21/95.
Patrick Quinn, M.D. 6/21/95.
Ronald Huhn, M.D. 9/12/95 & 9/21/95.
Shin E. Huang, M.D. 5/31/95 (partial).

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RE: CINDY BRYANT VS. DRS. HILL & CHAPNICK, INC.
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Cindy Bryant, delivered a baby on 5/9/90. At a post partum examination on 6/23/90 at age 26, Dr. Rutenbergs (of Lake County Obstetrics & Gynecology, Inc.) performed a PAP smear. No previous history of PAP smear abnormalities had been noted. The PAP smear was reported by Dr. Chapnick (of Drs. Hill & Chapnick, Inc.) as having "Clue" cells and exudate interfering with cell study. The cell study was considered negative and the recommendation was to repeat in one year.

The patient conceived and at eight weeks of pregnancy (3/14/91), Dr. Basquinez (of Lake County Obstetrics & Gynecology) performed another PAP smear of her cervix (nine months later). This PAP smear was reported by Dr. Chapnick as a low grade SIL (CIN I) and recommended colposcopy.

On 4/9/91, the patient was allegedly abused by her husband and considered terminating the pregnancy.

On 4/30/91, a colposcopy was performed by Dr. Basquinez at 14 weeks of pregnancy. Aceto-White epithelium was noted but no biopsy of the endo or ecto cervix was done. A repeat PAP smear was scheduled three months hence in July.

On 7/11/91, at 24 weeks of pregnancy, a third PAP smear was performed by Dr. Basquinez. The report by Dr. Stallworth (of Hill & Chapnick, Inc,) was of atypical glandular cells of undetermined significance with atypical parakeratosis. Of note was a high nuclear to cytoplasmic ratio. Dr. Stallworth thought these may be reactive to inflammation but recommended close, continued follow up.

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Cindy Bryant delivered a baby on 10/22/91. No follow up PAP smear was done. No repeat colposcopy was done. Dr. Quinn did a PAP smear on 4/24/92 (nine months after atypical glandular cells were noted). Dr. Quinn never took note of the three relatively recent PAP smear results. Dr. Quinn never knew Dr. Basquinez had considered repeat colposcopy after pregnancy. This PAP smear was interpreted by Dr. Stallworth as reactive changes associated with inflammation and that its adequacy for proper interpretation was less than optimal due to partially obscuring inflammation.

The patient was to have a sterilization procedure, but on 5/21/92 she had a positive pregnancy test and the bilateral tubal ligation was cancelled.

On 7/9/92, Dr. Huang treated the patient for an 18 week fetal demise using Prostaglandin Suppositories and requiring a D&C for retained products of conception at Ashtabula County Medical Center. The patient never returned to see Dr. Huang until 1/5/93, at which time a PAP smear was done. This was 18 months after atypical glandular cells were noted and 22 months after a low grade SIL was reported by Dr. Chapnick.

This last PAP was reported by Dr. Ronald Huhn to be at least carcinoma insitu of the cervix, and a tissue biopsy was recommended.

On 1/20/93, a laser Cone biopsy of the cervix was performed by Dr. Huang and reported by Dr. Huhn as a micro-invasive epidermoid carcinoma with positive vaginal margins, the tumor having been transected in this area (Revised report 1/27/93) encompassing the area from 10 o'clock to 2 o'clock of the entire specimen.

On 3/22/93 Dr. Huang, with the knowledge of the report from Dr. Huhn, performed a total abdominal hysterectomy and appendectomy using a bipolar cauterization technique. The pathology report by Dr. Huhn showed the surgical margins to be free of atypia. (The margins were burned twice-first by the laser which was used for the Cone biopsy, and secondly by the bipolar cauterization technique during the hysterectomy).

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**RE: CINDY BRYANT VS. DRS. HILL & CHAPNICK, INC.
(DRS. CHAPNICK & STALLWORTH)**

Three months later, a PAP smear of the vaginal cuff on 6/21/93 was reported by Smith Kline Beecham out of Lexington, Kentucky as being negative. The patient neglected to keep a six month post operative appointment for another PAP smear. She cancelled an additional appointment as well, and did not return to see Dr. Huang until 9/1/94 (15 months later), at which time a repeat PAP test was done and a left adnexal mass was palpated, for which an ultrasound was ordered. She was treated for a urinary tract infection. The PAP smear was read and reported by Dr. Huhn to be within normal limits.

The patient neglected to have the ultrasound and did not keep several other appointments. On 10/26/94 the patient was seen in the Ashtabula County Medical Center emergency department for vaginal bleeding. A pelvic fullness was appreciated. A "tear" in the vaginal cuff, perhaps attributable to coital injury, was diagnosed. An ultrasound revealed a left hydronephrosis and a urinary tract infection was also diagnosed and treated. She was requested to see Dr. Huang as soon as possible.

The patient missed another appointment and did not see Dr. Huang until 12/8/94 at which time a biopsy of "granulation tissue" of the vaginal vault was taken. The biopsy was reported by Dr. Huhn as grade 2-3 epidermoid carcinoma.

The patient was referred to Dr. Stachelek, a Radiation Oncologist, who obtained various tests, the results of which were consistent with metastatic, recurrent, cervical carcinoma.

On 1/4/95, another emergency department visit, reveled a possible vesico-vaginal fistula.

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RE: CINDY BRYANT VS. DRS. HILL & CHAPNICK, INC.
(DRS. CHAPNICK & STALLWORTH)

The original four PAP smears performed by Drs. Rutenbergs, Basquinez and Quinn and reported by Drs. Chapnick and Stallworth, have been re-examined. The original readings have been challenged. Reportedly they reflected less severe a disease process than really existed. Nevertheless, Drs. Chapnick and Stallworth did recognize cellular abnormality and did recommend additional diagnostic procedures. PAP smears are only a screening tool. They are representative only of exfoliated cells. A tissue diagnosis is necessary to confirm the extent of abnormality.

A prudent Gynecologist who reviewed the PAP report of 6/23/90 revealing "Clue" cells and exudate, would treat the bacterial vaginosis and repeat the PAP smear.

The next PAP report of 3/14/91, done nine months later while the patient was eight weeks pregnant, revealed a squamous intraepithelial abnormality. Dr. Chapnick recommended colposcopy and Dr. Basquinez concurred.

A prudent Obstetrician would perform a colposcopy, which Dr. Basquinez did on 4/30/91 at 14 weeks of pregnancy. Despite noting the presence of Aceto-White epithelium, no biopsy was obtained. Instead, Dr. Basquinez elected to repeat a PAP smear which was done on 7/11/91 at 25 weeks of pregnancy. Dr. Stallworth reported atypical glandular cells. Women with atypical glandular cells of endocervical origin should undergo biopsy and endocervical curettage by colposcopy. The patient, instead, was allowed to deliver the pregnancy on 10/22/91. However, instead of following with colposcopy and biopsy as was allegedly Dr. Basquinez's plan, the patient had no further studies until a PAP smear was performed six months later by Dr. Quinn. Dr. Quinn apparently was never made aware through any type of communication by Dr. Basquinez, of the necessity to do a repeat colposcopy, biopsy and endocervical curettage. Dr. Quinn should have arranged for a follow up PAP smear given the obscuring inflammation.

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RE: CINDY BRYANT VS. DRS. HILL & CHAPNICK, INC.
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In my opinion, the lack of action by the Obstetricians in not pursuing a tissue diagnosis, fell below the standards of care and missed the window of opportunity to diagnose a treatable, dysplastic lesion and thereby probably preventing the development of an invasive one.

Dr. Ronald Huhn reported the PAP smear of 1/5/93 by Dr. Huang as carcinoma insitu. Dr. Huang did a Cone biopsy. Dr. Huhn's revised report to Dr. Huang did not convey that this was indeed invasive, cervical carcinoma, with positive vaginal margins.

Dr. Huang, clearly read the report of Dr. Huhn as demonstrating positive vaginal margins. Hence, he could not exclude additional tumor remaining behind and being invasive beyond a five millimeter depth regardless of the width or bulkiness Dr. Huhn was trying to infer with his report. At this point, additional tissue should have been obtained by Dr. Huang because of the positive vaginal margins, if he believed that he was dealing with a micro-invasive tumor. In fact, had the report been clear, the proper action of Dr. Huang would have been to refer to a gynecologic Oncologist at this point. Under no circumstances should he have proceeded with a hysterectomy given the report of the Cone biopsy by Dr. Huhn. This action clearly fell below accepted standards of care and prevented a proper radical hysterectomy with lymphadenectomy or radiation therapy from probably curing the Ib carcinoma that existed on 1/20/93 and that clearly resurfaced 17 months later.

I therefore, as a Board certified Obstetrician and Gynecologist, believe the care and attention rendered by Drs. Basquinez, Quinn, and Huang, fell below accepted standards of care and contributed to the present medical condition relating to Cindy Bryant.

STEVEN M. KLEIN, M.D.
SS# 282 36 0644

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Also, the patient's own negligence by delaying repeat PAP smears and pelvic examinations also added insult to injury.

Sincerely,

Steven M. Klein, M.D.

SMK:rdm

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Milton J. Linden, M.D.
David P. Vexler, M.D.
Jocelyn Mentschukoff, N.D., C.N.M.

June 24, 1998

Steven M. Klein, M.D.
28150 Shaker Boulevard
Pepper Pike, Ohio 44124
SS# 282-36-0644

Mr. Stephen S. Crandall, Esquire
Reminger & Reminger
The 113 St. Clair Building
Cleveland, Ohio 44114

RE: LISA GRUBB & DON GRUBB vs ALAN ROSENWASSER, M.D., ET. AL.
PORTAGE COUNTY COMMON PLEAS CASE NO. 97 CV 0153
YOUR FILE NO: 2640-02-32972-97

Dear Mr. Crandall:

As per your request, pursuant to our telephone conversation of June 23, 1998, this is my report based upon the review of the following materials:

1. Office records of Drs. Egdell & Rosenwasser;
2. Robinson Memorial Hospital admission of 9/2/94 for Lisa Grubb;
3. Robinson Memorial Hospital admission of 9/3/94 for baby boy Grubb;
4. Deposition transcript of Lisa M. Grubb;
5. Deposition transcript of Robert W. Egdell;
6. Deposition transcript of Alan L. Rosenwasser;
7. Deposition transcript of Don E. Grubb.

Mrs. Grubb was a 27 year old Gravida 3, Para 1, TA 1 when she presented to Drs. Rosenwasser and Egdell on 2/2/94. Ultrasound at that visit demonstrated a 10 week 6 day intrauterine pregnancy, giving the patient a due date of 8/19/94.

Historically, other than an abortion in 1989, the patient had, at 43 weeks of gestation in 1992, a primary Cesarean section after failing to deliver vaginally after a 16 hour induction of labor for post date-ism.

