IN THE COURT OF COMMON PLEAS

OF LUCAS COUNTY, OHIO

JOSEPH STALMA, JR., a minor, by and through his mother and natural guardian, NORMA STALMA, Case No. CI0200101505

Plaintiff,

vs.

RAYMOND BUGANSKI, M.D., and THE TOLEDO HOSPITAL,

Defendants.

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The telephonic Videotaped Deposition of DR. LEE MARK WEINSTEIN, an Expert Witness in the above-entitled cause, taken by Shari J. Pavlovich, CSR-5926, Certified Shorthand Reporter, Registered Professional Reporter, and Notary Public for the County of Wayne, acting in the County of Oakland, State of Michigan, at 36700 Woodward Avenue, Suite 300, Bloomfield Hills, Michigan, on Friday, August 30, 2002 commencing about 11:05 a.m., pursuant to the applicable court Rules.

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EXHIBITS

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Bloomfield Hills, Michigan
Friday, August 30, 2002
About 11:05 a.m.

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(Deposition Exhibits 1-4 were marked for identification.)

VIDEO TECHNICIAN: One moment and we'll be underway.

On the record. This is the videotape deposition of Dr. Lee Weinstein being taken at 36700 Woodward, Suite 300, Bloomfield Hills, Michigan.

Today is Friday, August the 30th, year 2002. Time is 11:05 a.m. My name is David B. Schafer, Video Technician and Notary Public for the County of Wayne.

The attorneys please introduce yourselves for the record.

MR. KULWICKI: This is David A. Kulwicki from the law firm of Beckler and Mishkind. I am attending by phone. And I'm appearing on behalf of the plaintiff, Joey Stalma, Junior.

MS. COLWELL: This is Angelica Colwell from Marshall and Melhorn. I'm attending on behalf of the Toledo Hospital.

MR. WASUNG: John Wasung, Kitch

Drutchas, on behalf of Dr. Buganski.

VIDEO TECHNICIAN: Doctor, would you raise your right hand, please.

Do you swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

VIDEO TECHNICIAN: You may proceed.

MR. KULWICKI: Counsel, Attorney Wasung and Attorney Colwell, can we have a stipulation to the qualifications of the court reporter and the videographer?

MR. WASUNG: Yes. I've got no problem.

MS. COLWELL: Yes.

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EXAMINATION

BY MR. KULWICKI:

Q Doctor, good morning. Would you please state your full name and state your current business address.

A Lee Mark Weinstein. 36700 Woodward Avenue, Suite 300. This is Bloomfield Hills, Michigan. I also have another office in Farmington Hills.

Q Okay. Is the Bloomfield Hills address your primary office?

A Well, it's where we locate our business office, also.

So we do have pretty much an equal amount of patient care out of either office.

Q Why don't you give us the address for the Farmington office?

A That's 31182 Haggerty Road. That's Farmington Hills, Michigan. It's 48331.

Q Doctor, you're a board certified pediatrician?

A That's correct.

Q And you were asked by Dr. Buganski's counsel in this case to review the medical records in this case and provide opinions regarding the care provided to Joey Stalma, Junior; correct?

A That's correct.

Q Have you done any medical legal consultation work for either Toledo Hospital or their attorneys in their case, that being Nancy Moody and Angelica Colwell or their law firm Marshall and Melhorn or their former law firm Buckley King and Bluso(?) or Jacobson Maynard Toushman(?) and Kayler?

A No, I have not.

Q Doctor, do you have opinions in this case regarding the care that was provided to Joey Stalma Junior?

A Yes, I do.

Q Before we get to your opinions I'd like to review your credentials and your training and your background if

we could.

A Sure.

Q Please, would you tell us about your current practice. What type of patients do you see?

A Well, our practice is limited to pediatric and adolescent medicine. We have seven physicians with two offices. We work out of two hospitals, William Beaumont Hospital in Royal Oak and Huron Valley Sinai Hospital in Commerce Township.

So essentially, we see babies up to, you know, eighteen to twenty years of age. There are, as I stated, seven physicians, five full time, two part time. And we share, you know, all of the responsibilities in terms of hospital visitation, evening calls, those sorts of things.

Q So you, yourself, see patients both in the office and at the hospital?

A That's right.

Q And the patients that you see in the hospital, would those include newborns in the newborn nursery?

A Absolutely.

Q Doctor, what states are you licensed to practice medicine in?

A State of Michigan.

Q And how long have you been licensed to practice

medicine in the State of Michigan?

A That would be 1987, I believe. That's when I began residency at the Children's Hospital of Michigan in downtown Detroit.

Q Doctor, what does the term standard of care mean?

A I think it means that what would be expected of a reasonable physician based on the circumstances that are presented to him.

Q And Doctor, unless I ask otherwise, I'm going to be asking you about your opinions regarding the standard of care in 1991, which is the time relevant to this particular case. Fair enough?

A That's fair. Although --

Q What does the term on call mean?

A Sir, I will say that in 1991, you know, that was eleven years ago. So you know, my recollection of the exact differences between now and then are a little, you know, cloudy.

Q Well, let's do this. If there is a specific change in the standard of care that you're aware of, please bring that to my attention. On the other hand, if you're not sure of what the standard of care was at that time, please bring that to my attention. Okay?

A Fair enough.

Q Okay. Doctor, what does the term on call mean?

A On call essentially means that you're available to receive phone calls, either from patients or from the hospital, with regards to patients who are in your care. So signed up at your office or, you know, in the hospital receiving care by you or your partners.

Q Doctor, when you're on call, where might you be physically located?

A Well, in my case it's usually at my home.

Q Doctor, when you are on call, are you reachable by telephone or by some other communication device?

A Well, I carry a pager and I have an answering service. And the hospital has the numbers for the answering service. And the patients have that number.

So they make a call to the answering service. The answering service screens those telephone calls. And depending on the severity of the call, reaches me either immediately or within, say, an hour's time period.

Q And Doctor, do you have an opinion to a reasonable degree of medical probability as to whether the standard of care in 1991 required that a physician who was on call be reachable by some communication device?

A Oh, I think the standard of care then was that you should be available for, you know, consultation by whatever means you communicate.

Q Why is that important to be reachable when you're on call?

A Well, there may be questions regarding either, you know, from a parent with regards to what to do for their child in a particular circumstance.

Or you might receive a call from the hospital as to, you know, a question as to what the best course of action would be in a situation that might be going on at the hospital.

Sometimes it's just to notify us, you know, a lab result or something that might be coming in from the hospital.

Q All right. And Doctor, please, if I interrupt you, part of the problem that I'm having is because we're by phone, our conversation isn't as fluid as I'd like it to be. So please, if I interrupt you at any time, please bring that to my attention.

A I will.

Q Okay. Thank you.

Doctor, let me ask you about another term. And this term is an admission. What does it mean when a patient is admitted to a hospital?

A Well, it means that a decision has been made to place the child in the hospital to receive care.

Q Okay. Now, as parents we -- when we have a new baby

we see the little bracelet that they put on our new baby and we keep that. And that is part of the admission process; right?

A Yes, I would say that's true.

Q And that reflects that when the baby's born the baby is immediately admitted to the hospital; correct?

A Yes.

Q And when newborns are admitted to the hospital do they have an attending physician?

A Well, often parents when they enter the hospital, generally what happens is the hospital has a protocol that as the mother's admitted, she's asked, you know, who you would like to have as the pediatrician for the baby.

And if they don't have a choice there, then the hospital -- then the child is generally cared for by so-called staff doctors or people that are at the hospital. Neonatologists often will have a staff service.

So if there isn't a particular decision made there, then, you know, essentially the hospital usually has a vehicle for having somebody take responsibility for the baby.

Q And Doctor, your understanding in this particular case is that Joey Stalma's parents designated Dr. Buganski

as their pediatrician at or shortly after the time that Joey was admitted to Toledo Hospital; correct?

A Correct.

Q And can we agree that when a physician is designated as the attending pediatrician for a newborn admission that that physician has ongoing responsibility for the baby throughout the course of that admission?

A That's true, unless the baby is transferred to a different person's care.

