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THE STATE OF OHIO

COUNTY OF CUYAHOGA

IN THE COURT OF COMMON PLEAS

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BRENDA THOMAS, etc., et al., :

Plaintiffs, :

vs. : CASE NO. 160681

THE OBERLIN CLINIC, et al., :

Defendants. :

- - -

Deposition of CLARENCE R. MCLAIN, JR., M.D., a witness herein, taken by the defendants as upon cross-examination pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement and Notice To Take Deposition as to the time and place and stipulations hereinafter set forth, at the University of Cincinnati, College of Medicine, 231 Bethesda Avenue, Cincinnati, Ohio, at 12:45 p.m. on Saturday, July 7, 1990, before Amy E. Benjamin, a Professional Reporter and Notary Public within and for the State of Indiana.

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Q. Well, do you know in this case that Brett Thomas was born at about 31 weeks gestation? Is that your estimation as well?

A. 31 to 32.

Q. Okay. Which would be some three weeks or so before you would expect in the normal situation that surfactant would have developed in this child's lungs?

A. That's right.

Q. You have had the opportunity, as I understand it, to review the prenatal records of Brett Thomas --

A. Yes, I have.

Q. -- at the clinic. And I think you've also received a copy of the transcript of the deposition of Dr. Rollins, who was caring for Brett during the prenatal period.

A. Yes, I did.

Q. Is there anything in those records, Doctor, that suggests to you that in a period of weeks or more prior to his delivery there was any stressful event in the course of the pregnancy?

A. Only 48 hours before.

Q. Okay. So the first stressful event

rendered to Mrs. Thomas by Dr. Rollins during her prenatal period and up to and including his treatment of her in the periods of observation in the 48 hours prior to her delivery?

A. No, I don't. It would have been preferable to have an ultrasound at that time to see where the location of the placenta was. However, I have no criticisms of his management of the patient.

Q. Dr. Rollins has stated in deposition, and I believe his records also reflect his diagnosis as being one of a marginal sinus rupture. Do you recall that?

A. That's recorded in the chart.

Q. Marginal sinus rupture is not the same thing as a separated placenta, is it, Doctor?

A. Yes, it is.

Q. What does the term "abruptio placenta" mean?

A. Well, abruptio placenta is synonymous with premature separation of the placenta. Those are two terms that mean the same thing. Abruptio placenta has the implication of being a more severe degree of premature separation of the placenta. Marginal sinus rupture is a more mild form of

A. May or may not. A 1500-gram baby doesn't always have respiratory distress syndrome.

Q. But Doctor, is there anything about being delivered at Cleveland Metropolitan Hospital that would have prevented the child having respiratory distress syndrome as opposed to being delivered at Allen Memorial Hospital?

A. Absolutely.

Q. What?

A. This baby was practically ignored the whole delivery. No one was in attendance managing the labor. There should have been a fetal monitor. The mother wasn't even given oxygen during the labor. There wasn't even an I.V. fluid started in a patient who is bleeding in a premature labor. And I'm sure at a tertiary care center all of these things would be done.

Q. Had all of those things been done, are you telling me the baby would not have had respiratory distress syndrome?

A. No, I can't say that; but if it had respiratory distress syndrome, it would have been managed differently in that it would have been ventilated. The low Apgar score at the time of

delivery just indicates that this baby was depressed at the time of the delivery secondary to two factors.

One is the morphine that was given, that suppresses the central nervous system and the respiratory centers, about four hours before delivery. The second factor is that the patient was bleeding with some degree evidence of a premature separation of the placenta, which may have stressed the baby to one degree or another. We're not quite sure. But we do know this was a very depressed baby at the time of the delivery.

And then when the transport team arrived two hours after delivery, this baby was in shock from metabolic acidosis as well as respiratory acidosis. The baby didn't have an I.V. started for 80 minutes after delivery, and the baby wasn't ventilated during this time. And anyone you talk to will tell you that the first 60 minutes after birth really is a major factor that results in the outcome of the baby.