At that first visit of 2/2/94, the physicians recommended a VBAC (vaginal birth after Cesarean section) if the primary Cesarean section uterine incision was low and transverse in nature. It was noted that the patient, at the time, preferred a repeat Cesarean section and the reason was not given.

JUL - 1 1998

June 24, 1998

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28150 Shaker Boulevard
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Throughout the next 30 weeks, the patient was seen numerous times. She was referred for genetic counseling because of early pregnancy exposure to oral contraceptives. AT 25 1/2 weeks, an ultrasound was done that revealed a possible polyhydramnios that was eventually disproved at 28 weeks with a follow up ultrasound. She received Rhogam because of RH negative maternal status at 28 weeks.

At 41 weeks, a biophysical profile was performed to help insure fetal well being. At 41 1/2 weeks, a reactive non-stress test was obtained and a vaginal examination revealed a partially dilated cervix. At 42 weeks, on 9/1/94, another reactive non-stress test was obtained and an induction of labor was scheduled for 7 a.m. on 9/2/94 at Robinson Memorial Hospital.

On 9/2/94, with an intrauterine pregnancy at 42 weeks, based on an 11 week ultrasound, the patient was induced with Prostaglandin Gel followed by Pitocin and artificial rupture of the membranes. After a somewhat protracted second stage of labor, the patient was successfully, eventually delivered vaginally on 9/3/94, with the aid of a vacuum extractor , of an 8 lb. 5 oz. apparently healthy male, whose APGAR scores were 8 & 9. The patient had no episiotomy but did incur a 3rd degree laceration which was repaired.

The patient was seen at least 6 times by Drs. Egdell and Rosenwasser after this delivery.

The first time was on 9/7/94, at which time the patient was complaining of episiotomy discomfort, but apparently healing well.

The second time was 10/25/94 (approximately 7 weeks after delivery) voicing no complaints.

The third time was at 16 weeks post partum on 12/22/94 when the patient did voice a complaint of painful intercourse since delivery. Condylomata acuminata (venereal warts) were diagnosed at the posterior fourchette, but the patient refused therapy.

June 24, 1998

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The fourth time was May 23, 1995 (approximately 8 1/2 months after delivery) complaining of irregular menses. Birth control pills were prescribed.

The fifth time was on 10/16/95, a full year after delivery. At this visit the patient did complain of mild dyspareunia and slight burning. A complete physical examination and PAP smear were performed. No condylomata were noted but a yeast infection was treated with Diflucan and the patient was continued on birth control pills.

The sixth time was 11/1/96, more than 2 years after her successful vaginal delivery and at least 1 year after complaining of mild dyspareunia. At this visit, where a PAP smear was performed, the patient did complain of introital pain since delivery and a narrowed introitus was diagnosed. Manual dilatation with perineal massage and lubrication were suggested and a follow up appointment for 3 months was suggested. The PAP smear that was obtained revealed ASCUS atypia, consistent with the human papilloma virus previously diagnosed and a colposcopy was suggested at her 3 month follow up visit.

The patient elected to obtain a second opinion for her inability to have intercourse with Dr. Sandra Bellin on 11/6/96. Dr. Bellin's exam revealed subjective introital tenderness and an objective scar inside the hymeneal ring. Dr. Bellin suggested progressive vaginal dilatation followed, if needed, by a surgical revision of the laceration. The best chance of success would be a revision at the time of a second vaginal birth.

The patient additionally was apparently seen by Dr. Lester Ballard at the Cleveland Clinic whose opinion was similar to Dr. Bellin's.

June 24, 1998

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YOUR FILE NO: 2640-02-32972-97

At the time of her deposition on 8/26/97, almost 3 years after delivery, and allegedly after 3 years of being unable to have intercourse, the patient has yet to have a revision of the scarred perineum as suggested by Drs. Bellin and Ballard.

It is my conclusion that Drs. Rosenwasser and Egdell provided excellent antenatal care.

Her prenatal care and her care at delivery met the accepted standards of care and were not the proximate cause of any injury to the Grubb's.

I am available for any further inquiries as regards to this matter.

Sincerely yours,

Steven M. Klein, M.D.

SMK:rdm

In The Matter Of:

Cindy Bryant, et al. v.
Lake Obstetrics & Gynecology, et al.

Steven M. Klein, M.D.
Vol. 1, May 22, 1996

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IN THE COURT OF COMMON PLEAS
LAKE COUNTY, OHIO

CINDY BRYANT, et al.,)
Plaintiffs,)
) JUDGE MITROVICH
-vs-) CASE NO. 95CV000419
LAKE OBSTETRICS &)
GYNECOLOGY, et al.,)
Defendants.)

Videotaped deposition of STEVEN M. KLEIN, M.D., taken as if upon direct examination before Susan M. Cebron, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Ulmer & Berne, 900 Bond Court Building, Cleveland, Ohio, at 4:20 p.m. on Wednesday, May 22, 1996, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants, Drs. Hill & Chapnick, Inc., in this cause.

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M.D., and V. Rutenbergs, M.D., and
Obstetrics Gynecology Incorporation;
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Ronald Chapnick, M.D. And Carla M.
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Page 3

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On behalf of the Defendants
Ronald G. Huhn, M.D.
ALSO PRESENT:
Randy Andrews, Videotape Technician

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STEVEN M. KLEIN, M.D., of lawful age, called by the Defendants Drs. Hill & Chapnick, Inc., Ronald Chapnick, M.D. and Carla M. Stallworth, M.D. for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF STEVEN M. KLEIN, M.D.

BY MR. LENSON:

(Thereupon, Defendants' Exhibit A, Klein, Curriculum Vitae of Steven M. Klein, M.D., was marked for purposes of identification.)

(Thereupon, Defendants' Exhibit B, Klein, Pap Smear Cytology Report for Cindy Bryant dated July 2, 1990 was marked for purposes of identification.)

(Thereupon, Defendants' Exhibit C, Klein, Pap Smear Cytology Report for Cindy Bryant dated March 27, 1991, was marked for purposes of identification.)

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(Thereupon, Defendants' Exhibit D, Klein, Pap Smear Cytology Report for Cindy Bryant dated July 23, 1991, was marked for purposes of identification.)

(Thereupon, Defendants' Exhibit E, Klein, Pap Smear Cytology Report for Cindy Bryant dated April 30, 1992, was marked for purposes of identification.)

(Thereupon, Defendants' Exhibit F, Klein, Ashtabula County Medical Center records concerning Cindy Bryant, was marked for purposes of identification.)

MR. LENSON: This is the videotape deposition of Dr. Steven Klein, an expert called on behalf of Drs. Hill & Chapnick, Dr. Ronald Chapnick and Dr. Carla Stallworth in Case Number 95 CV 000419.

The doctor's deposition testimony is being utilized in lieu of his personal appearance at the trial of this matter scheduled to proceed on June 10, 1996

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before Judge Mitrovich.

Will all parties stipulate that they received Notice and waive any defects in Notice?

MR. TIRA: Certainly.

MR. HIRSHMAN: Yes.

MR. FULTON: Yes.

MS. SANDACZ: Yes.

MR. LENSON: All parties have agreed to the stipulation and we will proceed to depose Dr. Klein.

Q: Would you state your full name for the record, sir?

A: Yes. It's Steven, S-t-e-v-e-n, Michael Klein, K-l-e-i-n.

Q: Your profession?

A: I'm a physician, M.D., and obstetrician gynecologist.

Q: Dr. Klein, can you tell us your professional address?

A: 29001 Cedar Road, Suite 518, and that's in Lyndhurst, Ohio, 44124.

Q: Do you practice alone or with a group?

A: I practice with a group, all of us are doing obstetrics and gynecology.

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Q: And what is the name of the group practice?

A: Beachwood OB/GYN, Incorporated.

Q: Can you tell us your age, sir?

A: 52.

Q: Date of birth?

A: 10/12/43.

Q: Are you married?

A: Yes, I am.

Q: Do you have any children?

A: Yes, I do.

Q: Let's start next with your education and I have here curriculum vitae which I have marked as Exhibit A.

MR. LENSON: Counsel of record have received it, is that correct?

MR. TIRA: I have it.

Q: All right. I am going to hand you your curriculum vitae just to shorten it a little bit, and we are going to mark that as Exhibit A and produce it at the time of trial, but would you put us through your education background starting after high school?

A: Yes. I did a four year college training at the Washington Jefferson College in Washington, Pennsylvania, and finished there in 1965.

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I then went to the Ohio State University School of Medicine from 1965 to 1969, graduating and passed my Ohio State boards, and then I did a year of medical internship from 1969 to 1970 at University Hospitals at the Ohio State University.

Following that I went to Philadelphia at the University of Pennsylvania where I did a residency in obstetrics and gynecology from 1970 to 1974. That was my formal training.

Q: And what year did you enter active medical practice?

A: I came back to Cleveland in 1974, in July.

Q: Are you licensed to practice medicine in the State of Ohio?

A: Yes, I am.

Q: And when were you so licensed?

A: In 1970 –

Q: 1970?

A: 1969.

Q: '69. Have you ever been licensed to practice in any other state other than Ohio?

A: Yes. In Pennsylvania while I was a resident I had a license, but that lapsed because I no longer am in

tissue, [23] it doesn't necessarily have to be the cervix, [24] it's a type of preparation that is – tries to [25] diagnose whether cancer of the cervix exists.

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[1] **Q:** Based upon your experience, training and [2] education, are there limitations in respect to a [3] Pap smear?

[4] **A:** Oh, yes.

[5] **Q:** And what are those limitations?

[6] **A:** Well, sometimes a cancer can exist and the cells [7] are not exfoliated, so that the Pap smear misses [8] the cancer that does exist.

[9] Sometimes during the preparation or [10] preservation of the cells on the slide cells may [11] be lost, cancer cells may be lost.

[12] So again, it's used as a screening [13] methodology and not an absolute.

[14] **Q:** Logistically how is a Pap smear undertaken? Is [15] it done, first of all, in the clinician's [16] office?

[17] **A:** Yes. A woman comes in, routinely we do Pap [18] smears on sexually active women once a year, [19] unless there is a history of abnormality in [20] which case we may wish to do Pap smears more [21] frequently.

[22] We examine a patient. We place a speculum [23] into the vagina.

[24] **Q:** What is a speculum, doctor?

[25] **A:** Speculum is a device that is used to keep the

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[1] vagina open so that we can actually visualize [2] the cervix or the neck of the womb, at which [3] point in time we use spatula, which are either [4] plastic or wooden, to scrape the cervix and to [5] put it on a slide.

[6] We then preserve the cells and then make [7] certain notations as to when menstrual periods [8] occurred, whether there is a pregnancy or no [9] pregnancy, whether the patient is on birth [10] control pills, patient is on estrogen [11] replacement therapy, what we see, whether there [12] is inflammation, whether there is additional [13] infection.

[14] We send that information along with the [15] slide to the pathologist or pathologic [16] laboratory where cytologists, people who are [17] trained to look at these slides and interpret [18] them, look at them and interpret them with our [19] data that we send along and then they issue us a [20] report.

