IN THE CIRCUIT COURT OF
PRINCE GEORGE'S COUNTY, MARYLAND

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CHAE UNG CHO and AEGYUNG CHO, Individually and as Parents and Next Friends of SUJIN CHO, a Minor,

Plaintiffs,

v.

TAEK K. KIM, M.D.,

Defendant.

Civil Number: CAL95-9434

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COPY

Washington, D.C.

Friday, August 4, 1995

Deposition of:

RAOUL L. WIENTZEN, JR., M.D.

a witness of lawful age, taken on behalf of the Plaintiffs in the above-entitled action, before Eva M. Bridget, a Verbatim Reporter and Notary Public in and for the District of Columbia, taken at the Georgetown University Hospital Center, 3800 Reservoir Road, Bles Building, Room 6036, Washington, D.C., commencing at 2:05 p.m., when were present on behalf of the respective parties:

AUG 18 1995

APPEARANCES:

On Behalf of the Plaintiffs:

L. PALMER FORET, ESQ.
Foret & Thompson
1275 K Street, N.W., Suite 1101
Washington, D.C. 20005
202-408-4700

On Behalf of the Defendant:

PAMELA KINCHLOE, ESQ.
Armstrong, Donohue & Ceppos, Chtd.
204 Monroe Street, Suite 101
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301-251-0440

* * * * *

C O N T E N T S

P R O C E E D I N G S

(Whereupon, Wientzen Deposition Exhibit No. 1 was marked for identification, by Mr. Foret.)

Whereupon

RAOUL L. WIENTZEN, JR., M.D.

was called as a witness and, after having been first duly sworn, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. FORET:

Q State your name and address, please?

A Raoul L. Wientzen, Junior, M.D. The address is Department of Pediatrics, Georgetown Hospital, Washington, D.C.

Q Let me give you Deposition Exhibit 1, which is the notice for today's deposition. I just want to go through the categories listed thereon, and you tell me what, if anything, is responsive and if there is anything responsive, what it is.

Lump together categories 1, 2 and 3, and there are documents responsive, correct?

A Yes.

Q They are here in front of us?

A Right.

Q Anything responsive to category four?

A Yes.

Q What?

A These are my notes to the case, and there's also some notes on the cover of Ms. Cho's deposition.

Q Then I guess there's some underlining and maybe some notes in the materials you reviewed, too, correct?

A Right.

Q Anything responsive to 5?

A No.

Q Anything responsive to 6?

A No.

Q Do you have anything responsive to 7?

A No.

Q Do you have anything responsive to 8?

A No.

Q Do you have anything responsive to 9?

A No.

Q Is there anything responsive to 10?

A No.

(Whereupon, Wientzen Deposition

Exhibit No. 2 was marked for identification, by Mr. Foret.)

BY MR. FORET:

Q In terms of number 11, let's look at Exhibit 2, and tell me if that's your most current curriculum vitae?

A No, I think I have a CV that's one more up to date than this. In fact, I'm applying for full professorship this year and I have to update my CV, so there will be even one after that by the end of the summer. But this is not too out of date.

Q Can you easily put your hands on the updated one you're talking about?

A Either I can get you a copy or my secretary can cut one out of the computer.

Q It appears we'll probably be taking a break in a little bit, maybe you could get one then and bring it back?

A Okay.

Q Do you keep anything responsive to 12?

A No.

Q Is there anything responsive to 13?

A No.

Q How long have you been here at Georgetown, since '77?

A Yes. My eighteenth year -- my nineteenth year.

Q How does one apply for a full professorship?

A You basically meet with your chairman and say this is what your intention is, will he support your application, and then there is a sort of formal application where you get letters of recommendation from students, residents, faculty members, the chairman, and submit that plus your CV to a committee, basically, on rank and tenure and they say yea or nay.

Q Do you have to be at Georgetown for a particular length of time before you can apply?

A No. No. People come in as full professors or any rank.

Q Why are you just applying now, as opposed to five years ago or five years in the future?

A My wife asks me that same question all the time. In fact, when I applied -- when I told my chairman I was going to do that, he apologized for me -- to me for not having told me he wanted me to do this earlier. Just busy with life and it's nice to have a

title, but it doesn't mean too much more than that.

Q Is your wife also a physician?

A No.

Q Do you know who Virginia Wientzen is?

A Virginia Wientzen?

Q Yes. Spelled the same way as yours.

A Really? W-i-e-n-t-z-e-n?

Q That's what I saw. I can't tell you that I know anything more than I just saw the name.

A I would love to meet that person because there aren't too many.

Q Maybe it was a misprint.

A In this area?

Q I don't even know that.

A I don't know who she is.

Q Date of birth is on your CV as November 25, 1946, right?

A Right.

Q What's your Social Security Number?

A 101-42-9232.

Q Have you had any military service?

A No.

Q Have you ever been convicted of a crime?

That doesn't include traffic offenses.

A No.

Q Have you ever been a plaintiff in a lawsuit?

A No.

Q Have you ever been a defendant in a lawsuit?

A No.

Q Has Georgetown University even been a defendant in a lawsuit where the allegations in the lawsuit had anything to do with you?

A No. Well, I take that back. To do with me? I was a treating physician for a baby who was probably the first AIDS baby in Washington, D.C. Actually, I guess it's a matter of public record, because he was in Newsweek Magazine, Matthew Kozup, who sued Georgetown and the American Red Cross. I was his treating physician, but I was not named in the suit.

Q But the allegations in that lawsuit, I assume, had something to do with a blood transfusion?

A Exactly.

Q So the allegations in the lawsuit didn't have anything to do with your treatment?

A Correct.

Q There haven't been any other cases, correct?

A That is correct.

Q Have you taken the recent sub-specialty exam?

A Yes, I have.

Q Are the results back from that now?

A Yes, they are.

Q What were they?

A Six-fifty.

Q I don't know what that means.

A The average is 500.

MS. KINCHLOE: He passed.

BY MR. FORET:

Q So you passed?

A About ninetieth percentile. What was Bishara's, by the way, do you know?

Q I do not. So you now have the sub-specialty boards in pediatric infectious diseases?

A Correct.

Q That would be effective this year?

A The certificate is dated November '94, when we actually took the test.

Q So that's probably on your updated CV?

A Well, it will be on the one I submit for promotion. I'm not sure it's on the one that I have in

the computer right now.

Q Approximately how many depositions have you given?

A I've probably given an average of three or four a year over the last 10 years.

Q I assume that some of those have involved an allegation of failure to diagnose meningitis in a child?

A Correct.

Q More than half of them?

A I'd be reluctant to put a percent on them. It's a pretty -- I would say it's a sizeable percent, at least a third.

Q How do you approximate -- I'm not asking about depositions now, but in cases that you've reviewed, how do you approximate how many reviews are on behalf of the defendant and how many are on behalf of the plaintiff?

A Well, I think that has changed with time. I think right now it's probably 60 percent defendant, maybe two-thirds defendant, and the rest plaintiff. In earlier years it was more evenly split, or even more in the first years to the plaintiff.

Q Do you think that same division would apply to your depositions and also to your trial testimony --

A Probably.

Q -- that you just explained?

A Yes.

Q When was the last time you were deposed before today in a case where the allegation was failure to diagnose meningitis?

A I honestly can't remember. I can remember a case of group B strep. meningitis in a newborn back in probably March or thereabouts of -- of this year. It's probably the last case of meningitis I can recall being deposed in.

Q Who were the lawyers in that case?

A The defense lawyer was Mr. Mauro.

Q Mauro?

A M-a-u-r-o, yes.

Q Where is he from?

A West Palm Beach, I think, Florida. Fort Lauderdale. Somewhere down there.

Q You don't remember anything else about that case?

A I remember a lot about the case. It was a

fascinating case.

Q Do you remember the name of the plaintiff's lawyer?

A Mr. Searcy.

Q Do you know how to spell his name?

A S-e-a-r, either c-e-y or c-y.

Q He's probably from the same area?

A Yes, somewhere in Florida.

Q Is that case still open, as far as you know?

A No.

Q It settled?

A Yes.

Q Mr. Mauro advised you of that?

A Yes.

Q Were you privy to any of the particulars of the settlement?

A Yes.

Q What are they?

A Well, it's a very complex case.

Q Well, just tell me what it settled for.

A Seven million dollars. But that was down from 18 million, which was the first award.

Q Not bad. The first award or first demand?

A Well, no, first award. This case was tried in 1984 against an obstetrician, pediatrician and a hospital for a newborn baby who was delivered in 1984 or 1983, I can't remember which, and developed early onset group B strep. sepsis and meningitis and went on to survive.

Q Did you testify in the first trial?

A No.

Q You were not involved in the case, yet, correct?

A Not involved. To make a long story short, the plaintiff entered into an agreement with the defendant pediatrician to settle his policy limits on the plaintiff, in exchange for his continued participation as a defendant in the case, but there would be no more award that could be gotten from this physician.

So he entered into the court hearing and evidently when this case was finally tried or finished, they awarded $18 million to the plaintiff and then found out about this agreement between the pediatrician and the plaintiff and they took it to a higher court who turned it over and said you have to try it again.