Q Okay. Now, up until March 24, after Joey had had some seizure activity in the morning hours of that day, was he on Dr. Buganski's service based on your review of the records?

A Yes.

Q And so Dr. Buganski would have had responsibility for Joey up until those early morning hours when he got into trouble on March 24th; fair enough?

A Fair, um-hmm.

Q Now, Doctor, in preparing your opinions in this case can you tell us what materials you reviewed?

A Well, I was -- I looked through the entire hospital admission. I looked through some of the subsequent care that the child received after the incident in the hospital, or his stay in the hospital; and several depositions by different nurses who were involved in

the case, as well as several physicians' depositions that were provided to me.

Q Did you review, as part of the material that you reviewed, Dr. Buganski's deposition?

A Yes, I did. And his affidavit. He had an original deposition and then there was an affidavit done to, I think, help clarify what, you know, his opinions were in the case.

Q What's the date of that affidavit?

A Trying to find -- looks like the 29th of May 2002.

Q Can you give that to the court reporter? I'd like to mark that as Plaintiff's Exhibit 5.

MR. KULWICKI: Why don't we go off the record?

VIDEO TECHNICIAN: Going off at 11:19.

(Short recess.)

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(Deposition Exhibit 5 was marked for identification.)

VIDEO TECHNICIAN: Back on the record at 10:21 a.m. -- 11:21 a.m., I'm sorry.

BY MR. KULWICKI:

Q Doctor, when you are on call in your practice but you're not at the hospital, do you rely on the nurses in the newborn baby nursery to assess your newborn

patients?

A Yes.

Q And do you consider them to be your eyes and ears when you're not present assessing your newborn patients?

A I would say that's true. Yeah. Unless -- unless either they or myself are uncomfortable with what's going on. And then sometimes we'll call in, you know, a resident doctor or another doctor that's at the scene.

Q Doctor, do you have an opinion to a reasonable degree of medical probability as to whether it's reasonable for a pediatrician to rely on nurses in the newborn baby nursery to periodically assess newborn patients and report abnormal findings to the attending pediatrician?

A I'm sorry, could you repeat that? I'm unclear exactly what you're asking.

Q Sure. Specifically, I'm asking if you have an opinion to a reasonable degree of medical probability as to whether it's reasonable for a pediatrician to rely on nurses in the newborn baby nursery to periodically assess your newborn or assess newborn patients and report abnormal findings to the attending pediatrician.

A Well, I think that's reasonable. That's the standard

of practice of, you know, hospitals in general is that there are some doctors that stay in the hospital and there are doctors who -- that make periodic visits to the hospital.

And the nursing staff is generally doing the surveillance of, you know, what's happening on a minute-to-minute or hour-to-hour basis with the patient.

Q Doctor, can we agree that part of that assessment by the newborn nursery nurses should include vitals at intervals?

A Yes.

Q What, in your opinion, is a reasonable interval for vitals to be taken in a newborn baby nursery for a well baby?

A I would say generally every eight hours.

Q And what vitals would be, in your opinion, reasonable to record at eight-hour intervals in the newborn baby nursery?

A A temperature, a pulse rate, and a respiratory rate. And the other thing is just a general look at the baby in terms of how the baby appears, which is basically just done as you're taking the vitals.

Q Now, Doctor, do the two hospitals that you have privileges at and that you practice at have on-staff

neonatologists?

A They do.

Q In 1991 did they have a neonatologist available in the hospital twenty-four hours a day, seven days a week, three hundred sixty five days a year?

A Well, I have to take each hospital independently.

Q Okay.

A In 1991 I was actually a resident at Children's Hospital of Detroit.

Q Okay. Well, then --

A You know, I have to take that back. From '87 to '90 I was a resident. So in '91 I was actually practicing at William Beaumont Hospital but I was not practicing at Huron Valley Sinai Hospital.

And at William Beaumont Hospital they have several neonatologists that care for the neonatal intensive care unit. And I believe at the time -- and as is the case now, they are able -- they take their telephone calls from home. And they have an on-site like a nurse practitioner, you know, in the neonatal nursery. So they're available to come into the hospital within a short time frame.

Q And Doctor, I guess I should have you tell us what a neonatologist is.

A Well, a neonatologist is a physician that is -- first,

is a pediatrician. Then takes specialty training in the care of newborns and limits -- essentially limits their practice to caring for newborns and essentially focuses on the care of the very sick baby in the first, you know, couple of months of life. And they have a certification process for that position.

Q Doctor, do you have an occasion from time to time in your practice to consult with neonatologists?

A Oh, yes.

Q And generally, Doctor, during periods when you're on call but not at the hospital, under what circumstances would you ask a neonatologist to see one of your newborn patients in the well baby nursery?

MR. WASUNG: Objection to the form of the question. It's awful broad but go ahead if you can, Doctor.

THE WITNESS: I was going to say that you take each situation on a case-by-case basis. And I guess generally I would call a neonatologist any time I felt either uncomfortable with the situation or unable to make, you know, the expert decision in the case and just wanted some help making a decision as to where to proceed with a particular problem.

BY MR. KULWICKI:

Q Doctor, in this case do you have an understanding as

to whether Toledo Hospital in 1991 had a neonatologist available at the hospital twenty-four hours a day in 1991?

A I'm not a hundred percent certain about that. My sense is that there was one available. But I'm not expert as to what the -- what the relationship was with the neonatologist.

Q Fair enough. Doctor, I had faxed over a number of documents. And I'm going to have you turn to those now.

The first one I want you to look at if you would, please, is Exhibit 2. It's a two-page document. Tell me when you have that and we'll discuss it.

A Here we go. Okay. I have that document.

Q Doctor, have you seen Plaintiff's Exhibit 2 before today?

A Yes, I have.

Q And what is your understanding that Plaintiff's Exhibit 2 is?

A Well, it's a standing order list.

Q Do you have something similar in your practice?

A We do. Although I -- generally in our case the neonatology department really has gone further and superseded that.

There was a time where we did, I should say. And they now have their own kind of standard of care for each condition that may arise.

Q Let me ask you: In 1991 did you have something similar to Plaintiff's Exhibit 2 as part of your practice?

A I don't recall that.

Q You're not sure when the change came?

A That's correct.

Q Gotcha. In any event, do you expect nurses in the newborn baby nursery to comply with the requirements or recommendations or guidelines or protocols set forth in the standing order that you had or after the neonatology group came in and gave its own standing order, that standing order?

A Yes.

Q And Doctor, do you have an opinion to a reasonable degree of medical probability as to whether Dr. Buganski had a reasonable expectation that nurses in Toledo Hospital's newborn nursery would follow the guidelines set forth in Plaintiff's Exhibit 2?

A I'm not sure what you mean in terms of -- could you restate that, please.

Q Sure. I'm asking whether you feel or believe that Dr. Buganski would have a reasonable expectation that

the guidelines set forth in Plaintiff's Exhibit 2 would be followed by the nursing staff.

A Yes. I believe he felt that these guidelines were going to be followed by the nursing staff.

Q And Doctor, do you have an opinion to a reasonable degree of medical probability as to whether it would be below accepted standards of nursing care for the nursing staff to not follow the guidelines set forth in Plaintiff's Exhibit 2?

A Well, I'm not an expert on nursing issues or nursing care. So I wouldn't hold myself as an expert as to what the -- what the standards there are.

But I think it's reasonable to think that the since the doctors write the orders in the hospital and the nurses are there to follow them, that they would be expected to follow the orders.

Q Well, let me ask you about your expertise in nursing standards applicable to a newborn baby nursery. You on a weekly basis from the mid 1980s through the present have had interactions with newborn baby nursery nurses; correct?

A That's correct.

Q And during that interaction you'd have occasion to provide them with orders; correct?

A Correct.

Q And you would have occasion to communicate with them regarding their ongoing assessments of your patients that are admitted to the newborn nursery; correct?

A Yes.

Q And you'd be familiar with what is reasonable and safe practice on the part of those nurses when it comes to them monitoring your patients in the newborn baby nursery setting; correct?

A Correct.

Q All right. Doctor, let me have you turn to Plaintiff's Exhibit 3. Two-page document -- or I'm sorry, a one-page document. And tell me when you have that available to discuss.

