IN THE CIRCUIT COURT OF

CABELL COUNTY, WEST VIRGINIA

ADAM WESLEY MEADE, an infant, who by and through next friend and mother, PATRICIA MEADE, and PATRICIA MEADE and DAVID MEADE, individually,

Plaintiffs,

VS.

CABELL HUNTINGTON HOSPITAL, INC., a West Virginia corporation, D. RATCLIFF JR., M.D., individually, JOSEPH WERTHAMMER, M.D., individually, FRANK URREGO, M.D., individually, LIBERTY TABLANTE, M.D., individually, MAGDI Z. FAHMY, M.D., individually, LEO PAJARILLO, M.D., individually, SONG KIM, M.D., individually, and SUTIN SRISUMRID, M.D., individually,

Defendants.

CIVIL ACTION NUMBER 90-C-1067

The testimony of ELIAS GEORGE CHALHUB, M.D., taken at the Offices of Barlow & Associates, 3217 Executive Park Circle, Mobile, Alabama, on the 2nd day of February, 1993, commencing at approximately 4:30 o'clock, p.m.

A P P E A R A N C E S

FOR THE PLAINTIFFS:	WILLIAM deFOREST THOMPSON, P.A. ATTORNEYS AT LAW P. O. BOX 14334 FORT LAUDERDALE, FLORIDA 33302 BY: WILLIAM deFOREST THOMPSON, ESQ.
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A P P E A R A N C E S C O N T ' D

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LISA ELMORE PETERS
COURT REPORTER

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I, Lisa Elmore Peters, Commissioner and Court Reporter, certify that on this date, there came before me at the Offices of Barlow & Associates, 3217 Executive Park Circle, Mobile, Alabama, on the 2nd day of February, 1993, commencing at 4:30 o'clock, p.m., ELIAS GEORGE CHALHUB, M.D., witness in the above cause, for oral examination, whereupon the following proceedings were had:

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(Plaintiff's Exhibits 1 and 2 were received and marked for identification.)

ELIAS GEORGE CHALHUB, M.D.

The witness, after having first been duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. THOMPSON:

Q Your name for the record.

A Elias George Chalhub.

Q And your professional address?

A 1720 Springhill Avenue, Mobile, Alabama.

Q And how long have you been there?

A Three years.

Q Residence address?

A Pinebrook Avenue, Mobile, Alabama,

Q No current plans on leaving the Mobile area?

A I don't believe so.

Q Okay. My understanding, Dr. Chalhub, you've been asked by Mr. Cleek, who represents Dr. Pajarillo, to review certain records in a lawsuit filed in Cabell County, West

Virginia involving care and treatment rendered to and for Adam Meade by various physicians; is that correct?

A Right.

Q And when did that occur?

A Approximately a year ago.

Q Are we talking about roughly the early part of 1992?

A It may be somewhat later. It may be in the spring. Sometime in the spring.

Q Any correspondence by and between you and Mr. Cleek, Mr. Cleek's office concerning retaining you, asking you to review records, sending records back and forth or bills or whatever?

A Obviously when the records came, there were cover letters saying here are the records and, you know, any subsequent depositions, but I've not had any correspondence from my office to him.

Q You haven't written any reports --

A No.

Q -- at all?

A No.

Q Have you made any notes contemporaneous with your review of depositions or records?

A No.
Q So that with regard to the materials that you have here, and I understand from before your deposition you left some of the stuff at home or in your office?
A No, just the depositions.
Q Depositions?
A They were so voluminous to carry.
Q No notes on those depositions at all, no highlighting or --
A I'll be -- no, and I'll be glad, if you want them, to pack them up and send them to you, but there aren't any.
Q Okay. And I would take it then that for the last eight or nine months off and on you've been reviewing these materials?
A And for the last several days, yes.
Q Okay. Do you know how it was that Mr. Cleek got your name?
A No, I don't.
Q Have you reviewed other things for him?
A No.
Q Can you tell me what it was he asked you to do either verbally or in writing?

A He asked me to review these records and to give him an opinion as to what I thought caused neurological damage in this child.

Q Did you know who he represented?

A Yes.

Q It was Dr. Pajarillo?

A Correct.

Q You knew he was a pediatrician?

A Yes.

Q Were you not asked to review this case from the standpoint of deviation from acceptable standards of care?

A No, I don't practice general pediatrics.

Q Well, are you practicing any type of speciality at all now?

A Child neurology.

Q Child neurology still?

A (Witness nods head affirmatively.)

Q And how much of your time is spent practicing child neurology?

A Oh, about five percent.

Q And what is ninety-five percent of your time spent doing?

A Well, I'm president of the Mobile Infirmary

Medical Center.

Q Well, what do you do as president of the Mobile Infirmary Center?

A I manage and adminstrate the medical center.

Q You don't treat patients?

A No, not as the -- no, not as the president.

Q You've had a pediatric residency, you've had pediatric fellowships, have you not?

A Correct.

Q You don't feel that in 1992 when you got these records you were not competent to review this case from the standpoint of deviations from acceptable standards of care or whether or not a pediatrician acted within or comported with acceptable standards of care?

A I really wasn't asked to and I don't practice general pediatrics, so, you know, I think that that probably, you know, for what I was asked to do, is out of the scope.

Q Okay. If we can put aside for a moment, realizing, of course, that was my question before, but my most recent question is: Were you and are you competent to review medical records, to review depositions and make determinations as to whether or not pediatricians act within

or outside acceptable standards of care?

A Well, I think it depends on certain circumstances. I mean, if it's a type of entity or practice that I would do as a primary care doctor, as a neurologist, then -- and I felt comfortable with doing it, then I would do it, but if not, I would not elect to do it. In this case I was not asked to.

Q Have you ever testified that pediatricians or a pediatrician fell below or met with acceptable standards of care?

A Sure.

Q How many times?

A I don't know. It depends -- you know, it usually has to do with seizures or some neurological problem.

Q Well, if you were asked to do it in Adam Meade's case, assuming for the purposes of the moment Mr. Cleek or one of these other gentlemen, ladies, asked you to review this case from the standpoint of whether or not Dr. Pajarillo or someone else met with acceptable standards of care, you certainly were ready, willing and able to undertake that, weren't you?

A No. E mean, not until I would look at the case and see whether I thought it was appropriate.

Q You looked at the case?
A Yes.
Q Read all the records?
A Correct.
Q My question is: Are you, were you in a position to comment on whether or not Dr. Pajarillo or anyone else met with or fell below acceptable standards of care?
A No.
Q Why not?
A Because, you know, I don't intubate children any more. You know, I don't do ER work as a primary care doctor. So, I, you know, I don't think it's appropriate in this circumstance. I mean, I'm happy to comment as a pediatric neurologist to whatever you ask, but in terms of commenting on the standard of care, I did not review it from that aspect in each and every step of the way, so I'm really not prepared to do that.
Q I will accept for the purposes of any more questions that I may ask that you weren't asked to do it, you weren't assigned that task, and you did not do it.
A Correct.
Q My question, however, is: Weren't you competent in 1992 and aren't you competent now to review a record such

as Adam Meade and comment upon whether or not the care and treatment met with or fell below acceptable standards of care?

A Some aspects. Some aspects not.

Q Okay. Obviously you don't intubate children any more and haven't for how long?

A Gosh, since 1976, you know, unless it was -- I was the only individual there.

Q When is the last time you intubated a child, either a neonate or be it a year old or a forty day old child?

A You know, I don't honestly know. Perhaps sometime in the eighties.

Q Late eighties, early eighties?

A I don't know.

Q Obvious you don't practice and haven't practiced in an emergency room setting for how long?

A Well, as a primary care physician, that's correct.

Q The last time you would have been to an emergency room to see a patient, to assist a patient, to check on a patient's ventilatory capabilities would have been when, Dr. Chalhub?

A Well, they wouldn't call me to check on ventilatory capabilities. Now, if it was a child in the emergency room with a neurological problem, then I would go and see the patient as a consult, but not as a primary care doctor.

Q Okay. When is the last time you went to an emergency room for that purpose?

A About a year and a half.

Q Anything else with regard to the context of Adam Meade in addition to the fact that you don't intubate and don't practice in emergency rooms any more that you feel would hinder your review of this case from the standard of care aspect?

A No. I mean, I just didn't look at it from that aspect. I mean, you know . . .

Q Okay. You gave us a list which we've marked as Plaintiff's Exhibit number 2. This is in your handwriting?

A Yes.

Q I presume you made this, when; today?

A No, last night.

Q Last night at home?

A Correct.

Q And this is a list of the depositions that you

have reviewed?

A Correct.

Q And you have reviewed those things off and on for the last six, seven, eight months?

A Yes, whenever I received them.

Q Okay. I presume you made this list from the actual depositions that you had in front of you at that time?

A Yes, I piled them up and wrote them down.

Q And you previously told me there are no notes on any of these depositions; that is, if I had these depositions right here on this table and went through each and every page, there would be no notes of yours?

A Correct.

Q And there would be no notes or highlighting by anybody else including Mr. Cleek or some member of his office?

A I don't believe so. I can't absolutely tell you what Mr. Cleek put in them, but I don't believe so.

Q And you have made no summaries with regard to any of these depositions?

A Correct.

Q And on -- there's a line then, a vertical line

that you've drawn on the page and on the other side it says x-rays and you've got chest x-ray, right?

A Right.

Q What chest x-ray are you talking about?

A That were taken in the emergency room at Appalachian (Phonetic) Hospital.

Q And why did you review that?

A It was sent to me.

Q Okay. And can you tell me how many chest x-rays or whether or not it was just a single chest x-ray you saw? You've got a single one here.

A Two.

Q Two?

A Uh-huh.

Q And those are the ones reported on in the record by Dr. Sutin?

A That's correct.

Q And have you seen any other x-rays?

A The CT scans of July 18th, August 1st, November of '86 and then March of '88, I believe.

Q You see there's no CT scans written on there.

A Oh, I'm sorry.

Q Do you want to add to it?

A Sure.
Q Put anything else on there that you saw in addition to the CT scans.
A No, that's all. I thought that was on there. I apologize.
Q Where are the CT scans?
A They're -- I had returned them to Mr. Cleek.
Q And when did you do that?
A This morning.
Q When is the first time you looked at them?
A I don't know. Several weeks ago.
Q And Mr. Cleek has them now?
A No, they were returned to his office.
Q You mailed them back?
A Correct.
Q When?
A This morning.
Q And you don't have it written down here, but you have a recollection of what CT scans you reviewed?
A Sure.
Q Tell me.
A They're in the chart.
Q Okay. When were those CT scans taken?

