

1 IN THE COURT OF COMMON PLEAS
2 OF LUCAS COUNTY, OHIO

3
4 JOSEPH STALMA, JR., a minor, by
5 and through his mother and natural
6 guardian, NORMA STALMA,

Case No.

7 CI0200101505

8 Plaintiff,

9 vs.

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

12
13 Defendants.

14 - - - - - - - - - - / - - -

15
16 The telephonic Videotaped Deposition of
17 DR. LEE MARK WEINSTEIN, an Expert Witness in the
18 above-entitled cause, taken by Shari J. Pavlovich,
19 CSR-5926, Certified Shorthand Reporter,
20 Registered Professional Reporter, and Notary Public
21 for the County of Wayne, acting in the County of
22 Oakland, State of Michigan, at 36700 Woodward Avenue,
23 Suite 300, Bloomfield Hills, Michigan, on
24 Friday, August 30, 2002 commencing about 11:05 a.m.,
25 pursuant to the applicable court Rules.

1 APPEARANCES:

2 BY PHONE:

3 BECKLER & MISHKIND

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8 For the Plaintiff.

9 BY: DAVID KULWICKI

10 IN PERSON:

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15 For Raymond Buganski, M.D.

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20 Toledo, Ohio 43604

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22 For The Toledo Hospital.

23 BY: ANGELICA M. COLWELL

24 PRESENT: David B. Schafer, Video Technician

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1 Bloomfield Hills, Michigan

2 Friday, August 30, 2002

3 About 11:05 a.m.

4 - - -

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

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

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

12 Today is Friday, August the 30th, year
13 2002. Time is 11:05 a.m. My name is David B.
14 Schafer, Video Technician and Notary Public for the
15 County of Wayne.

16 The attorneys please introduce
17 yourselves for the record.

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

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

25 MR. WASUNG: John Wasung, Kitch

1 Drutchas, on behalf of Dr. Buganski.

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

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

7 THE WITNESS: I do.

8 VIDEO TECHNICIAN: You may proceed.

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

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

14 MS. COLWELL: Yes.

15 - - -

16 EXAMINATION

17 BY MR. KULWICKI:

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

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

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

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

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

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

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

7 Q Doctor, you're a board certified pediatrician?

8 A That's correct.

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

13 A That's correct.

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

20 A No, I have not.

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

23 A Yes, I do.

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

1 we could.

2 A Sure.

3 Q Please, would you tell us about your current practice.

4 What type of patients do you see?

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

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

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

18 A That's right.

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

21 A Absolutely.

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

24 A State of Michigan.

25 Q And how long have you been licensed to practice

1 medicine in the State of Michigan?

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

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

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

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

13 A That's fair. Although --

14 Q What does the term on call mean?

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

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

24 A Fair enough.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 A I will.

19 Q Okay. Thank you.

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

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

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

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

4 A Yes, I would say that's true.

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

7 A Yes.

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

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

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

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

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

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

3 A Correct.

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

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

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

14 A Yes.

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

18 A Fair, um-hmm.

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

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

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

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

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

9 Q What's the date of that affidavit?

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

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

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

15 VIDEO TECHNICIAN: Going off at 11:19.

16 (Short recess.)

17 - - -

18 (Deposition Exhibit 5 was
19 marked for identification.)

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

22 BY MR. KULWICKI:

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

1 patients?

2 A Yes.

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

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

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

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

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

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

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

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

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

12 A Yes.

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

16 A I would say generally every eight hours.

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

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

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

1 neonatologists?

2 A They do.

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

6 A Well, I have to take each hospital independently.

7 Q Okay.

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

10 Q Okay. Well, then --

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

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

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

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

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

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

9 A Oh, yes.

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

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

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

24 BY MR. KULWICKI:

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

1 to whether Toledo Hospital in 1991 had a neonatologist
2 available at the hospital twenty-four hours a day in
3 1991?

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

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

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

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

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

18 A Yes, I have.

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

21 A Well, it's a standing order list.

22 Q Do you have something similar in your practice?

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

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

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

7 A I don't recall that.

8 Q You're not sure when the change came?

9 A That's correct.

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

16 A Yes.

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

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

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

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

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

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

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

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

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

22 A That's correct.

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

25 A Correct.

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

4 A Yes.

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

9 A Correct.

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

14 A Okay, I have that.

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

17 A Yes, I have.

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

19 A That's correct.

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

22 A Yes, I do.

23 Q And using military time it's denoted here as
24 14:30; correct?

25 A That's correct.

1 Q Do you see where it says strip baby of clothes, retake
2 temperature in one hour and call me?

3 A Yes.

4 Q And it appears to be written by a nurse who writes
5 Dr. Buganski's name. Then it appears to be
6 countersigned by Dr. Buganski, as well. Do you see
7 that?