A Okay, I have that.

Q First of all, Doctor, have you seen this one sheet from Joey Stalma's hospital chart before?

A Yes, I have.

Q And do you understand it to be physician's orders?

A That's correct.

Q I'd like you to look at the entry from March 23, 1991 at 2:30 p.m. Do you see that?

A Yes, I do.

Q And using military time it's denoted here as 14:30; correct?

A That's correct.

Q Do you see where it says strip baby of clothes, retake temperature in one hour and call me?
A Yes.
Q And it appears to be written by a nurse who writes Dr. Buganski's name. Then it appears to be countersigned by Dr. Buganski, as well. Do you see that?
A Yes, I see that.
Q Is it your understanding that this is an order by Dr. Buganski to the nursing staff in the Toledo Hospital newborn nursery regarding Joey Stalma?
A Yes.
Q And when you give an order in your practice like this do you expect the nursing staff to follow it?
A Yes.
Q And do you have an opinion to a reasonable degree of medical probability as to whether Dr. Buganski had a reasonable expectation that the nurses would follow his order?
A I think you're asking me to get into Dr. Buganski's mind here.
Q Well, I'm asking you whether he would, as a reasonably prudent pediatrician, should expect his orders to be followed.
A Yes.

Q And Doctor, do you have an opinion to a reasonable degree of medical probability as to whether it would be below accepted standards of nursing care for the nursing staff to not follow an order like we have here at 2:30 p.m. on March 23, 1991?

MS. COLWELL: Objection.

MR. WASUNG: You can go ahead, Doctor.

MS. COLWELL: You can go ahead.

THE WITNESS: Okay. Well, again, I'm not an expert in nursing but I would expect the nurses to follow this order.

BY MR. KULWICKI:

Q Doctor, let me have you turn to the next document, which is a two-page document marked as Plaintiff's Exhibit 4. And please tell me when you're ready to discuss that document.

A Okay.

Q Have you seen this document before today?

A I don't believe I have seen this one.

Q Let me represent to you that this is a nursing protocol that was in effect at Toledo Hospital in 1991 on the topic of phototherapy. Okay?

A Okay.

Q Let me ask you, first of all, do any of the hospitals that you've practiced at have a similar protocol in

effect regarding nurses' responsibilities in the newborn nursery for patients that are undergoing phototherapy?

A I'm really not in the position to comment. I don't know what all of the standing orders are at our hospital.

Again, like I said, the department of pediatrics and the neonatologists have a set of guidelines for different therapies or, you know, situations at the hospital. And I am not certain what specifics are of those documents.

Q Okay. Fair enough, Doctor.

Let me -- why don't you set those documents aside. And I'm going to shift gears here.

Want you to define another term for us. What is a septic workup?

A Well, it's actually not a very good term. The term should be sepsis workup. And it's an evaluation to determine if a baby or a person has bacteria that has entered through the normal defenses into the bloodstream and into the rest of their body.

Q And Doctor, in 1991 in your experience what did a sepsis workup consist of?

A Well, it depended. It depended on the observation of the observer. So that sometimes a sepsis workup would

be a blood count, a blood culture, a urine culture, perhaps a chest x-ray. And then in other circumstances it might include a spinal tap. And I think to this --

Q Doctor, just so we're clear, the routine sepsis workup would include either all of those items --

A Um-hmm.

Q -- or all of those items except the spinal tap?

MR. WASUNG: Objection to form of the question. It implies routine. I think that's not the way the Doctor started his answer.

But go ahead, Doctor, as you can.

THE WITNESS: Well, I mean, there is some controversy. I think back then things like chest x-rays were routine.

But in this day and age I think the chest x-ray would be considered also an optional component of the evaluation.

BY MR. KULWICKI:

Q Okay. And Doctor, in your practice in 1991 was it the practice to begin antibiotic therapy intravenously when the results of the sepsis workup were pending?

A It depends what you're referring to. I mean, are you referring to a -- specifically a similar circumstance as this? Or, say, an older kid with a fever and a

situation where we're concerned about bacteria in the blood?

Q Fair enough. Let's confine it to the newborn period.

A Okay. So brand newborn, couple days old. Is that what you're talking about?

Q Yes, Doctor.

A Yes. I would say that our practice was to obtain the testing and begin treatment prior to receiving the results of the testing.

Q And why did you do that?

A Because the definitive diagnosis, you know, rests upon the blood -- basically the blood or urine or spinal fluid culture, which takes a day or two to obtain. And we didn't want to wait. You know, if the baby was sick, you didn't want to wait a day before instituting therapy.

Q Was part of the consideration that earlier treatment with antibiotic therapy when a baby indeed was infected with the bacterial agent like Group E Strep was better for the patient?

A Well, yes. I mean, if the concern is that the baby has an infection and we know the infection is treated by antibiotics, then you would want to start treatment as soon as possible.

Q And Doctor, can we agree that in 1991 it was well

established that antibiotics were useful in treatment of Group E Strep infections?

A Yes.

Q Now, Doctor, I'd like you to estimate, if you can, the number of septic workups that you had occasion to order on newborns in a given year during the early Nineties?

A Boy, I'm not sure I can give you a very good answer to that.

Q And I appreciate that without having records before you. But would you tell us whether it would be in the dozens or in the hundreds or in the thousands as a very, very general estimate?

A Well, understanding I'm in a group practice.

Q Sure.

A And are you referring to me, personally, on the one or two days a week that I do rounds? Or do you mean as a group where I would be then involved in the care of that child?

Q Let's talk about you specifically.

A So me initiating a sepsis workup?

Q Yes, Doctor.

A Again, it would really be just a guess. I would say, you know, every -- maybe every month or so there might be a baby who would be behaving in a concerning

fashion.

And we might -- for example, a baby breathing rapidly, and in those situations you're concerned that is it a respiratory condition like a premature lung, or is it an infection in the lungs. And in those cases you generally have to really look at all of the circumstances involved. And you would, you know, get the cultures, get your chest x-ray, and that was not an -- that's not an uncommon experience.

Q And Doctor, in those situations where you perform sepsis workups, would you agree that in the majority of those cases the culture information or the testing information comes back showing that the baby, in fact, did not have a bacterial infection?

A Yes.

Q So the idea is to be better safe than sorry when it comes to a sepsis workup?

A I think that's true, yes.

Q Doctor, in your practice and again, appreciating that it is a very, very broad question, what sort of clinical presentations might trigger a sepsis workup? In other words, what abnormalities in a newborn might lead one to perform further investigation to determine whether or not the baby is suffering from a bacterial infection?

A I would say the number one thing would be respiratory distress because frequently the infections occur through the respiratory tract. And the babies display things like rapid breathing or grunting respiration.

Next would probably be some temperature instability in the baby. So the baby not having a consistent body temperature.

Q Either high or low?

A That's right.

Q Okay.

A And then, of course, other observations, you know, baby's color not looking good or baby's not feeding like they had previously. Those would be the principle factors.

Q And Doctor, can we agree that when it comes to bacterial infections like Group E Strep the signs of such infections can be subtle?

A Definitely.

Q And they can be varied in the sense that there may be a set of symptoms for one child and another child may have a completely different set of symptoms?

A I agree with that.

Q And there's not any one thing that would be required to trip a sepsis workup?

A Well, I'm not sure I -- I'm not sure about that

question. I mean, if the child was having a severe respiratory distress or if a child was having, say, a seizure or stopped breathing or something, then that one event would necessitate a sepsis evaluation.

Q Okay. My question wasn't clear and I appreciate your answer.

What I was getting at is that there isn't one cardinal sign that is necessary in order to trigger a sepsis workup. In other words, every patient doesn't have to have temperature instability to trigger a sepsis workup. There could be other symptoms.

A Right. I agree with that.

Q Okay. There's not one symptom that in and of itself must appear before a sepsis workup is done; right?

A That's correct.

Q Okay. Now, Doctor, if you're on call and the nursing staff calls you and reports some suspicious behavior on behalf of the child like temperature instability, like difficulty feeding, like changes of breathing pattern, is the first thing that you do is perform an assessment of the child or have an assessment performed of the child by another physician, like another pediatrician or another -- or a neonatologist?