A July 18th, 1986; August 1st, 1986; November, and I can't remember the date, 1986, and then March of 1988.
Q Okay. Any other CT scans other than the one of July 18th, 1986; August 1st, 1986; November some day of 1986 and March some day of 19883
A No.
Q You didn't see any in February of 19913
A No, I did not have that.
Q Did you ask for it?
A No.
Q You think you ought to look at it?
A I'm not sure it would be a great deal different.
Q Okay. You haven't asked for it, you don't think it's necessary for you to have reached any opinions that you've reached?
A No.
Q What did your review of the chest x-rays tell you?
A Well, you know, I don't review chest x-rays as a primary care doctor, but the --
Q Well, if you're unable to interpret them, just tell me.
A Yeah. I mean, I'll be happy to agree with the

reports. I don't interpret those as an expert.
Q Okay. You've looked at the chest x-ray though?
A Correct.
Q Even though you aren't expert in reading them?
A That's correct.
Q And when you looked at the chest x-rays, even though you're not expert in reviewing them, did you see an endotracheal tube?
A Yes.
Q And can you tell me, the best of your recollection, in time when that first chest x-ray was taken, Doctor?
A Well, the x-ray, as I recall, states that it was developed at 9:47. I assume it was taken in the minutes preceding that.
Q Okay. When you say the film itself says, was the word "developed" 9:47 on it or was there a clock with the time on it?
A A clock with the time on it.
Q And you presume that that clock and the time, which was 9:47, was the time of development?
A That's what I'm assuming, yes.
Q That's the way it's done and been done in your

experience?

A Well, that's not the way I'm accustomed to, You know, it could have been taken at that time or it could have been developed at that time. I don't know which.

Q You don't know?

A (Witness shakes head negatively.)

Q Okay. And what was your interpretation, albeit the fact that you're not able to read those? I know you agree with the report.

A Yeah, and I'll get the report out, but basically the endotracheal tube was in the esophagus.

Q Probably why the chest x-ray was taken to determine where the tube was, right?

A I would assume.

Q And the esophagus would not be the place where you would want an endotracheal tube in anyone, including a thirty-nine, forty day old child, is it?

A That's correct.

Q And from your review of the records, that chest x-ray or -- excuse me. That intubation was accomplished at what time, from your review of the depositions and all the -- you've been handed something. I don't know what you --

A No, this (Indicating) was the x-ray report.

Q Okay.
A You know, it's rather difficult for me to tell you. I don't think I know the exact time. It says that the baby was intubated at 9:15 on the emergency room record. So, sometime between 9:15 or thereabouts.
Q Well, for the purposes of formulating any opinions that you've entered in this case, Dr. Chalhub, was it important for you to know when this child was intubated?
A Yes.
Q All right. And what did you glean from the records, what did you accept for the purposes of rendering your opinions as to the time of intubation of Adam Meade on July 6th, 1986 while he was in the emergency room at Appalachian Regional Hospital being treated by Dr. Pajarillo and others?
A 9:15.
Q Okay. And either the film was developed at 9:47, correct?
A Correct.
Q Or taken at 9:47?
A Correct.
Q Okay. Well, regardless of whether the film was taken or developed at 9:47, that was too late, wasn't it?

MR. CLEEK: Objection. This is --

BY MR. THOMPSON:

Q It should have been taken before then, shouldn't it?

MR. CLEEK: This is standard of care issues.

A You know, I think that's up to the individual physician in the course of a resuscitation, et cetera. You know, I -- again, that's certainly a decision to be made at that time. I'm not saying it shouldn't be taken earlier or later.

BY MR. THOMPSON:

Q You just don't know?

A I don't have an opinion.

Q Not a clinician?

A Well, no, I'm a clinician.

Q You are a clinician?

A Correct.

Q But if someone was to intubate a forty, thirty-nine day old baby at 9:15, shouldn't, in order to comport with minimal acceptable standards, that x-ray be taken within a minute or two, Doctor, or not?

MR, CLEEK: Objection. Don't answer that.

MR. THOMPSON: Certify it.

BY MR. THOMPSON:

Q Was that x-ray read by anybody?

A Yes.

Q Tell me, based upon your review of all the depositions, Dr. Chalhub, who it was at Appalachian Regional Hospital on the 6th of July, 1986, that reviewed that chest x-ray which showed an endotracheal tube in the esophagus of Adam Meade at or about 9:15 to 9:47.

A Well, I don't know who did that. I can tell you who signed the report.

Q Well, that was Dr. Sutin, wasn't it, the radiologist?

A Yes.

Q And when did he review this x-ray, sir?

A That doesn't say the time.

Q Well, you reviewed his deposition, didn't you?

A Yes, but, you know, I can't remember the exact time.

Q You can't remember that.

Do you know if he was in the hospital then?

A I don't believe so.

Q Do you know which of the doctors read that x-ray --

A No.

Q -- after it was taken?

A No.

Q Do you know whether or not any of those doctors should have read it?

MR. CLEEK: Objection. This is standard of care stuff. Don't answer standard of care. Just a continuing issue here so I don't have to *go* over it and over it and interrupt your flow, we identified this Doctor for a certain purpose. The Rules provide that you can examine for that purpose. Standard of care with respect to intubation was not one of those purposes.

BY MR. THOMPSON:

Q Should it have been read by one of those doctors immediately --

MR. CLEEK: Don't answer.

BY MR. THOMPSON:

Q -- on development?

MR. POE: Note my objection,

MR. CLEEK: Don't answer it.

BY MR. THOMPSON:

Q From your review of all the records, which of

these doctors in that emergency room, Dr. Chalhub, read that x-ray?

A I honestly can't tell.

Q Don't know?

A No.

Q You read all their depositions?

A Yes.

Q Did you get any --

MR. POE: Object to the form.

BY MR. THOMPSON:

Q Did you get any interrogatories with regard to who read the x-ray, when it was read and what was done in that regard --

A No.

Q -- by Dr. Pajarillo, Dr. Fahmy, Dr. Urrego, Dr. Kim and Dr. Tablante?

A No.

MR. POE: Objection as to form.

BY MR. THOMPSON:

Q Who ordered the x-ray to be taken?

A I believe Dr. Pajarillo.

Q What time did he order it taken?

A I don't know. All I can tell you is the time

that it was developed. So, I don't know that.

Q When was the first time that anyone in the emergency room on July 6th, 1986 recognized the misplaced endotracheal tube in Adam Meade's esophagus?

MR. CLEEK: Don't answer it. Standard of care.

MR. POE: Objection as to form.

MR. CLEEK: Don't answer it.

Go to your next question.

BY MR. THOMPSON:

Q When was the first time anybody addressed the misplacement of the encephalopathy tube in the morning of July 6th, 1986 and did something about it, Dr. Chalhub?

MR. POE: Objection as to form.

MR. CLEEK: I don't think you need to answer that either. Same thing.

BY MR. THOMPSON:

Q Well, let me ask you this, Dr. Chalhub: Was it important to you in your review of all these voluminous records and given your assignment of what caused the neurologic deficit, if any, in this child to know how long that endotracheal tube remained in the wrong place; that is, in his esophagus, on the morning of July 6th, 1986?

A Well, there's several ways you can approach that, Mr. Thompson, You can approach it by the laboratory data to support that and you can also approach it by the records and the testimony. I cannot tell you from the records, you know, when exactly it was recognized. Some time after 10:05 and between 10:20. And obviously when the x-ray was taken at 9:47, it was in the esophagus, but based on the course of this child and the blood gases and the subsequent radiographs, it could not have been there an extended period of time.

Q The endotracheal tube could not have been there an extended period of time?

A Correct.

Q Could not have been where?

A In the esophagus.

Q Okay. And what do you think an extended period of time is?

A Oh, you know, an hour. Since 9:15.

Q Okay. Was the endotracheal tube in Adam Meade's esophagus from 9:15 until sometime between 10:05 and 10:20 that morning, sir?

A I don't believe so.

Q Where was it?

A Oh, I believe it was in his lungs. In the trachea.

Q Okay. First of all, you assume for a moment that the tube was placed there by someone at 9:15? You told us that, right?

A That's what the record says,

Q Do you know who did that?

A No, I told you I cannot determine that.

Q And where was it between 9:15 and 9:47, assuming for a moment that that film was either taken or developed at that time?

A Well, I think for the majority of that time it was in the trachea, otherwise this child would have died and would have had a different set of gases.

Q How did it get from the esophagus to the trachea between 9:15 and 9:47, Dr. Chalhub?

A No, it came from the trachea to the esophagus.

Q Okay. Oh, you -- at 9:15 you are postulating that the endotracheal tube was placed into the trachea?

A Correct.

Q And what makes you believe that?

A Well, the blood gases, the PCO2, the condition of the child, the subsequent radiographs and the clinical

course of this child.

Q There weren't any blood gass taken for fifty minutes after the 9:15 placement.

A Oh, I understand that.

Q Okay. At 9:15, whoever it was, placed this tube into the trachea of this child, correct? That's your opinion?

A Intubated the child.

Q Intubated the child into the trachea, correct?

A Correct.

Q And that was the correct place?

A Yes.

Q The x-ray reports say a film was taken at 9:20 which showed that the endotracheal tube was in the esophagus, correct?

MR. CLEEK: I'm sorry, sir. Your time must be incorrect. Did you say 9:20?

MR. THOMPSON: That's what I said.

BY MR. THOMPSON:

Q Is that correct or not?

A s don't believe that's correct.

Q What is correct then? Why don't you tell me based on your review, expert review?

A It doesn't say on this report.
Q Look at the second interpretation, Dr. Chalhub, what does it say?
A It says the second set of films were taken at 10:20. You said 9:20.
Q That's right. What does it say with regard to when the first films were taken?
A Oh, it says which is in about an hour after the first set of -- the first set shows the distal end of the endotracheal tube in the right main stem bronchus.
Q Is that true or untrue?
A Oh, I would think based on the data that it's untrue.
Q Okay. You disagree with the records in that regard?
A With that statement, yes.
Q Okay. We have a tube at 9:15 placed by whoever placed it, which you don't know. Do you know whether or not anybody admits placing that tube based upon your review of the depositions?
A It's kind of difficult to tell. I think -- I really don't know.
Q Don't remember what they said?

A (Witness shakes head negatively.)
Q Okay. Where was Dr. Pajarillo when that tube was placed there at 9:15?
A I don't know.
Q Could have been there?
A Yes.
Q Could have done the intubation, couldn't he?
A Yes.
Q At any rate, it's your theory that this child was appropriately and properly ventilated when the first placement of the tube was made at or around 9:15?
A No, I didn't say that. You asked me if -- before if I felt that this tube was in the esophagus from 9:15 until it was -- between 10:05 and 10:20 and I told you no. Now, whether this child was properly ventilated or improperly ventilated, I can't comment on that.
Q Well, let's assume for a moment the Chalhub theory to be true, sir; that the tube, when it was first placed, was placed in the trachea. That's your assumption, correct?
A Sure.
Q Okay. Was that the right place or the wrong place?

A Sure, but that doesn't mean you can properly ventilate even if it's in the right place. So, I can't comment on that.

Q Okay. Was the child appropriately and properly ventilated when the tube was placed in the trachea at or around 9:15, Dr. Chalhub?

A I would assume, but I can't tell you that.

Q How long was he appropriately and properly ventilated after the tube was placed in the trachea?

A Until or about 9:47.

Q And at 9:47 you think what happens at that time?

A That the tube goes into the esophagus.

Q And why do you say that?

A Because it's in the esophagus when the film is taken.

Q Okay. You presume that the 9:47 time that you're talking about is when the film was taken?