8 A Yes, I see that.

9 Q Is it your understanding that this is an order by
10 Dr. Buganski to the nursing staff in the Toledo
11 Hospital newborn nursery regarding Joey Stalma?

12 A Yes.

13 Q And when you give an order in your practice like this
14 do you expect the nursing staff to follow it?

15 A Yes.

16 Q And do you have an opinion to a reasonable degree of
17 medical probability as to whether Dr. Buganski had a
18 reasonable expectation that the nurses would follow
19 his order?

20 A I think you're asking me to get into Dr. Buganski's
21 mind here.

22 Q Well, I'm asking you whether he would, as a reasonably
23 prudent pediatrician, should expect his orders to be
24 followed.

25 A Yes.

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

6 MS. COLWELL: Objection.

7 MR. WASUNG: You can go ahead, Doctor.

8 MS. COLWELL: You can go ahead.

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

12 BY MR. KULWICKI:

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

17 A Okay.

18 Q Have you seen this document before today?

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

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

23 A Okay.

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

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

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

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

12 Q Okay. Fair enough, Doctor.

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

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

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

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

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

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

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

7 A Um-hmm.

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

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

12 But go ahead, Doctor, as you can.

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

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

19 BY MR. KULWICKI:

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

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

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

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

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

6 Q Yes, Doctor.

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

10 Q And why did you do that?

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

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

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

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

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

3 A Yes.

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

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

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

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

15 Q Sure.

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

20 Q Let's talk about you specifically.

21 A So me initiating a sepsis workup?

22 Q Yes, Doctor.

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

1 fashion.

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

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

15 A Yes.

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

18 A I think that's true, yes.

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

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

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

8 Q Either high or low?

9 A That's right.

10 Q Okay.

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

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

18 A Definitely.

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

22 A I agree with that.

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

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

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

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

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

13 A Right. I agree with that.

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

16 A That's correct.

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

25 MR. WASUNG: Objection, form and

1 foundation.

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

4 BY MR. KULWICKI:

5 Q Uh-huh.

6 A Because it would depend on what the problem is.

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

12 MR. WASUNG: Same objection.

13 Go ahead, Doctor.

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

18 BY MR. KULWICKI:

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

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

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

1 have a suspicion of sepsis.

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

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

9 A Okay.

10 Q -- what sort of assessment would you do?

11 A Well, certainly an examination is the first thing.

12 Q And what would that examination consist of?

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

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

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

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

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

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

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

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

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

22 A Yes.

23 Q How long might such an assessment take?

24 A Ten to fifteen minutes, maybe.

25 Q With your attention focused only on that baby?

1 A That's right.

2 Q Now, Doctor, I want to switch gears on you for a
3 moment. I'm going to talk to you about phototherapy.

4 A Okay.

5 Q I take it that on occasion phototherapy, particularly
6 when the older-styled blue lights were used, can raise
7 an infant's temperature; correct?

8 A I think that's true, although I'm not an expert on
9 that.

10 Q Well, in your experience have you ever experienced
11 that particular phenomenon?

12 A I have.

13 Q And is it a rather uncommon event?

14 A Yes.

15 Q And Doctor, in your experience how long did it take
16 for the baby's temperature when it was raised by the
17 environment or by phototherapy lights, how long did it
18 take for the temperature to return to normal?

19 A I think it's hard to answer that question because like
20 we said, it's an uncommon event. And over the years I
21 can -- you know, I can't really point to specifics or,
22 you know, how many times it's happened to kind of make
23 a judgment on that.

24 Q Fair enough. Let me switch gears again.

25 In this case, Doctor, we know that the

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

4 A Yes, it is.

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

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

9 Q No, just your practice.

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

13 Q And why would you do that?

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

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

23 A In 1991 I don't remember.

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

25 A Right, right.

1 Q -- that the temperature was ninety nine degrees; that
2 Dr. Buganski wanted to be notified if it was ninety
3 nine or above, axillary; correct?