Q Is one of the names in that case Mary Carter?

A Mary Carr?

Q Carter.

A Carter, no. I believe it rings a bell.

MR. FORET: That's a Florida case.

MS. KINCHLOE: It is?

MR. FORET: Yes.

BY MR. FORET:

Q So then it got overturned and went back for trial and you became involved?

A Right.

Q It was not tried a second time, of course, as you just explained, correct?

A Well, it was in the process of trial. I didn't appear. It was in the process of trial.

Q You didn't provide trial testimony?

A Right.

Q Do any other depositions that you've given involving failure to diagnose meningitis come to mind where you can remember the names of the lawyers?

A Well, there was a case in Baltimore where the defendant attorney was Mr. Magee. I think it was Monty Magee. That goes back a number of years. I can't

remember the name of the plaintiff's attorney. I was actually a plaintiff's expert in that case.

Q What makes you remember Magee?

A I remember Magee, but the case was a child with a 106 fever who came through an ER to see a physician on the advice of his pediatrician after a phone call, never saw a physician and instead was taken care of by a physician's assistant. This was -- I guess why I remember it, it was the -- it was a telegraph of what managed care what might be like.

He never saw a doctor, saw a physician's assistant who treated him as if he were a doctor and the baby went on to develop shock and meningitis and I think the baby died. It was my opinion that a baby with a 106 fever should see a doctor.

Q But you don't remember the name of the plaintiff's lawyer?

A No.

Q Any other meningitis cases come to mind where you can remember the names of any of the attorneys involved?

A No. I'm sorry.

Q Approximately how many times have you

testified at trial?

A Probably eight times or nine times.

Q I assume some of those involve failure to diagnose meningitis?

A Yes.

Q Do you remember the names of the attorneys in any of those cases?

A Yes. There was a -- I was deposed in this case, so this would be a deposition too. This was a case in Florida. The defense attorney was Mr. Roy Watson. I think that's who I worked for. The case was a child who was seen in an ER with a fever and a stiff neck.

The ER doctor called the referring pediatrician who said this baby's got meningitis, I want you to come in and do a lumbar puncture. The parents didn't want to stay in that ER and wanted to go to a different ER. The child was transferred, the baby was tapped, and the baby had a stroke and died, and they sued everybody.

Q What part of Florida?

A Again, I'm not so good on the geography of Florida, but I would say somewhere around Fort

Lauderdale.

Q Do you remember the plaintiff's lawyer?

A No, I don't.

Q Roy Watson, W-a-t-s-o-n, was the defense attorney?

A Yes.

Q Do you remember any other trial testimony cases involving meningitis where you can remember the names of the lawyers?

A As I sit here, I really can't. I can't think of any.

Q Included in the materials that you have in front of you are two letters from Ms. Kinchloe. So as far as you know, those are the only two received, right?

A As far as I know, these are the only two I received, yes.

Q All the documents that you have reviewed to render your opinions in this case are before us, right?

A Right.

Q Have you ever sought or received medical treatment for a condition that did not allow you to practice your job?

MS. KINCHLOE: Objection.

THE WITNESS: Well, I had a cervical disc and I couldn't come to work for three weeks on the advice of my neurosurgeon, but other than that, no.

BY MR. FORET:

Q That's the only time?

A Yes. That was quite a time too.

Q Has your medical license ever been suspended or revoked?

A No.

Q Your hospital privileges ever been suspended or revoked?

A No.

Q Do you have a hospital privileges anywhere other than Georgetown?

A Yes.

Q Where?

A Fairfax Hospital.

Q For how long?

A Very recently. Probably three or four months ago.

Q Prior to obtaining those privileges at Fairfax, had you ever held privileges at any hospital

other than Georgetown?

A I have a -- sort of informal consulting privileges at Arlington Hospital and Washington Hospital Center where I see newborns.

Q For how long has that been?

A Ever since I've been here.

Q Anywhere else?

A No.

Q Have you reviewed any cases for any of the attorneys, including Ms. Kinchloe, at her firm other than this case?

A I can recall, I believe, two other cases that I've reviewed for either Ms. Kinchloe or the firm.

Q What did they involve?

A One involved basically failure to diagnose meningitis. I read it and I turned it away because I thought it was a good case.

Q A plaintiff case?

A Or a bad case.

Q It depends on how you look at it?

A How you look at it, yes. I don't remember what the other case was, actually.

Q What do you remember about the case you

turned away, factually?

A Before sitting with Ms. Kinchloe this afternoon, I had no recollection of that case.

Q I appreciate her refreshing your memory.

MS. KINCHLOE: Well, let me just say that the case is still pending and I'm not sure I want Dr. Wientzen to be testifying as to what his opinions were in the case.

MR. FORET: Well, let's make this agreement. Don't mention any names so nobody can find out what case this is.

MS. KINCHLOE: I know, but the -- I'm still uncomfortable with the testimony about even the events, because they could be easily connected up.

MR. FORET: Well, can 1 just somehow get, without getting into the specifics of the case so they can't be connected up, just why you thought that it was a viable case on behalf of the plaintiff?

MS. KINCHLOE: If Dr. Wientzen can do it in very general terms.

BY MR. FORET:

Q Maybe you can just give me the temperature and age of the child or something like that so that if

one of my colleagues reads this transcript they won't be able to tell what case this is?

A I don't remember the real specifics about the age of the child or the degree of fever. In fact, the only thing I remember is what Ms. Kinchloe reminded me of today, which is that this was a febrile child who looked sick and had no focus of infection. It was my view in reading the case that the physician, and I don't even remember whether it was a pediatrician or an ear doctor or whatever, didn't do what I thought needed to have been done.

Q What did you think needed to be done?

A I don't remember how the child appeared to say specifically what that was, but obviously some testing that normally would be done was not done.

Q All right. You thought something should have been done that wasn't done?

A Right.

Q That's about all we can say right now. All right. Have you been asked, do you know, to review cases where -- on behalf of a defendant, where the defendant is insured by the same insurance company that Dr. Kim is insured with? I assume he's insured with

Med Mutual?

A So the question is have I reviewed other cases for Med Mutual, is that it?

Q Yes. For Med Mutual or where you are asked, of course, by the defense firm, but you knew that Med Mutual was the insurance company.

MS. KINCHLOE: Well, in retrospect, is that what you mean?

MR. FORET: Yes.

MS. KINCHLOE: Obviously --

MR. FORET: Any way.

THE WITNESS: Yes. In retrospect I know I have reviewed cases for Med Mutual.

BY MR. FORET:

Q Do you know how many?

A No. No.

Q What percentage of your income, without telling me any numbers right now, is from providing or reviewing cases as an expert witness?

A Probably 30, 40 percent of my income comes from this work.

Q Thirty to forty?

A Right.

Q Do you advertise?

A No.

Q Have you ever?

A No.

Q Let me just ask you a couple of questions about your CV, and then I'll give you the marked copy. Tell me which of your publications, in your opinion, are -- involve the issues in this case?

A The publication in Clinical Pediatrics, I'm trying to find it here, number 11, Occult Bacteremia.

Q Wait. On what page?

A Page 7/9.

Q Page 7 what?

A It looks like it's 7 of 9. I have 7/9 on the top.

Q All right. It's which publication?

A Eleven. Have you got a different one that I do? Maybe one is the updated one. You may be on the abstracts.

Q Page 6. In Clinical Pediatrics, right?

A Right. I know I -- I don't see it on here, but I wrote a monograph for the American Family Physicians publication on sort of a general view of

pediatric infections. I believe that contains some writing on the topic that this case is about.

Q That would have been in which publication?

A It's called the American Family Physicians Monograph. I don't know how more precise to term it than that.

Q When would that have been, if you recall?

A Two or three years ago.

MR. FORET: Off the record.

(A discussion was held off the record.)

MR. FORET: Back on the record.

BY MR. FORET:

Q The publication number 3 on page 8 says in press. Is that out of press?

A Which one now? Page 3?

Q Page 8, number 3 under chapters and books.

A No. That -- this book was published and it's no longer in press. It's published. It was about 10 years ago, right, or more.

Q Do you have any chapters in any books that are on your updated CV you're going to give me that aren't on the one we're looking at?

A No.

Q When you took the pediatric boards, you only took them one time, correct?

A Correct. Well, there's an oral and a written part.

Q You took the written part once and you took the oral part once, right?

A Right.

Q The sub-specialty board was only a written exam?

A Yes.

Q Of course you only told me once, because it's only been given once, right?

A Correct.

Q In your current job, answer for me in whatever the easiest way is, in terms of telling me how your time is divided up between teaching, seeing patients?

A Well, it's hard to divide it up, becau e the teaching role is almost always with a patient present, so probably right now 70 or 80 percent of my time is clinical time seeing patients, inpatients and outpatients, often co-joined with teaching students and residents while I'm doing that.

The other 20 percent of my time is some of the research that I do, some of the administrative work for my division, for the department and for the university that I do.