A Well, we've already gone through that. On or about that. I mean, that's what you said. Those were your words.

Q If it was taken at 9:20, your theory wouldn't hold water, would it?

A Well, if it was taken at 9:20, this child would

have probably had cardiac arrest and died.

Q Why is that?

A Because ventilating a baby in the esophagus will, one, distend the stomach to an enormous level which will push the diaphragm up, compromise the lungs. Furthermore, when the pH drops for an extended period of time, you know, greater than ten minutes, below seven, you have cardiac arrhythmias and significant bradycardia and often cardiac arrest, which is not what this child did. Furthermore, the brain scans and CT scans does not demonstrate a hypoxic lesion. It demonstrates an ischemic lesion and it demonstrates focal infarcts, which is consistent with meningitis and consistent with the process that this child has. Not consistent with hypoxia or having an endotracheal misplaced for a period of ten to twenty minutes.

Q Well, we'll get to the CAT scans in a minute. Let's stick with these chest x-rays if we can.

A Well, I'm giving you all of the reasons and they all -- you know, you have to practice medicine based on all the facts. Not a couple of them.

Q Let's talk about these chest x-rays first. Okay?

A Sure.

Q 9:47 a chest x-ray is taken, according to your

theory, which shows an endotracheal tube in the esophagus?
A Right. That's your theory too. I mean, that's the time that's on the x-ray. Now, you know, I can't tell you, you know, exactly when it was taken, but I can tell you based on clinical medicine and based on observation, it has to have been shortly before then.
Q What time did the tube go from the trachea to this child -- this child's esophagus?
A I can't tell you exactly. I don't know.
Q Don't know.
Can you tell by looking at the clinical data and the --
A Yes. It has to be relatively close to that period of time.
Q Okay. Within four minutes, five minutes?
A I would think so.
Q And how did that occur, sir?.
A Well, I mean, I guess it slipped out of the trachea and went into the esophagus, which is not uncommon.
Q And how do you, as a clinician, detect the slippage of a tube from a trachea to an esophagus?
A By taking a chest x-ray.
Q And that was done?

A Correct.
Q Was there any air in the stomach on the chest x-ray that you reviewed?
A Yes, and it says here, and I would agree, that it's slightly distended. Certainly not something that you would expect with thirty minutes of bagging or an endotracheal tube in the stomach.
Q Who was doing the bagging? Do you remember?
A No, I don't know.
Q The child wasn't ventilated? Ventilated by a mechanical respirator?
A Oh, I can't -- well, the child was being ventilated, certainly. You know, at sometime bagging and then sometime by the ventilator.
Q Okay. When was the child placed on the ventilator, the mechanical ventilator in this time sequence?
A I don't know the exact time..
Q Sometime at Appalachian Regional Hospital?
A You know, I don't honestly know that.
Q Don't remember?
A No.
Q Not important to you?
A Well, no. I mean, the child was ventilated

either by bagging or by machine and is obviously reasonably well ventilated up until that period of time.

Q And you know this by all the subsequent laboratory data and films that you have reviewed?

A Correct.

Q Not by what is contained in the records, however, at Appalachian Regional Hospital?

A Well, by those too.

Q Okay. Were there blood gases taken between 9:15 and 10:05?

A No, I think the next set is at 10:35.

Q Okay. Was there any laboratory data taken? For instance, vital signs taken between 9:15 and 10:05 on this child?

A Well, I think that's kind of hard to determine. There's a --

Q You have the records,

A Well, I know that. I'm saying, you know, I can't determine that. I do not see any in the records.

Q Did you read any depositions by any of the respiratory personnel at Appalachian Regional Hospital as to how this child was being ventilated and who was doing it?

A I believe I did, but there were a lot of

depositions, so I can't tell you exactly by memory.

Q And you don't recall now whether it was by bagging or by mechanical ventilation?

A No.

Q And it's not important to you in any opinions that you have?

A No.

Q Okay. What happened between 9:47, the time this film was taken or developed, and 10:05 --

A Well --

Q -- with regard to the endotracheal tube?

Did it remain in the esophagus?

A Well, it was replaced, you know, after 10:05.

Q Maybe I'm having trouble communicating, you're having trouble listening.

What happened to the endotracheal tube which is shown to be in the esophagus according to your theory at 9:47 and the blood gas that was taken at 10:05, Doctor?

A Oh, I assume it stayed there.

Q Why do you assume that?

A Well, because it wasn't replaced until after the blood gases.

Q Could it have slipped back into the trachea?

A No.
Q What about the blood gases indicates to you that it remained there for approximately, what; twenty minutes, seventeen minutes?
A Well, from 10:00 o'clock, thirteen minutes.
Q Okay. No, not until 10:00 o'clock. Till 10:05. That's when --
A No, I think that's the report. I think the blood gases were drawn at 10:00 o'clock.
Q Were drawn at 10:00 o'clock?
A Correct.
Q Okay. And what about those blood gases indicate to you that the endotracheal tube remained in the esophagus?
A Well, you have a respiratory and a metabolic acidosis and a PC02 of about eighty-eight,
Q How was the child ventilating his vital organs including his brain for those thirteen minutes?
A Well, I think reasonably well.
Q How?
A What do you mean how?
Q How would he ventilate his major organs, including his brain, with an endotracheal tube in the esophagus for that thirteen minute period of time from 9:47

to 10:00 o'clock?

A I don't think I understand your question.

Q We have, according to your opinion, an endotracheal tube in the wrong place in the esophagus at 9:47 a.m. on July 6th, 1986?

A Correct.

Q According to what you theorize, it remained there for thirteen minutes?

A Yes.

Q And we would be ventilating what organ of this child during that time? The stomach?

A Correct.

Q Stomach going to become distended for thirteen minutes while this bagging or ventilation is going on?

A Sure.

Q What about oxygen to the brain?

A It's going to be decreased.

Q To what degree? To what extent?

A I don't know.

Q Why not?

A Well, there's no way to measure that.

Q Okay.

A Except by the subsequent studies.

Q Okay. And how much oxygen is he getting to his heart, to his kidneys, to his liver?

A Well, obviously enough that it doesn't cause any significant bradycardia or cardiac arrest which would indicate that he was able to compensate.

Q What was this child's heart rate at any time between 9:47 and 10:00 o'clock or 10:05 on the 6th of July, 1986?

A Well, it's not recorded.

Q It should have been too, shouldn't it?

A Well, I mean, that's certainly -- you know, I would -- if I were in that position, yes, I would record it.

Q Well, how do you know the child was bradycardic or tachycardia or whatever between 9:47 and --

A Well, I mean, your experts state that the child didn't have a cardiac arrest and wasn't significantly bradycardic and everybody else does too. So, I mean, all I can do is go by what was said.

Q Okay.

A I mean -- and also the child did not have intracardia epinephrine, have to be -- have external cardiac massage, and so --

Q You agree with all that?

Regardless of what they say, you agree with it?
A Well, yeah, I think it's consistent --
MR. **POE:** Objection as to the form of the question.
BY MR. THOMPSON:
Q You think it's consistent with what?
A With the clinical course of the child.
Q Okay. All right. The child's pH was what when the blood was drawn?
A Six point seven nine.
Q PO2 of?
A Thirty.
Q PCO2 of?
A Eighty-seven point eight.
Q And base excess, minus twenty-six?
A Correct.
Q Indicative ***of,*** what; metabolic acidosis?
A And respiratory acidosis.
Q The child's obviously hypoxic?
A Yes.
Q Cause of all that is what?
A **Is** -- you mean -- the cause of blood gases is --
Q No, no, no. The cause of the metabolic acidosis

and the hypoxia and ending up with the results that we see in the blood gases is what, in your opinion?

A Oh, I think at that point a combination of Group B Streptococcal sepsis and an esophageal intubation.

Q How close to death is the child at that time?

A Well, I mean, if it had been for any extended period of time, then I would have expected the child to have a cardiac arrest and die. So, obviously the child was close to death.

Q Child didn't die?

A No.

Q And how long did that tube remain, after that blood gas was taken, in the esophagus?

A Sometime between 10:05 and 10:20. I don't know the exact time.

Q And who was it that corrected the placement of the endotracheal tube?

A Well, I believe it was Dr. Fahmy.

Q And why do you believe that?

A Well, as best I can determine, that's what the testimony is.

Q Testimony of whom?

A Dr. Fahmy.

Q Okay. Anybody else?
A Maybe. I can't -- there are a lot of depositions.
Q Okay. And that correction wis made sometime between 10:05 and the time of the next chest x-ray?
A Correct.
Q Which you reviewed?
A Yes.
Q And your review of that chest x-ray was what, sir?
A Well, that the aeration was improved -- let me get the exact report. And the endotracheal tube was in the right main stem bronchus.
Q Okay, Blood gases taken shortly after that?
A 10:30 or 10:35.
Q Drawn then?
A Yes.
Q Okay. And show what: improved ventilatory status?
A Shows improved blood gases, yes.
Q Blood gases were improved because of what?
A Because the child had the endotracheal tube in the trachea.

Q Okay. The tube was removed from the esophagus and placed back into the trachea where it should have been?
A Well, that's the appropriate place, yes.
Q And the x-rays showed the tube to be in the right main stem bronchus, did it not?
A Correct.
Q As well as the trachea?
A Correct.
Q And it was shortly thereafter withdrawn?
A Pulled back.
Q Pulled back?
A Right.
Q And the child remained at Appalachian Regional Hospital for what period of time after that blood gas was drawn?
A Until about 12:00 or 12:30 and the child was transported.
Q And then medivac'd to Cabell Huntington?
A Correct.
Q What was your opinion, based upon your review of the records, what brought this child to Appalachian Regional Hospital?
A Well, the child was having apneic spells, had

decreased responsiveness, and the child appeared quite ill.
Q To whom?
A Mother.
Q And she and who else took the child where from their home?
A Well, the child was transported by ambulance.
Q Okay.
A How did the child get to the ambulance or the ambulance get to the child? Do you remember?
A No.
Q Do you remember who the ambulance driver was?
A No.
Q Okay. At any rate, do you remember what occurred from the time the mother thought the child was in trouble until the child got to the hospital? What the clinical appearance of the child was?
A Well, I think that there are various descriptions depending on who you look at and which records you look at, but the child -- let me just get the exact --
Q What are you looking at?
A I'm looking at the Appalachian Hospital, Regional Hospital records.
Q Well, do you have any records between the time

the mother called the transport and the child was received at Appalachian Regional Hospital that morning?

A Do I have any records?

MR. **CLEEK:** Your question is addressing the child's condition at home before it was brought in: is that right?

MR. THOMPSON: At home, in the ambulance, whatever.

A No, I think those were destroyed.

BY MR. THOMPSON:

Q Okay. By whom?

A I don't know.

Q Okay. You haven't seen them?

A Nope.

Q Okay. Do you recall what the descriptions of the child were by anyone who was with the child?

A Well, I think that there are various descriptions. The child was apneic, was cold, was cyanotic, was blue, and the -- you know, at arrival the child was ill.

Q Well, who said the child was cold during the period of time from the time the mother called the ambulance people until the child arrived at Appalachian Regional Hospital?