MR. WASUNG: Objection, form and

foundation.

THE WITNESS: That's a hard question to answer the way it's posed to me.

BY MR. KULWICKI:

Q Uh-huh.

A Because it would depend on what the problem is.

Q Okay. Well, let me try to make it a little simpler. If, in your mind, you suspect sepsis or sepsis is in your differential based on a report received by your on call, by the newborn nursery, what is the first thing that you do?

MR. WASUNG: Same objection.

Go ahead, Doctor.

THE WITNESS: Again, it's a little bit hard to answer from the way you're posing the question. It just depends what is being reported to me as to what you do.

BY MR. KULWICKI:

Q All right. Well, let me ask it this way: If you have a suspicion of sepsis in a newborn and either -- and you conduct an assessment of that infant, what would your assessment consist of?

A So you're saying that I've already reached a conclusion that I'm concerned that there's sepsis?

Q Right. You don't have a diagnosis of sepsis yet. You

have a suspicion of sepsis.

A Yeah. I think the problem is that we, as pediatricians caring for newborns, we always have that suspicion. Do you know what I mean? It's in the background.

Q Well, let me try to make this as easy as I possibly can. If you have enough of a suspicion of sepsis that you're going to assess the child --

A Okay.

Q -- what sort of assessment would you do?

A Well, certainly an examination is the first thing.

Q And what would that examination consist of?

A Well, a physical examination of the child. And then I would also, depending on the symptoms and the signs, that would dictate what the other evaluations might be.

So for example, if the kid's having breathing difficulties, I'd order a chest x-ray. But if he's not, I may not order a chest x-ray.

Q Let me focus on the physical assessment. We're zeroing in on what I really wanted to get information about.

Tell me what kind of physical assessment you do. What sort of things are you looking for? And how do you evaluate the child?

A Well, you're going to look at the child from top to bottom. You're going to look at their head. You're going to feel their fontanel to see if it's flat or whether there's a protrusion of it or bulging.

You're going to look at the baby's ears and throat and neck and check for any physical signs of -- that the baby is, you know, irritable if you shift the neck or, you know, move the legs in a way that flexes the body.

You're going to listen to the lungs and the heart and essentially do a complete evaluation. You're going to look at the skin color, the baby's tone. You know, you lift the baby up and you see, is the baby with good muscle tone or is the baby, you know, kind of floppy like a rag doll.

What's the baby's cry like when you are examining the baby? I'm not sure what else you're looking for. I mean, when I say a complete examination --

Q Do you auscultate the baby to listen to breathing sounds and heart sounds?

A Yes.

Q How long might such an assessment take?

A Ten to fifteen minutes, maybe.

Q With your attention focused only on that baby?

A That's right.
Q Now, Doctor, I want to switch gears on you for a moment. I'm going to talk to you about phototherapy.
A Okay.
Q I take it that on occasion phototherapy, particularly when the older-styled blue lights were used, can raise an infant's temperature; correct?
A I think that's true, although I'm not an expert on that.
Q Well, in your experience have you ever experienced that particular phenomenon?
A I have.
Q And is it a rather uncommon event?
A Yes.
Q And Doctor, in your experience how long did it take for the baby's temperature when it was raised by the environment or by phototherapy lights, how long did it take for the temperature to return to normal?
A I think it's hard to answer that question because like we said, it's an uncommon event. And over the years I can -- you know, I can't really point to specifics or, you know, how many times it's happened to kind of make a judgment on that.
Q Fair enough. Let me switch gears again.
In this case, Doctor, we know that the

nurses during their normal assessments took the baby's temperature under the arm or took an axillary temperature. Is that your understanding?

A Yes, it is.

Q In 1991 did you have a practice as to when you would take a rectal temperature?

A I wouldn't say I had a specific -- like a protocol, do you mean?

Q No, just your practice.

A I think if I was really suspicious of a temperature and I wanted another indicator as to the validity of it, then I would request that.

Q And why would you do that?

A Well, because the axillary temperature is more dependent upon external factors than the core body temperature taken rectally.

Q Now, in 1991 do you recall what your standing order was or what the neonatology group's standing order was with respect to when the nursing staff should contact the attending pediatrician for an axillary temperature? In other words, what was the cutoff? Like in this case --

A In 1991 I don't remember.

Q In this case you know from Plaintiff's Exhibit 2 --

A Right, right.

Q -- that the temperature was ninety nine degrees; that Dr. Buganski wanted to be notified if it was ninety nine or above, axillary; correct?
A Correct.
Q What was your practice in 1991?
A You know, again, it's hard to look back to 1991. I think somewhere around that area.
Q Doctor, I take it that you don't have any criticisms of the care that was rendered by Dr. Buganski; correct?
A That's correct.
Q Do you have any opinions regarding whether Joey's CP and mental retardation are related to the Group E Strep, meningitis, and sepsis that he had in 1991?
A Well, I think it's very likely that his neurologic condition was related to an infection of the nervous system.
Q Based on your review of the records and your training and experience could you state that opinion to a reasonable degree of medical probability?
A Yes.
Q And Doctor, do you have any opinions about whether or not his neurological status, whatever it is now, is permanent in nature?
A Well, again, I haven't -- haven't really been asked to

look at his care after the care that Dr. Buganski had provided.

Q Fair enough, Doctor. And I would assume, also, that you don't have any opinions about his life expectancy?

A No, I do not.

Q Doctor, do you spend fifty percent of your time in the active clinical practice of medicine, pediatric medicine, or in the teaching of that subject in an accredited medical school?

A Do I spend fifty percent, or at least fifty percent?

Q At least fifty percent.

A Yes. More like ninety percent.

MR. KULWICKI: Doctor, that's all the questions I have. I'll turn it over to Mrs. Colwell right now. And I may have some additional questions after her exam.

- - -

EXAMINATION

BY MS. COLWELL:

Q Doctor, I just have a few follow-up questions for you. Just a moment ago Mr. Kulwicki was discussing the taking of temperature by axillary versus rectal methods. Do you remember that?

A Yes, I do.

Q In your opinion, then, is it -- was it not the

standard of care in 1991 for temperatures to be taken rectally unless the physician requested them to be done that way?

A I don't know if there was a specific standard of care with regards to that. I think that there were different practices at different places.

So I'm not sure what the overall standards of care, if you will, would have been.

Q Okay. With respect to your practice, was it your standard of care for the nurses to take the temperatures axillary unless you requested otherwise?

A Yes, I believe so.

Q Based on your review of the medical chart in this case you would agree that aside from -- well, strike that.

You would agree that Joey Stalma was seen by a pediatrician on the mornings of 3/22/91 and 3/23/91; correct?

A Yes, um-hmm.

Q And you would also agree that the pediatrician that examined Joey in the morning of 3/23/91 was Dr. Buganski?

A Yes.

Q And according to your recollection, at the time that Dr. Buganski examined Joey Stalma he specifically noted that the baby was alert and had a good cry?

A That's correct.
Q In your experience have you taken care of babies that have received circumcisions?
A Yes.
Q According to your review of the chart would you agree that Joey had a circumcision sometime in the morning on 3/23/91?
A I believe so, yes.
Q Do you agree that in general as the result of a circumcision infants experience pain?
A They do. It's a little different than you would expect in, say, an older person but there is a pain response.
Q Okay, fair enough. Is that pain response something that you would expect to continue for a certain amount of time, say, hours after the circumcision?
A You know, it depends a little bit on how -- you know, what's done in advance of a circumcision. Sometimes people do nerve blocks and other kinds of techniques to limit the pain.
Q Fair enough.
A But generally, generally babies are -- for a couple hours after they tend to be a little out of sorts, if you will, maybe a little quieter.
Q In your experience that they tend to be quieter in

response to pain?

A Yes.

Q Would it be unusual for babies to cry or whimper if they had some kind of a pain experience going on?

A Would it be unusual? No.

MS. COLWELL: I think that's all I have.

MR. KULWICKI: Let's go off the record for a second. I want to take an opportunity to review the affidavit

VIDEO TECHNICIAN: Going off the record at 12:02 p.m.

(Short recess.)