Q All right. So now your division is pediatric infectious diseases, correct?

A Correct.

Q That's part of the Department of Pediatrics?

A Right.

Q You're the chairman of the division?

A Chief.

Q Chief.

A They don't call it chairman.

Q It's chairman of the department?

A Correct.

Q Who is chairman of pediatrics?

A Dr. Owen Rennart.

Q Who is the vice chairman?

A Actually, there are two vice chairmen. Siva Subramanion and Pedro Jose.

Q What other attending physicians are in your division?

A There's Dr. Charlotte Barbee-Morrell, who is

full-time in the division, and Dr. Joseph Bellanti, who does occasional work in my division.

Q How do you spell his name?

A B-e-l-l-a-n-t-i.

Q How long have they been with you?

A Dr. Bellanti has been here for 30 years, so I sort of was with him for a while in his division, and then it sort of split off, but we still do things together.

Dr. Morrell came right after Dr. Freij left, so I don't know when that was, in 1990 or 1991, somewhere around then.

Q Dr. Bellanti is in another division?

A He's in immunology, yes.

Q At the present time how many fellows are in your division?

A We have no -- we used to have a fellowship program. No longer do we have a fellowship program.

Q So the residents would be just residents in the Department of Pediatrics?

A Right.

Q That would include working with you, correct?

A Correct.

Q Why did you stop the fellowship program?

A It's very expensive. It's hard to get grants, hard to get funding. When it falls and you have them, you're responsible for them.

Q When did it stop?

A Either '89 or '90 was our last fellowship year.

Q How much of your clinical time would you describe being in general pediatrics as opposed to pediatric infectious diseases?

A Well, currently a small fraction of my time. I do give some general pediatric care to two groups of people. A group that was in a study that I did for oral immunity, which is pretty much finished now.

The other group would be children who are HIV positive who come to our AIDS clinic, and more for their convenience and cohesion of care we render -- I render both primary pediatric care as well as the infectious disease care until we know whether they're infected or not.

If they're not infected, we send them away. If they are infected, we keep them. So what fraction of that it is, five percent, eight percent. A small

percent.

Q So 95 percent of your time is in your specialty of infectious diseases?

A It hadn't always been that way.

Q For how long has it been that way?

A I was -- as it says somewhere in my CV, I was a member of the outpatient department part-time, the fifth person, if you will, and did general pediatrics probably for about 20 percent of my time from the late '70s until probably 1990 or '91.

Q Is that what's meant when it says attending children in youth ambulatory service?

A Correct.

Q What is your current involvement in the NICU?

A Right now it's only as a consultant to children who I get asked to see.

Q In the past?

A When I was in the pediatric clinic, there would be babies who would be in the regular nursery who would get sick and I would admit them to the NICU. I would surrender their care at that time, but I would still follow them and be their pediatrician in general.

Q So you have pretty much done everything at

Georgetown except your fellowship, right?

A Right.

Q Your fellowship was two years?

A Right.

Q Were both years of your fellowship under Dr. McCracken?

A Correct.

Q What's the difference between the two hospitals?

A It's poorly written in there. The fellowship really is a single program, and the patients are at Parkland Hospital and Dallas Children's Hospital. They're co-joined. You walk in the same hall and you go from one to the other and you never know -- other than one's newer and the one's dirtier, you never know that you've left the hospitals. So it's really just one program.

MR. FORET: Off the record.

(A discussion was held off the record.)

MR. FORET: Back on.

BY MR. FORET:

Q When were you first contacted in this case?

A Now that's a very hard question. I can tell

you when Ms. Kinchloe first contacted me, but I don't remember when you contacted me.

Q You don't have any recollection of that; is that correct?

A Yes.

Q Well, you know what, I won't ask you about it then. When did Ms. Kinchloe first contact you?

A By -- just by looking at the date here on her cover letter to me, sometime probably in August of 1994. About a year ago.

Q I won't bother marking all this, but we're looking at her letter to you of August 19, 1994, and evidently you had a conversation sometime before that? Does that comport with your recollection?

A Probably, yes.

Q Then there is a second letter to you from her dated March 16, 1995?

A Right.

Q As I read these letters, you received initially everything except the depositions of Ms. Cho and Dr. Freij, I think?

A I think. I'm honestly trying to reconstruct this. I made some notes to myself after I read, as you

can see, all the information, and there were some questions that I had, one of which was where is the deposition of Dr. Kim, which is supposed to be enclosed, but I don't believe it was.

Q Okay. Why don't you -- there are notes on her August 19th letter on both the front and the back page. For right now just read me the ones on the front page.

A On the front page it says was there a 10/27 ER visit to Shady Grove Hospital, question mark. Where are the strep. pneumo. sensitivities from the blood culture of 11/2 at Shady Grove Hospital, and number three, no deposition of Dr. Kim enclosed. Then I have some lab results from the Georgetown Hospital LP, which is what's in the record about the CSF findings.

Q Just read them so I can make sure --

A I have Georgetown University Hospital CSF 11/3 after stable, 6,000, which is white cells, 64 segs. Then I have 11/6 800 white cells, glucose 37, protein 176.

Q I'm sorry. What I'm pointing to, which is the second note from the first set, that says where are the what?

A Sensitivities, antibiotic sensitivities.
Q From Shady Grove?
A Right.
Q From the blood culture done at Shady Grove?
A Right.
Q Those were just not in the records you initially received?
A I couldn't find them.
Q Are there any?
A I still can't find them.
Q Okay.
A I can see in there that the zone of inhibition around the oxacillin disk was 23 millimeters, which would mean it's sensitive, but I don't see form MICs.
Q Let me go back. I told you I wasn't going to ask you about the conversation you and I had, and I'm really not, other than just to ask you this question. I understand you don't remember it, but can you explain to me in any way today why you didn't make the decision to review the case when I asked you to, but you did when Ms. Kinchloe asked you to?
A Again, I would give you my guess, but I don't

know that this is the only part of it, and that is you called me when I was much busier and I had more -- more things to do and I just didn't want to be hassled by another case or another problem.

Ms. Kinchloe called me in the summer, obviously, when things are quieter and I might have been more free to give up a Saturday to read this stuff.

Q The notes you just read from on the front page of the August 19, 1994 letter were made when, approximately?

A Probably in August of '94 when I read the records.

Q Have you submitted any bill yet?

A I probably did a year ago when I reviewed this stuff.

Q I didn't ask you this when we went through the deposition notice requests and you indicated you didn't have anything responsive to the question about a bill. You don't keep them?

A No.

Q So as far as you can recall, you may only have submitted one bill?

A Correct.

MR. FORET: Well, I might ask you for that. As a matter of fact, I think I will. You can take it under advisement.

MS. KINCHLOE: Okay.

MR. FORET: Thank you.

BY MR. FORET:

Q Then the notes on the back page of the August 19, 1994 letter were made when?

A The ones in red were made after I read the main body of medical records that came. The ones in blue were made after I read the -- so that would probably be August of '94, maybe within a few weeks of this letter.

Then the blue notes were made after I read Dr. Kim's deposition. I don't remember when I first read it, because I don't have a cover letter to tell me when it really was sent.

Q All right.

A May I explain that?

Q Yes. Go ahead.

A It gets confusing. I have a second cover letter here from Ms. Kinchloe dated, as you know, March

16th of '95, saying here are the transcripts of Dr. Kim, Dr. Cho and Dr. Freij.

I have transcripts, Dr. Kim, Dr. Cho -- Ms. Cho and Dr. Freij. Unfortunately, I have two copies of Dr. Kim and Dr. Freij. So obviously someone sent me those two depositions twice. I don't know when one -- the first set came.

Q Fine. What I'm now doing is just for my own purpose, because when I look at the copy of your notes that you just identified, I'm not going to see red and blue. But the blue is off to the right side of the notes and appears to refer to Dr. Kim's deposition as you just explained.

What I'd like you to do is read the notes on the back of the August letter, and I'm going to look over your shoulder while you're reading them since that's the only copy.

A I should read them, interpreting my abbreviations?

Q Please.

A Sujin Diane Cho, date of birth 5/25/90. Birth weight 8 pounds 14 ounces. 7/21/90, one and three-quarter months old, 15 pounds, 23.5, which would

probably be the length, smiles. Diagnosis mild URI. Weight too high. Weight increase. DPT, OPV vaccines.

9/26/90 height 24.5 inches, weight 20 pounds 1.5 ounces. This is at four months of age. Well baby exam, obesity. Oral polio virus vaccine and DPT vaccine.

10/30/90, five-and-a-half months of age. Cold, stuffy nose, fever since Saturday night. Took to hospital Sunday, temperature was 104, still has fever. Seen by Dr. Kyung Sik Kim, treated as URI on Sunday with IM Gentamicin. Fever up to 104, still eating well, playful.

Physical exam active, temperature 102.3 rectally, not toxic, not irritable. HEENT exam, fontanelle not tense. Tympanic membranes hyperemic both sides, throat congested, nasal congested. No neurologic anomaly. Impression, otitis media both sides, URI. Rule out FUO. Throat culture negative. Ampicillin one gram, amoxicillin 125, one-half teaspoon three times a day.