A I think those are descriptions of the child.
Q Who gave that description of the child being cold, Doctor?
A I don't recall.
Q Was that important?
A Well, I mean, obviously the description is important. Who said it, you know, I don't think, you know, makes a great deal of difference,
Q Okay.
A I mean, this child has Group B Streptococcal sepsis. I don't think there's any question about it.
Q My question is: Who described the child as being cold?
MR. CLEEK: You're talking about on the way in?
MR. THOMPSON: Yeah.
MR. CLEEK: He's still talking about on the way in.
A I don't know.
BY MR. THOMPSON:
Q Okay. Who described the child as being psychotic -- cyanotic? Excuse me. That's what I am.
MR. CLEEK: And that was a Freudian slip on

your part.

A The -- I don't know.

BY MR. THOMPSON:

Q Who described the child as being blue?

A Again, I can't tell you specifically who.

Q The child have a cardiac arrest at home?

A No.

Q The child have a respiratory arrest at home?

A Well, the child was apneic.

Q Child have a respiratory arrest at home before arriving?

A I don't believe so.

Q Why not?

A Well, you know, I think the -- you know, it depends on whether you're going to describe the length of time of the apnea as a respiratory arrest and I don't think that was timed. So, I don't know how to answer that.

Q At any rate, you don't think the child had a respiratory arrest; that is, a complete cessation of respirations or breathing for a significant period of time?

A I don't know.

Q Don't know?

A That's right.

Q Don't think the child had a cardiac arrest: that is, a heart stoppage?
A No.
Q Okay. Why not?
A Well, it's not described. The child obviously survives for an extended period of time and the laboratory data is not consistent with it.
Q Okay. Child's condition upon arrival at Appalachian Regional Hospital according to your review of the records was what, sir?
A The child had a pulse of one fifty-one.
Q How do you know that?
A Well, it says so on the records here.
Q Do you believe it?
A Well, I mean, why not?
Q Okay. I don't know. You tell me. Maybe you have a reason not to believe it based upon all the data that you have reviewed.
A No, I don't think that's inconsistent.
Q Okay.
A Why don't we take just a -- we've been going for an hour. Let's take a --
Q Have we been going that long?

A Close; forty-five minutes. Let's take a minute.
Q Oh, okay. Fine.
(Short break)
BY MR. THOMPSON:
Q The question we were on was this child's condition on arrival at Appalachian Regional Hospital.
You would agree with me the records clearly disclose that this child was there at about 8:45?
A Correct.
Q And can you share with me who it was that saw this child on his arrival at 8:45 in the emergency room based upon your review of all the records, Doctor?
A Where are they?
Q What do you want? This list?
A No, where are the -- your records.
Q I don't know. I haven't taken anything.
A Okay. I'm sorry. Here they are.
M. Titers (Phonetic). I guess that's who it is. That's the name.
Q Okay. Do you know who she is or who he is?
A No.
Q You didn't review that deposition?
A If it's not on there, I didn't.

Q It's not on your list.
A Then I didn't review it.
Q Okay. Who else was there?
A Well, I guess -- it says here M. Titers is L.P.N., Blackburn is an RN, and I don't know at which time that any of these people were --
Q Blackburn you read. Was she there?
A I assume so. The RN, yes.
Q Okay. Who else was there at 8:45?
A I don't know.
Q Okay. Was the emergency room physician there?
A Yes.
Q Was Dr. Pajarillo there?
A I don't believe so.
Q Was Dr. Kim there?
A I don't know.
Q Dr. Tablante?
A I don't know.
Q Dr. Fahmy there?
A No.
Q Okay. What was this child's condition as noted by any or all of them at that time based upon your review of the records and depositions, Dr. Chalhub?

A Well, the child had the -- was ambued at 8:45 and I assume the child was still having difficulty breathing as it was at home, you know, when the, you know, the mother recognized the child was not doing well and then transported. And then at 9:15 it states an endotracheal tube was placed.

Q Okay. Well, what else --

A It says the child was monitored continuously.

Q Monitored on what or by what?

A I assume by a stethoscope, palpation. You know, I don't know.

Q No records to that effect?

A None.

Q He had a pulse on arrival of one fifty-one?

A That's what it says on the ER sheet, correct.

Q Is that normal?

A Well, you know, for a child that has Group B sepsis with infection, yeah, it would be consistent.

Q Okay. At 8:45 to 9:15 on July 6th, 1986, what neurologic deficit, if any, did Adam Meade have?

A I don't know.

Q Any?

A I can't tell you that. There's no description.

Q You don't have any opinion one way or another whether or not he was normal in all neurologic aspects or not --

A Well, he's certainly not normal.

Q -- at that time?

A He has a depressed level of consciousness, he's being ambued and he has sepsis and meningitis.

Q Well, you say he's got a depressed level of mentation?

A Of consciousness.

Q Of consciousness?

A Right.

Q Where did you get that from?

A Well, the child is being ambued. He's not responding appropriately. He's not breathing, so it's obviously depressed.

Q Okay. Child is how old at this time?

A Thirty-nine days.

Q Okay. When did the damage, neurologic damage that this child now evidences occur, in your opinion?

A Well, you know, based on the complete sequence of events and the x-rays, the -- and, you know, it's, again, difficult to totally piece the, you know, all of the facts

together. The, you know, record from Cabell states that the child had an arrest at home, the mother gave CPR. Whether the child was bradycardic and had decreased perfusion to the brain at that time is unclear. It certainly could have occurred and then responded due to the stimulation and the CPR and then the transport and that -- at that point could have caused an ischemic insult to the brain. Certainly after the child is at Cabell, the child did not have any cardiac arrest. There's one description of a pulse of twenty by the transport nurse, and I don't know at which time that occurred. The best -- you know, the best evidence of when that occurred was between, you know, 9:15 and -- or 8:45 and -- the only time the child was there and --

Q Wait a minute. I don't understand that; 8:45 and the time the child was there. We're talking about the recorded heart rate of twenty.

A Right. I don't know what time it was. All I can tell you is there is a recorded heart rate of twenty.

Q Well, did that occur after 8:45?

A You know, it's -- there's no documentation of the time. It could have been on arrival. It could have been thereafter. I don't know.

Q Recorded heart rate of twenty consistent or

inconsistent with a pulse rate of one fifty-one?

A Well, I mean, you can be tachycardic and you can be bradycardic with stimulation. It depends.

Q You could have both?

A Sure.

Q So you don't know when that was during --

A No.

Q -- this morning?

A No, I don't know. There's no way to state in terms of the time.

Q And who reported the one fifty-one?

A The transport nurse -- oh, the one fifty-one, I don't know.

Q And who reported the twenty?

A I believe the transport nurse.

Q Is it your understanding that the transport nurse that recorded the twenty made the observation and --

A No, I believe this is something that was told to her.

Q Okay.

A As best I can recollect.

Q Do you know who told it to her?

A No.

Q Who was the ambulance driver or attendant that took this child to Appalachian Regional Hospital in the early morning hours of July 6th, 1986?

A I don't know the name.

Q You've got a deposition on here or among this list is the name of Deborah Preece. Did you read Deborah Preece?

A A good while ago.

Q Who was she?

A You know, I can't recall all of those. I mean, there a lot of depositions.

Q Well --

A But, I mean, if she's the person, I don't --

Q She's the person.

A Okay.

Q She's the person.

A Okay.

Q Do you recall what she said about this child's condition during the transport?

A No. I mean, we can get the deposition out and look at it. I can't tell you verbatim.

Q As you sit here right now, do you have any recollection of disagreeing with Deborah Preece's

observations of this child and recollection of this child?
A No. I mean, if that's what she recollects and describes, I have no disagreement with her.
Q As you sit here right now as you recall her deposition, do you recall anything inconsistent about what she said about the child when compared with the records from Appalachian Regional Hospital?
A Well, you know, I don't have her exact statements here, so I just can't tell you exactly. You know, I can't tell you.
Q Okay. I notice on here that you don't have David Meade's deposition, the father?
A Correct.
Q Do you know if he was with this child during the early morning hours of July the 6th, 1986?
A I don't believe so, but I don't know.
Q Would his observations of the condition of this child be important to you and what occurred before the child arrived at the hospital?
A Well, I mean, I think it's another person observing the child and if he did record it, I would certainly look at it.
Q Do you know why you didn't get that deposition?

A No.

Q The third name here escapes me. It seems to be Patricia and then there's a line and then there's a last name. Who is that?

A Stouffer.

Q Stouffer. Okay.

Did you read an individual by the name of Patricia Meade, the mother of the child?

A I don't believe so.

Q Would the observations of the mother who was with the child during the early morning hours of July 6th, 1986 be of any importance to you in formulating any opinions as to what the condition of the child would have been prior to arrival at Appalachian Regional Hospital?

A Yes, I think so. I think her -- the description is summarized in the Cabell chart as the mother describes grunting respirations throughout the night and into the a.m. and the child was unresponsive all night, prolonged apnea. At 8:00 a.m. the mother tried CPR. The color worsened and was taken by the ambulance driver and CPR was begun with oxygen.

Q Okay.

A And I think that's -- you know, I mean, that's --

I suspect that's a history, you know, taken by the individual at Cabell which is from the mother.

Q Okay. That recorder of that history was whom, please?

A I can't read the name.

Q Okay. You don't know whether or not the mother's deposition testimony is in agreement or disagreement for a that -- with that?

A Not to each and every statement, no.

Q Okay. And may or may not be important, I take it, then?

A Well, no, I think the mother's, you know, observations are important.

Q Okay.

A I mean --

Q Do you know why you didn't get the mother?

A No.

Q Did you ever ask for the mother?

A No.

Q Did you ever ask for the father?

A No.

Q Do you know who a Dr. Bodensteiner is?

A He's a neurologist.

Q How do you know him?
A I have met him, talked with him. He's a colleague.
Q When is the last time you saw him and talked to him?
A Gosh, I don't know. Several years ago, a year ago.
Q Do you respect his opinions as a pediatric neurologist?
A I think he's an excellent pediatric neurologist.
Q Do you know what role, if any, he plays with regard to Adam Meade?
A Well, he has seen the child. He has done an independent medical examination, summarized that, and I think a copy of it is in here.
Q Did you read his deposition?
A Yes.
Q How come it's not on here?
A Well, then I just left it off. I did receive that.
Q Well, let's add that one too.
A I think it's on here.
Q Well, if it is, point it out to me.

A We left that one off. I apologize.
Q Well, we got the CT scans we've apologized for and Bodensteiner. Can you think of any more right now?
A No, no. You know, I'm not --
MR. POE: Objection as to the form of that statement.
MR. CLEEK: Objection as to the absurdity of the question.
Don't harass the guy. Just ask the questions.
BY MR. THOMPSON:
Q Is his name Bodenstein or Bodensteiner?
A I think it's Bodensteiner.
Q You read his deposition?
A Yes.
Q And do you remember, have you any recollection as you sit here today whether or not you were in agreement with him or his report or disagreement with him and his report?
A Now, which; the deposition or report or both?
Q Either one or both.
A Well, I don't have any disagreement with his report. I mean, that's his observations and I think he's a good observer based on my experience with him. Let me get

that report out.