- - -

MR. KULWICKI: Okay, everybody. I have reviewed that and this isn't on the record.

VIDEO TECHNICIAN: One moment and we'll wrap this up.

MR. KULWICKI: Tell me when you're ready.

VIDEO TECHNICIAN: One moment.

We are back on the record at 12:04 p.m.

Anything further?

MR. KULWICKI: Nothing further.

MR. WASUNG: For the record, Doctor,

you've got a right to review the transcript made up of this testimony. It's your right to review and sign off to its accuracy. I leave that up to you. Normally it's a good practice.

THE WITNESS: I'd like to, yeah.

VIDEO TECHNICIAN: This concludes the videotape deposition. Going off the record at 12:04 p.m.

(Deposition concluded at about 12:04 p.m.)

- - -

FURTHER, DEPONENT SAYETH NOT:

_____

DR. LEE MARK WEINSTEIN

Subscribed and sworn. to, before me,

this ____ day of _____, 2002.

_____

Notary Public, _____ County, Michigan

My Commission expires: _____

- - -

ERRATA SHEET

PAGE	LINE	WORD OR WORDS WHICH READ	SHOULD READ

_____

DR. LEE MARK WEINSTEIN

Dated: _____

STATE OF MICHIGAN)
) SS
COUNTY OF OAKLAND)

I, Shari J. Pavlovich, Certified Shorthand Reporter, Registered Professional Reporter, and Notary Public duly commissioned and qualified in and for the State of Michigan, do hereby certify that pursuant to the Michigan General Court Rules, there came before me on the 30th day of August, 2002, at 36700 Woodward Avenue, Suite 300, Bloomfield Hills, Michigan, the following named person, to-wit: DR. LEE MARK WEINSTEIN, who was by me duly sworn to testify to the truth and nothing but the truth of his knowledge touching and concerning the matters in controversy in this cause; that he was thereupon carefully examined upon his oath and his examination was reduced to computer transcription under my supervision; that the deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially

interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Notarial seal this 4th day of September, 2002.

Shari J. Pavlovich
CSR-5926
Notary Public, Wayne County, MI
Acting in Oakland County, MI

My Commission expires:
April 14, 2005

371

FAMILY CENTERED MATERNITY CARE

NURSERY DAILY FLOW SHEET

Date 3/22/91 – 3/22/91

Weight 7 13

Change Box

Δ in condition/time

MRN 566728
S'ALMA, BABY BOY
TOPSCKAR, K P 00503
TOPSCKAR, K P 00503
000

-Addressograph Stamp

Assessment Time

Diet (type)
- Breast
- Formula
- Nipple Regular
- Premie Soft Nipple
- Gavage PRN

Hygiene
- Complete
- Staff
- Mother

Safety
- Bassinette
- Isolette
- Continually Attended by Mother or Staff

Neuro-Behavioral

Reflex Irritability
- Vigorous Cry strong
- * Lethargic

Suck
- Good
- Fair
- * Poor

Fontanells
- Flat
- * Other

Moro
- Good
- Fair
- * Other

Muscle Tone
- Good
- * Flaccid
- * Hypertonic

Moves All Extremities
- Yes
- * No

Cardio-Vascular

Mucous Membranes
- Pink
- * Other

Murmur Present
- * Yes
- No

AP
- Regular
- Irregular

Respiratory
- Quality
- * Unlabored
- * Nasal Flaring
- * Retractions
- * Grunting

Sounds
- Clear
- * Other

Skin

Temp.
- Warm
- * Hot
- * Cool

Turgor
- Good
- * Poor

Moisture
- Dry
- * Diaphoretic

Color
- WNL
- Pale
- Ruddy
- Jaundiced
- * Cyanotic

Cord
- Clamped
- Dry
- * Other

Caput
- Yes
- No

Cephalohematoma
- Yes
- No

Internal Monitor Site Present
- No
- Yes
- REEDA WNL
- * Other

Circumcision
- No
- Yes
- REEDA WNL
- * Other

GI
- Abdomen Soft
- * Distended

Bowel Sounds
- Present
- * Absent

Additional Assessments

Tests/Labs

PLAINTIFF'S EXHIBIT 1 083002 SSP

Time	
Test	Results
Metabolic Screening	
Test #	
Time	
Per Heelstick	
Signature	

Treatment	D	E	N
Eye Care:			
Cord Care:			
Turn/Reposition:			
Ea. Feed See I&O			
Betadine Scrub: to Internal Monitor Site Daily			
Circ Care: with each Diaper Change			
Phototherapy			
Eye Patches			
Gonad Protection			
Lambs Wool Pad			
Weight AC & PC			

Equipment			
Isolette (temp)			
Pelvic Harness			
Triple Diaper			
Perineal Rod			

Time	Intake PO	Intake Comments	Output Urine	Output Stool
07				
08				
09				
10				
11				
12				
13				
14				
15				
Totals				
16				
17				
18				
19				
20				
21				
22				
[illegible]				
24				
01				
02 26	[illegible] 1 oz	– fair	✓	
03				
04				
5	[illegible]	1 oz		
Totals				
24 Totals				

Time	Health Care Notes: document response to interventions, teaching, PRN medications or unusual occurrences.
0212	Received into 3 North Nursery from admission nursery. Quiet, [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

TIME	TEMP	PULSE	RESP	BP	TIME	PHYSICIAN NOTIFIED	INITIALS
0210	98	119	44				

Patient Goals		Outcomes A	Outcomes U	Progress
1. (Physical) A - achieved U - unachieved		A	U	Needs [illegible] [illegible] [illegible] [illegible]
Mutually set with pt/family		Yes	NA	
Will maintain temps 97.5–99	[illegible]			[illegible] [illegible]
2. (Physical)		A	U	
Mutually set with pt/family		Yes	NA	
Will void & stool in 1st 24°	[illegible]		[illegible]	Voided 0225 – Has not [illegible] as of 0500

Shift	Initials	Signature/Title

Discharge Planning Progress:

THE TOLEDO HOSPITAL

371

FAMILY CENTERED MATERNITY CARE

NURSERY DAILY FLOW SHEET

Date 3/22/91 – 3/23/91

Weight 7 13

Change Box
Δ in condition/time
Phototherapy Instituted

Addressograph Stamp

Assessment Time						
Diet (type)						
Breast						
Formula Sim	✓	✓	✓			
Nipple Regular	✓	✓	✓			
Premie Soft Nipple						
Gavage PRN						
Hygiene						
Complete	✓		✓			
Staff	✓		✓			
Mother						
Safety						
Bassinette	✓	✓	✓			
Isolette						
Continually Attended by Mother or Staff	✓	✓	✓			
Neuro-Behavioral						
Reflex Irritability						
Vigorous Cry	✓	✓	✓			
* Lethargic						
Suck						
Good	✓	✓	✓			
Fair						
* Poor						
Fontanells						
Flat	✓	✓	✓			
* Other						
Moro						
Good						
Fair						
* Other						
Muscle Tone						
Good	✓	✓	✓			
* Flaccid						
* Hypertonic						
Moves All Extremities						
Yes	✓	✓	✓			
* No						
Cardio-Vascular						
Mucous Membranes						
Pink	✓	✓	✓			
* Other						
Murmur Present						
* Yes						
No	✓	✓	✓			
AP						
Regular	✓	✓	✓			
* Irregular						

Respiratory						
Quality						
* Unlabored	✓	✓	✓			
* Nasal Flaring						
* Retractions						
* Grunting						
Sounds						
Clear	✓	✓	✓			
* Other						
Skin						
Temp.						
Warm	✓	✓	✓			
* Hot						
* Cool						
Turgor						
Good	✓	✓	✓			
* Poor						
Moisture						
Dry	✓	✓	✓			
* Diaphoretic						
Color						
WNL	✓	✓	✓			
Pale						
Ruddy						
Jaundiced						
* Cyanotic						
Cord						
Clamped	✓	✓	✓			
Dry						
* Other						
Caput						
Yes	✓	✓	✓			
No						
Cephalohematoma						
Yes						
No	✓	✓	✓			
Internal Monitor Site Present						
No						
Yes	✓	✓	✓			
REEDA WNL	✓	✓	✓			
* Other						
Circumcision						
No	✓	✓	✓			
Yes						
REEDA WNL						
* Other						