4 A Correct.

5 Q What was your practice in 1991?

6 A You know, again, it's hard to look back to 1991. I
7 think somewhere around that area.

8 Q Doctor, I take it that you don't have any criticisms
9 of the care that was rendered by Dr. Buganski;
10 correct?

11 A That's correct.

12 Q Do you have any opinions regarding whether Joey's CP
13 and mental retardation are related to the Group E
14 Strep, meningitis, and sepsis that he had in 1991?

15 A Well, I think it's very likely that his neurologic
16 condition was related to an infection of the nervous
17 system.

18 Q Based on your review of the records and your training
19 and experience could you state that opinion to a
20 reasonable degree of medical probability?

21 A Yes.

22 Q And Doctor, do you have any opinions about whether or
23 not his neurological status, whatever it is now, is
24 permanent in nature?

25 A Well, again, I haven't -- haven't really been asked to

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

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

5 A No, I do not.

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

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

11 Q At least fifty percent.

12 A Yes. More like ninety percent.

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

17 - - -

18 EXAMINATION

19 BY MS. COLWELL:

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

24 A Yes, I do.

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

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

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

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

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

12 A Yes, I believe so.

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

15 You would agree that Joey Stalma was
16 seen by a pediatrician on the mornings of 3/22/91 and
17 3/23/91; correct?

18 A Yes, um-hmm.

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

22 A Yes.

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

1 A That 's correct.

2 Q In your experience have you taken care of babies that
3 have received circumcsions?

4 A Yes.

5 Q According to your review of the chart would you agree
6 that Joey had a circumcision sometime in the morning
7 on 3/23/91?

8 A I believe so, yes.

9 Q Do you agree that in general as the result of a
10 circumcision infants experience pain?

11 A They do. It's a little different than you would
12 expect in, say, an older person but there is a pain
13 response.

14 Q Okay, fair enough. Is that pain response something
15 that you would expect to continue for a certain amount
16 of time, say, hours after the circumcision?

17 A You know, it depends a little bit on how -- you know,
18 what's done in advance of a circumcision. Sometimes
19 people do nerve blocks and other kinds of techniques
20 to limit the pain.

21 Q Fair enough.

22 A But generally, generally babies are -- for a couple
23 hours after they tend to be a little out of sorts, if
24 you will, maybe a little quieter.

25 Q In your experience that they tend to be quieter in

1 response to pain?

2 A Yes.

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

5 A Would it be unusual? No.

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

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

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

13 (Short recess.)

14 - - -

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

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

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

21 VIDEO TECHNICIAN: One moment.

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

23 Anything further?

24 MR. KULWICKI: Nothing further.

25 MR. WASUNG: For the record, Doctor,

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

5 THE WITNESS: I'd like to, yeah.

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

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

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1 FURTHER, DEPONENT SAYETH NOT:

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DR. LEE MARK WEINSTEIN

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10 Subscribed and sworn. to, before me,
11 this ____ day of _____, 2002.

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13 Notary Public, _____ County, Michigan

14 My Commission expires: _____

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DR. LEE MARK WEINSTEIN

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Dated: _____

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1 STATE OF MICHIGAN)

2) SS

3 COUNTY OF OAKLAND)

4 I, Shari J. Pavlovich, Certified

5 Shorthand Reporter, Registered Professional Reporter,

6 and Notary Public duly commissioned and qualified in

7 and for the State of Michigan, do hereby certify that

8 pursuant to the Michigan General Court Rules, there

9 came before me on the 30th day of August, 2002, at

10 36700 Woodward Avenue, Suite 300, Bloomfield Hills,

11 Michigan, the following named person, to-wit:

12 DR. LEE MARK WEINSTEIN, who was by me duly sworn to

13 testify to the truth and nothing but the truth of his

14 knowledge touching and concerning the matters in

15 controversy in this cause; that he was thereupon

16 carefully examined upon his oath and his

17 examination was reduced to computer transcription

18 under my supervision; that the deposition is a true

19 record of the testimony given by the witness.

20 I further certify that I am neither

21 attorney nor counsel for, nor related to or employed

22 by, any of the parties to the action in which this

23 deposition is taken; and, further, that I am not a

24 relative or employee of any attorney or counsel

25 employed by the parties hereto or financially

1 interested in the action.