Q Okay.

A And in terms of his deposition, I -- (Inaudible) -- you know, in general with some of the conclusions.

THE REPORTER: You do what in general with some of his conclusions?

THE WITNESS: Conclusions.

What do you want me to comment on? First the report of July 22, 1992 or what?

MR. CLEEK: He said he differed in general.

THE WITNESS: Yes, differed.

BY MR. THOMPSON:

Q My understanding is you agreed with his report?

A In terms of his observations.

Q In terms of observations?

A Right.

Q Do you disagree with his report in any regard?

A All right. Which part did you -- in any regard?

Q In any regard.

MR. McNEER: Could you have him refer to that specific document?

MR. THOMPSON: Yeah, I think he's referring to the report dated June the 22nd of 1992.

A July.

BY MR. THOMPSON:

Q July 22nd. I apologize.

And it's how many pages, Dr. Chalhub?

A Three pages.

Q Three pages.

I take it, while you're looking at it, you haven't talked to Dr. Bodensteiner about Adam Meade?

A No.

Q Nor has he talked to you about Adam Meade?

A That's correct.

Well, I disagree with his interpretation of the CT scan. I have not seen the February, 1991, but I suspect it's very similar to the March of 1988 and has the description here is the child has evidence of infarction or multiple place -- multiple places and there are certainly more areas of encephalomalacia and porencephalic cysts in the right hemisphere than the left hemisphere, although the left ventricle is larger than the right ventricle and this would be consistent with multiple infarcts and I would feel more consistent with a cerebral vasculitis of the large vessels. It certainly could be due to ischemia. It's not the typical hypoxic lesion and I would differ from that

interpretation. So, the -- one would state -- I would say I would just differ in that aspect.

Q Okay. Anything else you disagree with other than the fact that he feels that some of these lesions are secondary to hypoxia?

A Well, these are ischemic lesions and I think the morphon (Phonetic) infarct is an ischemic lesion and multiple infarcts are an ischemic lesion. Not a hypoxic lesion. You know, if there is any hypoxic damage, I don't know how you would tell it from that. What you can tell definitely is that this child has multi-systic (Phonetic) encephalomalacia predominantly in the right hemisphere, but certainly in the left hemisphere with dilated ventricles and hydrocephalus which became apparent on July the 18th when the first CT scan was done.

Q Okay. What do you mean by ischemia? What's your definition of ischemia?

A Is decreased blood flow or occlusion of blood vessels.

Q Occlusion secondary to?

A A vasculitis.

Q Vasculitis being an inflammatory condition of the vessel?

A Right, secondary to Group B Streptococcal meningitis.

Q Secondary to the bacterial infection itself?

A Secondary to the Group B Streptococcus, yes, absolutely.

Q All right. Anything else you disagree in his report other than what you've told us?

A No, the -- you know, if there is hypoxia, one, I don't see how one can tell the difference between the hypoxia, if you want to say that the child was hypoxic with a PO of thirty for whatever length of time at Appalachian when the child, for three days, was hypoxic at Cabell with a PO2's in the thirties. So, you know, why would one not attribute, if there was hypoxia, which I do not believe you can differentiate on that scale, why is it not due to that? Why is it due to a period of -- short period of time in an emergency room in which the PO -- PC02 is not very high, which would indicate that the child could not have been improperly intubated for an extended period of time, there was no cardiac arrest, no bradycardia. This child is moving all extremities after leaving there, and --

Q After leaving where?

A The Appalachian Regional Hospital.

Q And you say the PO2's at Cabell --
A Sure.
Q -- you talked about in the thirties?
A Yes.
Q What hospitalization are we talking about?
A 7/6/86 to 8/11/86.
Q On admission?
A Yeah.
Q Okay. All right.
A And then for three days afterwards.
Q All right, Secondary to?
A Group B Strep, sepsis, inadequate perfusion, a very sick child. And so, you know, so what you have is you have a child that has Group B Streptococcal sepsis, has a brief period of hypoxia --
Q Brief period being what?
A Thirteen minutes, fifteen minutes, seventeen minutes.
Q Okay.
A -- without any cardio/respiratory arrests.
Q Thirteen to seventeen minutes of hypoxia?
A Yes.
Q Okay.

A And the child, his blood gases respond immediately after being placed, after having the endotracheal tube replaced in the trachea, and then the child develops -- and, again, with not much air in the stomach, not much air in the abdomen which would not be consistent -- which would be consistent with the tube not been misplaced very long and certainly not ventilated for an hour or an hour and twenty minutes or whatever the length of time every one agrees upon, if that is possible. Then you have a child that subsequently has a course that is absolutely consistent with Group B Streptococcal meningitis, inadequate perfusion to the brain or vasculitis. Not hypoxia.

Q This Group B Streptococcus was acquired from what source, in your opinion?

A Well, you know, late onset Group B Streptococcus can either be just due to colonization and then become an evasive infection or it can be acquired from a caretaker such as the mother, or another family member, or it can be acquired as a respiratory route from somebody else.

Q In your opinion, where did Adam Meade get his bacterial infection, Doctor?

A Probably from the mother.

Q When?
A After birth.
Q At Cabell Huntington?
A Oh, yeah, I mean, I think that the child probably was colonized at Cabell Huntington, yes.
Q The child's condition on the 5th of July, 1986 when the child was discharged from Cabell Huntington was what?
A Well, you know, I didn't really review those records in detail, but as it was in the discharge summary, it was doing well.
Q Do you know what the mother's testimony is with regard to the condition of her child then?
A Well, I think the child was still having some apneic spells, was sent home on a monitor, but, you know, again, I -- you know, I did not review those records in detail.
Q Do you have an opinion whether or not the child should have remained in the hospital or should have been discharged?
A No, I don't.
Q Do you know what symptomatology, if any, the mother had observed the day and the day before this child's

discharge?

A No, I don't have her deposition. I can't recall.

Q Would that be important with regard to this child's condition on discharge or not?

A Well, it may be important in terms of the child's condition on discharge. It has no bearing on the causation.

Q Has no bearing with regard to your opinion on causation?

A No, I think based on the facts, Mr. Thompson.

Q But it's your opinion as to causation?

A No. I mean, you've got x-rays, you've got blood gases, you've got clinical course, you've got known pathophysiology, which is certainly not in dispute.

Q When did this child become infected and symptomatic with regard to his disease process?

A The child became symptomatic the evening prior to admission and -- I'm sorry. What was the rest of your question?

Q When did the child become symptomatic and infected with this -- you said the evening before. What time the evening before?

A Well, when the child started manifesting decreased responsiveness and recurrent apneic spells.

Q According to the history you got in the Cabell Huntington record as recorded by someone there on the 6th on his admission from the mother?

A Correct.

Q All right. Now, with regard to your review of the scans in this case, you reviewed multiple scans which you don't have with you today?

A Correct.

Q And those scans were returned yesterday to Mr. Cleek?

A Correct.

Q Any reason why you didn't keep them here?

A No. I mean, there's no view box, so I wouldn't have brought them anyway.

Q Well, we could have taken this deposition at a place where a view box was, I presume, including your office, right?

A No.

Q Was there any particular reason why you mailed them back yesterday, the day before this deposition, to Mr. Cleek?

A No.

Q Okay. You had reviewed them when and had those

CAT scans how long?

A At least several weeks.

Q Okay. And you made no notes concerning your review during those several weeks of those scans?

A No, I don't make notes reviewing x-rays.

Q All right. How many times did you look at the scans of Adam Meade that you were provided with, Doctor, and made no notes?

A Oh, I've looked at them multiple times. I can't tell you how many times. I looked at them this weekend.

Q Okay. Can we say you've looked at them on at least two or three occasions or more?

A Sure.

Q And over what elongated period of time have you viewed the scans?

Did you look at them for five minutes, twenty minutes?

A I can't tell you that, Mr. Thompson. I looked at them till I was able to interpret them to my satisfaction.

Q The first scan you looked at was July the 18th, as I recall?

A Correct.

Q Okay. Tell me what changes you recall in the

July 18, 1986 scan.

A Well, I think that they are very similar to the interpretation by the radiologist at Cabell.

Q You're pulling that out now?

A Sure.

Q Do you have any disagreement with that interpretation? Do you recall any disagreement with it?

A Let me get it and I'll tell you.

Q All right.

A No, I think it's total agreement with decreased attenuation in the white matter in both hemipsheres due to known meningitis,

Q You agree with his report?

A Sure. I mean, it tells you it's due to meningitis.

Q Do you have any other report or any other recollection of any other interpretation of yours that's not contained in there?

A No.

Q Okay. So, you agree totally with that interpretation?

A Yeah, I don't have any disagreement.

Q Okay. Next interpretation was when?

A 8/1/86.
Q Okay. And your review of that CT scan was what? I'll bet it was identical to what the radiologist read it as.
A Well, it's not identical. It 's similar.
Q Okay. Tell me how it was dissimilar.
A No, I said it was similar.
Q Okay. Was it -- did your opinion differ in anyway?
A Well, you may describe it differently and in different terms, okay. You know, you can't do it verbatim as somebody else would do it, but there -- there was hydrocephalus and there were porencephalic areas, which are areas of infarcts, within the brain slightly greater on the left than the right at that time. There was enhancement after contrast infection, which is, again, consistent with meningitis. And, you know, and consistent with a continued inflammatory reaction which the child had.
Q Okay.
A And **Dr.** Adam Winn (Phonetic) states that. This may represent enhancement, secondary residual inflammatory change.
Q Okay. You agree with that?

A Sure.
Q Any other comments that you recall based upon your review of that scan that you haven't told me about?
A No.
Q Next scan that you reviewed would have been when?
A November, 1 believe, of '86.
Q November what of '86?
A I don't remember that exact date. I can --
Q Have you got the report?
A No, I don't have the report in here.
Q Was there one in November of '86?
A Was there a report?
Q Yes.
A Yes.
Q Where was that scan done?
A I don't recall.
Q Who made that report?
A I don't know the name by memory.
Q Tell me what your interpretation was of the November scan, 1986, of Adam Meade.
A Well, there was hydrocephalus, multiple infarcts in both hemispheres.
Q Okay. Anything else you can remember about that?

A No.

Q Do you remember disagreeing at all or have anything in addition to what the reader of that CAT scan reported?

A I can't recall that report verbatim, so I can't tell you absolutely, but it's similar.

Q The infarcts in both hemispheres were particularly peculiarly where? Where were they within the hemispheres, if you know?

A The frontal parietal area and in the occipital area and the temporal areas.

Q Are these old infarcts?

A Yeah. At that time, sure.

Q Any different than the infarcts you had seen on the August 1st or July 18th CT scans?

A Yeah, they were more clearly defined.

Q Okay. Any additional infarcts or areas of infarct in addition to the ones you had previously seen on the first and second CT scan?

A Well, I'd have to have it out in front of me. I cant tell you exactly. Certainly they are more clearly defined in the March, '88 x-rays.

Q Next CAT scan you would have seen sequentially

after --

A March, '88.

Q That was the last one?

A Yes.

Q Date in March of '88?