Off to the right of that dates notes I have several Gentamicin and I have erythromycin, according to Dr. Kim's reading of his notes during his

deposition. Also has independent recollection of baby smiling and playful in office.

Q Since you're at this point, let me just ask you one thing, not about that but about your note about ampicillin one gram. Where did the one gram come from?

A That is a mistake. As I read through Dr. Kim's reading of his deposition, it's just -- it's what I thought was one gram is IM. There is no dose.

Q What would be a normal dose for this child?

A This baby weighed 10 kilos, probably anywhere from 250 milligrams to 1 gram would be a typical dose.

Q IM?

A IM.

Q All right.

A I have 10/27/90 down here, and I wrote it because I thought there was supposed to be an ER visit, according to the cover letter that I -- the medical contents that I got, but there turns out not to be -- not to have been a Shady Grove ER visit of 10/27/90, but I didn't know that at the time, so I left space.

10/28/90, office visit with another Dr. Kim. Temperature 104 rectally, beefy red throat, acute pharyngitis. Garamycin, 20 milligrams, pediatric IM.

Circle, call regular private medical doctor in a.m.

Q Is that note from the records from that day as you're reviewing them, you think?

A Yes. 11/2/90, Shady Grove Hospital, 10:22 a.m. to 3:30 p.m., transfer to Georgetown University PICU. Right tympanic membrane is full, not red. Fontanelle is tense lying down and full sitting up. I have blood culture positive. Strep. pneumo. urine positive antigen test.

11/2/90, Georgetown University Hospital admission. Right tympanic membrane injected and dull, stiff neck. LP 6,000 white count. Recrudescent fever on day four. LP 800 white blood cells.

Then on the other side I have the same Georgetown lab values.

Q Then on your reference on the cover sheet of the medical records, the side that's Shady Grove Hospital 10/27, I think I know what you're saying, but just read it.

A I have question mark, not in packet. Was there an ER visit prior to the seizure visit, question mark.

Q Does the fact that there was no ER visit on

10/27 1990 at Shady Grove make any difference?

A I don't see it making any difference. It was just something that was supposed to be there that wasn't that I didn't want to not review if it really happened.

Q Do you know Dr. Kim, the Defendant in this case?

A I don't think I do, although I gave a lecture at Shady Grove Adventist Hospital six months ago on antibiotic resistance, and I know I met a Korean doctor who I think is a Dr. Kim, but it turns out there may be many of those. We certainly didn't acknowledge each other as knowing each other through this case.

Q Do you know Dr. McDowell, who is an expert for the defense?

A Not personally, but I know the name.

Q How do you know his name?

A Just as a practitioner in the communit .

Q Of course you know Dr. Freij. I assume you regard Dr. Freij to be a good physician, correct?

A Yes, I do.

Q He would have worked with you here at Georgetown -- well, however long he did. It was

several years, right?

A I think it was three.

Q Then he received a position or an offer for the position where he currently is and that's why he left?

A Correct.

Q Why don't you read now for me the notes you have written on the front page of Ms. Cho's deposition?

A These notes come from her deposition and they are sort of a running tally of her perceptions of the baby during the course of the events.

Q You wrote that down because it's important when you reviewed this case?

A Yes. A little fever and runny nose 2:00 to 3:00 p.m., Saturday 11 -- I'm sorry -- 10/27. Sunday, 10:28 a.m., felt warm. 10/28, 2:00 p.m. warm and vomited times 1. 10/28, 3:00 p.m., axillary temperature 102 to Dr. Kim's office. This is the other Dr. Kim. 10/29, 6:00 a.m. to 7:00 a.m. the temperature was 102. A call from mother-in-law at noon to say that there was a temperature of 102 axillary.

12:00 to 12:30, phone conversation with Dr. T. Kim. The mother made an appointment for a 9:00 a.m.

visit on 10/30. On 10/29 at 6:00 p.m. there was a phone call with the mother-in-law again saying the baby is eating, playful and fine, but still fever.

The baby was asleep at 9:30 when mom got home and slept through the night. On Tuesday, 10/30, the baby was warm on awakening between 6:30 and 7:00, ate breakfast, which was formula, was calm, quotes, and was following what was going on.

9:00 a.m. visit with Dr. Kim, cold and throat infection. No mention of otitis media. If doesn't get well, come back Saturday morning. 1:00 p.m. phone call, happy, playful, eating. 6:00 p.m. phone call, antibiotics were given with Tylenol and the baby had a fever up and down. Temperature was up and down throughout the day. The baby slept through the night to Wednesday. Wednesday, 10/31, there was a noon phone call from the grandmother, decreased appetite with the fever. An 8:00 p.m. phone call with the grandmother, diarrhea since noontime. Had laid down all day, not playful as had been before.

Mom got home at 9:00 p.m., the baby looked exhausted while lying in bed asleep. Called Dr. Kim to state fever, diarrhea, doesn't eat much, lying down,

sick and tired. Temperature 102 to 103 axillary.

Asked why was there diarrhea, the answer was probably the antibiotics. Asked if the antibiotics were stopped would the diarrhea stop, Dr. Kim advised to stop antibiotics.

Thursday, 11/1, between 7:00 and 8:30 a.m., the baby was awake but Ms. Kim has no recollection of the baby's presentation. There was a noon phone call from the grandmother, the diarrhea stopped, but the baby still had fever and was lying down.

8:00 p.m., phone call, same circumstances. 9:30 Dr. Kim phone call, fever, tired, sick without diarrhea. Dr. Kim advised cool baths and if not better, bring to his office or hospital. That's it.

Q I think the rest of Ms. Cho's deposition you may have underlinings and markings on it. You don't have any more notes written on there, do you?

A No.

Q Do you have any writings that you made in the Georgetown records?

A Yes.

Q Can you identify those for me?

A Writings at the time I saw the child?

Q Correct.

A Yes. This on -- the date -- actually, there's a whole through the date. Probably the 6th. My pages aren't numbered.

Q I might be able to help you. Let me just get that.

A It's right here where it says ID. That's my note that goes with the full consult that was written by my resident.

Q But this is your writing?

A Yes, this is my writing.

Q Why don't you read that for me?

A Full consult entered. Recrudescence of temperature to 40 on day four of penicillin G therapy for strep. pneumo. meningitis. Line sight/bone/hips/ lungs negative on exam. Plan, rule out penicillin and sensitive strep. pneumo. Rule out line sepsis. Rule out intracranial separation.

Suggest add Cefotaxime, 200 milligrams per kilogram per day in four divided doses every six hours. CAT scan, blood culture, urine culture and chest x-ray, BAER, brain stem auditory evoked response, at the end of the week. Will follow.

Q Now, since you -- at some point, I assume, you've had an opportunity to review in your work on this case the entire Georgetown chart?

A Right.

Q At least the pertinent parts, right?

A Yes.

Q Why was your division, or you, infectious diseases, not consulted until the 6th? She was admitted on the 2nd.

A I think our intensivists here are very complete and generally good physicians. They commonly don't involve us in a case where the diagnosis is rather clear until there's a complication that they can't manage, not to say some other intensivist, even the ones here, wouldn't have called us right away, but it is rather straightforward what to do with a baby that has meningitis.

Q Was the baby developing a complication as of November 6th, then?

A Well, actually I see two things. I see in my note that the baby recrudesced with fever. That is the baby had lost fever and then it returned, which would be a concern. Although now that we know more about

steroids, what I didn't put in here and 1 would put today, that this could be rebound from the loss of steroids if you stopped the steroids. So in that regard this could be a complication. Although the consult and other notes in the record say the baby persisted with fever for four or five days, that would be a reason to have a consult and see the child.

I have one more note that I found if you want.

Q Yes. I want to keep doing it.

A This is on the 10th, I think. It's almost a blank page. Somehow nothing else was written.

Q Okay.

A It says ID will assume care. I think this is when the baby was transferred to the ward. Needs to complete 14 days therapy, penicillin and full developmental evaluation before discharge.

Q That's your signature?

A Right.

Q So the other infectious disease progress notes in the record are written by who?

A By the resident who is on the service at the time.

Q Do you know the name?

A You know, I don't. It might be Diane Bork, but I can't vouch for that.

Q B-o-r-k?

A It might be, yes.

Q Look at the infectious disease note on November 8th. Does that appear to be the same person?

A ID follow-up, yes.

Q Now, who is or was Dr. DeCarlo who did the discharge summary?

A Joe DeCarlo was one of our intensivists here at the time, and I think right now he's in Russia.

Q When you describe an intensivist, you mean someone working in the PICU?

A Correct. He's not a neonatologist, he's a pediatric critical care specialist.

Q Of course that's where this baby initially was treated?

A Right.

MR. FORET: Let me have this marked as Exhibit 3. It's the Georgetown bill.

(Whereupon, Wientzen Deposition Exhibit No. 3 was marked for

identification.)

