In The Matter Of:

Wagner v.
Litvak

Raoul Wientzen, Jr., M.D.
August 7, 1995

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IN THE CIRCUIT COURT OF THE 17TH JUDICIAL CIRCUIT
IN AND FOR BROWARD COUNTY, FLORIDA

ROBBIN M. WAGNER and DOROTHY S. WAGNER, as Personal Representatives of the Estate of RUSSELL WAGNER, DECEASED, : Plaintiffs,
v. : CA No.: 92-6493(13)
BARIS LITVAK, M.D., OSCAR BETANCOURT, M.D., LAURENCE PEARSON, M.D. and CHILDREN'S MEDICAL ASSOCIATION, : Defendants.

Monday, August 7, 1995
District of Columbia
Videotaped Deposition of
RAOUL WIENTZEN, JR., M.D.,
the witness, called for examination by counsel lor the Plaintiffs, pursuant to notice of counsel, held at Georgetown university Hospital, 3800 Reservoir Road, Northwest, Washington, D.C., beginning at 255 o'clock, p.m., before Justina M. Consoiazio, RPR, a Notary Public in and for the District of Columbia, when were present on behalf of the respective parties:

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[1] PROCEEDINGS

[2] THE VIDEOGRAPHER: This is the [3] videotaped deposition of Raoul Wientzen in the [4] matter of Wagner versus Litvak. Today's date is [5] August 7th, 1995. The time is 2:55. The recording [6] is taking place at 3800 Reservoir Road, Washington, [7] D.C. This deposition is being videotaped on behalf [8] of attorney, Stuart Ratzan, Esquire.

[9] I am neither counsel for, employed by or [10] related to any parties in this action, nor am I [11] interested in the outcome thereof. Counsel, please [12] introduce yourself and state your appeamnce.

[13] **MR. RATZAN:** Stuart Ratzan for the [14] Plaintiffs, Dorothy and Robbin Wagner and the Estate [15] of Russell Wagner.

[16] **MR. LURY:** Steven Lury for Dr. [17] Oscar Betancourt.

[18] **MR. KING:** David King for Dr. [19] Pearson.

1201 **MR. LEINICKE:** And Steven Leinicke [21] for Dr. Litvak.

[22] THE VIDEOGRAPHER: Okay, we're now

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[1] on the record. Would the reporter please swear in [2] the witness.

[3] Thereupon,

[4] RAOUL WIENTZEN, JR., M.D., [5] the witness, called for examination by counsel for [6] the Plaintiffs, and, after having been sworn by the [7] notary, was examined and testified as follows:

[8] EXAMINATION BY COUNSEL FOR THE PLAINTIFFS

[9] BY MR. RATZAN:

[10] **Q:** Good afternoon, Doctor. I introduced [11] myself earlier. My name is Stuart Ratzan. I [12] represent the Plaintiffs in this **case.** Could you [13] state your full name for us, for the record.

14] A: My name is Raoul L. Wientzen, Jr., M.D.

15] **Q:** Dr. Wientzen, you're aware, are you not, [16] that this deposition is being rideotaped for the [17] purpose of playng it to a jury in Broward County, [18] Florida?

19] A: Yes, I do.

201 **Q:** I assume you've been deposed before?

211 A: Yes.

221 **Q:** If you will do me a favor, then, if I ask

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11 you a question that you don't unierstand or you [2] didn't like the way it vas phrased, let me know, and [3] I'll try o rephrase it in a way that you do [4] inderstand it.

5] A: Fair enough.

6] **Q:** If you don't do that, I'm going to assume [7] that you've understood the questions as I've asked [8] them.

[9] A: Understood.

[10] **Q:** Is that fair?

[11] A: Yes.

[12] **Q:** Do you have a copy of your CV with you [13] today?

[14] A: No, I don't.

[15] **Q:** Can you obtain one for us by the end of [16] this deposition?

[17] A: Sure.

[18] **Q:** Okay, and where are you employed, sir?

[19] A: Georgetown University Hospital Department [20] of Pediatrics.

[21] **Q:** How long have you been here?

1221 A: This is my 19th year.

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[1] **Q:** And that's where we are today?

[2] A: Yes.

[3] **Q:** Do you have any particular titles or [4] positions in this hospital?

[5] **A:** Yes, I'm an associate professor of [6] pediatrics, and I'm chief of the division of [7] pediatric infectious diseases.

[8] **Q:** The CV that you will provide us, will you [9] make sure that it's a current and upto-date copy?

[10] A: It will be my most recent CV, but it needs [11] to be updated.

1121 **Q:** You have before you a packet of materials, [13] it looks like. Are those the materials that you've [14] reviewed for this case?

[15] A: Yes, they are.

[16] **Q:** Is there anything that is not there that [17] you have been sent or that you have reviewed?

[18] A: Yes, there is one item.

[19] **Q:** What is that?

[20] A: It was a letter, summary of the recent [21] deposition of one of your experts in California,

[22] **Q:** Is there any particular reason why you

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[1] don't have that letter here today?

[2] **A:** Yes, Mr. Lury took it from the packet.

3] **Q:** Did you read that letter?

4] A: Yes, I did.

5] **Q:** Did it make any - have any significance [6] to you?

7] **MR. LURY:** Did it have any [8] significance to him? What do you mean by 'any [9] significance to him?" Did he rely upon it, is that [10] your question?

111 **BY MR.** RATZAN:

12] **Q:** No, did it have any significance to iou in [13] formulating your opinions iere today?

[14] **A:** I have formulated my opinions well before [15] I read that letter, which was just I guess this [16] weekend,

[17] Q: Yes, sir.

[18] **A:** So, no, it had no significance with [19] respect to my opinions.

[20] Q: Did it confirm at all any of your [21] opinions?

1221 **A:** As I sit here, I read the letter once and

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111I can't even honestly recall all of the physician's [2] opinions in that letter. I can't even recall his [3] name, so I would be hesitant to answer that [4] question.

[5] Q: That's fine. The materials you have [6] before you, there is a letter or two. Are those [7] from Mr. Lury?

[8] **A:** Yes.

[9] **Q:** May I see those, please?

[10] **A:** Sure, and I have some handwritten notes on 1111 the back of the original cover letter.

1121 Q: The first earliest dated letter is [13] September **13, 1994.** Had you had any contact with [14] Mr. Lury prior to that time?

[15] **A:** I would expect he had called me about this [16] case prior to that time, yes, but I don't know that [17] for sure.

[18] Q: When do you think the first time was that [19] you and Mr. Lury spoke about this case?

[20] **A:** I really don't know.

[21] Q: I'll take a minute to read this letter, if 1221 you don't mind. I'd like to have this letter marked

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[1] as Plaintiffs' Exhibit 1 for identification for your 121 deposition.

[3] (Plaintiffs' Exhibit No. 1 marked for [4] identification by the reporter and [5] attached to the transcript.)

[6] BY **MR. RATZAN:**

[7] **Q:** Are you aware of which materials you [8] received together with this letter of September **13,** [9] **1994?**

[10] **A:** Pretty much so, yes.

[11] Q: Okay. Would you tell us what they are?

[12] **A:** I received the office records of the [13] pediatric group, Dr. Betancourt's group. I received [14] the death certificate of Russell Wagner. I received [15] a stapled package of records that represents the [16] resuscitation at the Humana Hospital Bennett on the [17] night of Russell's admission and then death in that [18] place. It also contains, I believe, a short version [19] of the autopsy that was done but not all of the [20] autopsy information.

1211 Q: May I see the office chart?

[22] **A:** Sure. The office chart **is** falling apart,

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[1] **so** they were at one time stapled together, and just [2] to continue so that I don't lose my –

[3] **Q:** Yes, please **do.**

[4] **A:** – my train of thought, I also received [5] Dr. Betancourt's deposition and the exhibit that [6] came with it which was his phone log of the phone [7] calls of the night of his interaction with the [8] parents. I think that's, let me just make sure, I [9] believe that's what came originally.

[10] **Q:** What was the last item?

[11] **MR. LURY:** The phone log that was [12] attached as an exhibit to Dr. Betancourt's [13] deposition.

[14] BY **MR. RATZAN:**

[15] **Q:** Is this your underlining here in red?

[16] **A:** Yes, it is.

[17] Q: Then you have another packet of materials [18] before you. I know you've put them all together [19] again, but you had other materials that you did not [20] receive –

[21] **A:** No, they're still separate as I told you [22] originally.

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[1] **Q:** Okay, forgive me. You have another packet [2] there in front of you. Did you receive those on 131July 20th, 1995?

[4] **A:** Or thereabouts, I think they were mailed [5] on that date.

[6] Q: Okay. What have you got there?

[7] **A:** I received the complete packet that's [8] labeled The Complete Autopsy File. I received the [9] depositions of Robbin, Mr. Robbin Wagner, two-part [10] deposition of Mrs. Dorothy Wagner, deposition of Dr. [11] Pearson and d e p osition of Dr. Litvak.

12] Q: Have you had a chance to review ill those [13] materials?

14] **A:** Yes, I have.

15] Q: Have you received any other letters from [16] Mr. Lury besides the two hat are here and the one [17] that you ;poke of regarding the other doctor in 18] California's testimony?

19] **A:** No, I have not.

201 Q: Have you received any medical 'ecords of 1211 any other kind besides the)nes you've talked to me 1221 about?

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11 **A:** No, I have not. I need to take a quick 2] break, I'm sorry. I just got paged.

3] **THE VIDEOGRAPHER:** Okay, we're iow [4] off the record. The time is 3:02.

5] (Thereupon, a brief recess was taken, after which [6] the deposition continued as follows:) [7] (Plaintiffs' Exhibit Nos. **2-9** marked for [8] identification by the reporter and [9] attached to the transcript.)

[10] **THE VIDEOGRAPHER:** Okay, we're now [11] back on the record. The time is **3:12.**

1121 BY **MR. RATZAN:**

[13] **Q:** Doctor, while we were off the record, I [14] marked for identification the next appropriate [15] numbers other materials on which you've written [16] notes and things.

[17] **A:** Okay.

[18] Q: Also this fell off the deposition of Dr. [19] Betancourt. I'd like to make that the next number [20] exhibit, whatever numberwe're on. That looks like [21] the phone log.

1221 (Plaintiffs' Exhibit No. 10 marked for

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[1] identification by the reporter and [2] attached to the transcript.)

[3] BY **MR. RATZAN:**

[4] **Q:** Dr. Wientzen, have you ever reviewed any [5] autopsy slides or photographs in this case?

[6] **A:** No, I have not.

[7] Q: Besides Mr. Lury, have you had any [8] conversations with any of the other lawyers in this [9] case?

[10] **A:** Yes, I have.

[11] Q: Who have you had conversations with?

[12] **A:** Very briefly this afternoon waiting for [13] this to start, Mr. Leinicke and Mr. –

[14] **MR. KING:** King, King.

15] **THE WITNESS:** King.