A I don't know the exact date.

Q Where was that on taken?

A I don't know.

Q Was there a report with regard to that one that you read?

A Yes.

Q Did you agree with that radiologist's report?

A Yes.

Q Did you have anything in addition to add to it?

A No. I mean, the -- there was a significant hydrocephalus, which were enlarged ventricles, there were multiple infarcts and, in my opinion, greater in the right hemisphere than the left hemisphere, although the left hemisphere was more dilated than the right and, you know, consistent with a post-meningitic encephalopathy.

Q Okay. And those were all the CAT scans that you reviewed?

A Correct.

Q And the CAT scans play what role with regard to your opining in this case that the neurologic deficit and damage is secondary to the meningeal infection?

A Well, they represent ischemic lesions either on a decreased perfusion basis or vasculitis with occlusion in multiple areas of the brain.

Q But with regard to balancing or weighing the testimony, the other clinical evidence from Appalachian Regional Hospital, the x-rays that you've talked about, how important are these CT scans to you in arriving at an opinion as to what caused this child's injuries and when?

A Oh, I think that they're another piece of evidence that it's absolutely consistent with the clinical course of a post-meningitic severe encephalopathy with multiple focal infarcts and multi-systic encephalomalacia.

Q Important to you?

A Sure.

Q Your training with regard to the reviewing of computerized tomography started when?

A 1974.

Q You were out of medical school at that time?

A Yes.

Q And you were where at that time?

A Barnes Hospital in St. Louis, Children's Hospital.

Q And you were doing what in '74?

A A pediatric --

Q Fellowship?

A Pediatric neurology fellowship.

Q And you spent how much time with regard to a computerized tomography at that time there?

A Well, off and on, three years.

Q Okay. Learned from whom?

A Well, there -- at the Malencrot (Phonetic) Institute of Radiology, there were multiple radiologists, but Luke Dargato (Phonetic) was one of the premiere radiologists in **CT** scanning. In fact, Barnes was one of the first hospitals to ever have a CT scan.

Q And what training, if any, after -- was it 1977 when you left there?

A '76.

Q '76. So, we've got 1974 to 1976 where you had three years of training in computerized tomography there?

A **No,** it was '72 to '76.

Q 1972 to '76. Okay. So, we're talking about a period of four years as opposed to three years or two years?

A Well, three years in a neurology fellowship, adult and child neurology. One year as a pediatric resident.

Q Okay. And **I** take it that you spent part of your time with neuroradiologists learning to review and interpret computerized tomography both with and without contrast?

A Correct.

Q And after 1976 what training, if any, did you have in computerized tomography?

A Well, you had continued exposure with teaching conferences, continuing medical education. I was in charge of child neurology at the University of Arkansas, in charge of neurology conferences and child neurology conferences, as well as consulting with radiologists on a continual basis.

Q Neuroradiologists in particular with regard to interpretation of computerized tomography of the head?

A I don't believe that there was -- there were -- radiologists at the University of Arkansas, my memory escapes me, as to whether they were actually neuroradiologists or radiologists with considerable experience in neurology. I can't tell you.

Q Okay. And **I** would take it that you would share opinions during that period of time?

A Sure.
Q And any training after you left Arkansas when?
A 1978.
Q And after 1978 you've been here in Nobile?
A Mobile.
Q Mobile. Sorry.
A University of South Alabama.
Q And did they have a neuroradiologist here that you consulted with in Mobile?
A Yes.
Q And who was that?
A I believe, and, again, that's a long time ago, I think Dr. Peter Dempsey.
Q Okay. Have you written anything on neuroradiology?
A I wrote an article with Dr. J. Powell Williams who is a neuroradiologist.
Q And when was that article written?
A Sometime in the eighties. It was on schizencephaly.
Q Well, that doesn't have anything to do with the pathology in Adam Meade, does it?
A No.

Q Can you find it for me on your list of publications or just give us the number in your list of publications it would be?

What was the fellow's name you wrote that with?

A Powell Williams.

Q Twenty-four; is that it?

A Yeah, that looks good.

Q Journal of Computer Tomography, 1983?

A Right.

Q Any other articles other than that one?

A Concerning what?

Q Computerized tomography.

A Well, I think the article number twelve; Porencephaly Associated with Coxsackie A9 Infection in the Neonate, described a child with large cystic formations secondary to that viral infection.

Q All right. Any articles that you have written with regard to Group B Streptococcal meningitis?

A Well, I mean, I think they're listed, the ones that I have.

Q Well, can you tell me what they are?

A Okay.

Q Number twenty-five is one, I take it; Group B

Streptococcal Infection, an Important Cause of Intrauterine Asphyxia?

A Correct.

Q And that was written in '83?

A Correct.

Q Any other articles about Group B Streptococcal meningitis?

A Number fourteen.

Q Group B Streptococcal Ventriculitis?

A Correct.

Q 1978?

A Correct.

Q Ventriculitis being what?

A An inflammation of the ventricles.

Q Secondary to, in this case, I take it through the subject matter, was the bacterial infection?

A Group B Strep, yes.

Q Any others other than those two?

A No, only relating to Group B Strep.

Q Have you written any articles on hypoxia, anoxia?

A No, not specifically.

Q Have you written any articles on the interpretation of computerized tomography and

differentiating ischemic damage versus hypoxic damage?

A No.

Q Do you know anybody that has?

A Oh, well, you know, I'm sure that there are a number of texts available and articles available concerning ischemic injuries.

Q What do you find or who do you find authoritative with regard to interpreting computerized tomography with an eye towards differentiating between ischemic and hypoxic injury, Dr. Chalhub?

A Well, you know, I can't recall the authors of the articles. I can tell you that there are a number of authors that have published excellent works which I think are good in part and I can't, you know, unless I have the article, tell you I totally agree with everything anybody writes unless you look at it.

Q You don't remember --

A But Luke Dargato, Peter Dempsey, J. Powell Williams, Barkovick (Phonetic), and I can't spell his name, the -- and there -- the other names -- there's several other excellent pediatric neuroradiologists - I just can't recall their names - that published textbooks.

Q And with regard to the subject matter of

differentiating between ischemic and hypoxic injury, you think all of these individuals you've told me about have written on that subject matter?

A Oh, I can't tell you specifically.

Q Okay. And you can't tell me where?

A Well, they're in their publications and, I mean, one could obtain the list of their publications or textbooks.

Q You can't tell me what journals they were written in or site me to any particular textbook or article and journal?

A No. I mean, the -- you know, the distribution of this lesion as a -- whether you want to call it a watershed infarct or multi-systic encephalomalacia or focal infarcts is an ischemic lesion. I don't think anybody will disagree with that.

Q Well, to a certain degree, Dr. Bodensteiner disagreed with it, didn't he?

A He's talking about the atrophy. I would interpret the atrophy as related to the infarcts. So, I think we perhaps disagree in that.

Q Okay. Did you read Dr. Zimmerman?

A Yes, I did.

Q Do you know who Dr. Zimmerman is?
A Only that he's a radiologist.
Q Okay. Never heard of him or read about him or anything like that?
A No.
Q And you disagree with him?
A Yes.
Q Why? What did he say that you disagreed with, if you remember?
A Well, I don't think he has a good understanding of Group B Streptococcal meningitis. I mean, this is fairly typical, at least in my twenty years experience, and I'm not sure he sees patients except reads films. And I think when you take care of babies and you do lumbar punctures and you count cells and you look at them over a period of time, you have a great deal more sensitivity for the development and the sequence of the disease process. And particularly also when you cause bacterial meningitis in animals and then look at their brains and then look at the brains of infants that have them.
Q How many patients have you seen, children have you seen and treated with Group B Streptococcal meningitis?
A You know, that's -- it's hard to give you an

absolute number over the years. I mean, certainly it's the predominant cause of meningitis in newborns and premature infants at the present time. You know, some years perhaps ten, some years perhaps five, some years --

Q Ten to five per year over what period of time, Doctor?

A Gosh, from the period of 1976 to the late eighties, you know, I would imagine it would be either seeing acutely or subsequently, you know, that number of children with post-meningitic encephalopathies.

Q So, about two hundred kids?

A No, I don't think it would be that many.

Q Well, you said five to ten a year for, what; twenty-four, twenty-five years?

A No, I said from 1976 to the eighties. About ten years.

Q I'm sorry. About ten years. I apologize.

A But that varies, okay. I mean, that's not necessarily that I took care of them while they were in their hospitalization, but you see them because these children are almost invariably severely involved such as this child.

Q More than a hundred?

A I don't know. I can't tell you that. Probably less than a hundred.

Q Other types of bacterial meningitis you've seen and treated, I take it, in addition to those?

A Yeah. The most common cause is Hemophilus influenza type B, but we don't see that very often any more because of the vaccine that's been produced.

Q And how many children like this have you seen with a Group B Streptococcal meningitis or other bacterial meningitis that have periods of apneic or respiratory insufficiency particularly as demonstrated in Adam Meade's case between thirteen and twenty minutes where they've been intubated into their esophagus? How many children like that have you seen?

A I haven't seen anybody like that.

Q Do you know of anybody that has?

A No. I mean, you'll have to ask them. I don't know.

Q Have you seen anything or read anything in the journals with regard to people who have followed patients like that?

A Who have followed patients with Group B Streptococcal meningitis?

Q Right. Who have had significant periods of apneic or respiratory distress or insufficiency or arrest as Adam Meade demonstrated at Appalachian Regional hospital?

MR. POE: Objection to the form of the question.

A What kind of arrest are you talking about?

BY MR. THOMPSON:

Q A cessation of respirations for a period of seconds, a period of a minute or two?

A Well, that's fairly common in Group B Streptococcal meningitis. So, that's not uncommon.

Q Have you seen and treated patients such as that?

A Sure.

Q And have you seen them with significant respiratory compromise where there have been thirteen to twenty minutes of compromised ventilation such as Adam Meade experienced, in your opinion?

MR. POE: Objection to the form of the question.

A Well, not with an esophageal intubation, but certainly compromised. You know, they arrest and they have cardiac arrest and many of them are in profound shock and remain that way no matter what you do.

BY MR. THOMPSON:

Q Any articles that you have seen with regard to interpretation of computerized tomography coming to conclusions that the damage as seen was caused by anoxia or hypoxia?

A I'm sorry. Say that again.

Q Any articles that you have seen or reviewed wherein a scientist or a group of writers, medical scientists have indicated that in their interpretation of computerized tomography what they are seeing and dealing with is hypoxic or anoxic insults?

A The predominant type of hypoxic or anoxic insults are in a laminar distribution in the cortical layers and predominantly in the hippocampus, the temporal lobes, the occipital lobes. It's not multiple infarcts, nor multi-systic encephalomalacia if it's due just to hypoxia,

Q And you've learned that from, I take it, your own experience, number one?

A Well, I think that's pretty common knowledge.

Q And who was it that taught you about that? Where is that common knowledge documented, written?

A In textbooks of neurology, textbooks of radiology.