[21] **Q:** Thank you, doctor. What is a biopsy?

[22] **A:** A biopsy is the procuring of tissue, a piece of [23] tissue, not just the exfoliated cells that come [24] off, but tissue itself that is also preserved [25] and then sectioned into fine, little microscopic

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[1] sections, placed on slides and looked at [2] serially by a pathologist to determine whether [3] there is pathology there.

[4] **Q:** Who actually performs the biopsy under the [5] situation of an OB/GYN?

[6] **A:** The gynecologist or the obstetrician performs [7] the biopsy and the pathologist then interprets [8] that biopsy.

[9] **Q:** And what is a colposcopy?

[10] **A:** A colposcope is simply a magnifying device, much [11] like a microscope except it's mounted [12] horizontally or parallel to the floor, which [13] enables us to visualize the cervix under a very [14] high magnification to allow us to then be able [15] to identify areas of pathology or that we feel [16] may be suspicions for pathology.

[17] **Q:** And is that done also in the office?

[18] **A:** Yes, that is an office procedure.

[19] **Q:** All right. So as I understand what you are [20] saying, forgive me for my layman approach to it, [21] but it sounds like it is a giant microscope in [22] which the practitioner, the clinician can look [23] inside and observe areas of suspicion?

[24] **A:** That's correct.

[25] **Q:** What is a cone, c-o-n-e, biopsy?

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[1] **A:** Well, it is a biopsy of the cervix that entails [2] removing a conical piece of tissue. It's a [3] significant biopsy. It is not just a small [4] piece of tissue. It is shaped like a cone, in [5] solid geometry, like an ice cream cone, if you [6] will.

[7] The base or the large part of the cone [8] should entail what's called a transformation [9] zone. That's where the cells of the lining of [10] the cervix meet the cells of the vaginal portion [11] of the cervix because this is an area where [12] pathology most commonly exists, if it exists at [13] all.

[14] So this tissue has to be removed and the [15] apex or the thinning out of that cone then goes [16] deeper into the cervical canal so that we can [17] ascertain whether disease or whether pathology [18] extends into the canal and how deeply.

[19] **Q:** Is that a procedure that occurs in the office or [20] does that require hospitalization?

[21] **A:** There is a technique where a wire electrode, a [22] wire loop electrode allows us to excise a cone [23] piece of tissue from the cervix and we can do [24] that in the office.

[25] There are other techniques, however, such

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[1] as using a knife or using a laser where the [2] discomfort is too great, we cannot anesthetize [3] adequately, bleeding can be rather – needs to [4] be controlled and we need a controlled [5] environment and so that is performed in a [6] hospital situation, but as an outpatient.

[7] **Q:** All right. Just so I understand, the Pap smear, [8] the biopsy, the colposcopy and the cone biopsy [9] are all what are called diagnostic studies?

[10] **A:** That's correct.

[11] **Q:** And the Pap smear being what, the first step, [12] perhaps, in the various diagnostic studies that [13] can take place in the event of a suspicion of an [14] illness or a disease with a patient?

[15] **A:** That's correct.

[16] **Q:** All right. What is a hysterectomy?

[17] **A:** Removal of the uterus.

[18] **Q:** And is that done because of some type of disease [19] or illness?

[20] **A:** Yes.

[21] **Q:** All right. And is that a surgical procedure?

[22] **A:** Yes, it is.

[23] **Q:** Does that require hospitalization?

[24] **A:** Yes, it does.

[25] **Q:** Is that something that you have performed during

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[1] your career?

[2] **A:** Yes, I have.

[3] **Q:** Do you still perform those?

[4] **A:** Yes.

[5] **Q:** And are there various types of hysterectomies?

[6] **A:** The uterus can be removed either vaginally or [7] abdominally, technically speaking. But a [8] hysterectomy is a hysterectomy, it is just the [9] removal of the uterus.

[10] There are modifications of hysterectomy [11] that include removal of lymphatic tissue, wider [12] margins going a little bit more lateral to take [13] more tissue when one suspects or one has a [14] diagnosis of, for instance, invasive carcinoma [15] of the cervix, and that would be a called a [16] radical hysterectomy.

[17] **Q:** Otherwise it is known as a simple or abdominal [18] hysterectomy?

[19] **A:** That's correct.

[20] **Q:** All right. I want to make sure my terms are [21] correct.

[22] **A:** That's correct.

[23] **Q:** Thank you.

[24] Do you perform the procedures that we just [25] went over, the Pap smears, the

mal. It falls [23] into that category of unable to be interpreted.

[24] **Q:** Would you look now at Exhibit C and is that also [25] a Pap smear report?

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[1] **A:** This is another Pap smear report generated by [2] Dr. Chapnick on Cindy Bryant. The date of [3] receipt was 3/15/91.

[4] **Q:** All right. In relationship to Exhibit B, what [5] is the time period in-between the two Pap [6] smears?

[7] **A:** This is nine months.

[8] **Q:** Okay.

[9] **A:** And the report was 3/27/91. The diagnosis was [10] low grade squamous intraepithelial lesion, [11] parentheses, CIN I, end parentheses. Recommend [12] colposcopy. Statement of specimen adequacy, [13] satisfactory for interpretation.

[14] **Q:** Doctor, if I might, by looking at that report, [15] to whom is that report being sent? I know it [16] relates to –

[17] **A:** To Dr. Basquinez.

[18] **Q:** So you assume by that that Dr. Basquinez has [19] requested the report?

[20] **A:** Yes.

[21] **Q:** All right. Would you tell us now what this [22] means to you as a practicing OB/GYN?

[23] **A:** This means to me that there is pathology present [24] in the cervix, the extent to which that [25] pathology is able to be interpreted by cytology

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[1] shows that it is a low grade squamous [2] intraepithelial lesion, meaning that the [3] superficial layers of cells of the cervix are [4] being infiltrated by abnormal cells, cells that [5] have a slightly increased nuclear-cytoplasmic [6] ratio. These are abnormal cells.

[7] The cytology here or the report here only [8] sees cells of a superficial nature, but as the [9] gynecologist I cannot assume that it's not more [10] pathologic than reported.

[11] **Q:** So pathologic means that there is – there is a [12] clinical finding, is that what you are [13] suggesting, a disease?

[14] **A:** Yes.

[15] **Q:** All right. So that the report is telling you as [16] an OB/GYN that there is pathology existing in [17] respect to the plaintiff, Cindy Bryant, as [18] determined by the Pap smear?

[19] **A:** That's correct.

[20] **Q:** You indicated that the specimen adequacy was [21] okay?

[22] **A:** The cytologist felt that it was okay as far as [23] his ability to report.

[24] **Q:** And that's different now than the first Pap [25] smear?

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[1] **A:** This clearly falls into an abnormal Pap smear.

[2] **Q:** And what is the requirement for a colposcopy [3] now, the suggestion for a colposcopy?

[4] **A:** Well, this, in order to ascertain the degree of [5] pathology, the next step or the next stage would [6] be for the gynecologist to do a – use the [7] colposcope to visualize the cervix, to see if he [8] or she can visualize the area of abnormality in [9] question, and if so, then perhaps doing a biopsy [10] of that area might be indicated, depending again [11] on the visualization at colposcopy in order to [12] ascertain the degree of pathology that's [13] present.

[14] **Q:** Now, you are aware having reviewed the [15] deposition transcript of Dr. Basquinez that, in [16] fact, Dr. Basquinez did do a colposcopy upon [17] Cindy Bryant, is that correct?

[18] **A:** Following this report, yes.

[19] **Q:** That's correct, I mean as a result of this [20] report she did a colposcopy?

[21] **A:** Yes. Right.

[22] **Q:** Which as you indicated before is done in the [23] office?

[24] **A:** Yes.

[25] **Q:** Are you aware from review of her transcript as

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[1] to what she observed?

[2] **A:** Yes. The first, Cindy Bryant was pregnant at [3] the time and she observed a condition called [4] acetowhite epithelium. That means that acetic [5] acid is used to prepare the cervix –

[6] **Q:** What is acetic acid vinegar?

[7] **A:** Vinegar, so in other words, in various [8] strengths, and the acetic acid is used to [9] highlight abnormal areas in the cervix, areas of [10] increased nuclear activity, cellular [11] proliferative activity, it looks white [12] underneath a green filter on the colposcope.

[13] Dr. Basquinez saw this area and noted it.

[14] **Q:** And what is the significance of a finding of [15] those white cells?

[16] **A:** It corroborates that, indeed, pathology is [17] present and Dr. Basquinez had located what she [18] felt to be where the pathology was.

[19] **Q:** All right. Now, what is the next step in [20] confirming or ruling out the scope and extent of [21] that particular pathology?

[22] **A:** The finding of white epithelium can mean a [23] pathologic process that is mild or moderate or [24] severe. One looks for other things as well, [25] terms such as punctation, which connotes certain

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[1] atypical areas of vasculature, mosaicism, which [2] is another term to describe pathology or [3] abnormal vessels, themselves, but apparently Dr. [4] Basquinez saw none of those and just saw the [5] white epithelium, and at this point in time, [6] again, depending on the clinician, depending on [7] previous history of the patient, previous [8] abnormal Pap smears, if there were any, [9] compliance of the patient and so forth, one [10] might elect to biopsy or one might elect, [11] depending on the aggressiveness, to delay biopsy [12] until after the pregnancy or repeat a Pap smear [13] to see that the low grade squamous [14] intraepithelial legion didn't progress while the [15] pregnancy was progressing.

[16] **Q:** I see. So in respect to the decision by Dr. [17] Basquinez, as we know, not to perform a biopsy, [18] but to go ahead and perform the colposcopy and [19] notwithstanding the finding of pathology, you [20] have no criticism of the fact that she decided [21] to wait until the pregnancy ended before [22] proceeding with more aggressive diagnostic [23] studies?

[24] **A:** Well, she did the colposcope, which was fine, [25] didn't do the biopsy, which I don't quibble

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[1] with, and she elected to proceed with a [2] follow-up Pap smear, which I thought was [3] appropriate. I have no criticism of that.

[4] **Q:** And was, in fact, a follow-up Pap smear [5] undertaken?

[6] **A:** Yes.

[7] **Q:** And when was the next Pap smear, would that be [8] Exhibit D?

[9] **A:** That is Exhibit D.

[10] **Q:** And the date, sir?

[11] **A:** The submission of the Pap smear to Hill & [12] Chapnick, this time it was Dr. Stallworth, the [13] receipt of the Pap smear was 7/12/91. The [14] report was generated on 7/23/91.

[15] The diagnosis was atypical glandular cells [16] of undetermined significance, and then there is [17] a note, typical and atypical parakeratosis. The [18] atypical glandular cells have a high N colon C, [19] which stands for nuclear-cytoplasmic ratio, [20] occasionally vacuolated cytoplasm and [21] neutrophils permeating some of the cell groups. [22] These may be reactive endocervicals; however, [23] close continued follow-up is recommended.