16] BY **MR. RATZAN:**

17] **Q:** Did they speak to you about anything [18] regarding this case?

19] **A:** Yes.

201 **Q:** What did they **talk** about?

211 **A:** We had a brief conversation about the [22] pathology of the adrenal.

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11 **Q:** Did you talk about their clients and he [2] care rendered by either of them?

3] **A:** No, it was pathology of the adrenal.

4] Q: What did they ask you about the lathology [5] of the adrenal?

61 **A:** Basically what Waterhouse-Friderichsen's [7] syndrome **is** and what it would look like, whether or [8] not the absence of hemorrhage would disallow hat [9] diagnosis. That was basically the conversation.

101 Q: And what did you tell them?

111 **A:** Well, I told them that basically the 121 diagnosis of Waterhouse-Fride-

richsen's syndrome is a diagnosis that has adrenal hemorrhage associated with it but that it sort of begs the point, and the point is that in this case this baby had fulminant sepsis and died of a very aggressive bacterial disease. Whether there **was** adrenal hemorrhage or not doesn't change the fact that this was a fulminant variety of bacterial sepsis.

Q: In other words, the issue of whether **Waterhouse-Friderichsen's** syndrome exists at all in this case, as far as you see it, is not relevant?

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MR. LURY: I object to the form.

THE WITNESS: In the sense that should the pathology show hemorrhagic adrenal, one could say this is Waterhouse-Friderichsen's syndrome.

BY MR. RATZAN:

Q: Yes, **sir.**

A: But that doesn't add more to knowing that this child died of an overwhelming variety of very fulminant sepsis.

Q: If you take the question the other way, Doctor, if there is no Waterhouse-Friderichsen's syndrome apparent on autopsy in this case –

A: Right.

Q: – does that have any bearing on your opinion as you sit here today?

A: No.

Q: So, what I suggested was the diagnosis or not of Waterhouse-Friderichsen in this case is not relevant to your opinions?

MR. LURY: I object to the form.

THE WITNESS: Well, I think all

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facts are relevant to some degree. I don't think it's crucially relevant to saying whether this child had overwhelming sepsis or not. His clinical course speaks to that better than any pathology report would ever.

BY MR. RATZAN:

Q: I understand, to be fair, because the diagnosis of Waterhouse-Friderichsen or not would not change your opinions?

A: Right.

Q: Is it fair that it's not relevant to your opinions whether the diagnosis is there or not there?

MR. LURY: I object to the form, asked and answered. Tell him once again, Doctor.

THE WITNESS: I think again to answer the question, I think the more information one could have about a case, the more complete you can be about your evaluation of the case, and certainly to have Waterhouse-Friderichsen's syndrome pathologically defined in **this** case would allow **a** physician to say that's for sure the compartment we

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can put this case into. Nonetheless, absent **Waterhouse-Friderichsen's** syndrome, this child had overwhelming fulminant sepsis. **So** it's relevant, but not importantly so.

BY MR. RATZAN:

Q: In your words, though, the issue of whether there is Waterhouse-Friderichsen at all begs the point?

A: Uh-huh, correct.

Q: And I'm sure we'll talk about that later. Have you had any conversation with any of the Defendants in this case?

A: No.

Q: Have you had any conversation with any other lawyer at all pertaining to Russell Wagner?

A: Just you.

Q: When Mr. Lury first contacted you, was that the first time any lawyer has ever contacted you about this case?

A: As far as I know, yes.

Q: And do you keep these records, as long as the case is ongoing, do you keep the records here in

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your office or wherever your office is?

A: I try to, yes.

Q: What did Mr. Lury ask you to do?

A: He basically asked me to review the case and determine whether or not Dr. Betancourt practiced within the standard of care; and number two, whether or not there was a likelihood of survivability or not during the course of the evolution of the various interactions that this baby had with Dr. Betancourt.

Q: What did you tell him?

A: Well, I –

MR. LURY: At what point in time?

BY MR. RATZAN:

Q: After he asked you to do that.

MR. LURY Wait, wait, before he reviewed the records or after he reviewed the records, Stuart? Put this in some time context.

BY MR. RATZAN:

Q: You can answer.

MR. LURY: No, don't answer it, put it in a time context for the Doctor, please.

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BY MR. RATZAN:

Q: Look, I'm going to try my best to ask you questions. If you understand them, I want you to as best you can answer them. If you don't, let me know; okay?

A: Okay.

Q: What did you tell Mr. Lury when he asked you those questions?

MR. LURY: I object to the form. At what point in time, before he reviewed the records or after, counsel? Doctor, do you understand the question?

THE WITNESS: I understand the question. I think there may be some confusion about the use of the term when he told you of this or whatever. I think I answered your question with respect to the request in the letter that Mr. Lury mailed to me, and I've reviewed the records and then made up my mind as to what was the issues.

BY MR. RATZAN:

Q: Right, I don't want to make this a more complicated question than it is. He sent you the

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records and he asked you the things you just told **me** he asked you?

A: Right.

Q: When you completed your analysis, what did you tell him that you thought about the case?

A: Okay, after I read through the records, it was my opinion that Dr. Betancourt practiced within the standard of care based on what he said in his deposition and what was in the records; and number two, that at the 6:00 o'clock juncture on the evening of the 1st of December, 1989, it was my view that Russell Wagner was not salvageable at that point regardless of the therapy he might have received.

Q: Now, you didn't prepare the written report?

A: No.

Q: You took notes, though, and I've tried to mark the documents on which you've taken notes.

A: Right.

Q: Did you take notes anywhere else on any other kind of legal pad or paper or any other kind

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of document?

A: Just what's written on tops of the deposition covers and the front pages you've already marked, no other notes.

Q: There would be no other notes in your possession regarding this case?

[7] **A:** That is correct. I hate to do this, but I [8] just got paged again.

[9] **MR. LURY:** Okay.

[10] **THE VIDEOGRAPHER:** Okay, the time [11] is 3:19. We're off the record.

[12] (Thereupon, a discussion was held off the record.)

[13] **THE VIDEOGRAPHER:** We're now back [14] on the record. The time is 3:21.

[15] BY **MR. RATZAN:**

[16] **Q:** Has Mr. Lury or his firm paid you for any [17] of the time you've spent reviewing this case?

[18] **A:** I'm sure I sent him a bill after I read [19] the records the fist time.

[20] **Q:** How many hours do you think you've worked [21] on this case so far?

[22] **A:** With the fist review, I would judge three

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[1] or four hours.

[2] Q: So far I mean.

[3] **A:** In the last week or ten days, reading [4] through the additional depositions that were sent, [5] as well as the original records and meeting with [6] Mr. Lury today, probably another **six** or eight hours.

[7] Q: Did you reach your initial conclusions [8] about this case before you received that second [9] batch of documents?

[10] **A:** Yes.

[11] **Q:** And in the last ten days is when you [12] received – I mean not received, but is when you [13] reviewed that second batch of documents?

[14] **A:** Correct.

[15] **Q:** Have you billed Mr. Lury for that second [16] group of work yet?

[17] **A:** I missed the question.

[18] Q: Have you billed Mr. Lury for that second [19] group of work?

[20] **A:** No.

[21] **Q:** What do you charge per hour for review of [22] records?

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[1] **A:** I charge $300 an hour for record review, [2] *$400* an hour for deposition.

[3] **Q:** And trial?

[4] **A: Well,** probably for a day, $3,000.

[5] Q: Have you been contacted as someone [6] Mr. Lury would like to testify at trial?

[7] **A:** In this case?

[8] Q: Yes, **sir.**

[9] **A:** I think he has asked me if I would come [10] and testify.

[11] Q: Do you know when the trial date is?

[12] **A:** I heard just as the proceedings began [13] sometime in early September.

[14] Q: **You** didn't know about it before then?

[15] **A:** I probably did, I just didn't remember it [16] before we sat down.

[17] Q: Are you available to testify at trial at [18] that time?

[19] **A:** Assuming the trial doesn't interfere with [20] my planned trip to the infectious disease meetings, [21] yes, I will be there.

[22] Q: Do you need to get that page?

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[1] **A: You** know, may I suggest that I ask my [2] partner to take calls for me this afternoon if she's [3] **still** here,

[4] Q: That would be good.

[5] **A:** It's usually not **like** this on a Monday [6] afternoon. I know this is annoying to everyone, as [7] well as to me. So, let me get this page and I'll [8] see if I can reach my partner and we'll get this [9] done. I'll buy an hour. I still need to do the [10] consult at 4:30, though.

[11] **THE VIDEOGRAPHER:** We're now off [12] the record. The time is 3:23.

[13] (Thereupon, a discussion was held off the record.)

[14] **THE VIDEOGRAPHER:** Okay, we're now [15] back on the record. The time is 3:27.

[16] BY **MR. RATZAN:**

[17] **Q:** Dr. Wientzen, have you testified before in [18] a medical malpractice case?

[19] **A:** Yes, I have.

[20] Q: About how many times do you think you [21] testified in deposition in a medical malpractice [22] case?

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[1] **A:** Probably three or four times a year for [2] the last eight or nine years.

[3] **Q:** And before the last eight or nine years [4] you've testified?

[5] **A:** Fewer times than that.

[6] **Q:** How many times a year do you think you did [7] before?

[8] **A:** Couple times, one or two times a year.

[9] Q: How many years have you been doing it all [10] together?

[11] **A:** Since about 1980 or '79.

[12] Q: And of those one to two times a year until [13] the last eight years, and then did you say two to [14] three times a year?

[15] **A:** Three or four times.

[16] Q: Three or four times a year, after that in [17] the aggregate what would you say your frequency is [18] testifying for the Plaintiff's side versus the [19] Defendant's side?

[20] **A:** Probably in the early years it was more [1211] Plaintiff than Defendants, and now it's more [22] Defendant than Plaintiff.

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[1] Q: In the last two years, what do you think [2] the ratio is between Defendant and Plaintiff?

[3] **A:** Probably 60/40.

[4] Q: Do you have any idea why that ratio has [5] changed?

[6] **A:** I probably get more cases from Defendant's [7] attorneys than Plaintiff's attorneys.

[8] Q: How many cases do you review in a year in [9] which you don't testify in a deposition?

[10] **A:** I probably review, where I don't testify, [11] probably 10 or 12 cases a year.

[12] Q: In addition to the ones you testify in?

[13] **A:** Right.

[14] **Q:** And of those, would you say the ratio is [15] the same, 60/40?

[16] **A:** I don't really know.

[17] Q: Okay. How many times have you testified [18] at trial?

[19] **A:** Probably eight or – now probably about [20] ten times.

[21] Q: And have you testified in that same ratio, [22] 60/40, Defendant/Plaintiff?

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[1] **A:** Probably.

[2] **Q:** Which Plaintiff's lawyer did you testify [3] at trial for?

[4] **A:** Here in this area, there is a Mr. Heller, [5] there is a Mr. – you said trial?