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

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Shari J. Pavlovich

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CSR-5926

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Notary Public, Wayne County, MI

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Acting in Oakland County, MI

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My Commission expires:

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April 14, 2005

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24:17,24 25:13	1-43:9 4:5	419-249-7100 2:21		
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36:25 38:14	11002:19			
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wouldn't 20:11 35:7	29th 13:10			
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year 4:12 16:5 27:6	5:20 44:10			
years 7:11 8:16	37 3:4			
34:20				
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FAMILY CENTERED MATERNITY CARE
NURSERY DAILY FLOW SHEETDate 3/22/91 - 3/22/91Weight 7.13Assessment Time 8:00

Change Box

Δ in condition/time

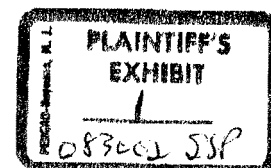
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Addressograph Stamp

Diet (type)		Respiratory		GI	
Breast		Quality		Abdomen	Soft <u>ju</u>
Formula		* Unlabeled	<u>ju</u>	* Distended	
Nipple Regular	<u>ju</u>	* Nasal Flaring		Bowel Sounds	
Premie Soft Nipple	<u>ju</u>	* Retractions		Present	<u>ju</u>
Gavage PRN		* Grunting		* Absent	
		Sounds		Additional Assessments	
Hygiene		Clear	<u>ju</u>		
Complete	<u>ju</u>	* Other			
Staff					
Mother		Skin		Tests/Labs	
		Temp.			
Safety		Warm	<u>ju</u>		
Bassinet	<u>ju</u>	* Hot			
Isolette		* Cool			
Continually Attended by Mother or Staff	<u>ju</u>	Turgor			
Neuro-Behavioral		Good	<u>ju</u>		
Reflex Irritability		* Poor			
Vigorous Cry <u>strong</u>		Moisture			
* Lethargic	<u>ju</u>	Dry	<u>ju</u>		
Suck		* Diaphoretic			
Good	<u>ju</u>	Color			
Fair	<u>ju</u>	WNL			
* Poor		Pale			
Fontanelles		Ruddy	<u>ju</u>	Time	
Flat	<u>ju</u>	Jaundiced		Test	
* Other		* Cyanotic		Metabolic Screening	
Moro		Cord		Test #	
Good	<u>ju</u>	Clamped	<u>ju</u>	Time	
Fair	<u>ju</u>	Dry		Per Heelstick	
* Other		* Other		Signature	
Muscle Tone		Caput			
Good	<u>ju</u>	Yes		O E N	
* Flaccid	<u>ju</u>	No	<u>ju</u>	Treatment	
* Hypertonic		Cephalohematoma		Eye Care:	
Moves All Extremities		Yes <u>ju</u>		Cord Care:	
Yes	<u>ju</u>	No		Turn/Reposition:	
No	<u>ju</u>	Internal Monitor Site Present		Ea. Feed See I&O	
Cardio-Vascular		No	<u>ju</u>	Betadine Scrub:	
Mucous Membranes		Yes		to Internal Monitor Site Daily	
Pink <u>ju</u>		REEDA WNL	<u>ju</u>	Circ Care: with each	
* Other		* Other		Diaper Change	
Murmur Present		Circumcision		Phototherapy <u>0.2.0</u>	
Yes	<u>ju</u>	No	<u>ju</u>	Eye Patches	
No	<u>ju</u>	Yes		Gonad Protection	
AP		REEDA WNL		Lamb's Wool Pad	
Regular	<u>ju</u>	* Other		Weight AC & PC	
Irregular				Equipment	
				Isolette (temp)	
				Pelvic Harness	
				Triple Diaper	
				Perineal Roll	

Revised & approved by Executive Committee 8/90



Time	PO	Intake		Output		Time	Health Care Notes: document response to interventions, teaching, PRN medications or unusual occurrences.
		Comments		Urine	Stool		
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Time	Intake		Output		Time	Health Care Notes: document response to interventions, teaching, PRN medications or unusual occurrences.
	FO	Comments	Urine	Stool		
37						
38						
39						
10:40	Sim	1/2				
11						
12						
13						
14	30	Sim 1/2 well	✓	ma		
15						
16						
17						
18	70	1/2	✓			
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M. K.