[24] **Q:** First of all, to whom was that

[24] **A:** Yes, I do.

[25] **MR. HIRSHMAN:** Objection.

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[1] **Q:** And what is that opinion?

[2] **A:** That it would have revealed it. It would have [3] revealed it.

[4] **Q:** Based upon your education, training and [5] experience, do you have an opinion based upon [6] reasonable medical certainty as to whether or [7] not the standard of care of an OB/GYN who has [8] similar training of you and education, would [9] have been required to perform a biopsy after [10] receiving Exhibit Number D – Exhibit D?

[11] **A:** Yes, I do.

[12] **Q:** And what is that opinion, doctor?

[13] **A:** That in this instance the standard of care was [14] not met because a biopsy was never performed.

[15] **Q:** So that the only diagnostic study that was [16] performed at all following these Pap smears was [17] the colposcopy, which was accomplished after [18] receipt of Exhibit C, is that correct?

[19] **A:** Yes, and additional Pap smears.

[20] **Q:** I understand that. But I am talking about [21] aggressive diagnostic studies were not performed [22] other than the one colposcopy, is that correct?

[23] **A:** Well, the colposcopy is not necessarily a [24] diagnostic study. It's a tool to help us to [25] obtain or to find where the pathology exists.

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[1] Then we have to biopsy that area, if we can find [2] it.

[3] If we can't find it, then we need to take a [4] cone biopsy, because we have to remove the [5] entire lesion since we couldn't locate it with [6] the colposcope.

[7] **Q:** So would it be fair to say that once observing [8] the white epithelium cells, that now at least [9] the clinician knows where the area to be [10] biopsied is?

[11] **A:** Yes.

[12] **Q:** Okay. Based upon your education, training and [13] experience, do you have an opinion based upon a [14] reasonable degree of medical certainty as to [15] whether or not the information provided by the [16] Pap smear reports prepared by Drs. Chapnick and [17] Stallworth and thereafter provided to the Lake [18] OB/GYN group were sufficient to allow the [19] clinicians to proceed with aggressive diagnostic [20] studies, including biopsies of plaintiff, Cindy [21] Bryant?

[22] **MR. FULTON:** Objection.

[23] **Q:** And what is that opinion?

[24] **MR. FULTON:** Objection.

[25] **A:** I believe that a biopsy should have been

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[1] performed.

[2] **Q:** Based upon the information provided?

[3] **A:** Based on the two abnormal Pap smear results was [4] enough information to me as a gynecologist to [5] warrant biopsying the cervix of Cindy Bryant.

[6] **Q:** You have also had the opportunity, have you not, [7] doctor, to review the care and attention [8] provided by – to plaintiff, Cindy Bryant, by [9] Dr. Huang when she moved to Ashtabula County?

[10] **A:** Yes.

[11] **Q:** I am going to hand you what has been marked for [12] identification purposes as Exhibit F, and would [13] you please review that for a moment and tell us [14] if those are essentially the records that you [15] have reviewed concerning Dr. Huang's care and [16] attention?

[17] **A:** Yes, these are the same records that I reviewed.

[18] **Q:** What did you determine with respect to the [19] diagnostic studies that were undertaken by Dr. [20] Huang prior to his performing an abdominal [21] hysterectomy?

[22] **A:** I am sorry. Would you –

[23] **Q:** Sure. What did you determine led Dr. Huang to [24] perform an abdominal hysterectomy, what [25] information?

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[1] **A:** The report of Dr. Huhn of the cone biopsy that [2] was performed by Dr. Huang led Dr. Huang to do [3] an abdominal hysterectomy.

[4] **Q:** And you have had the opportunity to review the [5] results of the cone biopsy?

[6] **A:** Yes. The results of the cone biopsy report.

[7] **Q:** That's what I am saying. In other words, you [8] didn't review the pathological slides?

[9] **A:** That's right.

[10] **Q:** What you reviewed was the report that was [11] provided to Dr. Huang by Dr. Huhn, is that [12] correct?

[13] **A:** Yes.

[14] **Q:** And assuming that you were in Ashtabula County [15] and you would get that report, you wouldn't get [16] the slides either, you would just simply get the [17] report, is that correct?

[18] **A:** That's correct.

[19] **Q:** Now, based upon the report that you reviewed, [20] which is in the exhibit marked F, based upon [21] your education, training and experience, would [22] you have proceeded to perform an abdominal [23] hysterectomy upon plaintiff, Cindy Bryant?

[24] **MR. TIRA:** Objection.

[25] **A:** No.

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[1] **Q:** What would you have done?

[2] **MR. TIRA:** Objection.

[3] **A:** I would have referred the patient to a [4] gynecologic oncologist.

[5] **Q:** And why is that, sir?

[6] **A:** Because the margins of the specimen were not [7] entirely free of disease, according to the [8] report, and my concern is, therefore, of [9] additional disease being present, the extent of [10] which could not be determined with the specimen [11] at hand.

[12] Moreover, the report indicated to me that [13] enough of the surface of the cervix was involved [14] to lead me to suspect that the condition was an [15] invasive carcinoma of the cervix and I, [16] therefore, would have referred the patient to a [17] gynecologic oncologist.

[18] **Q:** If your inclination when obtaining a report from [19] the pathologist concerning a cone biopsy is such [20] that there is a possibility of an invasive [21] carcinoma as opposed to noninvasive or [22] microinvasive, what is the reason why you refer [23] these type of patients to an OB/GYN oncologist?

[24] **MR. TIRA:** Objection.

[25] **A:** One would be to obtain a consultation regarding

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[1] their interpretation of the cone biopsy [2] specimen, their interpretation of the extent of [3] the disease process, and their suggestions and [4] consultation regarding how that disease process [5] should be handled for the proper care of the [6] patient in order to try and cure the patient of [7] this disease process, if possible.

[8] **Q:** Now, you mentioned before that you do not [9] perform radial hysterectomies, is that correct?

[10] **A:** That's correct.

[11] **Q:** And if there is an invasive cancer, is that the [12] appropriate treatment that should be rendered to [13] the patient, is a radical hysterectomy?

[14] **A:** Not necessarily. A radical hysterectomy would [15] be done if the disease process was invasive, but [16] not too invasive. Beyond a certain point [17] surgery is not indicated, but radiation therapy [18] might be.

[19] **Q:** Are their situations when a patient will receive [20] both a radial hysterectomy and follow-up therapy [21] such as radiation?

[22] **A:** Yes.

pathologist or a [24] cytopathologist describes the existence of clue [25] cells, c-l-u-e, he is not describing a cancerous

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[1] condition?

[2] **A:** That's correct.

[3] **Q:** And he is not describing a precancerous [4] condition?

[5] **A:** That's correct.

[6] **Q:** All right. Now, I want you to assume for a [7] moment that there are, in fact, cells present on [8] the slides which gave rise to the Pap report of [9] June 23, 1990 that would show HSIL.

[10] First of all, tell the jury, if you would, [11] what HSIL is?

[12] **A:** That is a squamous intraepithelial lesion. The [13] cervix has pathology in it that is high grade or [14] rather deep in penetration of the tissue [15] substance, cells that are abnormal clearly with [16] a high nuclear cytoplasmic ratio, which is [17] totally abnormal, are extending deep within the [18] substance of the cervix. This is a high grade [19] squamous intraepithelial lesion.

[20] **Q:** When that type of report comes back from a [21] pathologist to a gynecologist it's a red flag to [22] do something more to investigate, is it not?

[23] **A:** Yes, it is.

[24] **Q:** If, in fact, those slides have cells which are [25] HSIL, it's fair to say that Dr. Chapnick missed

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[1] the diagnosis, correct?

[2] **MR. LENSON:** Objection.

[3] **Q:** Correct?

[4] **MR. LENSON:** Objection. Dr. Klein [5] is not a pathologist. He is not here to [6] testify about the standard of care of a [7] pathologist. He is here merely to render [8] opinions regarding the standard of care of [9] an OB/GYN.

[10] **MR. HIRSHMAN:** He is here to [11] answer questions that I ask of him at this [12] point.

[13] **MR. LENSON:** That's not correct, [14] counsellor.

[15] **MR. HIRSHMAN:** He is here to [16] answer questions that I ask of him and if [17] the judge deems them inappropriate he will [18] rule accordingly.

[19] **MR. LENSON:** That is correct.

[20] **Q:** So my question to you is, I want you to assume [21] for a moment that there are cells in the [22] slides –

[23] **A:** So this is a hypothetical?

[24] **Q:** I am asking you to assume a hypothetical.

[25] **A:** Okay.

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[1] **Q:** Since you haven't read them and you can't [2] testify as to what those slides show –

[3] **A:** Absolutely.

[4] **Q:** – that's the only way I can address the subject [5] with you.

[6] **A:** Certainly.

[7] **Q:** I want you to assume that the slides that gave [8] rise to the June 23, 1990 Pap report, in fact, [9] show high grade squamous intraepithelial lesion, [10] HSIL, can you make that assumption?

[11] **A:** Right.

[12] **Q:** If you make that assumption, it's fair to say [13] that Dr. Chapnick missed the diagnosis, correct?

[14] **MR. LENSON:** Objection.

[15] **A:** Yes.

[16] **MR. LENSON:** Ask that the answer [17] be stricken.

[18] **Q:** Would that be –

[19] **A:** Well, let me qualify the yes. Insofar as that [20] there are inflammatory cells present, clue [21] cells, indicating the bacteria vaginosis that I [22] described before, I don't know that Drs. Hill & [23] Chapnick may not have been able to have noted [24] cancer cells – not cancer cells, but the high [25] grade squamous intraepithelial lesion until

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[1] after this inflammatory response was cleared.

[2] So I don't know that they missed the [3] diagnosis.

[4] **Q:** I am asking you to assume that HSIL is [5] present –

[6] **A:** Was present on the slides.

[7] **Q:** – is apparent on the slides, all right? If you [8] take that assumption, it's clear that Dr. [9] Chapnick missed that diagnosis, correct?

[10] **A:** Not being a cytologist or a cytopathologist I [11] don't know if the cytopathologist can venture a [12] diagnosis of a high grade squamous [13] intraepithelial legion with inflammation such as [14] a bacterial vaginosis present. You will have to [15] ask a cytopathologist.

[16] **Q:** That's why I am asking the question the way I [17] did. I am not asking you whether or not Dr. [18] Chapnick departed from acceptable standards of [19] care.

[20] **A:** You are not listening to what I am saying. What [21] I am saying is, is that cells that appear to be [22] high grade squamous intraepithelial legion type [23] cells, I don't know if a cytopathologist with [24] inflammation present might misinterpret those [25] cells. So I can't answer your question by

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[1] saying simply that if they were there, then they [2] missed the diagnosis, I don't know that they [3] could even venture a diagnosis.