[6] Q: Yes, **sir.**

[7] **A:** All right, in Florida there is a Mr. Allen [S] Friedman and Mr. Marvin Weinstein. I think they're [9] in Miami, and I don't think I've been to Florida for [10] a Plaintiff trial except for that firm.

[11] Q: How about other states besides Florida?

[12] **A:** Kansas, I did a – there was a trial [13] appearance for Mr. Jim Bartimus, James Bartimus, and [14] then in this area, I was a Plaintiff expert for a [15] Mr. Ropollo, R-O-P-O-L-L-O, I think.

[16] **MR. RATZAN:** Can we go off the [17] record for one second? **He's** back. You know, I was [18] just about to ask some questions that I think you'd [19] be interested in. So, I didn't want to do that [20] while you were out of the room.

[21] **MR. KING:** Thanks. *Sorry* for [22] holding you up.

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[1] BY **MR. RATZAN:**

[2] **Q:** Dr. Wientzen, do you have an understanding [3] as to Russell Wagner's presentation to Dr. Pearson?

[4] **A:** Yes, I think I do.

[5] *Q:* And before we go into that, are you aware [6] that there is a difference in perception between the VI events, both the signs and symptoms that Russell [8] presented, and what was actually described to Dr. [9] Pearson?

1101**MR. KING:** Objection to form.

[11] **MR. LEINICKE:** Join.

[12] **MR. LURY:** Join. At what time and [13] what presentation are you talking about, counsel?

[14] **THE WITNESS:** I don't understand [15] the question.

[16] **BY MR. RATZAN:**

[17] **Q:** Okay. Are you familiar at any time in the [18] three phone calls that Dorothy Wagner had with Dr. [19] Pearson that you, looking back on it, there has been 1201a difference of perception between Dorothy Wagner [21] and Dr. Pearson as to what Russell's signs and [22] symptoms were, as well as what was reported to Dr.

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111Pearson?

[2] **MR. LEINICKE:** Objection to the [3] form of the question. By the way, I just want to [4] state my objection so you can change it. I don't [5] know what you mean by the word "perception," and I [6] think that's vague and ambiguous, and I don't know [7] whether or not you are asking him whether or not [8] they just have a different statement between them or [9] description of what had occurred or whether or not [10] their observations of the clinical condition of the [11] child were different. I object to that as being 1121vague and ambiguous.

[13] **MR. KING:** I join in the [14] objection. I also think looking back is somewhat [15] vague and confusing.

[16] **MR. LURY:** Join.

[17] **BY MR. RATZAN:**

[18] **Q:** You can answer the question.

[19] **A:** The only information that I'm privy to is [20] the description the parents give as to their [21] recollection of how the child appeared to them and 1221what they think they said to Dr. Pearson over the

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[1] phone and Dr. Pearson's recollection of what he 121 recalls having talked to the parents about over the [3] phone on the evening of the 30th when those three [4] phone calls were made.

[5] *Q:* Which account of the events do you think [6] is more close to reality?

[7] **MR. LURY:** I object to the form.

[8] **MR. KING:** I object to the form.

[9] **THE WITNESS:** I can't choose [10] between the parents' recollections and the doctor's [11] recollections as to which was more close to reality [12] at that time.

[13] **BY MR. RATZAN:**

[14] **Q:** In these kinds of cases involving [15] bacterial meningitis, this has happened before; [16] you're aware of that?

[17] **MR. LURY:** I object to the form. [18] What has happened before?

[19] **BY MR. RATZAN:**

1201 **Q:** In your experience this difference in [21] perception.

[22] **MR. KING:** I object to the form.

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[1] **MR. LURY:** Join.

[2] **MR. LEINICKE:** Same.

[3] **THE WITNESS:** To answer your [4] question, I think parents frequently have a [5] different perception or appreciation of the level of [6] illness of a patient, their child, because they're [7] emotionally vested into the child's welfare, and [8] they see a change versus how a pediatrician or [9] another physician would interpret that knowing how [10] sick children really do appear. So, yes, I think as [11] a practicing doctor, I'm exposed to that change in [12] perception all the time, the difference of [13] perception all the time.

[14] **BY MR. RATZAN:**

[15] **Q:** Based on your experience and training, do [16] you feel you have an understanding or a perception [17] of your own as to which account, the mother's or the [18] pediatrician's, is most reliable?

[19] **MR. LURY:** I object to the form.

[20] **MR. LEINICKE:** I object to the [21] form of the question.

[22] **MR. KING:** Objection.

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[1] **MR. LEINICKE:** In this case or in [2] general terms?

[3] **MR. RATZAN:** In general terms.

[4] **MR. LEINICKE:** I object to the [5] form.

[6] **MR. KING:** Join.

[7] **MR. LURY:** Join.

[8] **THE WITNESS:** I don't know how to [9] answer your question with the terminology that you [10] used, namely more reliable. I think a physician has [11] to weigh everything a parent says, has to take into [12] account every statement a parent makes to him or her [13] over the phone about a child's signs and symptoms, [14] and then a physician has to ask appropriate [15] questions to try to get beyond the lay concept of [16] what's being stated to the medical understanding of [17] what's being stated.

[18] To give you a very concrete example of [19] that, I think the issue of possible convulsions in [20] this case is such a consideration. When a parent [21] says, "The child is making these strange motions, is [22] shivering or shaking and I'm worried it's a seizure,

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111what should I do, "I think a physician has a [2] responsibility if that information is offered to try [3] to come to some understanding over the phone whether [4] it is a convulsion or not, and there are questions, [5] behavioral observations that the parent can make [6] over the phone which can dispel the possibility of [7] there being seizures, and a physician would need to [8] do that.

[9] **BY MR. RATZAN:**

[10] **Q:** That's a great example. In this case, [11] Dorothy Wagner in her deposition, which I know you [12] read, discusses that and that she used the word [13] convulsions and/or shaking.

[14] **A:** Right.

[15] **Q:** Yet Dr. Pearson, whose deposition you also [16] read, doesn't acknowledge that she ever used either [17] of those words.

[18] **A:** Correct.

[19] **Q:** That's a difference in at least perception [20] as to what happened?

[21] **MR. KING:** Excuse me, I object to [22] the form of the question because I don't think that

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[1] accurately reflects the testimony of Mrs. Wagner.

[2] **MR. LURY:** Join.

[3] **MR. LEINICKE:** Same.

[4] **THE WITNESS:** Again, I'm not in [5] any position to disagree with your reconstruction of [6] Mrs. Wagner's deposition testimony. Maybe she said [7] that and maybe not. I do - in reading both the [8] mother and father's depositions, I spent some time [9] trying to answer in my own way whether or not [10] Russell was having seizures that night, and I found [11] two statements that the parents made that would to [12] me dispel the concern that this was seizures, and if [13] Dr. Pearson had a similar understanding of the [14] events, then it would have dispelled that for him [15] also.

[16] **BY MR. RATZAN:**

[17] **Q:** What were those statements?

[18] **A:** The mother in her deposition states that [19] she was talking to Dr. Pearson and describing the [20] motor activity that she was observing and was [21] concerned, and she said somewhere in her deposition 1221 **"I** saw Russell standing there shaking, shivering."

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Now, if you're having a seizure, you can't stand there. You would collapse You would have no motor tone. You cannot have a standing up seizure.

Second feature, and this is the father's deposition, was when he was being - the question about the motor activity, he may have mentioned the fact that the motor activity continued until he put the child in a cool bath and a cool bath made the shaking stop. Cool baths do not stop seizures.

So, hearing that, I mean, I don't know what else Dr. Pearson could have heard, but to me if I had heard that as a description of the child, he's standing here, he's shaking, you say to yourself as a doctor that's not a seizure, your child is having a chill.

Q: Do you recall Dorothy Wagner testifying that she picked Russell up and he was trembling in her arms as she was holding him?

A: I believe that's in her deposition, yes.

Q: In any event, the question I was asking was that Dr. Pearson has no recollection in his deposition of this discussion?

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A: Correct.

Q: Of convulsion or seizure or shaking or any of it?

MR. KING: I object to the form.

BY MR. RATZAN:

Q: Is that consistent with your recollection of Dr. Pearson's deposition?

A: Let me just look at the cover of his deposition because I think I made some notes as to what he recalls. He recalls that the first call was about the fever but the mother didn't know the temperature, and so she took the temperature, called him back, and it was at that juncture that he asked questions about the use of Tylenol, how well he was drinking, breathing, whether there was any pain, his eye contact, vomiting, diarrhea, prior medicines, his temperature and gave some instruction to do a tepid bath and to call back. Then on page *24* he says there was no conversation concerning convulsions or shivering, possibly being a convulsion that he can recall. So, you're right, he does not recall.

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Q: Now, for purposes of this deposition, if we call that a difference in perception or at least a different account of what happened, what I want to know is whether you have any experience or training that would enable you to have your own perception as to which account, Dorothy Wagner's or Dr. Pearson's, is more reliable regarding that issue?

MR. KING: I object to the form of the question, number one, asked and answered, also it might not be their perception, it might be recollection.

MR. LEINICKE: Same.

MR. LURY: Join.

BY MR. RATZAN:

Q: You can answer the question.

A: You're referring I think to whether or not the conversation existed between the two of them, not whether or not these motor activities were seizures or not?

Q: That's right.

A: Because **I've** already told you my opinion on that.

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Q: I understand.

A: I wouldn't be able to pick which one I would find more reliable. On the one hand, you're asking what would be indelible in the memory of a physician whose patient dies *24* hours later, and on the other, you're asking what's indelible on the memory of a parent whose child dies, and they're both very difficult events for both parties, and I don't know who, and I'm not going to pick one or the other.

Q: Is that something you would ever do?

A: I think it would depend on other circumstances, but in this case, I just don't see how I could choose one side or the other.

Q: When the mother called Dr. Pearson and reported that the baby was hot, she also recollects that she called back and gave the doctor a temperature of 105 degrees?

A: Right.

Q: That temperature of 105 degrees made its way into the history note of Dr. Litvak the next day?

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A: Correct.

Q: Dr. Pearson doesn't recall the temperature.

A: Okay.

Q: Whose perception do you think is more accurate?

MR. KING: I object to the form of the question. This Doctor is not the fact finder here. If you have a question of the Doctor based upon the facts as you see them or hypothetically, I think that's a proper way to ask the Doctor questions. This way is *im* proper, and I object to it.

MR. LURY: I join in the objection.

MR. LEINICKE: Same objection.

BY MR. RATZAN:

Q: You can answer the question.

A: I think to me the fact that this temperature of 105 **is** entered the next day in the medical record suggests that a temperature of 105 definitely was recorded prior to this child coming

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into the emergency room, and based on all the other information, that probably would have been the even**ing of** the prior night. Whether or not that was given to Dr. Pearson is a separate question, and I would just from having dealt with parents probably say yes, she probably did tell Dr. Pearson of that degree of temperature.