GI						
Abdomen Soft	✓		✓			
* Distended						
Bowel Sounds						
Present						
* Absent						
Additional Assessments						

Tests/Labs

0700 Bili 5.0 called to Dr. [illegible] — McK

1300 Bili 5.9

1900 Bili 6.1

2115 Dr Torsako

[illegible signature]

Time	
Test	Results
Metabolic Screening	
Test #	
Time	
Per Heelstick	
Signature	

	D	E	N
Treatment			
Eye Care:	✓		
Cord Care:	✓		
Turn/Reposition:	✓	✓	
Ea. Feed See I&O			
Betadine Scrub: to Internal Monitor Site Daily	✓		
Circ Care: with each Diaper Change			
Phototherapy	✓	✓	✓
Eye Patches	✓	✓	✓
Gonad Protection	✓	✓	✓
Lambs Wool Pad	✓	✓	✓
Weight AC & PC			
Equipment			
Isolette (temp)			
Pelvic Harness			
Triple Diaper			
Perineal Roll			

* Approved by Executive Committee 8/90

Time	Intake PO	Intake Comments	Output Urine	Output Stool	Time	Health Care Notes: document response to interventions, teaching, PRN medications or unusual occurrences.
07					[illegible]	[illegible]
08						[illegible]
09						[illegible]
10 [illegible]	[illegible]					
11						
12						
13						
14 30	[illegible]	[illegible]	✓	[illegible]		
15						
Totals						
16						
17						
18 [illegible]	1½ oz		✓			
19						
20						
21						
	1 oz.		✓			
Totals						
24						
01 45	2 oz.	well	✓	[illegible]		
02						
03						
04						
	[illegible]	[illegible] - well				
Totals						
24 Totals						

TIME	TEMP	PULSE	RESP	BP	TIME	PHYSICIAN NOTIFIED	INITIALS
[illegible]	98.4	124	44				
[illegible]	97.6						
[illegible]	96.7	132	40				
[illegible]	[illegible]						
[illegible]	98	140	40				
[illegible]	99						

Patient Goals	Outcomes	Progress
4. (Physical) A - achieved U - unachieved	A U	[illegible]
Mutually set with pt./family	(Yes) NA	[illegible]
[illegible] 24 hrs.	[illegible]	
4. (Physical)	A U	
Mutually set with pt./family	Yes NA	
[illegible]		[illegible]

Shift	Initials	Signature/Title
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Discharge Planning Progress: See [illegible] sheet

McKee

[illegible]

THE TOLEDO HOSPITAL

3/21
7945

FAMILY CENTERED MATERNITY CARE

NURSERY DAILY FLOW SHEET

Date 3/23 + 3/24/91

Weight 7

Change Box
Δ in condition/time

Addressograph Stamp

Assessment Time

Section	Item	Entries
Diet (type)	SIM	
	Breast	
	Formula	Am / BG / CR
	Nipple Regular	Am / BG / CR
	Premie Soft Nipple	CR
	Gavage PRN	
Hygiene	Complete	Am
	Staff	Am
	Mother	
Safety	Bassinette	Am / BG / CR
	Isolette	
	Continually Attended by Mother or Staff	Am / BG / CR
Neuro-Behavioral		
Reflex Irritability	Vigorous Cry	Am / BG / CR
	* Lethargic	
Suck	Good	
	Fair	CR
	* Poor	
Fontanells	Flat	Am / CR
	* Other	
Moro	Good	CR
	Fair	
	* Other	
Muscle Tone	Good	Am / BG / CR
	* Flaccid	
	* Hypertonic	CR
Moves All Extremities	Yes	Am / BG / CR
	* No	
Cardio-Vascular		
Mucous Membranes	Pink	Am / BG / CR
	* Other	
Murmur Present	* Yes	
	No	CR
AP	Regular	BG / CR
	Irregular	
Respiratory	Quality	
	* Unlabored	Am / BG / CR
	* Nasal Flaring	
	* Retractions	
	* Grunting	
Sounds	Clear	
	* Other	
Skin		
Temp.	Warm	Am / BG / CR
	* Hot	
	* Cool	
Turgor	Good	Am / CR
	* Poor	
Moisture	Dry	Am / CR
	* Diaphoretic	
Color	WNL	Am / BG
	Pale	CR
	Ruddy	
	Jaundiced	Am / CR
	* Cyanotic	CR
Cord	Clamped	
	Dry	Am / BG / CR
	* Other	
Caput	Yes	
	No	Am
Cephalohematoma	Yes	
	No	Am / CR
Internal Monitor Site Present	No	
	Yes	Am / BG / CR
	REEDA WNL	BG / CR
	* Other	
Circumcision	No	
	Yes	Am / BG / CR
	REEDA WNL	Am / BG / CR
	* Other	
GI	Abdomen Soft	Am
	* Distended	CR
Bowel Sounds	Present	
	* Absent	
Additional Assessments		

Tests/Labs

0700 Bili 7.2 called to B Bugorski / —] McKee

1900 Bili 8.0 called to Dr. Bugorski ... } [illegible]

0310 Blood drawn for CBC - CBG - PH.] [illegible]

Time	Test	Results
	Metabolic Screening	
	Test #	
	Time	
	Per Heelstick	
	Signature	

Treatment	D	E	N
Eye Care:	Am		
Cord Care:			
Turn/Reposition:		BG	CR
Ea. Feed See I&O			
Betadine Scrub: to Internal Monitor Site Daily	LDG		
Circ Care: with each Diaper Change	Am	BG	
Phototherapy		BG	
Eye Patches		BG	
Gonad Protection		BG	
Lambs Wool Pad		BG	
Weight AC & PC			

Equipment			
Isolette (temp)			
Pelvic Harness:			
Triple Diaper			
Perineal Roll			

8/04/87 ... Executive Committee 8/90

Approved [illegible]

Time	Intake PO	Intake Comments	Output Urine	Output Stool
07				
08				
09				
10				
11	1 bag			
12				
13			✓	
14				
15 15-	1oz - took well		✓	
Totals				
16			✓	
17				
18 18.30	3/4 oz - fed in nsy			
19				
20				
21			✓	
30	1oz fairly well (Mom fed in nsy)		✓	
Totals				
24				
01				
02	1oz fair		✓	
03				
04				
06				
Totals				
24 Totals				

TIME	TEMP	PULSE	RESP	BP	TIME	PHYSICIAN NOTIFIED	INITIALS
1120	98.4	138	48				
1400	100.6						
[illegible]	99.6						
1630							
1900	101.4						
1930	99.2						
1955	99.8						
1915	98.6						
2400	97.9	136	40				

Health Care Notes: document response to interventions, teaching, PRN medications or unusual occurrences.

Time	
0730	Dr. Buganski [illegible] [illegible] [illegible] [illegible]
1235	Dr. Buganski [illegible] NPO [illegible] [illegible]
1530	[illegible]
1835	Mom states baby has arched back and stiffened extremities while feeding. Cyanosis around mouth & forehead noted. Baby suctioned @ bedside of mouthful of formula & mucus. Continues to have difficulty breathing - [illegible].
1840	Baby returned to nursery [illegible] Johnson RN. Color cyanotic [illegible] [illegible] [illegible] x 30 [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
1845	[illegible] W. Zettel RN
1950	Color pink [illegible] W. Zettel RN
2100	Dr. Buganski notified of above episode. [illegible]
2400	Remains under Phototherapy quiet & sleeping color pink [illegible]
0215	[illegible] for formula fair [illegible] burped [illegible] placed under Phototherapy [illegible] on abdomen [illegible] high pitched cry [illegible] arms [illegible] [illegible] [illegible] [illegible] 3-5 liters [illegible] [illegible] notified STAT

Patient Goals — Outcomes — Progress

4. (Physical) A - achieved, U - unachieved — Adaptive [illegible] — C. Rose
Mutually set with pt./family (Yes) NA
[illegible] 1-1½ oz q 3-4 hr — 15-23 — nipples slowly, but retaining