This baby was not properly ventilated during the first two hours after birth, and this baby was a very high-risk baby at this time. Would

have been managed totally different in a tertiary care center.

Q. I guess what I'm trying to draw in my own mind, Doctor, is the distinction between the extent and number of the factors that made this baby a high-risk baby as opposed to your criticisms of its management.

Now there were preexisting high-risk factors here, were there not? Regardless of where the child was born.

A. During the process of labor, there were high-risk factors and they weren't attended to. And the outcome of these babies is entirely different -- a 1500-gram baby has approximately a 90-percent chance of being a normal baby with proper management.

Q. Meaning that a low birth-weight baby of 1500 grams, that only ten percent of them develop neurological sequelae?

MR. BECKER: Assuming proper management?

MR. ROBERTSON: Yes.

A. Assuming proper management that we can give a baby in 1983. Good management and delivery.

A. No, not necessarily. And it is not unusual for a baby to initially cry and then not. This will probably reflect more the sedative factor of morphine on the respiratory system.

Q. Well, Doctor --

A. That the baby might have cried initially and then respirations not continued.

Q. Wouldn't it be even more evidence of depressive effect of morphine if he hadn't of tried at all?

A. Not necessarily.

Q. Is the use of morphine to attempt to control or prevent labor an acceptable practice?

A. Absolutely not.

Q. Have any literature or references, Doctor, that would tell us that?

A. I don't have the specific references, but it's in the literature that -- years ago people used to give -- physicians used to give patients morphine to try to knock out premature labor; but then it became evident that the central nervous system in a premature baby was extremely susceptible to narcotics, and no longer is that acceptable treatment of prevention of premature labor.

Q. Was the physiology of administration of medicine to the mother reaching the baby?

A. Any medication or drug that is given to the mother crosses the placenta to the baby.

Q. How long does it take for a drug administered to the mother to reach the baby?

A. It depends on probably a number of different factors in terms of transport across the placenta. But with narcotics, crossing the placenta should occur within about 15 minutes.

Q. And how long does the effect of the narcotic persist?

A. Probably four to six hours.

Q. And if you're talking about the administration of a 15-milligram dose, would those time frames still apply?

A. Oh, yes. That's a very high dose.

Q. Doctor, your report of February 8th -- I'm sorry, February 6, 1990, says that -- the bottom of page 1, under Heading No. 2 continuing over to the top of page 3 -- "The heavy sedation with morphine added to the severe respiratory depression and attributed to the asphyxia."

Asphyxia is a medical term that means

what, Doctor?

A. A very depressed baby.

Q. Also on page 1, under Heading 2 you say "The low Apgar rating helps direct attention to immediate needs and reflects preexisting fetal distress secondary to abruptio placenta during the process of labor."

Do you see that statement, Doctor?

A. Yes.

Q. Your letter of September 29, 1989 -- on page 3, paragraph 7 -- says, and I quote, "There was no evidence in the medical record that there was fetal heart rate monitoring and, therefore, it is unknown whether there was significant fetal distress during the entire labor and delivery."

Do you see that statement, Doctor?

A. Yes, I do. But I followed that with a statement "The infant was severely depressed at the time of the delivery." So the fact that there was no monitoring or attention to the welfare of the fetus during labor doesn't rule out that the baby was distressed.

What we say is the end product. The baby was depressed, and he had to be depressed due to

the baby versus the possible hazards of her going into labor and delivering on the way. Now --

Q. Are you saying it was preferable to have this child delivered in the ambulance as opposed to being delivered at Allen Memorial Hospital?

A. No. You have to consider that when you decide when you're going to tranfer: How far you have to go, what are her possibilities of delivering the baby before she gets to where you're taking her.

And that is why this is important, and I think it's very negligent that an obstetrician admits a patient 31, 32 weeks gestation and who is in active labor when she comes in because two days before the cervix was closed and long and not dilated and the presenting part was floating high.