Q: Are you aware that the mother testified that signs and symptoms of Russell Wagner on the night of November 30, the night that she made those three or she had those three telephone contacts with Dr. Pearson, were that her baby was screaming, he was hot and trembling, breathing rapidly, vomiting, that he had never had any signs or symptoms before, that he had had his head in his hands at dinner and was acting fussy and that she had given him Tylenol before dinner and before bed?

A: I certainly recall all those pieces of information in her deposition.

MR. KING: I object to the form, *sorry.*

BY MR. RATZAN:

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Q: When Dr. Pearson learned of the temperature of 105 degrees, did Dr. Pearson have a responsibility to ask the mother questions to elicit that information?

MR. LURY: I object to the form.

THE WITNESS: Yes.

BY MR. RATZAN:

Q: Do you believe Dr. Pearson did that?

A: Based on his deposition, it sounds like he went over many of the features that you're supposed to go over when you have a child with a high fever.

Q: What are the things you're **sup**posed to go over?

A: How the child is interacting with the parent. In other words, what we're trying to get to **as** physicians is whether this is an acutely ill child who is toxic or sick appearing and needs to be seen that night or whether this is something that is more standard and can wait until the next morning to

[20] be evaluated.

121 In general what physicians attempt is to 1221 bring the temperature down through medicines and

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[1] through cool baths and then to have the parents 121 judge the level of irritability, listlessness, lack [3] thereof, the interactivity of the child with the [4] environment, how well the child will be comforted by [5] the family or by the parent.

[6] They are the key features in the initial [7] evaluation of such a fever, as well as trying as [8] best as one can to over the phone localize the [9] fever. Does the child have an ear ache? Could this [10] be an ear infection? Is there a sore throat? Is [11] there a lot of diarrhea? Is there vomiting, which [12] could be a gastrointestinal infection, those sorts [13] of things.

[14] **Q:** Well, let me ask you this: At 10:00 p.m., [15] after the third phone call and after Dr. Pearson had [16] gained whatever information existed to him at the [17] time, what should his differential diagnosis have [18] been?

[19] MR. KING: I object to the form.

1201 THE WITNESS: At the end of the [21] third phone call, I think the differential diagnosis [22] should be a brewing viral infection. and I think one

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[1] always has in the back of his mind the possibility [2] that this is the opening of what could be a [3] bacterial process.

[4] BY MR. RATZAN:

[5] ***Q:*** At any time during that evening, should [6] Dr. Pearson have considered or suspected bacterial [7] meningitis as one of the possibilities for Russell [8] Wagner?

[9] A: It's my personal belief that every time a [10] physician interacts with a parent of a young baby [11] with fever, that automatically gets put on the list [12] of considerations, not to the point where you say [13] oh, I'm going to do a lumbar puncture on this child [14] obviously, but to the point where you're getting [15] information back from the parent to help you judge [16] should I do the lumbar puncture at this point, [17] should I refer this child to the emergency room.

[18] So, from that standpoint, yes, although [19] that's not often a consciously stated thing in the 1201 minds of physicians. The mind of the physician is [21] let's talk some more to this mother to determine how 1221 sick this child is. Meningitis can be one of the

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[1] things to make a child sick, and if so, we'll do the [2] right thing for the child.

[3] ***Q:*** Aside from the fever. whv else should Dr. [4] Pearson have considered bacterial meningitis on the [5] evening of November 30th?

[6] MR. LURY: I object to the form.

[7] MR. KING: Join.

[8] THE WITNESS: I think the signs [9] and symptoms of meningitis are very nonspecific in [10] the initial phases especially, and so when a patient [11] presents with fever and non-specific signs and 1121 symptoms such as vomiting, poor appetite, crying, [13] irritability, they would be some of the other [14] non-specific features that are found with many, many [15] illnesses, hundreds of illnesses, but meningitis [16] being one of them. ***So,*** a physician takes [17] information about those features in an effort to [18] make a determination whether or not a lumbar [19] puncture should be done.

1201 BY MR. RATZAN:

1211 **Q:** Okay. Dr. Wientzen, what I want to know 1221 is what symptoms or signs did Russell Wagner present

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111 that should have given Dr. Pearson the impetus to [2] consider bacterial meningitis?

[3] MR. LURY: I object to the form.

[4] MR. KING: Join.

[5] MR. LEINICKE: Same.

[6] THE WITNESS: I think I just told [7] you that.

[8] BY MR. RATZAN:

[9] ***Q:*** Respectfully, I think, Doctor, what I [10] heard was a summary of the general guidelines for [11] considering meningitis, but what I need to know is 1121 because, Doctor, you already stated that Dr. Pearson [13] should have considered bacterial meningitis in light [14] of the high fever, you said any doctor should do [15] that, what I want to know is what other signs or [16] symptoms, even though they may be non-specific in [17] your words, besides the 105 fever would give cause [18] to Dr. Pearson to consider bacterial meningitis on [19] November 30th?

201 MR. LURY: I object to the form. [21] It mischaracterizes his prior testimony.

221 MR. KING: I object to the form of

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11 the question, if any.

21 MR. LEINICKE: Okay, same. By the [3] way, could we just have perhaps an agreement to [4] speed this up that if one of us objects, that's an [5] objection for all of us? Would you agree to that so [6] we don't all have to -

7] MR. RATZAN: I'll agree eo that. [8] That's fie, unless one of you doesn't want that [9] objection for you, you can av it.

[10] MR. LEINICKE: Is that acceptable, [11] guys?

[12] MR. KING: Yes.

[13] MR. LURY: Yes.

[14] MR. LEINICKE: Okay, then we don't [15] all have to keep chiming in on this, thank you.

[16] BY MR. RATZAN:

[17] ***Q:*** Okay, you can answer the question.

[18] ***A*** In looking over the list of things that [19] Mrs. Wagner states in her deposition were features 1201 of Russell's initial illness, there is fever, there [21] is crying and there is vomiting, and those three 1221 things can be seen with meningitis. They're

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[1] non-specific features of many, many things, but [2] those three things are non-specific features that [3] can be associated with meningitis.

[4] **Q:** When Dr. Pearson or any doctor hears a [5] mother talk about trembling, maybe it's convulsions [6] over the telephone, would it be appropriate for the [7] doctor to do a physical exam of that baby to rule [8] out convulsions or seizures as opposed to a mere [9] shake?

[10] MR. KING: I object to the form, 1111 incomplete hypothetical.

[12] MR. LURY: Join.

[13] THE WITNESS: I think the answer [14] to your question **is** that it would not really be a [15] typical scenario where a physician could get that [16] infornution over the phone, have the child come in [17] and that motor activity would still be present an [18] hour later. Seizures would either have stopped [19] spontaneously or when the temperature is controlled, [20] the shivering would stop. So, no, I don't think one [21] could ever practice medicine that way.

[22] BY MR. RATZAN:

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[1] **Q:** Bacterial meningitis is a life-threatening 121 condition?

[3] A: **Yes,** it is.

[4] **Q:** If a baby is showing signs and symptoms of [5] bacterial meningitis, enough that the doctor - [6] strike that. If the shaking and the convulsions are [7] indeed a sign or symptom of bacterial meningitis, [8] does the doctor, hearing that sign or symptom [9] reported over the phone by the mother, should he [10] include that as well as the other things you [11] mentioned in the constellation of signs and symptoms [12] to cause him to suspect bacterial meningitis?

13] MR. LURY: I object to the form.

14] THE WITNESS: I think you can't [15] rule out both shaking and convulsions in

your question. [16] It's either one or the other, and I think a [17] physician makes a determination which of the two it [18] is. If he determines it's convulsions, then the [19] answer to your question would be yes, it needs to be [20] put into the list of things that could possibly be [21] meningitic symptoms in this patient. If he [22] concludes no, this **is** shaking, based on the

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[1] information he gets from the mother, then that is [2] not put into the list of things that raises the [3] issue of meningitis again,

[4] **BY MR. RATZAN:**

[5] **Q:** Do you fairly believe that a pediatrician [6] can determine whether it's shaking or a convulsion [7] on a telephone?

[8] **A:** Yes, I think oftentimes a physician can.

[9] **Q:** Have you done that?

[10] **A:** Yes, I have.

[11] **Q:** At any time, should Dr. Pearson have [12] considered or suspected bacteremia?

[13] **A:** Yes.

[14] **Q:** Why should he have done that?

[15] **A:** The symptoms that this baby presented [16] with, mainly high fever, is the way bacteremia is [17] presented.

[18] **Q:** What did Dr. Pearson do to nile out [19] bacterial meningitis?

[20] **A:** I think he ruled out bacterial meningitis [21] overthe course of several phone calls with this [22] mother based on his deposition and determining how

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[1] sick the child appeared during the course of the two [2] hours that he had conversations with her.

[3] **Q:** I understand that. I would like you to [4] describe for me the specific things that Dr. Pearson [5] did to rule out bacterial meningitis in this baby.

[6] **A:** Again, it's basedon the list of things [7] that he says he discussed with Mrs. Wagner. At the [8] time of the second phone call, it'slisted in his [9] deposition, and that was a discussion of a list of [10] questions, a **sort** of review of systems list of [11] questions that he says he remembers having asked [12] Mrs. Wagner overthe phone, and that included things [13] like the drinking history of the child, his [14] breathing ability, whether or not he was having any [15] pain, what his eye contact was with **Mrs.** Wagner, [16] probably Mr. Wagner, the vomiting, diarrhea, the [17] medicines he was on and the height of his [18] temperature.

[19] **Q:** What did Dr. Pearson do to rule out [20] bacteremia?

[21] **A:** Same.

[22] **Q:** You teach residents and interns, fellows?

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[1] **A:** Yes.

[2] **Q:** Here at Georgetown?

[3] **A:** Correct.

[4] **Q:** You teach them pediatric infectious [5] disease?

[6] **A: Right.**

[7] **Q:** When you're teaching your residents, [8] interns or fellows, what do you teach them to do in [9] order to rule out bacterial meningitis when they [10] suspect it in a patient?

[11] **MR. LEINICKE:** I object to the [12] form.

[13] **THE WITNESS:** I teach them to take [14] a good history and do a very good physical exam. I [15] teach them to have a concern for bacterial [16] meningitis when the child looks sick or toxic. I [17] teach them if they are unconvinced of the absence of [18] meningitis at the time of their first examination [19] with the child that it'sprudent to keep the child [20] under evaluation for an hour or two and reevaluate [21] the child even cursorily to see whether or not [22] there's been progression of the neurologic findines

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[1] that are commensurate with bacterial meningitis, and [2] I teach them that follow-up in the short term is [3] very helpful in determining whether or not a patient [4] has bacterial meningitis.

[5] **BY MR. RATZAN:**

[6] **Q:** What do they do to reevaluate and follow [7] up? Do they perform a second exam?