BY MR. FORET:

Q I want you to either identify it for me or tell me how to identify what charges are for your service on that bill. I know your name shows up on here. Nothing on the first page, right?

A No. Consult, patient, new comprehensive. There's no way to know if that's me.

Q What's written? I-v-e is part of comprehensive, right?

A Comprehensive, right. What date is that, the 6th? That might be me unless she had a developmental consultation on that same day. Then the 8th a follow-up, which is me because it's got my name. I would bet you that the 6th is my consult.

Q All right.

A Ventilating -- ventilation. I don't know. These might be my charges for follow-up.

Q What day are you looking at?

A I'm looking at the 7th, 8th and 9th.

Q It just says follow-up, right?

A Yes.

Q Is there any way to tell from the CPT code?

A There may be. I'm certainly no expert in CPT codes. The CPT codes are the same, aren't they? No, I see a couple are different.

MR. FORET: Then there's one on the final page that has your name on it, so we know that's you.

It's three o'clock. Why don't we take the break.

(Whereupon, a brief recess was taken.)

MR. FORET: Let's go back on the record.

BY MR. FORET:

Q Dr. Wientzen, why don't you tell me what your opinions are in this case?

A Okay. I think my basic opinion is that the care Dr. Kim rendered this baby at the time of his visit with the baby on 10/30/90 was within the standard of care. The question of a phone call and the conversations, I mean, I don't have any firm facts to answer a question like that, but if you wanted to give me a hypothetical situation, I could tell you what a physician should have done or had to have done or would have done.

I can't sort of drum up an opinion because no phone calls existed.

Q Anything else?

A Well, there's a lot of derivative opinions in terms of what this child had at different periods of the evolution of the illness. My view is that this baby did not -- I agree with Dr. Freij -- probably did not have meningitis at the time Dr. Kim was seeing this child on the 30th. It may have been bacteremic and may not have been bacteremic.

To me that is a function of whether or not Ms. Cho actually did stop the antibiotics on Wednesday night. If she did, an alternative evaluation or explication of the case would be that the baby could have become bacteremic after stopping the amoxicillin.

Q But what is your opinion as to whether the child was bacteremic as of the visit to Dr. Kim on October 30th?

A I would -- the way I would look at the case is this. If Ms. Cho had not stopped the antibiotics on Wednesday, there would be no question in my mind that this child must have been bacteremic at the time of the Tuesday morning visit on the 30th, because one cannot really become bacteremic while being prophylaxed with amoxicillin.

So the bacteremia must have been there at the time Dr. Kim was seeing the baby. If the mother did not stop the antibiotics -- had she stopped the antibiotics, I don't know how to pick between those two scenarios, that the mom stopped the antibiotics and the baby had a viral disease and the bacteremia began Thursday and eventuated to meningitis Friday, or Dr. Kim's therapy was not sufficient for the bacteremia that existed on Tuesday and it persisted and progressed to meningitis.

Q Let me just ask you a general question that's obviously related to this case, but I'm not asking you about the facts of this case. I want you to just answer for me, in whatever the easiest way is that you can, what the standard of care requires in terms of a pediatrician treating a child with fever?

A Can we just cone it down to the age group that we're dealing with, because it's complicated.

Q Absolutely.

A I think the two things that a physician has to do as he approaches a baby with fever is, number one, make a general assessment as to whether this baby looks sick or toxic or septic, whatever terminology you

want to use. Should a baby look that way with fever, the baby is immediately hospitalized and everything gets done for the child.

The second feature, assuming a baby does not look septic or toxic or sick, is a physician has a responsibility to identify a focus of that infection. Depending on whether or not a focus is found and depending on how high the fever is, a physician may need to do laboratory testing on a patient with fever, and specifically with no focus of infection and a fever that exceeds 102 or 102.5, in that neighborhood, a physician, in general, would be required to perform at least a CBC blood count on a febrile baby between the ages of three months and two years or so.

Depending on the results of that blood culture, he would then opt to take a -- I'm sorry -- depending on the results of that blood count, he would then opt to take a blood culture, a urine culture and a number of other things.

Q Is the standard of care different for a child under three months?

A Certainly it's different under a month. I don't think there's any question. Under a month with a

fever, you hospitalize, you **do** everything and you treat. Between one month and three months, what else is thrown into the mix nowadays is the determination not only does the child look sick and how high is the fever, but is this child a high risk infant. Basically a high risk infant is anything other than a pristinely normal term healthy baby.

So a premature baby at two months who comes with fever, the workup is done. A baby who had respiratory distress in the newborn period and comes with fever, a workup. If you take that out **of** the picture, it's a fat, healthy baby, no problems, comes in at six weeks with fever, then one follows the same algorithm that you would do for a five-month-old baby.

You look for a focus, you don't find it, you do a blood count and a workup if it's needed.

Q Sujin Cho would be classified as a normal child under the description you were just talking about, right?

A Correct.

Q Let me go back to what you told me. When does the standard **of** care require a CBC in this age group?

A In a non-toxic baby who doesn't look septic, it would be when one does not have -- when one has not identified a focus of infection.

Q So when the treating physician, in his own clinical judgment, has decided that he or she has not identified a focus, a CBC should be done?

A In general. There are certainly exceptions to that, epidemiologic exceptions exist all the time.

Q What do you mean by that?

A The child's in a day care center and there have been five cases of roseola, and this child has classic roseola. Do you need to do a blood count, no. I think there would be a lot of reasons not to do a blood count. But in general, yes, a blood count would be done.

Q Now, when does the standard of care require a treating pediatrician to do a CBC, even though a focus has been identified but the fever has not subsided?

MS. KINCHLOE: Objection.

THE WITNESS: I don't know what you mean by not subsided. You mean the child's had fever for two or three days?

BY MR. FORET:

Q That's what I'm asking you. What period of time?

A I think one doesn't so much use the period of time so much as how the baby appears clinically. That is to say, an ear infection after three or four days of fever is still an ear infection, if the baby apparently has nothing else going on on examination.

In truth, there's a lot of gradations of the baby's physical exam on what's known as the observational variables. There are babies where, you know, the baby sort of sits in the middle of the road. He's a little bit irritable, but not that irritable, has some inter-activity with the examiner, but not as much as normal. Those cases maybe you would do a blood count.

But a baby who is, for instance, described as happy and playful, I think would be not anywhere near the middle of the road and, in fact, would be on the good side of the road and safe and far away from a blood count, should you find a focus.

Q Why does the standard of care require immediate hospitalization for a neonate who has fever as opposed to an older child?

A Probably a number of reasons. One is that newborn babies are less likely to show how advanced the illness is versus older children. The second is that the observational variables that we use in six-month-old babies are not very well-developed in six-day-old babies.

So we really can't even use the basic approach that's been worked out for older kids very well. They are the two main reasons, I think. People would add to that a third feature probably that sepsis is probably more common in that first month of life than ever, ever again, and so the risk is higher.

Q In the age child of Sujin Cho, am I correct that the physical exam is not very reliable at that age?

A Reliable for what?

Q In terms of diagnosing what's causing the fever.

A No, I think the physical exam is the only reliable thing that you have. In other words, if you see pus on the throat, whether it's a six-month-old baby or a six-year-old, you know the child has tonsillitis. If you see middle ear disease, you know

it's otitis media.

Q Toxic signs are not as well identified in a four-month-old child as opposed to a child who would be older, correct?

A I think if you compared, for instance, a five-year-old to a five-month-old, you'd be right. There would be more signs that you could elicit from a five-year-old than a five-month-old, but in general, in the age group that we're dealing with, three months to two years or three months to three years, where there's a fever without focus approach being used now, physicians are comfortable with the observational variables and physical exam that's presented in a five-month-old.

Q This case of Sujin Cho, she had a Gram-positive coccal infection, right?

A Right.

Q Now, in terms of classifying the various bacteria, that's one of the more easily treatable, correct?

A In general it's easier to treat that organism than any Gram-negative rods. It takes less medicine to treat it, so from that standpoint that's true, yes.

Q In terms of my general question that I've asked about the standard of care in dealing with a febrile child four months old, when should a urinalysis be done?

A Actually, this has been looked at in the literature for a while, and the answer is, in a female who has no significant findings to explain where the fever is, a urinalysis is almost always done. If you have otitis media, copious upper respiratory findings, bad runny nose, definite signs, there's no requirement to do a urinalysis in that instance.

Q Same question in terms of the general standard of care dealing with a four-month-old child. When should a blood culture be done?

A Again, in a toxic child, right away on all. In a non-toxic child, a blood culture is done if you have not identified a focus of infection and a blood count exceeds 15,000. So they would be the two requirements. No focus, you do a blood count and it's high, more than 15,000 a blood culture is taken.

Q Then when, in the general standard of care question I'm asking, when should the four-month-old be admitted to the hospital?

A Again, a sick, septic baby, right away. A baby who is not toxic or septic and who has a positive CBC for 15,000, some physicians elect to put those children in the hospital, but it's not the standard to do that. Those patients can be managed as an outpatient.

Q When would the standard require hospitalization?