On admission the cervix was one and a half to two centimeters dilated in the position -- presenting part was a minus one station. So things had changed in 48 hours. This patient was obviously in early active labor, and to leave the hospital and not observe that patient to see what she's going to do within the next 30 to 60 minutes -- she

demonstrated she was changing. It was then that she should have been transported, and she would have gotten to the tertiary care center before she delivered at that point.

Q. We know that with the benefit of 20/20 hindsight that she would have delivered at the hospital, but can we say that in prospective view?

A. Prospectively, if I had been on the spot, that's the decision I would have made.

Q. You were not on the spot, were you, Doctor?

A. No.

Q. And Dr. Belizaire had been and had examined this patient, had he not?

A. Yes.

Q. Is it not generally true that a clinician present dealing with the patient is in a better position to make decisions to her appropriate care than one who is not?

A. I think we have the evidence in the record of what was going on at that time, and it's a his decision versus what you think is the right decision.

Q. Your opinion letter states low Apgar

ratings reflect preexisting fetal distress. Cannot low Apgar ratings merely be a reflection of an infant with severe RDS?

A. RDS is not present immediately at the time of delivery. RDS occurs following, so RDS would not cause a low Apgar rating in the first minute.

Q. How about at five minutes?

A. Would not be a significant factor because RDS doesn't usually occur to an hour, two, three, four, five, even six hours after delivery.

Q. You go on to say that the preexisting fetal distress was secondary to abruptio placenta during the process of labor.

A. Plus morphine, as I mentioned.

Q. How do you know that there has been an abruptio placenta, Doctor?

A. She was bleeding and she was in labor and the uterus was contracted.

Q. We talked before about the fact that you believe that the terminology "marginal sinus rupture" is simply another way of saying abruptio placenta; is that correct?

A. That is correct.

Q. It's a matter of degree as to whether it's considered entirely marginal or whether it's more serious?

A. That's correct.

Q. And what evidence is there in the record that is not equally consistent with the fact that at the time Dr. Belizaire saw this lady that the bleeding she was experiencing was not simply a renewed bleeding from the same marginal sinus rupture diagnosed by Dr. Rollins?

A. Because the uterus was contracting. The bleeding was associated with passage of clots, and this was particularly evident in an hour, hour and a half later. So what happened, I'm sure, is that a little more of the placenta had separated than had separated 48 hours before.

Q. Incidently, was Dr. Rollins not notified by the nursing staff at Allen Memorial Hospital an hour later of those clots?

A. Dr. Rollins?

Q. I'm sorry, Dr. Belizaire.

A. No, he wasn't. He wasn't notified by the nurses at Allen Memorial Hospital until 2:29 a.m., and then he did not come into the hospital

even though she was four or five centimeters dilated.

Q. Your opinion goes on to say "There is no evidence that the mother was given oxygen, I.V. fluid, or repositioned in the lateral position during labor."

A. That is correct.

Q. What significance would it have if any of those things were done but simply not recorded?

A. The baby would have been better oxygenated if the oxygen would have been administered. By moving the patient to the lateral position you take the fetus off the inferior vena cava, you help prevent the mother's blood pressure from dropping and, therefore, increase the uterine blood flow to the placenta and, therefore, the blood flow to the baby.

So hydration, I.V. fluids, left lateral position, oxygen is a treatment for any labor in which there is a problem going on that might adversely affect the fetus.

Q. If any of these things --

A. It's routine.

Q. If any of these things were done but

simply not properly recorded in the record, would that, in your opinion, be evidence mitigating against the incidence of severe brain damage in this child?

MR. ZELLERS: Objection.

MR. BECKER: Objection.

A. I think those are factors that in all probability would have helped to improve the outcome. But there were so many other factors that were also not performed that it would be hard to say that if those things had been done the outcome would have been different.

Q. Doctor, with respect to administration of morphine, it's your view, as I understand it, that it was totally inappropriate to use morphine at all; is that correct?

A. That is correct.

Q. And the dosage is not of significance?

A. Well, the dosage is a very high dose. It's as high as we ever give an adult.

Q. Are you suggesting that a smaller dose of morphine might have been all right? Five milligrams, ten milligrams?

A. No. I would suggest that morphine

various structures of the baby.