[8] **A:** Not **so** much a second exam necessarily as a [9] brief observational evaluation of the patient to see [10] whether or not the child continues to be alert and [11] interactive, to see whether the level of [12] irritability if it was present initially has gotten [13] worse, the level of lethargy if it was present [14] initially has gotten worse. The presumption is that [15] patients with bacterial meningitis will progress [16] with their signs and symptoms over the short term.

[17] **Q:** Do you teach them to perform a hands-on [18] exam?

[19] **A:** Yes, I do.

[20] Q: Do you teach them to, in reevaluating [21] them, to view the patient themselves?

[22] **A:** Yes.

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[1] **Q:** Can you tell me or describe for me, if you [2] would, the importance of a physical exam -

[3] **MR. KING:** I object to the form.

[4] **BY MR. RATZAN:**

[5] **Q:** - when **a** physician considers or suspects [6] bacterial meningitis in a baby?

[7] **MR. KING:** I object to the form of [8] the question, incomplete hypothetical.

[9] **BY MR. RATZAN:**

[10] **Q:** You can answer.

[11] **A:** I think the physical exam **is** helpful. I [12] think unfortunately neurologic meningeal signs, as [13] they'recalled, are not always present during the [14] course of bacterial meningitis. One can find some [15] pertinent positive features of an examination that [16] could guide the decision to do a lumbar puncture.

[17] More important in my judgment in the [18] effort to make a decision to do a lumbar puncture [19] are the observational variables that you really [20] don't need a physical exam to do but which can be [21] done by basically observing the patient in a period [22] of time.

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[1] **Q:** If Dr. Pearson considered or **suspected** [2] bacterial meningitis in Russell Wagner at 10:00 p.m. [3] on November 30th, 1989, what should he have done?

[4] **MR. KING:** I object to the form.

[5] **THE WITNESS:** If after discussing [6] the various list of things that we've already talked [7] about that he said he discussed he still has the [8] concern for bacterial meningitis at that juncture, [9] he should have referred this patient to a facility [10] where a lumbar puncture could have been done.

[11] **BY MR. RATZAN:**

[12] **Q:** And what should have followed from there?

[13] **A:** Depends on what the lumbar puncture [14] showed.

[15] **Q:** Did you agree with Dr. Pearson's diagnosis [16] of November 30th, 1989?

[17] **A:** As I sithere, I don'tremember him being [18] asked the specific diagnosis' that he had in mind. [19] You can refresh my memory. You probably know his [20] deposition better than I.

[21] Q: I don't. I don't know what his diagnosis [22] was.

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[1] **A:** I can't recall what he said his diagnosis [2] was.

[3] Q: Did you read any notes that Dr. Pearson [4] made of histelephone calls of that night?

[5] **A:** No.

[6] **Q:** I noticed Dr. Betancourt provided a log to [7] his deposition which you

reviewed?

A: Yes.

Q: Did you see any kind of log that Dr. Pearson had written of his phone calls of that night?

A: I did not see such a thing, no.

Q: Do you teach your residents to make notes of phone calls that they receive from others reporting signs and symptoms, all be it non-specific, for meningitis?

MR. LEINICKE: I object to the form.

MR. KING: I object to the form, incomplete hypothetical.

THE WITNESS: No, no, I generally don't teach my residents to make phone call notes.

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BY MR. RATZAN:

Q: Do they know to do that anyway?

MR. LURY: I object to the form.

THE WITNESS: I think they know to do that for certain reasons, oh, if a medicine is going to be prescribed, for instance, to note that so it goes into the medical record, but not necessarily each and every febrile baby to have a phone message written as to the signs and symptoms and the interaction between the parents and the doctor.

BY MR. RATZAN:

Q: In the clinical practice that Dr. Pearson had with Dr. Litvak and Dr. Betancourt, should Dr. Pearson have written some notes to transfer the information he was receiving from Dorothy Wagner for Russell's appointment the next day with one of his partners?

MR. KING: I object to the form.

THE WITNESS: I don't think there's any rule that requires a physician to do that. I think there needs to be a way of

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communicating important information from one person in the department or division or practice to another, but it need not be written.

BY MR. RATZAN:

Q: Okay. It might be oral?

A: Yes.

Q: And if Dr. Pearson was making an appointment for 8:30 - I'm sorry, if Dr. Pearson was making an appointment the next morning for Russell to see one of his partners, do you think Dr. Pearson should have discussed all the signs and symptoms and history that existed in Russell the night before with Dr. Litvak, the next physician to see the baby?

MR. KING: I object to the form.

THE WITNESS: I think, again, if Dr. Pearson felt there was something particularly unusual about the presentation of a 17 month old baby with high fever, he would have to tell Dr. Litvak what that unusual feature was, but this is such a common thing for a physician to be called about in the off hours, high fever, that I know when

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I was doing general pediatrics we never had that need, I never had that need to tell my partners the story of each and every child whose parents had called me the night before because of a fever, and if the child was to come in, the history would be obtainable again from the parent.

BY MR. RATZAN:

Q: Now, to be fair, there was more than a fever with Russell Wagner on the evening of November 30th, 1989?

A: True.

Q: And depending on whose account you believe, there was in addition to fever vomiting?

A: Right.

Q: Shaking?

A: Right.

Q: Screaming?

MR. KING: I object to the form.

THE WITNESS: Sure.

BY MR. RATZAN:

Q: And some irritability?

A: Screaming and irritability I would say is

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the same.

Q: Does Dr. Pearson, after knowing all of those signs and symptoms at 10:00 p.m. on November 30th, 1989, assuming for the moment that he did, what should his differential diagnosis have been at 10:00 p.m. on November 30th, 1989?

MR. KING: Excuse me, I object to the form of the question. I think the question is unclear because it makes it sound like these items are continuing in nature, and I don't think that's the case. Anyway, I object to the form.

BY MR. RATZAN:

Q: You can answer the question.

A: Well, I'm not sure a physician truly develops a differential diagnosis necessarily when he's discussing something over the phone with a parent. He draws up a preliminary list of things that might be present but not truly a formalized differential diagnosis.

So, to substitute that as, you know, as a preliminary list of things, I think in the physician's mind would be a viral syndrome brewing.

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with fever and maybe vomiting in a child who's very unhappy because of the fever and therefore crying. That would be I think the most likely differential diagnosis or preliminary, number one on the preliminary list, and number two would be the onset of a bacterial superinfection of something such as a middle ear infection, strep throat, a bacterial enteritis.

Number three would be the possibility of some more deep seeded tissue infection such as the beginning of a pneumonia, the beginning of what might be bacteremia, and then I think one would continue in the face of any febrile baby as I said before to think we still need meningitis in the back of our minds as this child's illness progresses with time.

Q: Do you think Dr. Pearson should have made arrangements to visit that baby at that point in time?

A: Are you talking about 10:00 o'clock at night?

Q: Yes. sir.

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A: No, I think based on the information that he received, that he says he received during the course of his conversation with Mrs. Wagner, the child was not apparently sick enough to require that sort of intervention.

Q: If you assume that he received the information that Mrs. Wagner reported, does your opinion change?

A: No, I think Mrs. Wagner doesn't talk in her deposition about the salient feature of what Dr. Pearson got to in his conversation with the mother, that is to say the level of toxicity of the child based on his ability to interact, as Dr. Pearson uses his eye contact with the mother, and that is something that physicians get skilled in in eliciting, even over the phone, from parents who are very concerned about their children.

Q: Does eye contact in the face of all those other non-specific signs and symptoms that existed with Russell Wagner on November 30th, 1989, does eye contact rule out bacterial meningitis?

MR. LURY: I object to the form.

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MR. KING: Join.

THE WITNESS: No, nothing rules out bacterial meningitis. There is always a chance for bacterial meningitis to be present, even in a baby who looks

spectacularly well, but it does rule [6] out the need of a physician to act any further.

[7] BY MR. RATZAN:

[8] Q: Why is that?

[9] A: Because it would be an extremely rare [10] circumstance for a child with bacterial meningitis [11] to be very interactive with the environment, to be [12] comforted by the mother, to be comfortable, to have [13] the irritability and the crying and the screaming [14] dissipate when the fever comes down.

[15] Q: If a baby presented to you with 105 fever, [16] irritability, vomiting, shaking but had good eye [17] contact, would that rule out bacterial meningitis?

[18] MR. LURY: I object to the form.

[19] MR. KING: Join.

[20] THE WITNESS: Again, as I said [21] before, that single feature would not rule out [22] bacterial meningitis. It would be strong evidence

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[1] against bacterial meningitis, and if one could then [2] be comfortable that the level of irritability that's [3] being proffered by the parent was not that level of [4] irritability which is consistent with meningitis, [5] then you would be very certain that this is not [6] bacterial meningitis.

[7] BY MR. RATZAN:

[8] Q: How do you do that on a telephone?

[9] A: This is a skill physicians have honed over [10] many years of practice, and one gets a sense of what [11] a parent means when she says the child is fussy or [12] crying or irritable, and that takes years I think of [13] experience to get.

[14] Q: Do you think Dr. Pearson - I'll strike [15] that. Do you have any criticisms of the care [16] rendered by Dr. Pearson?

[17] MR. KING: I object to the form.

[18] THE WITNESS: **Assuming** that Dr. [19] Pearson's rendition of his list of questions to the [20] mother is about right, no, I don't.

[21] **BY MR.** RATZAN:

[22] **Q:** If you assume what the mother says she

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111 told Dr. Pearson is accurate and that the baby had [2] all the signs and symptoms that the mother reported, [3] do you have any criticisms of the care rendered by [4] Dr. Pearson?

[5] MR. KING: I object to the form of [6] the question.

[7] THE WITNESS: Again, I'm not [8] discounting that the mother or I'm not saying that [9] the mother's list of complaints weren't told to Dr. [10] Pearson. I'm merely saying that Dr. Pearson had a [11] duty to discuss, for instance, the irritability with 1121 the mother to get a sense of that irritability, to [13] make a determination that that level of irritability [14] was not consistent with bacterial meningitis, rather [15] it was consistent with a child who was unhappy [16] because he had a fever.

[17] So, even if the mother complained of [18] irritability and vomiting and so on, as long as Dr. [19] Pearson got through those complaints to the point 1201 where he was comfortable that it wasn't bacterial 1211 meningitis, then I would have no criticism of Dr. [22] Pearson.

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111 BY MR. RATZAN:

[2] Q: As you understand it, Russell Wagner [3] appeared at the office the next morning with his [4] mother?

[5] A: Right.

[6] Q: Do you think it was appropriate for Dr. [7] Pearson to arrange for that appointment or recommend [8] that appointment for the next day?

[9] A: Yes, I think it was.

[10] Q: Why do you think so?

[11] A: I think a young baby at 17 months of age [12] with a high fever probably needs to be evaluated for [13] that fever within a reasonably short period of time.

[14] Q: Why is that?

[15] A: For all the reasons we just discussed [16] right now.

[17] Q: I'm not clear. What needed to be done in [18] the office the next day in the face of the symptoms [19] and the fever for Russell Wagner?