[4] Cells can sometimes appear to be what they [5] are not, and I was led to believe that [6] inflammations obscure an ability to make a [7] diagnosis. The inflammation has to be cleared [8] and then one can then make a diagnosis.

[9] **Q:** So you don't know one way or the other whether [10] the diagnosis could have been made on that [11] slide?

[12] **A:** I don't know that.

[13] **Q:** All right. Assuming it could have been made, [14] it's clear that it wasn't, correct?

[15] **A:** That's correct, no diagnosis of HSIL was made.

[16] **Q:** And assuming it was made and appropriate [17] treatment was given, what would that treatment [18] have been?

[19] **A:** Well, I don't know that – treatment would have [20] been for bacterial vaginosis or are you talking [21] about treatment of HSIL?

[22] **Q:** HSIL. Let's assume it was HSIL.

[23] **A:** Well, it wouldn't have been treated at that [24] point. Further diagnostic procedures would have [25] been indicated.

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[1] **Q:** And assuming those further diagnostic [2] procedures, in fact, concluded that there was an [3] HSIL present, it would have been treated, [4] correct?

[5] **A:** That's correct.

[6] **Q:** And the treatment for it is essentially one [7] hundred percent curative, am I not correct?

[8] **A:** I don't know that to be true.

[9] **Q:** Let me ask this question then. Assuming [10] treatment had been rendered for an HSIL around [11] or shortly after June 23, 1990, you can state to [12] a reasonable medical probability that the [13] condition would have been alleviated?

[14] **A:** No, I really can't. Simply because [15] abnormalities of the cervix are notoriously [16] multi-focal. They don't exist necessarily in [17] only one location.

[18] Had additional procedures been performed [19] such as colposcopy, biopsy, even a cone biopsy, [20] there could have been skip areas or areas that [21] were not noted. So to have cured the HSIL, the [22] cells could have been exfoliated from other [23] areas that weren't even noticed at these [24] additional procedures.

[4] **A:** Not solely.

[5] **Q:** You are of the opinion that she is in some part [6] responsible?

[7] **A:** Yes.

[8] **Q:** All right. I want you to go through with me [9] some of the records that you have as it relates [10] to Cindy and her care and treatment.

[11] She came for a prenatal visit on March 14, [12] 1990 as scheduled, did she not?

[13] **A:** Yes.

[14] **Q:** She then returned and came for a prenatal visit [15] as scheduled on March 22nd of 1990, did she not?

[16] **A:** Yes.

[17] **Q:** She then came for yet another prenatal visit as [18] scheduled on March 26, 1990, did she not?

[19] **A:** Yes.

[20] **Q:** She then appeared for yet another one on April [21] 6, 1990 as scheduled, did she not?

[22] **A:** Yes.

[23] **Q:** And she then appeared once again for a prenatal [24] visit on April 13, 1990 as scheduled, did she [25] not?

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[1] **A:** Yes.

[2] **Q:** And she then appeared for yet another prenatal [3] visit on May 2, 1990 as scheduled, did she not?

[4] **A:** Yes.

[5] **Q:** And then she came on June 23, 1990 for a [6] postpartum visit as scheduled, did she not?

[7] **A:** Yes.

[8] **Q:** And at that time a Pap was taken, correct?

[9] **A:** Yes.

[10] **Q:** And that Pap –

[11] **A:** Well, I am sorry. June –

[12] **Q:** June 23, 1990.

[13] **A:** Oh, okay.

[14] **Q:** And at that time the Pap came back showing clue [15] cells and suggested that treatment occur and [16] that a re-Pap be done?

[17] **A:** Yes.

[18] **Q:** No treatment ensued, am I correct?

[19] **A:** I only have to assume that no treatment ensued. [20] I didn't see any in the record.

[21] **Q:** And no re-Pap was done?

[22] **A:** That's correct.

[23] **Q:** A doctor missed that opportunity to make the [24] diagnosis, correct, not Cindy?

[25] **A:** That's true.

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[1] **Q:** All right. Then she came in for yet another [2] visit on March 14, 1991 as scheduled, did she [3] not?

[4] **A:** Yes.

[5] **Q:** And a Pap was done at that time by Dr. [6] Basquinez?

[7] **A:** Yes.

[8] **Q:** And, again, at that time as you have already [9] indicated, LSIL was the diagnosis that came back [10] on that screen, correct?

[11] **A:** Yes.

[12] **Q:** And it's your testimony that something should [13] have been done to pursue that diagnosis on [14] cytology?

[15] **A:** Well, if not at that time –

[16] **Q:** After the pregnancy?

[17] **A:** Well, even before then, three to four months she [18] still would have been pregnant.

[19] **Q:** Something should have been done?

[20] **A:** Something should have been done, yes.

[21] **Q:** We have a pink flag, if not a red flag?

[22] **A:** That's true.

[23] **Q:** And, again, that wasn't Cindy's responsibility [24] to know what LSIL meant, it was the doctor's [25] responsibility?

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[1] **A:** Correct.

[2] **Q:** Not Cindy's fault?

[3] **A:** Right.

[4] **Q:** On April 16, 1991 she was asked to undergo a [5] colposcopy. That much they did?

[6] **A:** Yes.

[7] **Q:** And she, in fact, went ahead and submitted to [8] the colposcopy as suggested?

[9] **A:** Yes.

[10] **Q:** No fault there?

[11] **A:** No.

[12] **Q:** But after having that colposcopy done Dr. [13] Basquinez, if I understand your opinions [14] correctly, failed to take biopsies and missed [15] yet another opportunity to make a diagnosis, [16] correct?

[17] **A:** Yes, although a biopsy might not necessarily [18] have fallen – not taking a biopsy doesn't [19] necessarily fall below any standard of care as [20] long as a close follow up and biopsy eventually [21] soon after the pregnancy.

[22] **Q:** Is done?

[23] **A:** Is done.

[24] **Q:** And it wasn't done?

[25] **A:** Correct.

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[1] **Q:** That's not Cindy's fault?

[2] **A:** No.

[3] **Q:** The doctors have responsibility there, not [4] Cindy?

[5] **A:** That's true.

[6] **Q:** All right. And then she came in for a prenatal [7] visit as scheduled on May 23, 1991, am I [8] correct?

[9] **A:** Uh-huh.

[10] **Q:** And then she came back as scheduled for a [11] prenatal visit on June 13, 1991, correct?

[12] **A:** Correct.

[13] **Q:** And then she came in for a visit July 11, 1991, [14] correct?

[15] **A:** Correct.

[16] **Q:** And at that point she submitted to yet another [17] Pap, correct?

[18] **A:** Correct.

[19] **Q:** The Pap results were findings of atypical [20] parakeratosis and atypical glandular cells?

[21] **A:** That's correct.

[22] **Q:** And as you have already testified, another pink [23] flag was raised?

[24] **A:** Correct.

[25] **Q:** Not withstanding that pink flag, proper

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[1] follow-up was not taken by Drs. Basquinez and [2] Quinn, correct?

[3] **A:** That's true.

[4] **Q:** And, again, it was the doctors, not Cindy, who [5] failed to take advantage of an opportunity, [6] correct?

[7] **MR. FULTON:** Well, objection. She [8] had already left by then.

[9] **MR. HIRSHMAN:** She was there.

[10] **MR. FULTON:** No, she wasn't.

[11] **Q:** July 11th.

[12] **A:** July 11th, right, when she had the repeat Pap [13] smear.

[14] **Q:** Okay. You don't blame Cindy for that, do you?

[15] **A:** No.

[16] **Q:** And then she came in for a prenatal visit on [17] August 30, 1991 as scheduled, correct?

[18] **A:** Yes.

[19] **Q:** She came in on October 7, 1991 as scheduled, [20] correct?

[21] **A:** Yes.

[22] **Q:** And she came in to see these doctors again on [23] October 21, 1991 as scheduled, correct?

[24] **A:** Yes.

does reflect to [20] a great degree the probability that there would [21] have been a significant chance of cure.

[22] **Q:** Well, I am not asking you whether he [23] intentionally misrepresented anything to her.

[24] **A:** I am not saying he misrepresented anything [25] either.

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[1] **Q:** Assuming that she has invasive carcinoma and she [2] was given a simple hysterectomy, to tell her [3] that she had a 99 percent cure rate was [4] inaccurate, correct?

[5] **MR. TIRA:** Objection.

[6] **Q:** If you know.

[7] **A:** Dr. Huang did not interpret the cone biopsy. [8] Dr. Huhn did. Dr. Huang didn't interpret the [9] specimen after the hysterectomy. Dr. Huhn did.

[10] Dr. Huang, I believe, felt that he was [11] dealing with microinvasive carcinoma of the [12] cervix and, therefore, made that statement.

[13] It turns out that it was erroneous.

[14] **Q:** Understood, understood. My question to you is [15] assuming, I am not asking you to – let's just [16] rephrase the question, if we can.

[17] It's – assuming that Dr. Huang was [18] treating an invasive carcinoma and further [19] assuming that he did a simple hysterectomy on [20] Cindy, it's fair to say her chances of [21] recurrence were greater than one percent?

[22] **A:** Absolutely.

[23] **Q:** All right. And for him to tell her that her [24] chance of recurrence was only one percent would [25] have been an inaccurate statement?

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[1] **MR. TIRA:** Objection.

[2] **A:** Assuming that he knew that he was dealing with [3] invasive carcinoma, that's true.

[4] **Q:** I am not asking you whether or not he [5] intentionally told her a lie. If you assume [6] that she had invasive carcinoma and if you [7] assume he did a simple hysterectomy, the simple [8] fact is she had a greater rate of recurrence [9] than one percent?

[10] **A:** But I don't believe that he believed that he was [11] dealing with invasive carcinoma.

[12] **Q:** So whether intentionally or unintentionally he [13] provided her with inaccurate information, is [14] that correct?

[15] **MR. TIRA:** Objection.

[16] **A:** Correct.

[17] **Q:** All right. And by giving her that information, [18] whether doing so intentionally or [19] unintentionally, he misled her as to the [20] significance of or likelihood of recurrence, [21] correct?

[22] **MR. TIRA:** Objection.

[23] **A:** Yes.

[24] **Q:** All right. Now, as it relates to Dr. Huang, he [25] was provided with a report, as I understand it,

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[1] which indicated from the cone biopsy –

[2] **A:** Yes.

[3] **Q:** – that there were margins of the biopsy [4] specimen that were involved with cancer, [5] correct?

[6] **A:** Yes.

[7] **Q:** And it's your testimony that when confronted [8] with that type of a report, the thing for a [9] reasonably prudent gynecologist to do is to seek [10] the assistance of a gynecologic oncologist, [11] correct?

[12] **A:** Yes.

[13] **Q:** Dr. Huang did not do so and the failure to do so [14] constituted a departure from acceptable [15] standards of care, correct?

[16] **MR. TIRA:** Objection.

[17] **A:** Yes.

[18] **Q:** Okay.