Q Can you site me to any? Can you show me any?
A I believe the textbooks of -- and I can't tell you specifically -- of Menkes, of Swaiman and Wright, of Volpe.
Q Anybody else?
A Dubowitz. And, again, I'm doing this by memory. You know, whether it's their articles, I can't tell you particularlly.
Q Have you formulated any opinions in this case about the life expectancy of this child?
A I have seen the videotape and I've read Dr. Bodensteiner's report and this child is severely involved. And, you know, based on -- and I've not examined the child and, you know, I would prefer to examine the child to comment specifically on it, but based on the condition of this child with severe involvement of the brain, looking at the scans with hydrocephalus, recurrent seizures, a G tube and tracheostomy, certainly less than two decades would be consistent with that type of life expectancy.
Q So, your opinion -- you have formulated an opinion and your opinion is this child is going to live less than twenty years?
A Correct.

Q Is that twenty years from today or twenty years from his birth?
A Twenty years from his birth.
Q Okay. So we're talking about: a period of not in excess of fourteen years?
A Correct.
Q And I presume that's statistically?
A Yes, I would say certainly greater than fifty percent.
Q Based upon any studies that you have seen other than your own experience?
A Well, if you looked at the studies, it would probably be shorter. Based on my experience, I would give some latitude. I've seen some children, in this condition, live up to their late teens, but beyond that you see very few. I mean, I don't see them anywhere.
Q Well, you, as a pediatrician, wouldn't?
A I'm a neurologist, okay, as well as -- a pediatric neurologist --
Q As a pediatric neurologist you wouldn't --
A And adult neurologist. You take care of people in a vertical speciality.
Q Well, what's the oldest individual that you have

seen and treated with catastrophic substantial neurological deficit like Adam Meade?

A Twenties at the most.

Q Okay. And the last time you would have seen a patient of that age; late teens, early twenties, would have been when, Doctor?

A Gosh, it could have been in the past couple of years.

Q Okay.

A You mean like Adam Meade or just in their late twenties with devastating brain involvement?

Q Like Adam Meade.

A Well, you know, I can't --

Q Whatever the age was.

A I can't tell you specifically from memory, no.

Q And basically your clinical practice which you indicated to me comprises five percent of your time now?

A That's right.

Q You do what and where do you do that?

A I do it at the Mobile Infirmary Medical Center.

Q And do you have a certain time that you see patients or --

A Yes, Monday afternoon.

Q And what patients do you see on Monday afternoon? How do they get to you?

A They are referred to me.

Q By other physicians?

A Correct.

Q Do you hospitalize patients there?

A No. I do if I need to, but I rarely hospitalize anybody.

Q When is the last time you would have hospitalized a patient and followed a patient in a hospital setting?

A Oh, about a year and a half ago.

Q Okay. And that's when you left the active practice of medicine to take this administrative position?

A Correct.

Q And your title is --

A President.

Q -- associate medical director?

A No, that was prior --

Q Administrator and chief operating officer?

A No, president of the Mobile Infirmary Medical Center. Here (Indicating) is the most recent deposition (sic).

Q I've got 1991 till present, administrator, chief

operating office, Mobile Infirmary Medical Center. Executive vice-president, Infirmary Health Care System. Is that true too?

A Correct.

Q What is that?

A That's the holding company.

Q Okay. Are you an owner of that company?

A No.

Q What do you do for that company?

A I run the medical center.

Q You run the --

A Medical center.

Q Okay. And it's how many beds?

A Seven hundred and four.

Q Okay. Owned by?

A The Mobile Infirmary Association.

Q Which is a nonprofit organization?

A Correct.

Q And are you an officer, director of that institution?

A Secretary.

Q Secretary. Okay.

And who owns the stock in these corporations?

A There's no stock.
Q There is no stock?
A Correct.
Q And who owns these corporations?
A The holding company.
Q Okay. And what's the holding company's name?
A Infirmary Health System.
Q And who owns Infirmary Health System, Inc.?
A There's no stockholders. It's just a holding company.
Q Okay. All right. And you have no interest in that, I take it?
A No financial interest.
Q Who is your supervisor? Who do you report to, if anybody?
A The CEO of the holding company.
Q And who is the CEO of the holding company?
A Mr. Bramlett.
Q Spell his last name.
A B-R-A-M-L-E-T-T.
Q And his office is the same as yours?
A Yes.
Q And basically your role and function as the

president, administrator, chief operating officer for Mobile Infirmary Medical Center is -- what do you do day in and day out in layman's terms?

A I insure that there is cost effective measurable quality of care delivered to a seven hundred and four bed hospital in which there is thirty-five operating rooms, five intensive care units, a hundred telemetry beds, medical/surgical beds, an active obstetrical and pediatric hospital with a pediatric intensive care unit, an emergency room that sees approximately sixty thousand visits a year.

Q And you took this position a year and a half ago or so because why?

A Because I thought it would be fun to do.

Q Okay. And was there any particular reason why you left the practice of medicine to do something more fun?

MR. POE: Objection to the form of the question.

A Well, I've practiced medicine for twenty plus years and I was very interested in getting involved in delivering care on a larger basis and being a part of being creative and innovative in a health care system, and particularly in the era of difficult health care reform, I think that physicians with management experience and

abilities have a better opportunity to control cost and improve the quality of care.

BY MR. THOMPSON:

Q And do you have any plans on returning to the active practice of medicine to a greater degree than five percent of your time?

A Well, it depends. I mean, it depends on my success in this endeavor.

Q And your success in this endeavor is measured by what and by whom?

A It's measured by the Board and by the productivity and the bottom line of the hospital, as well as the perception and measurable quality of care.

Q Bottom line being dollars and cents?

A Correct.

Q And who's on the Board besides this Mister -- was it Bramlett or --

A Most are people from the community of Mobile.

Q Okay. And how much of your time is spent in a forensic setting: that is, reviewing medical/legal letters like you've done for Mr. Cleek in this case?

A About ten percent of my time.

Q And how much of your income is derived from doing

this type of thing?

A Probably about the same; perhaps ten to fifteen percent.

Q Have you ever testified under oath as to dollars and cents wise how much you made in a given year, given series of years from testifying in medical malpractice cases?

A No.

Q You are now currently reviewing how many cases?

A Gosh, maybe ten to fifteen.

Q And who is it that manages the time, sends your bills out for your medical/legal work?

A Me.

Q Do you have a secretary that does that for you?

A No.

Q Do you keep any records with regard to this, including your bills and your time and the records that we're talking about here that you reviewed?

A Well, I usually send the bill after I review them.

Q No. Where do you keep all these records concerning your review of medical/legal work, including records and depositions and videotapes and x-rays and bills?

A Either at home or in my office.
Q The office address you gave me?
A Well, it's in the Mobile -- I have two offices. One is in the hospital and one is at 1720 Springhill Avenue.
Q Okay. And how do you keep track or who is it that keeps track of the income derived from doing this work?
A I do.
Q And you give this information that you get to your accountant?
A Correct.
Q Okay. And who is that?
A I don't think that's really --
MR. CLEEK: That's none of his business. Don't answer it.
BY MR. THOMPSON:
Q You've got ten to fifteen cases now? Is that what you told me?
A Yeah.
Q And you started reviewing cases when? What year in a medical/legal setting?
A Gosh, the early eighties, I think.
Q And back in the early eighties, the mid eighties you were reviewing a lot more cases than ten or fifteen a

year, weren't you?
A You said currently now. I mean, you know, I don't know how many it is on a year. I mean, it's certainly less than I've done in the past because I don't have the time any more.
Q You first started doing this when?
A Early eighties.
Q And how many cases were you reviewing in the early eighties on a yearly basis roughly?
A In the -- I can't tell you. Not very many. Several.
Q And when did it increase?
A Somewhere around the mid eighties, 1984, '85, '86.
Q And how many were you reviewing in '84, '85 and '86 a year?
A I guess sometimes it got up to approximately fifty cases.
Q And how much testifying were you doing?
A Oh, I'd give ten to fifteen depositions a year, be in court anywhere from one to five times.
Q And how much were you charging back then?
A A hundred and fifty dollars an hour.

Q And how much are you charging now?
A A hundred and seventy-five dollars an hour.
Q And what do you charge for deposition time?
A Two hundred and fifty dollars an hour.
Q And trial time?
A Fifteen hundred dollars a day.
Q And how many times have you testified in the last two or three years? First of all, at trial?
A Perhaps twice last year. In trial and by deposition, you know, maybe ten times.
Q And most of your work is done for the defense, is it not?
A That's right.
Q And most of this work germinated or started or the increase in your work occurred at or about the time that you were invited to give a lecture to St. Paul Fire and Marine people in St. Paul, Minneapolis, including their attorneys?
A No, prior to that.
Q Prior to that?
A (Witness nods head affirmatively.)
Q But that guest appearance, that invitation to come and speak to them and their attorneys occurred when?

A Gosh, time goes by. Four or five years ago. Late eighties.

Q Have you given any other similar talks to the defense industry, St. Paul Fire and Marine, any other liability insurance carrier?

MR. POE: Objection to the question. The form of the question. Reference to insurance.

BY MR. THOMPSON:

Q Or any other defense groups, including defense lawyers?

A Well, I gave a talk to the -- I think the Florida bar, defense bar by invitation just a few years ago.

Q Mr. Conrad invite you?

A No, I can't remember who, but somebody from -- I think he was the current president. I don't recall who it was.

Q Okay. Was there a time when you were reviewing all of St. Paul's cases involving obstetrical cases, brain-damaged children?

A I don't think anybody would have the time to do that.

Q You weren't doing that?

A No, certainly not all of their cases.

Q A substantial number of their cases?
A Well, you know, I don't -- you know, there's -- I think that they're -- you know, they're twenty thousand cases pending against children, so, I mean --
Q If we wanted to find out whether or not ten percent of your income or fifty percent of your income or one percent of your income was derived as a result of medical/legal work at any given time, how would we do that, Dr. Chalhub?
A You would have to know what my total income was, which I don't think is any of your business.
MR. CLEEK: And you're not going to answer that. So, don't even respond to it.
BY MR. THOMPSON:
Q And with regard to -- whether or not it's any of my business, with regard to determining what percentage was derived as a result of doing this type of work in this setting for a defendant like Dr. Pajarillo and his insurance carrier, could we break that out?
MR. POE: Objection in regard to the reference to liability insurance and I would like a continuing objection when you mention that.
MR. CLEEK: Same objection. This is just

getting to the point of harassment. We all know that, so he's not going to answer any more questions after he finishes this line.

A I'm not sure what the question was.

BY MR. THOMPSON:

Q Could we find out from those records, wherever those records are, how much was derived from testimony?

MR. CLEEK: Actually you're going to take his word for it. You're not going to get any records.

A I don't know to be honest with you.

BY MR. THOMPSON:

Q Just don't know?

A (Witness nods head affirmatively.)

Q Okay. Do you get 1099's from lawyers, from insurance companies concerning amounts of payment they made to you over a particular year?

A I get lots of 1099's on patient treatment, insurance companies, you know, and I don't, you know, sort those out.

Q You don't keep separate records?

You haven't kept separate records with regard to this aspect of your earnings as opposed to the delivery of health care services to children and to hospitals?