A I think the standard would normally require hospitalization when the blood culture comes back positive and the patient hasn't had a very nice clinical response to the antibiotic that was used.

Q Now, in a four-month-old, febrile infant where a focus has been identified and there are not any toxic signs --

A Could we switch to a -- she was five-and-a-half months at the time. Could we just make all of these questions five months or five-and-a-half, because that's really --

Q Does it matter?

A No.

Q Okay. I'm sorry.

A I missed the first part of your question.

Q I'll ask it again. In a child of Sujin Cho's age, where the treating pediatrician has identified a focus and there are no toxic signs, what does the standard of care require in terms of a follow-up appointment?

A The -- well, typically for middle ear disease an appointment is made about two weeks to four weeks after the diagnosis of middle ear disease is made. Oftentimes in the case of well babies, for instance, babies this young, they have well-baby checks so frequently spaced that there's not really a need to do that, because they're going to come in and have their ears checked in a timely way no matter what.

Older children probably two to four weeks would be the typical time. The other, I think, requirement would be some sense to the parent that there is an expected course for resolution of this illness, which if it doesn't happen, we would need to see this baby or at least discuss the illness again.

In the case of otitis media, that typically is -- you should see significant improvement within 48 to 72 hours.

Q So if there is no improvement within 48 to 72

hours and the pediatrician is notified, then a follow-up visit would be required under the standard of care, correct?

A I would say most of the time, although I think depending on what information is exchanged at that point, a different diagnosis could possibly come to light over the phone, in which case maybe a visit wouldn't be needed, but in general it would be.

Q Is there a classification in terms of a normal temperature for otitis?

A No.

Q Do you have any opinions in this case regarding the treatment rendered to Sujin Cho by the first Dr. Kim?

A Assuming I'm reading the first Dr. Kim's notes correctly, I don't agree with Dr. Freij. There's no place in pediatric medicine for a blind injection of Gentamicin to a baby where there is no diagnosis made.

Q Any other criticisms of the first Dr. Kim's treatment?

A I think his follow-up and his directions were pretty good. No, I don't think there's any others. His therapy was not really pediatric therapy.

Q Did his giving of the Gentamicin have any effect or does that have any significance on this child's course as we now know it was?

A No. Gentamicin is not really active against pneumococcus and would have done nothing for this infection, assuming it was even present.

Q Can you place a percentage on whether or not Sujin had a bacterial illness as of Sunday, October 28th, which is two days before the visit to Dr. Kim, the Defendant in this case?

A The percentage? I think it would be a very low percentage. I mean, assuming Dr. Kim's exam, the first Dr. Kim's exam, of the middle ears disclosed no abnormalities and all he could identify was, I think, a beefy, red throat, to me that sounds like this child had a viral illness.

Q Most fevers are caused by a virus, right?

A Absolutely.

Q Can you classify -- I guess maybe my percentage question in terms of what percentage of fevers, in your experience, are viral illnesses and what percentage are bacteria?

A Well, if you just take the first day of

fever, let's say, in young infants like this, it's probably 98 percent that are viral, or more.

Q All right. Then Sunday would have been -- do you agree with me, that would have been her second day of fever?

A Right.

Q So what does the percentage become then?

A It probably doesn't change very much with that within 24. The issue becomes -- many of these viral diseases become a bacterial super infection or sinus or middle ear on the second, third, fourth day of fever, then the ratio changes.

Q So is the most probable diagnosis of Sujin as of Sunday a viral illness?

A Yes.

Q What about as of Monday? What's her most probable diagnosis?

A Well, again, without an exam being done it's hard to know whether the ear infection was present or not. I think that's, to me, the guts of the issue. So I don't know. I really don't have a percent likelihood of it being viral or bacterial. I mean, certainly the otitis media developed at some time, but I don't know

whether it was before that or not.

Q Has her chance of developing a bacterial illness as of Monday without any physical exam changed since she's now been febrile for approximately 48 hours?

A If I understand your question, not having been examined doesn't change the statistical chance of her progressing to an otitis media, let's say, on that next day. If you want to just talk statistics, it's still viral on Monday.

Q But the statistics are the same or have they changed?

A There may be data on this, but they probably have changed so that a few more percent of babies who are going to get otitis media by the fourth day of fever will have had otitis media now on the third day of fever.

So if it was a two percent risk on Sunday where we know there was no -- we're very certain there was no middle ear disease, maybe it's a five percent risk on Monday or a ten percent.

Q Why shouldn't a CBC be done after 48 hours of fever?

A Well, in most instances it's not necessary or indicated. That's the only reason. I mean, lab tests are important to help guide a physician when the diagnosis isn't apparent. When a diagnosis is apparent, then laboratory studies are really not helpful.

Q When do you -- do you have an opinion as to when, had a CBC been done in this case, at what point in time it would have revealed a white blood count of greater than 15,000?

A Well, I think that goes back to the answer I gave a little while ago about whether this baby was bacteremic on Tuesday the 30th. That's, again, the question that's risen with respect to what Ms. Cho did with the antibiotic.

Assuming Ms. Cho had continued the antibiotic and she mis-remembers about having stopped it on Wednesday, then I'm sure the baby was bacteremic at the time Dr. Kim saw the baby on Tuesday, and the white count would have been, more likely than not, more than 15,000.

If Ms. Cho actually stopped the antibiotic on Wednesday, then in my judgment I can't tell you whether

the baby was bacteremic on Tuesday the 30th. It could have become bacteremic two days later, in which case the white count would have been below **15,000** on the **3**0th.

Q Now, why is it so significant if she did not stop the antibiotic that certainly the baby would have been bacteremic as of Tuesday?

A Because, as I mentioned a little while ago, I think if this baby had been treated with intramuscular ampicillin, which we know the baby was, and then promptly begun on oral amoxicillin, which, by the mother's deposition, in fact, she was, it would be virtually impossible for that baby to acquire pneumococcal bacteremia after the injection of ampicillin.

She would be, in fact, prophylaxed against that the way we prophylax sickle **cell** patients. So knowing that she at some point had bacteremia, if the medicine had never been stopped, it had to have started -- the bacteremia had to have started before that injection was given.

If the mother stopped the antibiotics, then the bacteremia could have occurred later.

Q What, if any, significance is there to you that Dr. Kim diagnosed Sujin with bilateral otitis, but also put in his notes that he was concerned about a fever of unknown origin?

A Looking at the record without hearing his deposition, I'd just be confused as to what he meant by that. Reading his deposition and having him explain that he meant this could be roseola, I don't know anybody else who would use FUO to describe a specific process, but if that's his practice, that's his practice.

Q What you were telling me earlier about defining a focus of the fever, making a diagnosis of otitis would be finding a focus for the cause of her fever, right?

A Correct.

Q Would an upper respiratory infection also be a focus of the cause of the fever?

A No.

Q Why not?

A It's just -- what one really -- I think the whole nuts and bolts of this is one identifies or tries to identify a treatable bacterial -- presumed bacterial

focus of infection so that one can then say this is the cause for the fever and, more importantly, this baby is going to be getting antibiotic therapy. So the issue of bacteremia is no longer a pressing issue.

A runny nose, a mild cold, is not a treatable cause for the fever, and so it would not count. It has not counted, in fact, in the -- in all the work of the research work that's been done looking at this -- at this issue of occult bacteremia or outpatient bacteremia, call it what you want. Even in the study that we did, a runny nose and a little bit of a red throat is not a reason to identify a focus.

Q I want you to assume that Dr. Kim did not make a clinical judgment on October 30 that the fever was not caused by the otitis media, and that's why he wrote down rule out fever of unknown origin. Assuming that to be true, what did the standard of care require him to do?

MS. KINCHLOE: Objection.

THE WITNESS: Assuming that he did not make a diagnosis of otitis media?

BY MR. FORET:

Q No. He made a diagnosis of otitis media, but

in his clinical judgment, that was not the focus of the fever.

MS. KINCHLOE: Objection.

THE WITNESS: I don't know how one can do that. I think, in fact, it's a little oxymoronic. I mean, the reason you look for otitis media is to explain fever. So I wouldn't -- I wouldn't --

BY MR. FORET:

Q You have trouble accepting it. I understand that. Please do so. Maybe I can ask the question this way. Let's assume that he did not identify a focus of the fever and not identifying a focus of the fever would be making a diagnosis of fever of unknown origin, correct?

A Yes. Well, yes.

Q Go ahead.

A Fever -- FUO is a precise definition that everybody sort of bastardizes, and it should be probably fever without focus. FUO means fever for weeks and so on.

Q In any event, if he had not identified a focus of the fever as of the visit on Tuesday, October 30th, what did the standard of care require him to do?

A I think at that juncture she would have been a baby who needed a CBC, to start, and then depending on the magnitude of the white count, a blood culture and a urinalysis would be considerations.

The urinalysis, I think, would be a very important thing to do in the face of a baby whose physical exam doesn't show an upper respiratory infection. In this instance if you don't have a focus, all you have is copious runny nose and a very red throat, I think you do need a blood count. But a UA, I think, is still optional at that juncture because it would be unusual to see a urinary infection to present that way.