[19] **MR. HIRSHMAN:** Off the record, [20] please.

[21] **VIDEOTAPE OPERATOR:** Off the [22] record.

[24] (Off the record.)

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[1] **VIDEOTAPE OPERATOR:** On the [2] record.

[3] **Q:** One additional line of questioning, doctor.

[4] You indicated that you are licensed to [5] practice medicine in the State of Ohio, correct?

[6] **A:** Yes. That's correct.

[7] **Q:** And it would be fair to say that greater than 50 [8] percent of your professional time is engaged in [9] the active practice of medicine?

[10] **A:** Yes.

[11] **MR. HIRSHMAN:** Thank you. I have [12] no further questions.

[13] **VIDEOTAPE OPERATOR:** Off the record

[15] (Off the record.)

[17] **VIDEOTAPE OPERATOR:** On the record

[19] CROSS-EXAMINATION OF STEVEN M. KLEIN, M.D.

[20] **BY MR. FULTON:**

[21] **Q:** Yes, doctor. Good evening. My name is Burt [22] Fulton and I represent Lake OB/GYN. I am going [23] to ask you some questions here in which I [24] probably will mispronounce some terms. I don't [25] know quite as much medicine as some of these

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[1] people, but just for my information and the [2] jury, how do you get this cancer of the cervix, [3] what's the primary cause of it?

[4] **MR. HIRSHMAN:** Objection.

[5] **A:** I suppose that it is a combination of various [6] elements. One might be a genetic [7] predisposition. Another might be smoking. A [8] third may be sexually transmitted diseases such [9] as the human papilloma virus or Herpes, but in [10] conjunction with a predisposition constitution, [11] other factors may lead to cancer of the cervix.

[12] **Q:** Well, what does the literature show with respect [13] to what is the most prominent cause of it?

[14] **MR. HIRSHMAN:** Objection.

[15] **A:** The papilloma virus seems to be the most [16] prominent culprit today, along with smoking.

[17] **Q:** What is that virus? I don't understand that.

[18] **A:** It is a virus that is sexually transmitted and [19] it has a tendency to cause venereal warts in [20] some people, and in others other strains of that [21] virus can cause cervical abnormalities under the [22] right conditions, which can lead to a cancer of [23] the cervix. That's the current thought.

[24] **Q:** Well, if you as an OB/GYN feel that it's in some [25] way related to activity of that nature, do you

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[1] try to advise the patient that perhaps they [2] ought to take a new course in life or what do [3] you say?

[4] **MR. HIRSHMAN:** Objection.

[5] **A:** Well, I suggest to my patients to be careful to [6] try to avoid sexually transmitted diseases. [7] Sometimes that's unavoidable.

[8] **Q:** Has that been shown to be more prevalent, if a [9] person has a number of partners or –

[10] **MR. HIRSHMAN:** I am going to [11] object again and, Burt, I am going to ask [12] whether I can have a continuing line of [13] objection to this line of questioning?

[14] **MR. FULTON:** Well, whatever you [15] wish to do.

[16] **MR. HIRSHMAN:** It is all right [17] with me. I just don't want to be held to [18] not having objected.

[19] **MR. FULTON:** I am just trying to [20] find out something, doctor. I will agree

[20] **A:** The Pap smear of 6/23/1990, she says is [21] decidedly below the standard of care.

[22] **Q:** Decidedly below the standard?

[23] **A:** That's what she put in her report.

[24] **Q:** How about the next one, what does she say?

[25] **A:** She said the Pap smear report of 3/14/91, after

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[1] she reviewed those slides or that slide of that [2] Pap smear was below the standard of care.

[3] **Q:** All right. How about in the next report, would [4] you give us the date?

[5] **A:** The next Pap smear was of 7/11/91, and Dr. [6] Rosenthal said that Dr. Stallworth's [7] interpretation of that Pap smear was definitely [8] below the standard of care.

[9] **Q:** Definitely below the standard?

[10] **A:** That's the term that Dr. Rosenthal is using.

[11] **Q:** All right. Now, and the last report which is [12] dated when, that's that April one?

[13] **A:** April 24, 1992.

[14] **Q:** Did she say it was decidedly below?

[15] **A:** Interpreted by Dr. Stallworth is way below the [16] standard of care.

[17] **Q:** Way below. You understand what that means in [18] the English language, don't you?

[19] **A:** Yes.

[20] **Q:** You have no reason to dispute any of those [21] findings, do you?

[22] **A:** Nor to support them. Dr. Rosenthal reviewed [23] slides of another pathologist and it's beyond my [24] expertise to comment.

[25] **Q:** Well, another couple of things I just wanted to

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[1] cover and then I will go off in the wild blue [2] yonder, I guess.

[3] She describes those, I wasn't at her [4] deposition, but she described something about, [5] what's that word, parakeratosis, it didn't seem [6] to mean much to her. Does that word mean [7] anything to you? Does that word mean anything [8] to you?

[9] **MS. HIRSHMAN:** Object.

[10] **A:** When I see that I suspect that there is a [11] significant thickness of cells, the superficial [12] layers of which are devoid of nuclei making an [13] interpretation of what lies below difficult, if [14] not impossible.

[15] So parakeratosis is seemingly a response of [16] cells, kind of a callus, if you will, and one [17] has to kind of get rid of that callus to find [18] out what's underneath.

[19] **Q:** Kind of what you call sort of a wastepaper [20] basket type of classification?

[21] **A:** No, I wouldn't call it a classification. I [22] think that the pathocytologist or [23] cytopathologist was just describing what they [24] saw.

[25] **Q:** Well, I thought that this Dr. Rosenthal said she

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[1] would not expect a gynecologist to recognize the [2] significance of an atypical parakeratosis? [3] Would you agree with that? Maybe you disagree.

[4] **A:** The significance has to be put into perspective [5] of what had transpired prior to this, previous [6] Pap smears, if there were any previous [7] biopsies. I have no problem understanding what [8] atypical parakeratosis is.

[9] **Q:** All right. By the way, we do know that at least [10] there came a point in time when the plaintiff [11] came back and was seen by Dr. Quinn the last [12] visit. She was going to go in - she was [13] pregnant again by that time, wasn't she? This [14] was after she delivered?

[15] **A:** I believe he was going to see her for a [16] sterilization procedure and it turned out that [17] she was pregnant at that time.

[18] **Q:** Somewhere in there she had something about [19] having problems with her husband or something, [20] something in the medical record?

[21] **A:** I don't remember exactly when that occurred, [22] but, yes, she was having some problems, but I [23] think that that was prior to this particular [24] pregnancy.

[25] **Q:** And she never then returned to see Dr. Quinn,

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[1] isn't that true?

[2] **A:** That's correct. She went -

[3] **Q:** She went on to another physician?

[4] **A:** Went on to another physician.

[5] **Q:** All right. By the way, do you know Dr. Burkons?

[6] **A:** I know Dr. Burkons.

[7] **Q:** I take it that you know him as an active [8] practicing OB/GYN?

[9] **A:** I see him at meetings and see him over at the [10] university when I go over there for rounds and [11] so forth.

[12] **Q:** He is out on the east side with -

[13] **A:** He is associated with University Hospitals.

[14] **Q:** And incidentally, you being in your practice of [15] fertility, I take it - do you have very many [16] patients that are on welfare in your practice?

[17] **MR. HIRSHMAN:** Objection.

[18] **A:** We have several patients that are on welfare.

[19] **Q:** Several, out of how many?

[20] **A:** I can't give you -

[21] **Q:** About 400?

[22] **A:** 400 patients on welfare?

[23] **Q:** You must have at least 300, 320 a year, wouldn't [24] you say, babies and people who have come in for [25] consults?

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[1] **MR. HIRSHMAN:** Objection.

[2] **A:** On welfare?

[3] **MR. LENSON:** No, no.

[4] **Q:** No. Altogether you have that many patients?

[5] **A:** I would think so, yes.

[6] **Q:** Now, just winding up, and I don't want to [7] belabor this, I take it you have testified in [8] the past on cases involving medical malpractice?

[9] **A:** Yes.

[10] **Q:** And have you testified for the same attorney who [11] has retained you in this case ever before?

[12] **A:** Never.

[13] **Q:** And I take it when you have testified before you [14] always - I mean, you came in as an OB/GYN about [15] other OB/GYNs or in favor of what they did? You [16] look at it and make a determination with respect [17] to OB/GYNs medical treatment?

[18] **A:** I was asked to render an opinion as to whether [19] that treatment was appropriate or inappropriate.

[20] **Q:** Well, you seem like a pretty intelligent guy, a [21] lot more so than me, but were you curious about [22] the fact that knowing that the attorney who [23] wrote you, that they were representing [24] pathologists were going to ask you to testify [25] regarding gynecologists or OB/GYN, did that

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[1] puzzle you at all why you were asked to take on [2] that role?

[3] **A:** This case apparently touches on various aspects [4] of health care, and I was asked to render an [5] opinion as to the care given or not given to [6] Cindy Bryant, to the best of my ability, and [7] that, you know, that's all I can do is -

[8] **Q:** I understand that, but my question is a little [9] broader. I mean, weren't you kind of curious [10] that here is somebody, Murray Lenson, a very [11] good lawyer representing a pathology group [12] asking you to testify regarding some

thologist who rendered [19] the original report so that the gynecologists [20] gets a handle on things, an appropriate handle.

[21] **Q:** If you turn your attention to the revised [22] pathology report done by Dr. Huhn on January [23] 27th of 1993, there is an indication of [24] malignant cells present at vaginal margins of [25] resection, is that correct?

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[1] **A:** That's correct.

[2] **Q:** And you would agree with me that that is a [3] significant findings on that report, is that [4] correct?

[5] **A:** That's correct.

[6] **Q:** And I think it's your opinion that based upon [7] that significant finding that Dr. Huang should [8] have either sought a gynecologic oncologist or [9] done some additional testings based upon those [10] findings, is that correct?

[11] **A:** That's correct.

[12] **MS. SANDACZ:** Thank you. That's [13] all I have.

[14] **VIDEOTAPE OPERATOR:** Off the [15] record.

[17] (Off the record.)

[19] **VIDEOTAPE OPERATOR:** On the [20] record.

[22] REDIRECT EXAMINATION OF STEVEN M. KLEIN, M.D.

[23] **BY MR. LENSON:**

[24] **Q:** Dr. Klein, Murray Lenson again.

[25] Just very briefly. Plaintiff's counsel

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[1] suggested to you that the two abnormal pathology [2] reports that were provided to the Lake OB/GYN [3] group were in his terminology pink flags, is [4] that correct?

[5] **A:** That's correct.

[6] **Q:** And he didn't say red flags, he said pink flags, [7] meaning that you agree as your original [8] testimony that they were – they did demonstrate [9] pathology, correct?

[10] **A:** Pathology, enough on which to additionally act, [11] get more information.