4. (Physical) A U
Mutually set with pt./family (Yes) NA
Bilirubin Levels will decrease — 15-23 — See Bili Graph. one lite [illegible] @ 1500

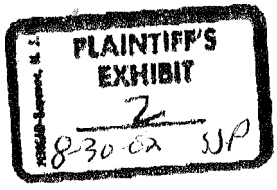
Shift	Initials	Signature/Title
7-15	[illegible]	[illegible]
7-3	[illegible]	[illegible] CA
15-23	[illegible]	[illegible] RN
23	[illegible]	[illegible] RN
23	[illegible]	[illegible] RN
23	[illegible]	[illegible] RN
	[illegible]	[illegible]

Discharge Planning Progress: See Mothers Chart

Margin annotations: McKell; L. Johnson; Nurse Osterhout; Zettel; Rose; Cline/Mills; Osterhout; Rose; Brothers; Osterhout; TPR: Rose; Osterhout; Osterhout; Zaleski; McKell; Cline

Date	Health Care Notes: (continued)
230	AP ille Irregular @ the time, R. 40 - Grunting - Subcostal Retraction.
	O2 per mask given. Continuing rigidity for 5 min Relaxed Sounds
	@ the time [illegible] NICU nurse arrived here @ the time.
	Color continues Pale grey-cyanotic. Breath sounds coarse. Bagged per
	NICU nurse. Dr Satish in [illegible] examined - Orders received.
	Dr Buganski notified of above. Chest X-Ray Done.
	BP. [illegible] 62/42/41 mean [illegible] 69/42/mean 43.
	Blood Culture drawn Plasmanate given by NICU nurse.
	Lab work done. — — — — — M Zaaga[illegible]
2330	Taken to visit mother Transferred to NICU in Isolette [illegible] Portable
	Oxygen following another dusky episode. M Zaaga[illegible]

M-Zaaga[illegible]



T-BRT

Center for Women and Children

The nurses of The Toledo Hospital Normal Newborn Nurseries would like to improve communications with the physicians. You will help us achieve that goal by answering the following questions. We would also appreciate one group response from those physicians in a group practice.

1. What do you consider an elevated temperature for which you wish to be notified?

   99°

2. Do you wish to be notified after office hours if an infant appears jaundiced?

   only if sig infant

3. Do you wish to be notified after office hours of a positive coombs test?

   Yes

4. Do you want breast fed babies to be supplemented with dextrose water?

   no

5. When a mother is breastfeeding, she is given the option of breastfeeding during the night or having her baby fed in the nursery. If her decision is to have the baby fed in the nursery, do you want the baby to receive dextrose water or formula? what ever mother prefers

   _____ Dextrose OR _____ (Specify the kind of formula you prefer)

6. If a breastfeeding infant is under phototherapy, do you want to pc with dextrose or formula? no

   Dextrose OR

7. If baby's bottom becomes reddened and/or raw, what do you want applied, if anything? Desitin ointment

8. If mom is O+ do you want a type and Coombs ordered? not necessary

If you have any questions and/or concerns, please include them.

Sincerely,

Pat Clay, R.N.

J T Emerson

BREAST FED BABIES

PHYSICIAN	TEMP	H URS IF... POSITIVE COOMBS	JAUNDICE	SUPPLE-MENT WITH DEXTROSE WATER	IF FED IN NURSERY GIVE	UNDER PHOTO THERAPY PC	SORE BUTTOCKS APPLY	MOM O POSITIVE ORDER TYPE & COOMBS
Drs. T-S-S-T	99	Yes	only if significant	No	What mom prefers	No	Diaper cream	Not necessary

T-ART

Center for Wonderland Children

The nurses of The Toledo Hospital Normal Newborn Nurseries would like to improve communications with the physicians. You will help us achieve that goal by answering the following questions. We would also appreciate one group response from those physicians in a group practice.

1. What do you consider an elevated temperature for which you wish to be notified?

   99°

2. Do you wish to be notified after office hours if an infant appears jaundiced?

   only if significant

3. Do you wish to be notified after office hours of a positive coombs test?

   yes

4. Do you want breast fed babies to be supplemented with dextrose water?

   no

5. When a mother is breastfeeding, she is given the option of breastfeeding during the night or having her baby fed in the nursery. If her decision is to have the baby fed in the nursery, do you want the baby to receive dextrose water or formula? ~ what ever mother prefers

   _____ Dextrose OR _____ (Specify the kind of formula you prefer)

6. If a breastfeeding infant is under phototherapy, do you want to be
   with dextrase or formula? no
   with dextrose or formula? no

7. If baby's bottom becomes reddened and/or raw, what do you want applied, if anything? desitin ointment

8. If mom is O+ do you want a type and Coombs ordered? not necessarily

If yon have any questions and/or concerns, please include them.

Sincerely,

Pat Clay, R.N.

J T Cousley

PLAINTIFF'S EXHIBIT 3

KB 6-5

BREAST FED BABIES

PHYSICIAN	TEMP	POSITIVE COOMBS	JAUNDICE	SUPPLE-MENT WITH DEXTROSE WATER	IF FED IN NURSERY GIVE	UNDER PHOTO THERAPY PC	SORE BUTTOCKS APPLY	MOM O POSITIVE ORDER TYPE & COOMBS
Dra. T-B-R-T	99	Yes	only if significant	No	What mom prefers	No	Diaper cream	Not necessary

t

4

PLAINTIFF'S EXHIBIT 3 8-30-02 SSP

The Toledo Hospital
Physician's Orders

DATE/TIME

3/23 1100 Discontinue ~~T~~ bili light @ 1500
TO Dr Buganski
Bugenski

0000005413745 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SCN1 000
03/21/1991

U. CLERK	NURSE	DIET VERIFICATION

1430 Strip baby of clothes
Retake temp in one hour
+ call me
TO Dr Buganski
Bugenski

0000005413745 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SCN1 000
03/21/1991

U. CLERK	NURSE	DIET VERIFICATION

3/23/91 2100 Continue phototherapy until 0300 3/24; then dc lite.
Repeat bili @ 0700 3/24/91
t.o. Dr Buganski
Bugenski

0000005413745 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SCN1 000
03/21/1991

U. CLERK	NURSE	DIET VERIFICATION

3/24/91 0242
1. Blood C/s, CRP, CBC c diff + plts stat
2. CRP — 7:00 AM
3. Abdomen xray AP + decubitus c (R) side up R/o perforation
4. Continuous pulse oximeter
5. CBG ASAP
6. Continuous Dinamap
7. Urine cong
8. I.V. Ticarcillin 260 mg q 8 hrs IV
9. Gentamicin 8.75 mg q 12 hrs IV
10. Ampicillin 750 mg IV stat
Bugenski

0000005413745 1
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P 00503
TORSEKAR, K P 00503
03/21/91 SCN1 000
03/21/1991

U. CLERK	NURSE	DIET VERIFICATION

Children's
MEDICAL CENTER OF NORTHWEST OHIO

Clinical Nursing procedures

Index No. 89
Date December 1989
Supersedes: 3/88

Subject: PHOTOTHERAPY

BACKGROUND:

Phototherapy is commonly used for treatment of rising bilirubin levels (hyperbilirubinemia). Bilirubin is broken down by the light to a decolorized, water soluble, apparently non-toxic product. It is not known how the light affects bilirubin metabolism.

EQUIPMENT

1. Phototherapy light with blue light (free standing) or the Wallaby Blanket or Ohmeda Bili Blanket (as ordered by physician)
2. Ophthalmic eye pads or bili mask
3. Measuring tape
4. Yellow plastic shields, if needed

PROCEDURE

1. Obtain phototherapy light according to physician's order.
2. Completely undress infant and place in isolette or bassinet, cover perineum with diaper or disposable face mask with noseguard removed.
3. Cover baby's eyes securely with disposable bili mask to prevent retinal or corneal damage/ulceration.
4. Place light over isolette or bassinet. Plug in cord and turn on lights. Distance from lights to infant should be approximately 18 inches. When using the Wallaby, or Ohmeda, cover the pad with a disposable cover and place infant directly on the Wallaby pad.
5. If desired, obtain and fasten yellow plastic sheets around edges of light to prevent scatter of blue light. Plastic sheets are reusable and should be cleaned with A-33 between uses.
6. Infants may receive phototherapy in open cribs provided:
   a. Infant is of term gestation
   b. Temperature is stable

PLAINTIFF'S EXHIBIT 4 8-30-02 SJP

c. Infant is well with no outstanding physical difficulties. Care should be taken to shield surrounding cribs from phototherapy - distance of eight (8) feet is recommended.