[20] A: Well, if one presumes that the physical 1211 examination based on the review of systems that a [22] physician gets is going to be negative, then a blood

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[1] count is often done in a febrile baby this age with [2] no focus of infection. So, what would be done, [3] typically a blood count, and depending on other [4] features of the exam, maybe a throat culture, maybe [5] antibiotics for a trivial ear infection, maybe a [6] chest x-ray.

[7] Q: I guess I didn't make my question clear. [8] What is the physician or physicians looking for in [9] evaluating the baby the next day in the face of [10] those signs and symptoms?

[11] MR. LEINICKE: Objection to the [12] form, vague and ambiguous.

[13] THE WITNESS: I think the [14] physician is looking for further confirmation that [15] the child does not have a life-threatening illness, [16] number one. The physician is looking for further [17] progression of the initial presentation to a defined [18] diagnosis, whether it be a viral diagnosis, an ear [19] infection diagnosis, a throat infection diagnosis on [20] the other hand. So, they would be the two reasons [21] for the examination.

[22] BY MR. RATZAN:

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[1] **Q:** Now, again, you're aware there is a [2] difference in either perception or reporting as to [3] what Russell's signs and symptoms were at 10:00 a.m. [4] in Dr. Litvak's office between the mom and the [5] doctor?

[6] MR. LEINICKE: I object to the [7] form.

[8] THE WITNESS: As I sit here, I [9] don't independently recall what the mother in her [10] deposition says about Russell's signs and symptoms [11] while he was in the office with Dr. Litvak. I do [12] know what Dr. Litvak writes about his exam, but I [13] don't recall independently what the mother says was [14] going on.

[15] BY MR. RATZAN:

[16] Q: Okay. Well, I want you to assume for the [17] purpose of this question that the mother testified [18] that Russell was pale, that he was quiet, that he [19] didn't want to do anything, that he wanted to be [20] held, that he didn't want to eat, that he had been [21] *drinking* a little Gatorade, that he hadn't slept [22] well and that he had been taking Tylenol. If you

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[1] assume those things to be true, do you agree with [2] Dr. Litvak's diagnosis of viremia?

[3] A: Do I agree that it's a proper diagnosis to [4] make?

[5] **Q:** Do you agree that his diagnosis of viremia [6] was correct?

[7] A: Well, I wouldn't need the parents' list of [8] things knowing the subsequent course of events with [9] the retrospective scope to know or not know whether [10] Dr. Litvak's diagnosis is correct. It is my opinion [11] that this baby probably was bacteremic at the time [12] of his evaluation by Dr. Litvak at 10:00 or 11:00 in [13] the morning.

[14] Whether it was prudent or reasonable or [15] proper for Dr. Litvak to have made a diagnosis of [16] bacteremia when the white count comes back 5,000 is [17] a different question, and I would say yes, it was [18] reasonable based on his evaluation of the child, but [19] in retrospect he would have been wrong.

[20] **Q:** *All* right, we'll get to the white count. [21] This is your copy of the notes from December 1st, [22] 1989?

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[1] A: Yes.

[2] Q: From Dr. Litvak?

[3] **A:** Right.

[4] **Q:** You've written something there in red ink?

[5] A: Yes.

[6] ***Q:*** Can you read what this says?

[7] A: This is actually a translation of the [8] handwriting in the bracketed area to the left of the [9] note. It says, "acted same," referring to the sib, [10] "per mom for one to two days."

[11] ***Q:*** What's in that bracket? What does that [12] say?

[13] A: It says, "Sib questionable viral illness [14] one week ago," and then - I'm *sorry,* my [15] handwriting, my red handwriting doesn't explicate [16] what's in the bracket, it explicates what's next to [17] the bracket.

[18] ***Q:*** Okay. The bracket says, "Sib [19] questionable" -

[20] A: "Viral illness one week ago," and then [21] there's next to that, "acted the same per mom times [22] one to two days," meaning the sibling had a viral

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[1] illness a week ago and acted the way this baby is [2] acting now.

[3] ***Q:*** **Is** that significant at all?

[4] A: Yes, I think it is.

[5] ***Q:*** Why is that?

[6] A: Viral diseases are certainly transmissible [7] in a family. It's very common for an older child to [8] acquire a viral illness and then infect or bring the [9] infection into the family, and other family members 1101 can get it. So, when one sees this sort of 1111 epidemiologic transmission of the illness, it lends [12] some weight, epidemiologic weight that it's the same [13] disease.

[14] **Q:** I'm glad you used that word. Epidemiology [15] is the study of, **is** it not, the transfer or the [16] origin of a virus or a bacterial infection?

[17] A: In part.

[18] ***Q:*** So, in this case, it was important for Dr. [19] Litvak to know about that viral history from the [20] sister in reaching his diagnosis of viremia?

[21] MR. LEINICKE: Objection to form.

[22] THE WITNESS: Again, the word

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[1] important isn't what I would use. I think that -

[2] **BY MR.** RATZAN:

[3] ***Q:*** I'm ***sorry,*** what word would you use?

[4] A: I think it is another piece of information [5] that helps Dr. Litvak in coming up with the [6] diagnosis of a possible or probable viral disease. [7] In and of itself it's not crucial to that diagnosis, [8] but it helps.

[9] ***Q:*** Sometimes do babies also get bacterial [10] infections from their siblings?

[11] ***A*** Yes, certainly they can.

[12] ***Q:*** And if you're treating a baby, **is** it [13] important to you to know if any siblings have had a [14] recent illness?

[15] A: I think again it's helpful sometimes to [16] know that. One would certainly not expect a [17] self-limiting illness in an older child to have been [18] bacterial, and I think that's the issue that comes [19] up with the sibling's case in this regard, that is [20] if the child had it, the older child had it and got [21] better spontaneously, it is evidence against Russell [22] Wagner's illness being anything but a viral disease.

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[1] **Q:** Because the sibling had a viral disease?

[2] A: Because the sibling got better [3] spontaneously, and children with Hemophilus [4] meningitis or bacterial sepsis don't get better [5] spontaneously.

[6] ***Q:*** The bacteria that causes Hemophilus [7] meningitis **is** called Hemophilus influenzae B?

[8] A: Type B, yes.

[9] ***Q:*** And that bacteria can cause other [10] infections besides meningitis in children?

[11] A: True.

[12] ***Q:*** That bacteria, in fact, is one of the [13] leading causes of an ear infection?

[14] A: Untrue.

[15] **Q:** Would you agree that - strike that. The [16] Hemophilus influenzae virus -

[17] A: It's not a virus.

[18] ***Q:*** I'm *sorry,* you're right, Hemophilus [19] influenzae bacteria can cause ear infections?

[20] A: Are you talking about type B 1211 specifically?

1221 ***Q:*** In general, the bacteria Hemophilus

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[1] influenzae, not type B.

[2] A: Not type B, yes, it can cause it.

[3] ***Q:*** Can the Hemophilus influenzae B cause ear [4] infection?

[5] A: Yes, it's a rare cause of middle ear [6] disease.

[7] ***Q:*** The - strike that. Should Dr. ***Litvak*** [8] have considered or suspected bacterial meningitis in [9] Russell Wagner as one of the possibilities?

[10] **A:** I think the duty that Dr. Litvak would [11] have for Russell would be the same duty that I laid [12] to Dr. Pearson, that is to say history of a high [13] fever in a baby with the other complaints that are [14] listed here, the vomiting, the mother's complaint of [15] listlessness would raise that as an issue, a general 1161 issue but nonetheless an issue, yes.

[17] ***Q:*** Should Dr. Litvak have considered or [18] suspected bacteremia in Russell Wagner as one of the [19] possibilities?

[20] A: Yes.

1211 ***Q:*** By the way, do you recall that Mrs. Wagner [22] actually suggested to Dr. Litvak that her baby might

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[1] have bacterial meningitis?

[2] A: I'm *sorry,* I missed your question.

[3] **MR. LEINICKE:** Objection to form.

[4] THE WITNESS: Did I remember -

[5] **BY MR.** RATZAN:

[6] ***Q:*** Do you recall that Mrs. Wagner, the mom, [7] while she was in Mr. Litvak's (sic) office actually [8] suggested the possibility of bacterial meningitis to [9] the doctor?

[10] **MR. LEINICKE:** I object to the [11] form.

[12] THE WITNESS: As I stated, I don't [13] recall that's in her deposition, but I certainly [14] take your word for it if you say it is.

[15] **BY MR.** RATZAN:

[16] ***Q:*** Do you recall it being in Dr. Litvak's [17] deposition?

[18] **A:** No.

[19] ***Q:*** Did Dr. Litvak do anything to rule out [20] bacterial meningitis?

[21] A: Yes, he did.

1221 ***Q:*** And before I get to that, if you take **my**

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[1] word that Mrs. Wagner did suggest to Dr. Litvak or [2] at least raise the suspicion of bacterial [3] meningitis, would that be significant to you?

[4] **MR.** LEINICKE: Objection to form.

[5] THE WITNESS: It would be [6] significant in one regard, and that is the parent [7] obviously has a concern that needs to be discussed [8] with the physician. It may not be a legitimate [9] medical concern, but it's certainly a concern that a [10] physician would spend a little time trying to [11] diffuse.

[12] **BY MR.** RATZAN:

[13] ***Q:*** On December 1st when Dr. Litvak was [14] getting a blood count done and doing a neurological [15] exam, testing for what's called nuchal rigidity, I [16] guess a stiff neck, some doubt existed at that point [17] before he was done -

[18] **MR.** LEINICKE: Objection.

19] **BY MR.** RATZAN:

201 ***Q:*** - as to whether Russell had bacterial [21] meningitis?

[22] **MR. LEINICKE:** Objection.

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[1] **MR.** LURY: Object to the form.

[2] **MR. LEINICKE:** I object to the [3] form as vague and ambiguous. The concept of some [4] doubt existed has absolutely no meaning in this case [5] and is **so** vague as to possibly be answered yes or [6] no. Are you talking about a doubt in the doctor's [7] mind, a doubt in the mother's mind or a doubt [8] retrospectively? I object to the form.

[9] BY **MR. RATZAN:**

[10] **Q:** Doctor, you can answer the question.

[11] **A:** You know, doubt is again a **difficult** word [12] to deal with. Physicians have what's known as [13] clinical certainty that there is or isn't something [14] present but that doesn't remove all doubt. Even [15] after a full evaluation, even after a lumbar [16] puncture, it doesn't remove all doubt that there's [17] no meningitis.

[18] So, I would have to answer your question [19] with that as my concept of doubt, as saying 1201 certainly, there's always doubt every time a patient 1211 leaves a doctor's office, certainly before the [22] examination is done there is some doubt that the

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[1] diagnosis is correct. All we can offer is a [2] reasonable medical clinical certainty that we have [3] discharged our duty and ruled out what is apparent [4] at the present time.