TIME	TEMP	PULSE	RESP	BP	TIME	PHYSICIAN NOTED	INITIALS
100	98.4	124	44				
101	97.0						
102	96.9	132	40				
103	96.6						
104	98.6	140	40				
105	99						
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Patient Goals	Outcomes	Progress
4. (Physical) A - achieved U - unachieved	A U	
Mutually set with pt/family	Yes NA	
With school ins		
24 hrs.	1-70%	
4. (Physical)	A U	
Mutually set with pt/family	Yes NA	
Bedrooming needs		
with school		

Discharge Planning Progress: See Mother's chart

Zaenya

320

001 2745

Change Box
Δ in condition/time

00/21/91
00/21/91

120503

008

Addressograph Stamp

Diol (type)		Respiratory		Addressograph Stamp	
Breast		Quality		GI	
Formula		* Unlabeled		Abdomen	Soft
Nipple Regular		* Nasal Flaring		* Distended	
Premie Soft Nipple		* Retractions		Bowel Sounds	
Gavage PRN		* Grunting		Present	
		Sounds		* Absent	
Hygiene		Clear		Additional Assessments	
Complete		* Other			
Staff					
Mother		Skin			
		Temp.		Tests/Labs	
Safety		Warm		0700 Bilirubin 2d collected	
Bassinette		* Hot		to Dr. Bergeron	
Isollette		* Cool			
Continuously Attended		Turgor		1900 Bilirubin 8.0 collected to	
by Mother or Staff		Good		Dr. Bergeron	
Neuro-Behavioral		* Poor		0300 Blood drawn for	
Reflex Irritability		Moisture		CBC - CAG - PH.	
Vigorous Cry		Dry			
* Lethargic		* Diaphoretic			
Suck		Color			
Good		WNL			
Fair		Pale			
* Poor		Ruddy			
Fontanelles		Jaundiced			
Flat		* Cyanotic			
* Other		Cord			
Moro		Clamped			
Good		Dry			
Fair		* Other			
* Other		Caput			
Muscle Tone		Yes			
Good		No			
* Flaccid		Cephalohematoma			
* Hypertonic		Yes			
Moves All Extremities		No			
Yes		Internal Monitor Site Present			
* No		No			
Cardio-Vascular		Yes			
Mucous Membranes		REEDA WNL			
Pink		* Other			
* Other		Circumcision			
Murmur Present		No			
* Yes		Yes			
No		REEDA WNL			
		* Other			
AP					
Regular					
Irregular					

Approved and
Signed _____

Time	PO	Comments	Intake	Output	Urine	Stool	Time
27							
26							
25							
24							
23							
22							
21							
20							
19							
18:30		3/4 oz dex - fed in a syringe					
17							
16							
15:15		1 oz - formula well					
14							
13							
12							
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8							
7							
6							
5							
4							
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2							
1							
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Time	PO	Comments	Intake	Output	Urine	Stool	Time
0:30							
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6:30							
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Time	PO	Comments	Intake	Output	Urine	Stool	Time
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Time	PO	Comments	Intake	Output	Urine	Stool	Time
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Time	PO	Comments	Intake	Output	Urine	Stool	Time
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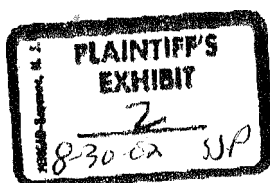
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e Health Care Notes: (continued)

- 230 AP 1/16 Irregular @ the time, R. 40 - Counting - Subcostal Retraction.
 O2 gas mask given. Contains rigidity for some relaxed sounds
 @ the time. NICU nurse moved her @ the time.
 Color continues Pale green-cyanotic. Breasts small. Cords bagged for
 NICU use. Dr. Satish in bed examined. Orders remain.
 Dr. Buganski notified of above. Chest X-Ray Done.
 BP. drug 62/42/43 mm Hg 69/42/43 mm Hg.
 Blood Culture drawn. Plasma sent given by NICU nurse.
 Lab work done. ————— M. Zaeng
- 2330 Taken to visit mother. Transferred to NICU in Eubank Potable
 Oxygen. following under dusky epiride. M. Zaeng

M. Zaeng



T-BRT



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 prefer

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? diaper cream

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

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

Sincerely,

Pat Clay, R.N.

J T Cullen

BREAST FED BABIES

URS IF...