Q Certainly we can probably agree that from what we know about Sujin Cho, a urinalysis wouldn't have shown anything at any time before one was finally done I guess, right?

A Right.

Q So if Sujin had presented to the visit on Tuesday, October 30th, and assuming Dr. Kim had not identified a focus of the fever, the standard of care would have required him to do a CBC, right?

A That is right.

Q Then the results of the CBC come back in within how long?

A If his office does it, probably within half an hour. If he has to send the child to a lab across town or across the street, within a couple of hours.

Q Then if the CBC comes back in that time frame and shows a white blood count of 15,000 or above, then the standard of care requires a blood culture?

A That's right.

Q If the white count comes back at 14,000, what do you do? Is it a clinical judgment?

A It is a clinical judgment. I think most people really use the 15,000 cutoff. I do. Sometimes you see 15,502 and you say, I'm sorry, I'm not going to subject this child to a blood culture.

Q Why not just do the -- since you're drawing the blood anyway, why not just do the CBC and the blood culture with the same specimen?

A In fact, a lot of times that's what's done and the blood culture is inoculated and then sent to the lab to be processed if the blood count comes back high enough or thrown out of the blood count doesn't come back. It saves the parents some money, basically,

if you don't send a blood culture that's not necessary.

Q The blood culture results will be available within 24 hours?

A Well, at 24 hours in general. There is a preliminary reading and probably half of the bacteremias or more would be at least preliminarily diagnosable at that point, and then definitively at 48 hours.

Q Had Sujin been bacteremic with what we now know she eventually had as of Tuesday, that type of bacteria would be showing on the culture within 24 hours?

A In general, yes.

Q Then again, making the assumptions that I'm asking you to make, what would the standard of care have required Dr. Kim to do on Wednesday, October 31st, in the face of a positive blood culture?

A I think when notified of that positive blood culture, I think Dr. Kim would have to recall Sujin for reexamination and for a repeat blood culture, and at the bare minimum, assuming his therapy and so on, amoxicillin he had used, rendered this child normal, that's all he would have to do, and then continue

therapy.

If there were persistent symptoms at 24 hours, he would then have to complete a workup, which would, in general, include a lumbar puncture.

Q What do you mean by persistent symptoms?

A Fever, specifically irritability, but some of the things she didn't have, poor feeding and a fever.

Q But if making all the assumptions that I made, and if the CBC comes back over 15,000 and the blood culture is done and that comes back positive and she still has a fever as of Wednesday, October 31, then a further workup would have been required under those facts?

A Yes. I think I said that.

Q I just wanted to make sure.

A Yes. Absolutely.

Q A further workup would have included a lumbar puncture at that time?

A Correct.

Q Now, had that all been done, again, based on all the assumptions I've asked you to make, her injury, her hearing loss would have been avoided, correct?

A Assuming no meningitis existed at the time of

the further workup, absolutely true. She would have avoided any and all nerve injury. If meningitis had already been there, unbeknownst to Dr. Kim at the time of the recall on Wednesday the 31st, depending on how aggressive the meningitis was, some or all of the injury could have been avoided.

Q What's your opinion as to when her meningitis developed? Would it depend on the antibiotic being given or stopped at all, or not?

A I think, again, it's not always easy to know when a baby develops meningitis, but if you look at the -- at the rendition of the events according to Ms. Cho, by Wednesday evening when the baby was no longer playful, looked exhausted, was lying all day, she certainly could be describing a baby who might have meningitis.

Also, you could be describing a baby who has become bacteremic, since she hadn't stopped the antibiotics by the time the call was made, it goes to what I said before, I think at that point the baby would have had meningitis, more likely than not, by Wednesday night.

Q That's predominantly based on Ms. Cho's

description of her, correct?

A Right. Entirely, because there's no other -- now, I also said -- let me also balance that by saying the medical records written downstream are in somewhat of a conflict with that deposition testimony of Ms. Cho, namely the Shady Grove Hospital records and the Georgetown records speak to this baby improving with time. That's -- in fact, that's as far as they take it, to basically say the baby gets ampicillin intramuscularly, amoxicillin orally and gets better, only to have an unexpected seizure on Friday morning while being fed by, I guess, the caretaker grandparents.

So depending on which scenario really is a more accurate rendition of events, this baby may not have had meningitis on Wednesday.

Q Going back to my same assumptions and the blood culture has been done and it's come back and it's positive, we would now be at Wednesday, October 31, and the child still has fever. You've already told me that a workup should have been done which would have included a lumbar puncture.

What, if any, different antibiotics should

have been given while the workup was being done?

A Well, two things. If the baby looked okay, the workup could have been done as an outpatient. If the lumbar puncture were clear, a physician could -- and a chest x-ray were done and that was normal, a number of other things, but the physician could have given an intramuscular injection of an antibiotic. I would use the one -- I think most people would have used the one that Dr. Freij mentions in his deposition, Ceftriaxone, which would, in fact, provide yet another 24 hours worth of pretty aggressive therapy, and then the baby would be re-evaluated again.

Q Would the baby also be continued on oral antibiotics in addition to that IM, or just the IM shot?

A Just that one dose. That's it.

Q By the way, the dosage that Sujin was actually given by Dr. Kim, number one, we don't know what the dosage was of the IM ampicillin, correct?

A Yes.

Q But the dosage that we do know existed as to the oral amoxicillin, that would be a normal dosage for an otitis?

A That is right.

Q What would that -- assuming Sujin was bacteremic as of the beginning of Dr. Kim's medications, what would that dosage have done?

A Well, certainly combined with an intramuscular dose of ampicillin and then followed with oral therapy to sort of consolidate that, the average child with pneumococcal bacteremia would be rendered normal, would be treated.

In fact, to jump maybe to one of your future questions, that is why there is no pressure to get a blood culture on a child with a defined treatable source of infection, because it's understood that conventional therapy for that source will treat a bacteremia, if it happens to be present, as it might be even with otitis media.

So in this instance, what one would normally expect would be return to normalcy in 24 to 36 hours with that oral therapy, even if the baby had a bacteremia with or without otitis media.

Q Say that last part again.

A Normally one would expect, whether there was otitis media with bacteremia or bacteremia alone,

intramuscular ampicillin followed by oral amoxicillin should treat the disease.

Q So now what causes a child with bacteremia to develop meningitis?

A Well, the long answer to your question is that some children already have meningitis when the physician treats for what he thinks to be bacteremia. No one has a crystal ball. Early, early, early meningitis, it can't be -- I'm sorry -- it can't be identified by a physician clinically. So there are cases on record where therapy for bacteremia fails because meningitis is already extant.

Q So if that's the case, the dosages that she were receiving don't do anything?

A No dose would have made any difference of any oral or IM antibiotic as an outpatient. The second is that there is -- there is a defined failure rate to the parenteral or oral therapy for bacteremia that exists. Some fraction of kids will continue to have bacteremia and seed their meninges. To some degree I think it's a race. I think it's a race between the load of bacteria in the body, the rapidity with which the antibiotic gets absorbed, the height of the blood level of the

antibiotic, the resistance or partial resistance of the agent and the immune response of the host.

I think all these things figure into an equation sometimes, which is solved not in the patient's best interest and the patient gets meningitis, even though it's being treated for the illness that precedes the meningitis, namely bacteremia.

Q What does the blood-brain barrier have to do with any of this, if anything?

A Well, not too much, really. I think when you use intramuscular ampicillin, you're going to cross the blood-brain barrier. Oral amoxicillin wouldn't give much of a CSF level, but a good slug of ampicillin intramuscularly would be how we treat meningitis so it gets in. I don't think it has much to do with the blood-brain barrier.

Q You agree that Sujin's hearing loss was caused by her meningitis?

A Yes.

Q Can you quantify when, in the course of her meningitis illness, that she suffered what is her current injury, her bilateral hearing loss?

A My view is that it was probably a progressive injury over the course of however long her meningitis existed before therapy was first instituted.

Q Of course therapy being first instituted was done --

A Shady Grove Hospital early afternoon of the 2nd.

Q Did the injury continue even after the Shady Grove therapy began?

A Probably.

Q For how long?

A I don't think anybody can quantitate that.

Q Can you get to a date in the course of her treatment where you can say more probably than not no additional injury occurred after that date?

A Well, I mean, it would be almost a guesstimate in my view. I don't think there's any scientific data to support anyone's judgment about that. My view, certainly by the time the repeat lumbar puncture was done.

Q Here at Georgetown?

A Here, and the cell count had fallen to 600 there is very strong evidence of shutting off the

inflammatory response.

Q Is your opinion that steroids do prevent hearing loss?

A Well, you asked a very hard question. I don't think there's any question in my mind that steroids prevent hearing loss in hemophilus meningitis. In my view -- which could change tomorrow, depending on what's published -- my view is that they probably provide some benefit to pneumococcal meningitis and do prevent some pneumococcal meningitis from developing into hearing loss.

But I would say it's an opinion that is with medical certainty, but there's a lot of work being done on this and it could change at any time.