[5] **Q:** Well, let me put it this way, before Dr. [6] Litvak commenced all of the tests that he commenced, [7] some doubt existed which probably motivated him to [8] do those tests?

[9] **MR. LEINICKE:** Objection to form.

[10] **THE WITNESS:** Yes, I would agree [11] with you that using the word doubt in the sense that [12] a laboratory determination can shed some light on [13] the clinical exam and diminish that doubt, yes.

[14] BY **MR. RATZAN:**

[15] **Q:** Now, you said that Dr. Litvak did some [16] things to rule out bacterial meningitis?

[17] **A:** Yes.

[18] **Q:** Would you describe for me the specifics of [19] what he did to rule out bacterial meningitis on 1201 December 1st, **1989.**

[21] **A:** All right, he did a series of physical [22] examinations.

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[1] **Q:** By the way, I'd like to take them one by [2] one, okay, so identify the first series of physical [3] examinations.

[4] **A:** Well, there are here in his record a few [5] things that are called observational variables that [6] enable a physician to separate children who are ill [7] and who need evaluation in a hospital versus those [8] children who are ill but have a viral syndrome or a [9] trivial bacterial process.

[10] The first would be the determination that [11] this child **was** alert. That **is** an evidence that the [12] child's neurologic functioning **is** high level and not [13] compromised, and it's a sign of intact nervous [14] system functioning.

[15] **Q:** Okay. What was the next thing?

[16] **A:** Second thing is his statement that the [17] child is active. The level of activity **is** a helpful [18] determinant as to how sick the child is. A child [19] who is active, moving around is a child who has a [20] less chance of having a serious bacterial infection [21] certainly than a child who is lethargic, laying [22] there, not moving and so on.

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[1] **Q:** Babies can be alert and active yet still 121 have bacterial meningitis?

[3] **A:** Again, as I said before, even alert, [4] active children with a negative lumbar puncture can [5] have bacterial meningitis.

[6] **Q:** And a baby that's alert and active [7] obviously can be bacteremic?

[8] **A:** True.

[9] **Q:** What else did he do after alert and [10] active?

1111 **A:** He determined the level of irritability in [12] the child and notes the child to be mildly [13] irritable, which is evidence for a non-serious [14] ongoing process. Next he determines that the child [15] is responding appropriately. These are listed [16] observational variables. You can find them in [17] something called the Yale observation score, which [18] are ways of looking at children to determine who is [19] sick or who is not sick.

[20] **Q:** What was the next thing he did?

[21] **A:** The next thing he did was to perform a [22] physical examination, searching for a particular

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[1] site of infection. None was found.

[2] Q: What did he do?

[3] **A:** He did a general examination looking in [4] the - he basically has written here that the [5] physical exam all was negative, and I'm sure that [6] means he looked in the child's throat and his ears, [7] listened to the chest and listened to the heart, he [8] checked the skin and the joints, he felt the [9] abdomen, and then he writes more specific features [10] about the child's neurologic exam including the fact 1111 that the neck is supple, including the fact that the [12] neurologic exam was normal.

[13] **Q:** What does that mean, the neck is supple? [14] What is he looking for?

[15] **A:** He's looking for the nuchal signs of [16] bacterial meningitis.

[17] Q: What does that mean?

[18] **A:** That means when one flexes the neck in a [19] child with bacterial meningitis, one can sometimes [20] find resistance to that passive flexion of the [21] neck. It hurts when you stretch the nerves of a 1221 child who has bacterial meningitis and he'll refuse

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[1] to let you flex his neck.

[2] **Q:** Does the absence of any symptoms in his [3] neck, the absence of nuchal rigidity rule out [4] bacterial meningitis?

[5] **A:** No, it does not.

[6] **Q:** Would you have expected that a baby [7] Russell Wagner's age would have presented with [8] nuchal rigidity, Doctor?

[9] **MR. LURY:** I object to the form.

[10] **THE WITNESS:** The majority of [11] children after **15** months of age with bacterial [12] meningitis have nuchal rigidity, but still a large [13] fmction, a third, *40* percent do not. So, the [14] answer to the question is more likely than not, but [15] it's **still,** to go back to your prior question, does [16] not rule out bacterial meningitis.

[17] BY **MR. RATZAN:**

[18] **Q:** *40* percent is a large enough number to [19] continue with the examination?

[20] **A:** That's right.

[21] **MR. LURY:** Is that a question?

1221 **MR. LEINICKE:** I object to the

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[1] form.

[2] **MR. RATZAN:** He understood me.

[3] **THE WITNESS:** The physical [4] examination is what I understood you meant to say.

[5] BY **MR. RATZAN:**

[6] **Q:** Right. When you teach your residents, [7] interns and fellows, in fact, you would teach them [8] the test for nuchal rigidity in a baby of Russell [9] Wagner's age does not rule out bacterial meningitis?

[10] **A:** Yes, that's what I would teach.

[11] Q: Did he do anything else besides the things [12] you've mentioned so far that would rule out [13] bacterial meningitis?

[14] **A:** No, I think this is the standard approach [15] to make a determination as

to whether or not a baby [16] needs a lumbar puncture.

[17] **Q:** Well, what of those things ruled out [18] bacterial meningitis?

[19] A: The fact that the child was alert and [20] active and responding approp riately, had negative 1211 nuchal signs and a normal neurologic exam is about [22] as close as you can do in determining whether or not

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[1] a child has bacterial meningitis, and clinically [2] speaking, it's reasonable evidence against there [3] being bacterial meningitis.

[4] **Q:** If Russell Wagner had bacterial meningitis [5] at 10:00 a.m. on December 1st, is it possible that [6] he could have been alert and active?

[7] **MR. LURY:** Just alert and active?

[8] THE WITNESS: Yes.

[9] BY MR. RATZAN:

[10] **Q:** Is it possible he could have been alert 1111 and active and had the physical and neurological 1121 exam that Dr. Litvak noted in his office chart?

[13] **A:** Yes.

[14] **MR. LEINICKE:** I object to the [15] form.

[16] BY MR. RATZAN:

[17] **Q:** On December Ist, 1989 after Dr. Litvak had [18] concluded his physical and neurological exam and [19] written down that the baby was alert and active, the 1201 possibility existed that Russell Wagner was still 1211 bacteremic?

[22] A: True.

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[1] **Q:** Dr. Litvak had not yet ruled out that [2] Russell Wagner was bacteremic?

[3] A: Well, again, I'm not sure what time the [4] CBC was done, so you may be right, but I don't [5] recall reading his deposition whether that was done [6] in the middle of his exam or the end.

[7] **Q:** Well, putting aside the CBC for a second, [8] okay, just put that aside, on the basis of that [9] information alone, the diagnosis of bacteremia was [10] not ruled out?

[11] A: I see your question. True, I don't think 1121 the physical exam is necessarily ever capable of [13] ruling out the possibility of bacteremia, which is [14] why we proceed to laboratory tests.

[15] **Q:** In fact, with the retrospective scope, [16] Russell Wagner was indeed bacteremic at 10:00 a.m. [17] on December 1st, 1989?

[18] A: I believe he probably was, yes.

[19] **Q:** Even the white blood count, whatever it [20] was, in the face of it, Russell Wanner was [21] bacteremic on December 1st, 1989?

[22] **MR.** LURY: It was ***5.400.*** that's

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[1] what it was.

[2] **THE** WITNESS: The white blood cell [3] count was 5,400, and it had a normal differential, [4] and unfortunately Russell did not have an elevated [5] white count to give the physicians the laboratory [6] tip off that this child could be bacteremic.

[7] BY MR. RATZAN:

[8] **Q:** Does a white blood count of ***5,400*** rule out [9] bacterial meningitis?

[10] A: No.

[11] **Q:** You talked about the differential. There [12] were ***65*** percent neutrophils and 35 percent [13] leukocytes - I'm *sorry,* lymphocytes or monocytes?

[14] **A:** Right.

[15] **Q:** Do you know the mean percentages of [16] neutrophils versus lymphocytes in a child Russell's [17] age?

[18] A: **Yes,** I do.

[19] **Q:** What are they?

[20] A: In a baby who is about 18 months of age, [21] it's usually about 50/50.

[22] **Q:** The other thing about the differential is

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[1] that in what I saw there doesn't appear to be any 121 study of band cells.

[3] **A:** Well, there may or may not be bands. [4] There are ***65*** segs. That would typically mean mature [5] cells.

[6] **Q:** But there's no breakdown that I could see, [7] if you saw one, let me know, identifying the number [8] of band cells?

[9] A: Again, I don't know whether this blood [10] count can assess for bands. I just see segs here.

[11] **Q:** Well, they're called neutrophils?

1121 A: Right.

[13] **Q:** A band cell, in fact, is a variety of [14] neutrophil that's not yet segmented?

[15] A: Actually that's not true. It is segmented [16] but it is not polymorphonuclear. It's using two [17] lobes.

[18] **Q:** Okay, I appreciate that. The band cell [19] then is segmented and it's a type of neutrophil?

[20] **A:** It's immature or early form of [21] neutrophils, yes.

[22] **Q:** What is a shift to the left. Doctor?

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[1] A: A shift to the left is when there are [2] excessive number of neutrophils in the peripheral [3] smear.

[4] **Q:** When using a white blood count - [5] strike that. Explain to me how it could [6] be that a white count in Russell Wagner was reported as 5,400 and [7] yet he was at least bacteremic.

[8] A: Well, you've put your finger on the [9] limitation of the laboratory. Right now it's [10] estimated that about ***85*** or 90 percent of children [11] who are bacteremic will have an elevated white [12] count, more than 15,000, and that is assessed to be [13] about as sensitive a test as we can have for [14] bacteremia.

[15] As you asked me a little while ago, and [16] the truth of the matter is there is nothing on the [17] physical examination that will rule out bacteremia [18] in a febrile baby. Physicians then turn, if there's [19] no focus of infection in the right age with the [20] right fever which there was here, to the white count [21] as a further guide to the possible presence of [22] bacteremia, and when they turn, they know that

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[1] they're dealing with an 85 to 90 or 92 percent [2] certainty that the white count will be elevated if [3] the baby is bacteremic.

[4] Putting that together with the physical [5] exam is what physicians have to rely on to make a [6] decision to do a blood culture or not do a blood [7] culture for bacteremia. So, the answer to your [8] question is it's intrinsically a test that has a 90 [9] percent sensitivity, and that's as good as it gets.

[10] **Q:** That, in all fairness and with respect to [11] your answer, I don't feel was the answer to my [12] question. What I asked -

[13] A: Give me your question again.

[14] **Q:** Okay, what I asked was, and I'll rephrase [15] it, could you describe for me the process of what is [16] going on in the baby so that he's bacteremic and yet [17] at that moment in time his white count reads *5,400,* [18] an otherwise normal amount of overall white blood [19] cells?

[20] **MR. LURY:** Well, before you [21] answer, in all fairness, I think it was responsive [22] to his question, but go ahead and answer this

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1] different question.