[12] **Q:** And that would be as you indicated way at the [13] beginning of this deposition further diagnostic [14] studies?

[15] **A:** That's correct.

[16] **Q:** Now, Mr. Fulton asked you the reason why I would [17] retain you when we do represent pathologists. [18] Pathologists do not, in your profession – in [19] your experience, do not generally set forth to [20] clinicians what follow-up attention should be [21] undertaken, is that accurate?

[22] **A:** Some pathologists will recommend certain [23] follow-up procedures to be done. I believe if [24] their interpretation is good and their [25] association with the gynecologist with whom they

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[1] are dealing is adequate, then that gynecologist [2] knows from the report what to do or should know [3] from the report what to do and, but some [4] pathologists do render opinions and some [5] pathologists just make the diagnosis and allow [6] the gynecologist to make his own opinion as to [7] follow-up care.

[8] **Q:** In your professional experience, is it your [9] choice for the pathologist to recommend a [10] certain procedure or would you rather that a [11] pathologist not do that?

[12] **A:** I would rather that the pathologist not do [13] that.

[14] **MR. LENSON:** Okay. Thank you, Dr. [15] Klein. I have no further questions.

[16] **VIDEOTAPE OPERATOR:** Off the [17] record.

[18] **MR. HIRSHMAN:** On the record. I [19] have nothing further.

[21] (Off the record.)

[23] **VIDEOTAPE OPERATOR:** On the [24] record. Doctor, you have a right to review [25] this videotape in its entirety or you can

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[1] waive that right.

[2] **THE WITNESS:** I will waive it.

[3] **MR. HIRSHMAN:** You have a right to [4] review the written transcript or you can [5] waive that right, also.

[6] **THE WITNESS:** I will waive that.

[7] **MR. LENSON:** Let the record show [8] that we will make Exhibits A through E part [9] of the record with Dr. Klein's deposition.

[10] We will also be filing the [11] transcript, which is required by court [12] rule, and the signature has been waived. [13] The videotape, also.

[14] I'm sorry, A through F will be [15] filed with the court. Thank you.

[16] **VIDEOTAPE OPERATOR:** Off the [17] record.

[18] (Signature waived.)

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CERTIFICATE

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

I, Susan M. Cebron, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named STEVEN M. KLEIN, M.D. Was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____ A.D. 19 ____.

Susan M. Cebron, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 17, 1998

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WITNESS INDEX

EXHIBIT INDEX

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OBJECTION INDEX

E

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IN THE COURT OF COMMON PLEAS

PORTAGE COUNTY, OHIO

LISA GRUBB, et al.,

Plaintiffs,

-vs- JUDGE JOHN ENLOW
CASE NO. 97CV00153

ALAN L. ROSENWASSER, M.D., et al.,

Defendants.

- - - -

Deposition of STEVEN M. KLEIN, M.D., taken as if upon cross-examination before Elaine S. FitzGerald, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, The 113 St. Clair Building, 113 St. Clair Avenue, Cleveland, Ohio, at 9:25 a.m. on Friday, August 6, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

- - - -

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On behalf of the Defendant Robinson Memorial Hospital.

EXHIBIT INDEX

STEVEN M. KLEIN, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF STEVEN M. KLEIN, M.D.

BY MR. HIRSHMAN:

Q. We'll forego most of the formalities other than have you state your name for the record so that we have it on the transcript.

A. Steven M., as in Michael, Klein, K-l-e-i-n.

Q. And you're an M.D.?

A. Yes.

Q. You have been retained as an expert to testify in the case of Lisa Grubb against Doctors Rosenwasser and Egdell. I'm going to be asking you questions about your opinions in regard to a review of various materials.

Let's start by having you tell me what it is that you have reviewed.

A. I don't have my report. Can I see a copy of my report?

Q. Sure. I've got a copy of your report right in front of me. Oh, there is one. You have got one in front of you, too, now?

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relates to any discussions that took place between Lisa on the one hand and Doctors Egdell and Rosenwasser on the other hand regarding her desire for a particular mode of delivery, if mode of delivery makes sense to you?
A. May I answer the previous question concerning the size of the vaginal delivery, the second baby?
Q. Yes.
A. In my report on page 2, I did note that the baby was 8 pounds 5 ounces and was male. I do not know the size of the -- I don't remember the size of the first baby.
Q. All right.
A. Now, your second question regarding discussions with Doctors Egdell and Rosenwasser and Mrs. Grubb?
Q. You want me to repeat the question?
A. Please repeat the question.
Q. Okay. What is your understanding as to whether any conversations occurred between Lisa on the one hand and Doctors Egdell and Rosenwasser on the other hand regarding whether she wanted a repeat C section or whether she was willing to attempt a trial of labor?

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A. The records indicate that when she was first seen, she preferred to have a repeat Cesarean section. Subsequent conversations regarding this must have occurred, but I don't know exactly where the documentation occurs. Can you be more specific in --
Q. You're dealing with the issue that I'm addressing. The question then I guess in follow-up to your answer is, you responded by indicating that further conversations must have occurred regarding whether delivery would be by VBAC or C section.
A. Yes.
Q. Why do you conclude that further conversations must have indeed occurred?
A. Mrs. Grubb at first had preferred a repeat Cesarean section. As time went on, and I believe it was in the chart August 5th, Dr. -- one of the doctors had discussed with Mrs. Grubb signs of labor. This to me indicated that there was no appointment to plan a repeat Cesarean section and that labor perhaps was going to occur.
Prior to the admission on 9-2-94, a conversation must have occurred because the

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admission for 9-2-94 was for induction of labor vaginally and not for a repeat Cesarean section. We know from the notes of the nurses that both Mrs. Grubb and her husband who was present did receive prostaglandin jell in order to try and induce that labor.
At around 12:55, 9-3-94, when in fact the prostaglandin had not satisfactorily induced labor, Dr. Rosenwasser, whom I believe was present, must have discussed with Mrs. Grubb further therapy and asked her whether she wanted to go home since it hadn't worked thus far or whether she would continue on with the induction of labor with pitocin and artificial rupture of the membranes and so she elected to do that. So from these instances, I conclude that Mrs. Grubb and the doctors did discuss vaginal birth versus repeat Cesarean section.
Q. Do you see anywhere in the records other than the entry of February 2nd of 1994 any documentation that a further discussion of C section versus VBAC occurred?
A. No.
Q. So you have concluded that a further discussion must have occurred because for a patient to be

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sent down that path for a trial of labor under circumstances where she's previously expressed a desire for a C section would require that a further discussion occur, correct?
A. For the patient to allow herself to go on a certain path would indicate to me an approval of a change of mind and hence she was willing to undergo an attempt at a vaginal birth after her first Cesarean section.
Q. In other words, as you review these records, you interpolate into them or you conclude from reviewing them that there must have been at the least a passive acceptance of a trial of labor?
A. I believe that the patient gave her approval for the trial of labor.
Q. I know you believe that, and what I am asking you is this: Do you see any evidence in the records to establish that that approval was active as opposed to passive.
A. Oh, yes.
Q. And what is that?
A. She signed a -- in the admission, she signed a patient directive and I believe -- if we can read that. I don't have it with me.
Q. I am looking at a document here that's called

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Q. It's a pretty specific question.
A. Oh. You mean would I make such a statement?
Q. Would you make such a statement to your patients?
A. Concerning a vaginal birth after a Cesarean section?
Q. Yes. I want you to assume you've got a patient who's had a previous Cesarean section, she comes into you for her first visit for her second pregnancy, for a second pregnancy which is going to go to term having had one pregnancy go to term before, and you recommend a vaginal birth; she tells you, "I don't want a vaginal birth. I want a C section." Would you in your practice tell that patient, "We don't do C sections in this office. If you want to stay with us, you're going to have to undergo a vaginal birth or at least a trial of labor"? Would you do that in your office?
A. No.
Q. And why is that?
A. I want to embark upon a dialogue with my patient and attempt to convince her of my strong feelings and would do that, but I wouldn't be dictatorial on that, on this particular issue.

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Q. That's because you understand it as being the right of a woman under these circumstances having had a previous low transfer Cesarean section to make up her own mind as to which route of delivery she wants for her subsequent delivery?
A. No. I disagree with that statement.
Q. You disagree with the statement. Well, tell me why it is you disagree with that statement.
A. Because I think decisions, especially as they pertain to surgery or medical therapy for that matter, are decisions reached with the input of both the physician who does the treating and the patient on whom the treatment is to occur, not the patient's so autonomous as to make a medical or obstetrical judgment on her own.
Q. But to foreclose that dialogue by making a dictatorial statement that we do not do repeat C sections is not the way that you would practice medicine, is it?
A. Well, that's correct. If, however, I was so strong in that opinion, I would ask the patient to go elsewhere, but I don't do that.
Q. And you wouldn't be that strong in your opinion? You'd enter into a dialogue with your

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patient, and when you have a patient who expresses her firmly stated wish to undergo a repeat Cesarean section, you respect those wishes, correct?
A. If the opinion or if the wishes of the patient are made for the correct reasons, I respect those wishes, always respect the patient's wishes but may not agree with the patient, and if I don't, then I would ask her to seek the services of another physician.
Q. You have done repeat Cesarean sections on patients who don't have a separate medical indication for a Cesarean section, have you not?
A. I can't think of any off the top of my head. I'm sure I have, but they are not very frequently done.
Q. Would you agree that the actions or policies of a physician that coerce a prior Cesarean section patient to undergo a trial of labor interfere with a patient's autonomy and undermine informed consent?
A. I agree that coercion is improper.
Q. And there were ACOG standards that were in existence in 1994 that specifically note that coercion of a patient into accepting a VBAC when

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she does not want one is improper, were there not?
A. Yes.
Q. And you would agree that the standard of care in 1994 required that Lisa Grubb be given a Cesarean section if she did indeed so choose?
A. No.
Q. You disagree?
A. Yes.
Q. And why?
A. If after she was informed of the pros and cons of VBAC versus repeat Cesarean section and then chose on that basis to have a Cesarean, then I agree with you.
Q. In other words, a doctor has an obligation to discuss with the patient his preferences and his recommendations and why he has them?
A. Correct.
Q. All right. Having done so, if the patient chooses a Cesarean section, she's entitled to have it?
A. Correct.
Q. So somewhere along the line between giving advice and coercion, one crosses a line, correct?

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asking the person herself whether or not she has painful intercourse.
Q. Right. Are you suggesting that Lisa's a liar or a malingerer?
A. I'm not suggesting anything.
Q. All right. She certainly has objective evidence of a scar which was observed by your own partner?
A. That's correct.
Q. And your partner in her letter to Doctors Egdell and Rosenwasser doesn't raise the possibility of her faking this, does she?
A. I'm not raising that either.
Q. I don't know if I ever got a response to the initial question I asked regarding the contributory negligence of Lisa or Donald. Do you believe any actions or inactions on Lisa's part or Donald's part have caused her to sustain the injury that she's sustained?
A. No.
Q. In addition to having sustained pain, is it your understanding that Lisa has indicated that by virtue of the pain, that she is unable to have intercourse?
A. That's what she testified.