Q Sujin was treated with steroids here in 1990, correct?

A Right.

Q You still treat the same today?

A Today, you know, the American Academy has come out on record saying that steroids are not indicated in the treatment of bacterial meningitis. You can do it if you want, but it's not standard care.

More work is being done on the -- that's

because hemophilus has disappeared.

Q Because of the vaccine?

A Exactly.

Q More work is being done on the pneumococcal thing. There was just two articles out recently that are pro-steroids, but to me that is not standard care yet. Would I do it myself? Yes. Would my partner do it? She may not and I wouldn't criticize her for not doing it.

Q But you, yourself, would still treat a child in Sujin's condition the same today as she was treated in 1990?

A Yes.

Q Is your experience here at Georgetown -- you probably just answered this, but let me make sure -- your experience is the use of steroids does prevent hearing loss in pneumococcal meningitis?

A I wouldn't say my experience has been. It's my belief that it does. I don't know that we've had enough cases where steroids are used and enough cases where they weren't to make a -- you know, a scientific judgment.

I'll tell you quite honestly, one of the

reasons I would do it is, just like Dr. Freij, I trained under Dr. McCracken, and the man is a spectacular researcher. He is a genius when it comes to formulating answers to clinical questions, and I'd take his opinion with a very, very strong bias.

Q He's of the opinion that steroids help?

A He is of the opinion that steroids help. So I'm not going to -- he's probably right. That's what I'm saying. Until someone proves him wrong, I think he's probably right.

Q One of the problems is that in terms of numbers of patients in the studies, even as of today the numbers are still mostly for hemophilus meningitis?

A True.

Q Although that's now starting to change?

A Right.

Q What's the current status of the pneumococcal vaccine?

A The pneumococcal vaccine is -- the one that's presently available is not immunogenic under the age of two years. It does not produce an antibody to the capsular polysaccharide that's injected.

In the next year there will be a series of

vaccines probably coming out that are like the hemophilus vaccine, which will be what are known as conjugated vaccines, which are pneumococcal antigens linked to proteins that trick the immune response even at two months of age to produce antibody against those antigens, just as the hemophilus vaccine now is conjugated.

It sort of tricks the immune response to work earlier than it normally would. It's going to be at least a year, maybe several years, before there'll be a vaccine program.

Q Now, the current pneumococcal vaccine is used in children over two years of age, but not every child?

A Oh, no. There are certain indicated -- sickle cell anemia, asplenic patients. What else?

Q There are certain indications when it's not done?

A This is not a board exam. I don't have to know.

Q That's right. In answering the question as to when -- at what point in time treatment would have stopped or prevented Sujin's injury, is there any significance to the initial CBC findings at Shady Grove

to you in terms of the protein, the glucose, the sodium, whatever?

A The CBC was 13,000, I think. You're talking about the blood count?

Q Correct. Yes.

A No. There's no -- to me that doesn't shed any light on how severe the meningitis was, how longstanding it was.

Q What about the initial lumbar puncture findings?

A That spinal fluid finding, unfortunately, was done 24 hours after admission, so 24 hours into therapy. So it doesn't shed any real light on duration of illness, severity of disease, CSF findings and meningitis can *go* very high with therapy.

Q So the only -- I just want to make sure I'm correct. The only significance in terms of any -- any of the lumbar puncture findings was from the second one when the cell count had dropped to 600, which would indicate the disease process is stopping?

A Right. Just to complete my answer about that, that spinal fluid was done on the fourth and fifth day of therapy, and it might have been that low even two days earlier. I don't know, because it wasn't

done. It wasn't needed to be done.

Q Can you render an opinion as to assuming that proper therapy had been started, for whatever reason, as of Thursday, November 1, whether or not her bilateral hearing loss would have been prevented?

A So you're talking, like -- go back 24 hours, say she had come in --

Q Yes.

A I think, you know, certainly she would have had an improved prognosis. Whether it would have been ameliorated to any degree, I don't really know. I would, if you want -- if I was forced to say yea or nay, I would say yea.

I would say probably 24 hours earlier therapy would have made some difference in her ability to hear, at least in one ear. But it's a reluctant opinion without a lot of scientific background. If you go two days --

Q But we just don't have the scientific background in this case?

A Right.

Q I'm sorry. If you go two days earlier, 48 hours, your opinion becomes much stronger?

A I would have really -- I would have no reluctance to say, yeah, I think she probably would have had significant preservation of her hearing, at least in one ear, assuming she got standard therapy at that juncture.

Q Well, assuming she got the therapy that she got.

A Okay. Yes.

Q Would it also be more probable than not that she would have had improvement in both ears two days earlier?

A The way the literature talks about it, it's one ear, so I don't know.

Q What about you, your experience, your opinion? I mean, you're entitled to render these.

A Well, see, I think the issue that comes to my mind, really, that is the only -- the real crucial issue is would she have enough hearing so that her speech would be intact, and you only need one ear for that. That's how the data is always presented in the articles, so I don't know. Two ears I don't know.

Q But significant improvement in one ear makes a big, big difference, particularly as to speech

development, correct?

A Yes.

Q Have there been any other cases where you have been a treating physician -- you're a treating physician in this case, correct?

A Yes.

Q Have there been any other cases where you've been a treating physician where you've also rendered expert testimony?

A This is the only one. As far as I can recollect, yes. In the Kozup case I wasn't even -- I wasn't deposed, I was sort of interviewed.

Q The which one?

A Kozup, the AIDS baby that I told you about. I don't believe there's any other -- any other cases.

Q Why is that okay, in your opinion, in your capacity as a treating physician, to also become an expert in the case?

A Why is it okay? I don't think morally there's any different with being a treating physician or not being a treating physician and giving an expert opinion or expert witness testimony.

I don't even see there's a -- maybe you could

give me, from your side, why -- why you think there would be a problem.

Q I can't. I can't today.

A Okay.

MS. KINCHLOE: You can't do it today?

BY MR. FORET:

Q Let me ask you this. You will agree with me that, from a patient confidentiality point of view, nobody on behalf of the Cho family has waived the physician-patient privilege between you and Sujin Cho, correct?

A Not that I know of. I would have to get a release from them.

Q What do you mean you'd guess you'd have to get a release from them?

A To waive physician-patient -- in other words, if I wanted to go to the press and say I have this case, I wouldn't be able to do that without their written consent, right?

Q I mean, these questions aren't easy, but what the heck. I mean, why was it okay for you to get involved looking at this case and discussing it, then, with Ms. Kinchloe, and I'm not saying anybody did

anything wrong, but I'm also at the same time not saying anybody did anything right, just to be fair, without such a waiver from the Cho family?

MS. KINCHLOE: Objection. You're asking him a legal question, because there's a legal basis.

MR. FORET: I'm not.

MS. KINCHLOE: Yes, you are.

MR. FORET: No, I'm not. I'm not asking a legal question in my opinion, because I'm just asking him why he felt it was okay, whether there's a legal basis or not. If that's your answer, that's your answer.

MS. KINCHLOE: Well, I think that you are, because what you're asking him to do is to assume or having him assume that in speaking with me about the case he has violated that privilege, and he hasn't, and you know it.

MR. FORET: No. I don't agree with you.

MS. KINCHLOE: Yes, you know it.

MR. FORET: No, I don't. There's a case in D.C. which is not very specific in terms of, in my humble opinion, what it stands for, but if that's your answer, that's your answer.

BY MR. FORET:

Q I mean, is that your answer?

A I don't even know what your that refers to. I'm not sure if that that refers to Ms. Kinchloe's explication of your answer --

Q I want to know in your own mind why you felt it was okay to review this case without a written authorization from the Cho family?

MS. KINCHLOE: Can I just add one more thing?

MR. FORET: Yes.

MS. KINCHLOE: He would have reviewed the case not in terms of his care and treatment, but he reviewed the case in terms of someone else's care and treatment.

MR. FORET: I agree with that.

MS. KINCHLOE: That doesn't have anything to do with his relationship with the Chos.

BY MR. FORET:

Q Now, can you answer my question?

A Well, I mean, my first answer would be, which is not a legal but more of a medical answer, that --

Q Which is what I'm asking.

A -- that my recollection is Ms. Kinchloe

called me to review the case, knowing that I was a treating physician of this baby while the baby was here at Georgetown, that she had seen the records and I don't know whether that's why she called me or not, but I assume that this is kosher.

When a physician gets sued, anybody can be asked to be an expert, and it doesn't matter that you were a treating physician. That was my assumption.

MR. FORET: No questions. No more questions.

MS. KINCHLOE: Thanks.

MR. FORET: You have no questions?

MS. KINCHLOE: No.

(Whereupon, at 4:33 p.m., the deposition of RAOUL L. WIENTZEN, JR., M.D. was concluded.)

* * * * *

(Signature waived.)

CERTIFICATE OF NOTARY PUBLIC

I, Eva M. Bridget, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me using stenomask dictation and thereafter reduced to typewriting under my direction, that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition is taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

_____

Notary Public in and for the
District of Columbia

My commission expires:
February 28, 1998