PHYSICIAN	TEMP	COOMBS	POSITIVE	COOMBS	LAUNDICE	SUPPLE- MENT WITH DEXTRASE WATER	IF FED IN NURSERY GIVE	UNDER PHOTO THERAPY PC	SORE BUTTOCKS APPLY	MON O POSITIVE ORDER TYPE 2 COOMBS
Drs. T-B-R-T	99	Yes	only if significant	No	What mom prefers	No	Diaper cream	Not necessary		



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.

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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 NO pc 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? diaper cream

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

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

Sincerely,

Pat Clay, R.N.

J T Conner

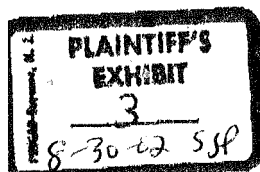
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EXHIBIT

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KD 65

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

SHOULD BE FED BABIES



The Toledo Hospital
Physician's
Orders

DATE/TIME

3/23
1160

Discontinue me
high 2 1580

TO Dr. Bugarski
Bryant

000005413745
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P
TORSEKAR, K P
03/21/91 SENT 000
03/21/91

00503
00503

U. CLERK	NURSE	DIET VERIFICATION

1430

Stop baby clothes
Rethink temp for me now
& call me

TO Dr. Bugarski
Bryant

000005413745
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P
TORSEKAR, K P
03/21/91 SENT 000
03/21/91

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U. CLERK	NURSE	DIET VERIFICATION

3/23/91 2100 Continue phototherapy
until 0300 3/24; then dr. ltr.
Repeat bili @ 0700 3/24/91

t.o. Dr. Bugarski

Bryant

000005413745
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P
TORSEKAR, K P
03/21/91 SENT 000
03/21/91

00503
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U. CLERK	NURSE	DIET VERIFICATION

3/24/91 ① Blood Gs, CP2, CK & diff + platelets stat
② CP1 - 7:00 AM

③ Abdomen xray AP & decubitus (R) side up to perforation
④ Continue pulse oximetry
⑤ CBC ASAP

⑥ Continue Dinamap

⑦ Urine clogs

⑧ I.V. Ticarcillin 200mg q 8 hrs Id

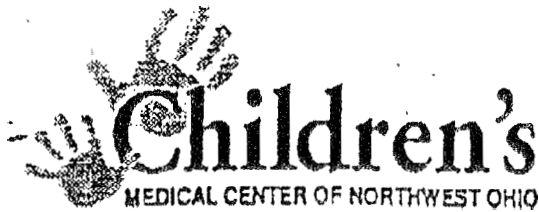
⑨ Gentamicin 8.75mg q 12 hrs ID

⑩ Ampicillin 750 mg IV stat after stat

000005413745
MRN 000000566728
STALMA, BABY BOY
TORSEKAR, K P
TORSEKAR, K P
03/21/91 SENT 000
03/21/91

00503
00503

U. CLERK	NURSE	DIET VERIFICATION



Clinical Nursing procedures

Subject: PHOTOTHERAPY

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

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 nose guard 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



Phototherapy - Page 2

- 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 fontanel, dry mucous membranes or poor skin turgor
4. Observe infant's color 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 be.
2. Record on Kardex date phototherapy started, and date discontinued,

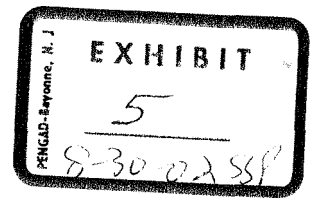
Phototherapy

Page 3

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,

Plaintiff,

vs.

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

Defendants.

* Case No. CI0200101505

* JUDGE LANZINGER

* **AFFIDAVIT OF RAYMOND**
* **BUGANSKI, M.D.**

STATE OF OHIO

COUNTY OF LUCAS

)
) SS:
)

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., the plaintiff minor in this litigation.

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

6. That I personally examined the child at 07:30 a.m., on March 23, 1991, at which time 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 this Stalma baby would have been at 14:30 hours on March 23, 1991, when the nurses' notes indicate "Dr. Buganski notified of increased 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 telephone order that the baby be stripped of any unnecessary clothes or coverings, and that 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 any temperatures over 99 degrees, when I was not called back upon the retaking of the temperature, I took that to mean that temperatures were again below 99 degrees Fahrenheit.

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

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 O₂ 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.

/-

20. That at the time 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 need 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, I 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 incident 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.

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