Q. Amniotic fluid also performs a function as a shock absorber, does it not?

A. To a certain extent.

Q. And if the amniotic fluid is drained by an amniotomy, there is no longer this buffer of fluid between the infant's head and the cervix, is there?

A. If you have a mother who has a premature separation of the placenta and the baby's head is down so it's safe to do an amniotomy, then -- and if you're not going to transport the patient and you're going to deliver the patient in that labor and delivery area, then it is recommended that you do an amniotomy so that you can accelerate labor and deliver the baby so that fetal distress doesn't occur over a longer period of time than is necessary. And also to see what color the amniotic fluid is to see whether there is meconium staining, which also helps to tell you whether the baby is in distress.

And then of course, because the external monitor is not quite as accurate as the internal monitor in terms of abnormalities in the fetal heart

rate, you attach scalp electrodes to the baby's head and then if fetal distress by the fetal monitor and the meconium staining of the amniotic fluid is judged to be severe enough that you don't think the baby is going to deliver within a reasonable period of time, then intervention by cesarean would be indicated.

Q. There was no meconium staining in this case, was there, Doctor?

A. Well, the amniotomy was done just prior to delivery, and there is no recording in the medical record that there was meconium.

Q. I'm not sure I understand that answer in comparison to my question. Are you saying that there was meconium staining but it wasn't recorded?

A. I'm just saying there's no recording in the medical record. I would like to point out in that regard that Dr. Belizaire never has any recording in the medical record except for the first few words when he describes the slight amount of bleeding on admission. There is no delivery note written by Dr. Belizaire to even say what he did do or didn't do.

So my answer to your question is that he

exactly the time of injection.

Q. Doctor, I assume it was appropriate to give the dose of Narcan, right?

A. Under the circumstances.

Q. And within what time frame should that initial dose of Narcan have been given in this case? How soon after delivery?

A. As soon as possible, preferably intravenously. And I say intravenously because this -- if your baby is really depressed and the baby is in shock and the circulation is not really good and doesn't take it up intramuscularly, as soon as you can possibly give it. Probably ideally it should be given to the mother, I.V., just prior to delivery.

Q. Doctor, from your review of the records in this case, do you have an opinion as to whether or not there was significant fetal distress during Mrs. Thomas' labor and delivery?

A. Based on the condition of the baby at the time of delivery, there was a stressful event that occurred during labor and delivery.

Q. Any way to time that stressful event?

A. That it probably occurred sometime

between admission and delivery.

Q. Do you have an opinion --

A. I don't think I can say to what degree except that the baby was very severely depressed.

Q. Do you have an opinion as to whether or not there should have been electronic fetal heart monitoring in this case?

A. Oh, yes. There should have been.

Q. And should that have been continuous or intermittent?

A. Should have been continuously.

MR. ZELLERS: I have nothing further. Thank you, Doctor.

MR. ROBERTSON: On the subject of electronic fetal monitoring, Doctor, you've already said that you have not seen the protocols from Allen Memorial Hospital which deal with that.

THE WITNESS: That is true.

MR. ROBERTSON: So you don't know whether or not the protocols spell out whether or not the nursing staff, for instance, has the authority under the protocols to institute without doctor's orders electronic fetal monitoring?

THE WITNESS: I'm speaking of

standards of care with a similar patient in 1983. Dr. Belizaire in his testimony said that it was the responsibility of the nurse to place the electronic monitor, for whatever that's worth.

MR. ROBERTSON: Nothing further.

MR. ZELLERS: Just very quickly on that, Doctor. Does the attending physician have any responsibility in terms of ordering electronic fetal heart monitoring independent of whatever the policies of the respective hospital?

THE WITNESS: I think so, definitely.

MR. ZELLERS: And what about calling in a pediatrician for delivery, does the attending --

THE WITNESS: It's the obstetrician's responsibility.

MR. ZELLERS: Does your response depend upon the standards or protocols at Allen Memorial Hospital?

THE WITNESS: No.

MR. ZELLERS: I've got nothing further. Thank you.