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Q. Do you have any reason to doubt her as it relates to that assertion by Lisa and her husband?
A. Well, no, I have no reason to doubt, except that in the post partum notes of Egdell and Rosenwasser, they mention dyspareunia which is pain on intercourse. There seems to be a little bit of unclearness if you will. Painful intercourse means that intercourse was accomplished, albeit painfully. Inability to have intercourse, there can't be dyspareunia because there can't be intercourse. So it might be a moot point. I just bring that up.
Q. So what you're suggesting is that if you look at Dr. Egdell's and Dr. Rosenwasser's early post partum notes, one could conclude that she was having intercourse but it's painful?
A. Yes.
Q. And by virtue of those notes, we could come to at least one of two conclusions I presume? One is that she indeed was having intercourse and it was painful, the other conclusion would be that she was describing an inability to have intercourse because of the pain which was not effectively communicated or understood, correct?

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A. Correct.
Q. And I take it you're not in the position to say which one of those two circumstances happened?
A. That's correct.
Q. You would agree, however, that part of a doctor's job is to listen carefully to his patients' complaints and concerns and desires?
A. Yes.
Q. And that to the extent that a doctor does not listen to his patients' complaints, concerns and desires, he has failed in his job as a physician?
A. No. He simply has failed to listen to the patient's complaints and desires in that particular instance.
Q. I guess what I'm getting at is this: It's important and you consider it an important part of your practice to listen to your patients?
A. Yes.
Q. As I read your letter, do I understand you to be criticizing Lisa for not undergoing surgery to correct this problem more quickly?
A. No.
Q. You're unaware that Dr. Ballard performed surgery upon her?

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A. Mr. Crandall told me that this morning. I was unaware of that at the time I wrote the letter, my report.
Q. And what is your understanding as to the success or lack of success of that surgery?
A. I understand that it was not successful.
Q. So Lisa has been to the Cleveland Clinic where she's undergone surgery in order to correct this problem. The surgery has failed. It's your understanding she's also prior to the surgery made attempts at dilatation? Were you aware of that?
A. That was suggested to her, that's correct.
Q. And attempts were made to do that, correct?
A. I don't disbelieve that.
Q. And they were also unsuccessful, correct?
A. Presumably.
Q. Presumably because you wouldn't go to surgery if dilatation had worked?
A. Correct.
Q. Given the circumstances that now exist, would you agree that Lisa is suffering from a permanent problem?
A. No.
Q. So you believe that more can be done for Lisa?

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that had been published to that point demonstrating the safety of VBAC versus a repeat Cesarean section suggested that we as practicing obstetricians entertain perhaps a change of thought in how we practice and give more credence to doing an attempt at a vaginal birth rather than just opt to do an immediate repeat Cesarean section.

From that, it was my assumption that insurance companies picked up on that, thought perhaps that it's much more expensive to do a surgical procedure such as a C section, and suggested also that perhaps physicians ought to go along with the American College of OB/GYNs' suggestion to try an attempt at vaginal births, but I -- and this is where the naivete comes in. I was unaware of any pressure per se at that time or even now on myself. I can't speak for other people in other communities.

Q. So you did not feel in 1994, nor do you feel today, pressure to perform a VBAC rather than a C section on any particular patient?

A. No. I simply feel that through my education subsequent to my residency training and my first years in practice, that indeed I have changed

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the way I practice because of the literature, because of my professional college, but you're correct, I do not feel myself any financial pressures to push a patient towards a VBAC rather than a C section.

Q. Were you required to respond to inquiries in 1994 or earlier regarding your C section rate and your VBAC rate which pertained either to you or to the hospitals in which you practiced by insurance companies or third-party payers?

A. I don't remember, Mr. Hirshman. I really don't.

Q. So it's fair to say that you personally didn't feel a pressure being exerted upon you by such third-party payer?

A. That's correct.

Q. And I assume you would agree that if a third-party payer were to exert pressure on you to reduce your C section rate and increase your VBAC rate, it would be your obligation to protect your patients from those pressures once they have made a decision to undergo a repeat C section?

A. Yes. It's my policy to do no harm to my patients.

Q. What's an episiotomy?

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A. A terrible thing.

Q. Do you do them?

A. Yes.

Q. What is an episiotomy?

A. It's an incision made in the lower aspect of the vaginal outlet to allow the fetus to come out, hopefully avoiding any extensions or tears, or extensions. I try to avoid them if I can, if I get an adequate amount of pliability, but rather than have a jagged type of laceration to repair, I would prefer to do an episiotomy and it usually is more uniform and more easy to repair.

Q. And when do you do them, in what kinds of situations?

A. When the head is crowing.

Q. You do it in all cases where the head is crowning?

A. No.

Q. You do it when the head is crowning and you have reason to believe that there is a possibility for a tear?

A. Correct.

Q. And one reason that you might do it is if you have a baby that's large in relationship to the pelvis of the mother?

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A. Well, I wouldn't know that until the baby came out. I could estimate perhaps, but I wouldn't necessarily do the episiotomy if I thought the baby was large. I would simply do it if the baby's head seems to be -- if this is a vertex delivery versus a breach, I would simply do it to try and protect, as I say again, a jagged outlet problem or to help the patient deliver, have the baby come out a little sooner perhaps if the soft tissues are holding the baby's head back.

Q. Are episiotomies more likely to occur with large babies as opposed to small babies?

A. Yes.

Q. And was an episiotomy done in this case?

A. Not to my -- I don't believe it was.

Q. Had an episiotomy been done, the likelihood is that a third degree tear could have been avoided?

A. That's not true.

Q. In other words, an episiotomy in your opinion would not have prevented this tear in this case?

A. I don't know that.

Q. Well, let's put it this way. Episiotomies are done to avoid the type of outcome that occurred

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A. No.
Q. It would not?
A. No.
Q. You wouldn't be concerned as to whether or not the size of the second baby was as big or bigger than the size of the first baby?
A. If that were going to present an obstetrical problem, it would present the obstetrical problem during the labor process and I would act on it if it needed to be acted on, but I would not take that into consideration prior to the attempt at vaginal birth.
Q. It certainly could present itself as a reason for yet another C section?
A. Yes.
Q. And in your review of these records as you've already indicated, you were unaware of the fact that a biophysical profile was done?
A. I just didn't remember.
Q. All right. Now, do you know what the size of the baby was by a projection? Do you know what the estimated size of the baby was on the biophysical profile that was done?
A. I do not. I don't remember.
Q. Do you know why a vacuum extraction was done in

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this case?
A. To help Lisa get the baby out.
Q. Because the baby was having difficulty getting out?
A. Or Lisa couldn't push satisfactorily to get the baby out. It just expedited delivery.
Q. You have indicated in your report that there was a protracted second stage of labor.
A. Yes.
Q. What is second stage of labor?
A. Where the patient reaches complete dilatation of the cervix, from that point until the delivery of the baby is the second stage of labor.
Q. And that stage of labor in this case went on for how long?
A. Four hours I believe.
Q. Which is a long time once you've reached 10 centimeters in dilatation, correct?
A. Yes.
Q. What would be a typical period of time for a second stage of labor?
A. It varies from whether this is a first baby or second baby. It can vary from two minutes to two hours to three hours and in some instances four hours. I don't know that there is a

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typical period of time.
Q. So we'll just leave it at that.
You have characterized it as being a prolonged second stage?
A. Somewhat prolonged second stage, yes.
Q. Meaning that that baby was not coming quickly or easily?
A. It wasn't coming quickly.
Q. Vacuum extraction has certain risks associated with it, does it not?
A. Yes.
Q. And what are those?
A. Hematomas of the scalp.
Q. Of the baby?
A. Yes.
Q. In other words, traumatic damage to the baby's head?
A. Yes.
Q. Does it have any risks to the mother associated with it?
A. Not to my knowledge.
Q. All right. Do you know why a vacuum extraction was elected by Dr. Rosenwasser in this case?
A. To help the baby out. To expedite the completion of the second stage of labor.

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Q. You saw nothing in the records to indicate that there was fetal distress requiring that that be done?
A. That's correct.
Q. It was done simply to expedite the delivery?
A. That's my belief.
Q. All right. And the delivery was prolonged or the second stage was prolonged for what reason, if you know?
A. I don't know.
Q. What are the possibilities?
A. Inadequate contraction activity on the part of the uterus, choreoamnionitis, electrolyte imbalance, size of the fetus, size of the maternal pelvis. That's all I can think of right now.
Q. How about inadequate assistance from the mother in terms of ability to push?
A. Yes. That would go along with the contraction activity, but both of those, yes.
Q. Do you give epidurals to mothers as an anesthetic during child birth?
A. I do, yes.
Q. During vaginal child birth?
A. Yes.

CERTIFICATE

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

I, Elaine S. FitzGerald, a Notary Public within and for the State of Ohio, 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 was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 13th day of August, A.D. 1999.

Elaine S. FitzGerald

Elaine S. FitzGerald, Ware Reporting Service
3860 Wooster Road, Rocky River, Ohio 44116

My commission expires July 13, 2004

MR- 204954 F- 920876
GRUBB, LISA M 9-02-94
028Y 6-02-66 EGDELL, ROBERT
216 678-5526

DEPOSITION EXHIBIT
1
8-6-99 EF
PENGAD-Bayonne, N.J.

ADVANCE DIRECTIVE INFORMATION FORM

The following information must be furnished to the patient and answers to all questions completed:

The law requires that each patient be made aware of their rights pertaining to making health care decisions for themselves. This includes the right to accept or reject medical or surgical treatment. Each patient has the right to express their wishes in documents known as advance directives (Living Will and Durable Power of Attorney for Health Care) so that a patient's wishes may be made known when they cannot speak for themselves.

Each patient is to receive the information booklet concerning advance directives. Whether or not a patient has an advance directive cannot be a basis for being offered or given hospital treatment.

RESPONSES TO THE FOLLOWING QUESTIONS ARE IMPORTANT:

QUESTIONS	YES	NO	NOT APPLICABLE
Patient given information booklet concerning advance directives.	☒		
Does patient have an advance directive.	☐	☒	
Patient has an advance directive a copy of which is given to admitting representative for inclusion in the medical record.	☐	☒	☐
Patient has an advance directive but does not have it with them. Patient advised to give the advance directive to the physician or nursing for inclusion in the medical record.	☐	☒	☐
Patient not able to answer questions and the legal representative is not available.	☐	☐	☒

TO THE PATIENT

I have read and had explained to me the information on this sheet and have received answers to my questions and received the written materials as indicated above.

Lisa M Grubb
Patient or Legal Authorized Representative

Relationship of Legally Authorized Representative to Patient

K Meucke RN
Witness (RMH Representative)

9-2-94
Date

-F-

-G-

-H-

-I-

-J-