A At certain times and then certain times not.
Q What times did you and what time didn't you?
A I can't tell you over the years.
Q Okay. Do you still maintain those records yourself from 1980 on?
A Oh, no. I mean, you know, the -- I don't think you're required to more than three years. So --
Q The records that you would have, accounting records only go back three years?
A No, I mean, I don't even keep the 1099 forms. My accountant says I don't have to.
Q But any accounting records, tax returns, the data that you would have given to accountants with regard to your earnings during a given year, they only go back two or three years?
A Three years, yes.
Q Have you ever been sued?
A No.
Q Have you ever testified in a medical malpractice case involving one similar to Adam Meade and rendered opinions as to causation of damage; that is, that it was ischemic secondary to meningitis as opposed to a hypoxic episode?

A I can't tell you that specifically. I've certainly reviewed and testified in a number of cases involving meningitis because that's been an area of my special interest and speciality in research. So, you know, whether it specifically dealt with hypoxia or ischemia or secondary -- you know, I can't tell you specifically. I mean, it's clear when you have an ischemic lesion and you understand the pathophysiology of the basic process, what it's due to. I mean -- and if one has expertise in that area and one studies meningitis and studies it for twenty years, I mean, that's what you see. I mean, this is not a hypoxic lesion. This is an ischemic lesion and it's due to involvement secondary to meningitis. There is no question about that.

Q And that's your opinion?

A It's not only my opinion. I mean, the facts and the x-rays will substantiate that.

Q And do you have any other opinions other than that one in this case as to causation?

A Other than the ones that I've given you for the past couple of hours?

Q Other than the ones you've given me?

A No.

Q And you don't believe in this particular case that the hypoxic episode between, as you have opined, 9:47 and 10:00 or 10:05 had one iota thing to do with the neurologic deficit of this child: Adam Meade?

A No. It really doesn't make any sense, does it? When you have a child whose stomach is not dilated, his blood gases respond quickly, whose scan is inconsistent, who has three or four days of hypoxia at another hospital, why are you picking out a twenty minute period of time and trying to relate all of this child's injuries when he has a devastating Group B Streptococcal infection which causes this type of severe injury in children and often results in their death? I mean, I don't understand.

Q What if that endotracheal tube was in the esophagus for a longer period of time than thirteen to twenty minutes?

A It does not substantiate -- by the clinical facts that child would have had a cardiac arrest because the heart would have been hypoxic and would have stopped or had severe bradycardia and had to be resuscitated and then you would have seen a, you know, a different set of circumstances, but that didn't occur.

Q Assuming that endotracheal tube went into the

esophagus at about 9:15 and remained there, how long would it have been before that child, in your opinion, Dr. Chalhub, had had a cardiac arrest?

A Well, you know, certainly the longer it is -- when you got past, you know, ten, fifteen, twenty minutes, you're going to have significant bradycardia if you're not oxygenating the heart. You cannot withstand it any longer.

If you had a pH below seven for minutes thereafter, you cannot sustain a normal heart rate. Then you go into shock and you go into cardiac arrest.

Q Your opinion is he would have had it about, what; 9:30, 9:45, somewhere in there, a cardiac arrest if the tube was placed in the esophagus at 9:15?

A Certainly before 9:47, yes.

Q Okay. The first diagnosis of the Group B Streptococcal meningitis and antimicrobial or medical treatment for it occurred when and where in this baby's case?

A At Cabell.

Q And how was the diagnosis made?

A By lumbar puncture.

Q Should it have been made sooner?

A You know, I didn't, again, didn't look at it from

that aspect.

Q Don't --

A But, you know, this child was critically ill and had to be resuscitated. I mean, you know -- and the child was there for a short period of time at the previous hospital. You know, the child received antibiotics.

Q Was critically ill when and where?

A At Appalachian Regional.

Q And was there for a short period of time?

A Yes.

Q How long a short period of time, in your opinion?

A 8:45 to noon.

Q And the diagnosis of Group B Strep was made on lumbar puncture, correct?

A Correct.

Q Do you know what the mortality and morbidity is either in your own experience or in the literature for Group B Streptococcal meningitis?

A Well, it depends on the presentation. A child that presents with sepsis, poor perfusion and meningitis, the overall percentage is probably twenty percent. In this particular child with this clinical presentation it will probably exceed fifty percent to sixty percent.

Q Was this child septic on arrival at 8:45 at Cabell Huntington?
A Yes, absolutely.
Q And you know that how?
A By the clinical presentation.
MR. CLEEK: I believe he said 8:45 at Cabell Huntington.
BY MR. THOMPSON:
Q Excuse me.
A Oh, I'm sorry.
Q Appalachian Regional
No, I think he's accusing me or misrepresenting the facts.
A You wouldn't do that, would you?
MR. CLEEK: I would accuse you of that, but I think that time you just misspoke because of old age or senility or something.
BY MR. THOMPSON:
Q And time, and time, and you're waving your hand at me.
At 8:45 at Appalachian Regional Hospital in South Williamson, Kentucky, this baby was septic as evidenced by the symptomatology?

A Sure. In retrospect, absolutely.
Can we take a one minute break or two minute break?
Q Sure. Sure. Anytime you want to.
(Short break)
BY MR. THOMPSON:
Q On admission, I believe at Appalachian Regional Hospital as I stood corrected, this child, in your opinion, based upon your review of the records, was septic?
A Correct.
Q Septic meaning?
A Blood and/or bacterial products. I mean, bacteria and/or its products in the blood.
Q The child have a temperature?
A It wasn't taken.
Q Vital signs other than a pulse of one fifty-one were what?
A They weren't taken.
Q The evidence on admission at Appalachian Regional Hospital on July 6th, 1986 of poor perfusion was obtained from what source? The records?
A The records and I think some testimony and I can't tell you exactly when and where.

Q Okay. And the records --
A Certainly there is poor circulation and -- I mean, poor capillary refill described by the time the child gets to Cabell.
Q Well, that's four and a half, five hours later?
A Yeah. Well, I mean --
Q On admission to Appalachian Regional Hospital, was there evidence of, quote, poor perfusion, and, if so, where was that evidence or where is it contained?
A Oh, I don't know whether it's specifically referred to in those records, so I can't tell you that.
Q Do you know as you sit here now whether or not anywhere in the Appalachian Regional records there's any evidence of poor perfusion in Adam Meade at or around 8:45 on July 6th, 1986?
A You know, I can't really tell you because I can't read all of the progress notes with the writings, so I don't know.
Q Well, you had depositions, didn't you?
A Well, yeah, but it doesn't translate all of the progress notes.
Q Whose progress notes are you looking at?
A Well, some of them -- the signatures are -- in

fact, the majority of them are illegible.
Q Well, you know who wrote all those progess notes, don't you?
A Dr. Parea (Phonetic).
Q Who's Dr. Parea? Sounds like a disease.
A Pediatrician.
Q Okay. That's Pajarillo, the one that asked you a to --
A Pajarillo, yeah. I'm sorry.
Q -- review these records.
A I'm sorry.
Q He wrote them all, didn't he?
A Yes.
Q You don't know him and haven't talked to him?
A No. That's correct.
Q Do you know any of the physicians in this case?
A That is correct.
Q Do you know any of the physicians in this case?
A No, I said no.
Q Okay. And you haven't spoken to any of them?
A No, no. Wait a minute. In the record it states that there is no capillary refill, which would certainly indicate poor perfusion.

Q And you're looking at?
A It's a stabilization note at 11:15.
Q And who wrote that note at 11:15?
A Well, I guess this is -- I'm sorry. This is the transfer note.
Q May I see what you're looking at so I'll know what it is before we get too . . .
(Document handed to Mr. Thompson.)
BY MR. THOMPSON:
Q Okay.
A That's the transfer note.
Q This transfer note by Karen White?
A Right.
Q Did you read her deposition?
A If it's on there, I did.
Q I don't -- Karen Wright; do you remember reading it?
A (Witness nods head affirmatively.)
Q Okay. Well, there's evidence of poor perfusion at 11:15?
A Correct.
Q By Karen Wright, correct?
A Correct.

Q There is no evidence of poor perfusion at or around the time of this child's admission at Appalachian Regional Hospital about 8:45 in the morning?

A No, there's no record of it, that's correct.

Q Okay. 'Do you think the child had poor perfusion though?

A I think the child was septic. I can't tell you though. It just wasn't described.

MR. THOMPSON: Okay. That's all I've got. Thank you, sir. Other than those other questions that I may have to ask that you wouldn't let him ask -- answer.

MR. OFFUTT: I have no questions.

MR. ADKINS: No questions.

MR. POE: No questions.

MR. McNEER: I have no questions.

MR. ROSINSKY: Well, I want to ask a few follow-up questions just to make sure I understand.

EXAMINATION

BY MR. ROSINSKY:

Q You had an opportunity, Doctor -- by the way, I represent the hospital. I'm Tim Rosinsky. Cabell Huntington Hospital.

You've had an opportunity to review the records of both of Adam Meade's hospitalizations at Cabell Huntington; is that correct?

A Yes.

Q And you have no opinion as to whether the Strep B or the Group B Streptococcal meningitis should have been diagnosed earlier at Cabell; is that correct?

A That's correct,

Q Do you have any criticism of the care and treatment of Adam Meade at Cabell Huntington Hospital?

A No.

Q Or any of its physicians?

A No.

MR. ROSINSKY: Thank you, Doctor. I have no further questions.

MS. LILLY: Nothing.

MR. CLEEK: No questions. He'll read.

THE WITNESS: We'll read and sign, *yes.*

FURTHER, DEPONENT SAYETH NOT

CERTIFICATE OF WITNESS

I, ELIAS GEORGE CHALHUB, M.D., do hereby certify that on this the _____ day of _____, 1993, I have read the foregoing transcript and, with corrections attached hereto, if any, it constitutes a true and accurate transcript of my testimony taken on oral examination on February 2, 1993.

_____
ELIAS GEORGE CHALHUB, M.D.

Subscribed and sworn to before me this the _____ day of _____, 1993.

_____
Notary Public, State of _____
at Large

My Commission Expires: _____

CERTIFICATE

STATE OF ALABAMA)
COUNTY OF MOBILE)

I do hereby certify that the above and foregoing transcript of proceedings in the matter aforementioned was taken down by me in machine shorthand, and the questions and answers thereto were reduced to writing under my personal supervision, and that the foregoing represents a true and correct transcript of the proceedings given by said witness upon said hearing.

I further certify that I am neither of counsel nor of kin to the parties to the action, nor am I in anywise interested in the result of said cause.

LISA ELMORE PETERS
COURT REPORTER

4-261> Estate of Ashley Carr

DEPOSITION OF ELIAS CHALUB, M.D.
[Adam **Wesley** Meade]

TAKEN ON February 2, 1993
by William deForest Thompson, ESQ.

Pg / Ln	
9/20	About 5% of time **is** spent practicing child neurology; other 94% of **time is** spent as President of Mobile Infirmary
42/3	Acidosis: combination of Group B Strep and esophageal intubation
101/11-13	Mostly testifies for defense

ELIAS CHALHUB, **M.D. - Deposition Index**
Meade vs. Cabell

Nothing of use for **us except some background information.**