7. Monitor and record intake and output every shift.
8. Bilirubin levels should be done every 12 hours or as ordered while infant is under phototherapy.
9. A Bilirubin level should be done 12 hours after phototherapy is discontinued to determine amount of "rebound" bilirubin rise.

NURSING RESPONSIBILITIES:

1. Check placement of eye shields frequently
   a. Check for signs of eye irritation or drainage
2. Check temperature every 3-4 hours for elevation. Infant may require Servo control on the isolette to regulate temperature.
3. Observe and note any alterations in the infant's activity pattern as a result of this treatment.
   a. Lethargy
   b. Loose, explosive, bright green stools
   c. Rash with bronzing
   d. Signs of dehydration; e.g., sunken fontanels, dry mucous membranes or poor skin turgor
4. Observe infant's calor frequently, especially if under blue light, since recognition of cyanosis may be difficult. Turn light off For feedings.
5. Turn infant frequently to provide maximum amount of exposed surface. Use "fuzzy" pads to prevent skin breakdown.
6. Do not use ointment or lotions to exposed skin areas when infant under phototherapy.
7. Reinforce physician's instructions and explanations about jaundice, bilirubin levels and use of phototherapy to parents.
8. Notify physician of rapidly rising bilirubin levels as an exchange transfusion may be necessary.

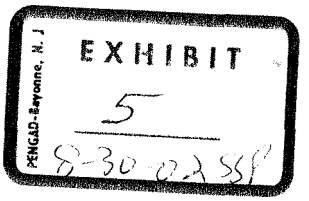
CHARTING

1. Chart and plot bilirubin on bilirubin graph for term or preterm infant, whichever the case may he.
2. Record on Kardex dace phototherapy starred, and date discontinued,

3. With pen on bilirubin graph, denote actual start and stop dates and time of phototherapy.
4. Chart on Flow Sheet the time and date phototherapy started; use assessment boxes on Flow Sheet to address phototherapy usage. Denote number of lights used.
5. Record bilirubin and lab results under Lab section of Flow Sheet.

Written by: Ellen Joslin, RNC, NICU Instructor
Approved by: Nursery Management Team
Reviewed: 3/88, 12/89, 8/94, 7/97

mw



IN THE COURT OF COMMON PLEAS OF LUCAS COUNTY, OHIO

JOSEPH STALMA, JR., **A** MINOR, BY AND THROUGH HIS MOTHER AND NATURAL GUARDIAN, NORMA STALMA,	* * *	Case No. CI0200101505 JUDGE LANZINGER
Plaintiff, vs.	* * *	**AFFIDAVIT OF RAYMOND BUGANSKI, M.D.**
RAYMOND BUGANSKI, M.D., and THE TOLEDO HOSPITAL,	* * *	
Defendants.	* * *	

STATE OF OHIO)
) SS:
COUNTY OF LUCAS)

Raymond Buganski, M.D., being first duly sworn, says that he has personal knowledge of all the facts contained in this affidavit and that he is competent to testify to the matters stated herein, and states as follows:

1. That up until my retirement in 1997, I was licensed and practiced as a physician, specializing in pediatrics, in the State of Ohio.

2. That during the course of my practice I was board certified in general pediatrics.

3. That I practiced extensively at The Toledo Hospital, and was well familiar with the procedures and personnel there.

4. That in March 1991, I became involved in the care of Joseph Stalma, Jr., th plaintiff minor in this litigation.

5. That I have reviewed the medical record from The Toledo Hospital relating to plaintiff minor Joseph Stalrna, Jr.

6. That I personally examined the child at 07:30 a.m., on March 23, 1991, at which tirne he had normal temperature, pulse and respiration, appeared well besides some underlying jaundice, and was updated by the nurses on his progress.

7. That my next contact with regard to ths Stalma baby would have been at 14:30 hours on March 23, 1991, when the nurses' notes indicate "Dr. Buganski notified of ncreased temperature, orders received."

8. That the genesis of this call notifying me of increased temperature was the standing order maintained by my practice requiring that we wish to be notified of any elevated temperature, which we indicated was 99 degrees Fahrenheit (copy of the practice request form and nurses' notification chart are attached to this Affidavit, and previously marked plaintiffs Exhibit 3.)

9. That in response to this notification of increased temperature, I gave a elephone order that the baby be stripped of any unnecessary clothes or coverings, and hat the temperature be retaken in one hour and I be advised as to same.

10. That in light of the standing order with my practice that I be contacted for iny temperatures over 99 degrees, when I was not called back upon the retaking of the smperature, I took that to mean that temperatures were again below 99 degrees Fahrenheit.

11. That this standing 99 degree notification requirement was established by nyself and my practice with the acknowledgment that core or rectal temperatures could

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actually record higher than the axillary temperatures standardly taken at The Toledo Hospital.

12. That after 14:30 hours on March 23, 1991, I was not informed of any further or continued increases in temperature above 99 degrees.

13. That the next contact I had with regard to baby Stalma was a call at 21:00 hours on March 23, 1991, from Nurse Osterhout.

14. That at 21:00 hours, when I was primarily called with the 1900 bilirubin results, I was also advised that the Stalma baby had had a choking event some 2 ½ hours prior to said call.

15. That the medical records indicate that at 18:35 hours, on March 23, 1991, the mother stated the baby had an arched back and stiffened extremities while feeding, and at that time the nurse noted cyanosis around the mouth and hands, and the baby was suctioned at bedside of a mouth full of formula and mucous and continued to have difficulty with breathing on expiration.

16. That the medical record notes that at 18:40 on March 23, 1991, the baby was returned to the nursery and DeLee'd three times with the baby belching with suction, and passing a lot of flatus, it being reported that mucous and formula was suctioned up with DeLee.

17. That the records indicate that at 18:45 on March 23, 1991, the lungs were clear, nail beds pink, and color improving with facial 0 2 for one minute.

18. That the records indicate that at 18:50 on March 23, 1991, the baby was pink in color with underlying jaundice.

19. That when I was notified at 21:00 hours on March 23, 1991 of the above incident, which had occurred 2 ½ hours earlier, it was described as a choking incident which had resolved.

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20. That at the tirne I was called at 21:00 hours, on March 23, 1991, the baby was described as behaving and reacting well. The last prior temperature was noted at 98.6 degrees.

21. That at 21:00 hours on March 23, 1991, there was no indication for the neec to immediately examine the child or request a consult to conduct same.

22. That had I been called concurrent with the events described by the mother, would have come shortly to examine the child myself, or had a consult by another care provider to further investigate this incident.

23. That when reported 2 ½ hours later, at 21:00 on March 23, 1991, when the baby was reported as appearing fine and had a normal temperature, I reasonably relied upon the report from the nursery nurses that this had been a transient choking or reflux ncident which had fully resolved, requiring no additional action or investigation at 21:00.

24. That the medical records reflect that at 24:00 baby Stalma remained under phototherapy, was quiet, sleeping, and retained a pink color, with a temperature of 97.9, pulse of 136, and respirations at 40.

25. That I received no further contact with regard to baby Stalma until 02:30 on March 24, 1991, after the NICU was already called in directly by the nurses, for the Stalma baby having taken a downward turn.

26. That had I been contacted with regard to continuing increased temperatures beyond the single report to me at 14:30 on March 23, 1991, or some other downward change in the infant's general status, I would have initiated some additional investigation as to same.

Further affiant sayeth naught.

Raymond Buganski, M.D.

Raymond Buganski, M.D.

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Sworn to before me and subscribed in my presence this 29TH day of

_____ 002.

Sharon M Mouch
NOTARY PUBLIC

SHARON M. MOUCH
NOTARY PUBLIC, State of Ohio
My Commission expires: Jan. 30, 2007

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