2] **MR. KING:** I object to the form of [3] the question.

4] **THE** WITNESS: I think if you're [5] asking the molecular reason, the bone narrow [6] molecular reason for a normal white count in the [7] face of an ongoing bacterial bloodstream infection, [8] the answer is that there are toxins that are [9] produced by bacteria that can actually suppress the [10] bone marrow response, and it can be evidence for the [11] beginning of an overwhelming process. Can we take a [12] two-minute break? I got

paged a minute ago.

[13] MR. LURY: Yes.

[14] MR. RATZAN: Sure.

[15] THE VIDEOGRAPHER: Okay, the time [16] is 4:28, and we are now off the record.

[17] (Thereupon, a discussion was held off the record.)

[18] THE VIDEOGRAPHER: Okay, we're now [19] back on the record. The time is 5:15.

[20] BY MR. RATZAN:

[21] Q: Okay, Doctor, I think we were talking [22] about the white blood count before our break, and I

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[1] asked you how it could be that Russell Wagner could [2] have a white count of 5,400 and yet be bacteremic, [3] and I think you had described or you were going to [4] describe the mechanism by which that could occur. [5] Would you do that for me, describe the mechanism [6] that exists allowing him to have a normal white [7] count -

[8] A: Right.

[9] Q: - and yet be bacteremic.

[10] A: I think I gave a short view of that before [11] the break, and the answer is that there are [12] chemicals or toxins that are produced by various [13] bacteria, Hemophilus being one, that can actually [14] repress or suppress bone marrow, release of cells. [15] It can actually kill white blood cells. They're [16] called leukocidin, and some bacteria have the [17] ability to produce them.

[18] Q: Also we talked about a shift to the left. [19] In looking at a normal white blood count, what does [20] seeing a shift to the left indicate as far as a [21] bacterial infection?

[22] A: It's consistent with a bacterial

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[1] infection. It's consistent with an acute viral [2] process, too, in the earliest stages.

[3] Q: And can you explain the mechanism in [4] common terms so that the jury can understand what is [5] happening when there is a shift to the left?

[6] A: When there is a shift to the left, the [7] bone marrow has released into the circulation and [8] the non-circulating pool of white blood cells has [9] been recruited into the circulation in an effort to [10] fight an infection, in effort to send white blood [11] cells, which are sort of the soldiers of the immune [12] response, to an area of infection.

[13] Q: Here at this institution when you order a [14] differential, do you usually have the ability to [15] determine whether there is a shift to the left?

[16] A: Yes. if we use the main lab. If we use - [17] what we used to use in our pediatric clinic did not [18] give anything but segs and bands - segs and lymphs [19] rather, which could tell us whether there is a shift [20] to the left, but it couldn't give us bands; but if [21] we use the main lab, we can get bands.

[22] Q: What does - how can you tell if there is

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[1] a shift to the left if you are not able to identify [2] the percentage of band cells?

[3] A: Well, again, a shift to the left can mean [4] and often does mean a predominance of [5] polymorphonuclear leukocytes, a predominance of [6] segmented neutrophils. *So,* to have more segmented [7] neutrophils than should be present by age would be a [8] shift to the left. To have some of them to be bands [9] would also be a shift to the left.

[10] Q: If the neutrophil count is elevated and [11] you don't know how many band cells there are, the [12] elevated neutrophil count can indicate a shift to [13] the left?

[14] A: Yes.

[15] Q: Now, we talked about what Dr. Pearson did [16] to rule out meningitis. We also talked about what [17] Dr. Litvak did to rule out meningitis. Did Dr. [18] Pearson indeed rule out meningitis?

[19] A: Again, I don't know how you're using the [20] term "rule out." He had a clinical diagnosis or [21] judgment made that the likelihood of meningitis was [22] not high enough to warrant a further evaluation at

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[1] that time.

[2] Q: Fair enough. We need to define the term [3] "rule out." When you use the word "rule out," [4] whether it's in medical literature or here at the [5] hospital, what generally does that term really mean?

[6] MR. LURY: I object to the form.

[7] THE WITNESS: In general, the term [8] means that the process to be ruled out is [9] consideration that is raised based on the [10] presentation of the patient. That's about all it [11] means. It doesn't necessarily mean one needs to do [12] a laboratory study to further eliminate the thought [13] of that.

[14] It just means that the original [15] presentation calls that diagnosis to mind, and one [16] is going to proceed according to clinical practice [17] along a path that will allow you to say this process [18] needs further evaluation or we can say no, we don't [19] need further evaluation of this process.

[20] BY MR. RATZAN:

[21] Q: Is there a difference between reaching a [22] level of suspicion, if you would, that would maybe

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[1] warrant you or not to go to a next diagnostic level [2] and ruling out a disease?

[3] MR. LEINICKE: Objection to form, [4] vague and ambiguous.

[5] MR. KING: Objection.

[6] THE WITNESS: I don't think I [7] understand the distinction you're trying to make.

[8] BY MR. RATZAN:

[9] Q: Fair enough. You did the right thing. Is [10] there a difference between ruling out a disease and [11] not having the necessary level of suspicion to do [12] additional tests to rule out a disease?

[13] MR. LEINICKE: Objection to form, [14] vague and ambiguous.

[15] THE WITNESS: If I understand your [16] question, I think we're really sort of wrapped up in [17] a semantic argument or discussion about what the [18] word rule out would mean or require a physician to [19] do. I myself use the word rule out very frequently [20] even at the very first writing up of a patient and, [21] for instance, if I were to see a child where I [22] think, I don't know, strep throat might be present

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[1] based on my initial history or my initial physical [2] exam, it wouldn't require me, for instance, to do a [3] rapid strep test or a throat culture. There would [4] be other features that would play into that, but it [5] would require me to continue to keep that in a list [6] of things that possibly will be raised again pending [7] the evolution of the patient's clinical [8] presentation.

[9] BY MR. RATZAN:

[10] Q: Well, so that we don't get too wrapped up [11] in semantics, what is the best single test to rule [12] in bacterial meningitis?

[13] MR. KING: I object to the form of [14] the question.

[15] THE WITNESS: The best laboratory [16] test to rule in bacterial meningitis would be a [17] lumbar puncture.

[18] BY MR. RATZAN:

[19] Q: If Dr. Litvak did consider or suspect [20] bacterial meningitis before Russell Wagner left his [21] office on December 1st, 1989, what tests should he [22] have performed to rule out bacterial meningitis?

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[1] MR. LEINICKE: Objection to the [2] form of the question. It's a multiple question. [3] You've got to assume there's a difference between [4] consider and suspect. Certainly a physician can [5]

consider something without suspecting that it is [6] indeed present, but I object to the form of the 171 question as being multiple and vague.

[8] THE WITNESS: I think the answer [9] to your question is that the physical examination [10] and history is what determines in a physician's mind [11] whether the level of suspicion about any diagnosis 1121 including meningitis raises to a or rises to a level [13] that requires another level of diagnostic testing, [14] and so what tests did he do or what did he do, it [15] was his history and his physical exam, his [16] observation of the child.

[17] BY MR. RATZAN:

[18] Q: I didn't ask what he did do. What I'm [19] trying to find out is if Dr. Litvak suspected 1201 bacterial meningitis on December lst, 1989, what [21] single laboratory test should he have done to rule 1221 out bacterial meningitis?

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[1] MR. LURY: I object to the form.

121 MR. LEINICKE: Objection to form.

[3] THE WITNESS: Again, I will use [4] your word suspected meningitis being that his [5] examination rose to a level or his concern after his [6] examination rose to a level that he really felt the [7] need to be much more certain about the possibility [8] of meningitis, if that were the case then he needed [9] to have done a lumbar puncture.

[10] BY MR. RATZAN:

[1 11 Q: And if the lumbar puncture were - tell us [12] what a lumbar puncture is.

[13] A: Lumbar puncture is an examination of the [14] or is a test whereby one obtains spinal fluid from [15] the sac around the spinal cord of a child and sends [16] it to the laboratory to test it for the presence of [17] pus cells, the presence of sugar, protein and the [18] bacteria.

[19] Q: If the results of the lumbar puncture were 1201 indicative of bacterial meningitis, what would have 1211 happened next?

[22] MR. LEINICKE: Objection to form.

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[1] THE WITNESS: The child would have [2] been admitted to the hospital, and he would have [3] been treated with antibiotic therapy.

[4] BY MR. RATZAN:

[5] Q: If Dr. Litvak had diagnosed Russell Wagner [6] with bacteremia on December lst, 1989, what would he [7] have been required to do to treat that disease?

[8] A: If he had diagnosed him with bacteremia, [9] there would be no way to diagnose somebody with [10] bacteremia without a positive blood culture. So, I [11] don't think he could have made a definitive or a [12] firm proven diagnosis of bacteremia at the time of [13] that visit

[14] Q: Fair enough. He did diagnose him with [15] viremia. Had he written bacteremia as his [16] presumptive diagnosis on December lst, 1989, what [17] would he have been required to do for Russell [18] Wagner?

[19] MR. LEINICKE: Objection to form.

1201 THE WITNESS: The typical standard [21] in 1989 would be to obtain a blood culture and to [22] start the child on an antibiotic regimen. It could

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[1] be done as an outpatient. It could be done as an [2] inpatient. If the child didn't appear very sick, [3] most physicians would have used oral Amoxicillin.

[4] BY MR. RATZAN:

[5] Q: How would you characterize - strike [6] that. Would you characterize the care that Russell [7] received at 10:00 a.m. in that office visit by Dr. [8] Litvak, would you characterize that care as [9] excellent?

1101 A: I don't know how you mean by excellent. I [11] think the care that he received was within the [12] standard of care based on how I read the record. He [13] had a competent examination, which included the [14] important things for a physician to note. He had a [15] blood count done, which was required I believe based [16] on his absence of physical finding to find where his [17] illness was. [18] He had a history, one that included a [19] salient epidemiologic variable mainly with his [20] sister, and he had very good follow-up instructions [21] to have a phone call back. So, I don't know, I [22] don't grade outpatient visits A, B or C, but he had

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[1] a very standard visit that was within the standard.

[2] Q: Okay. As you would use the word [3] "excellent," would you characterize Dr. Litvak's [4] care as excellent?

[5] MR. LURY: I object to the form.

[6] MR. LEINICKE: Objection to form.

[7] THE WITNESS: I don't know how I, [8] without having been in the room watching the [9] interaction, how I could even proceed to go beyond [10] what I feel my role is here, namely to say this was [11] Standard, appropriate, within the standard or not. [12] So, I couldn't answer your question more precisely [13] than that.

14] BY MR. RATZAN:

15] Q: And on the issue of the viremia and the [16] sister's - the epidemiologic inquiry that he made [17] regarding the sister's virus. You mentioned that it [18] went away by itself, meaning the sister's problem?

[19] A: Right.

[20] Q: What did you mean by that?

[21] A: Meaning that from what I can gather from [22] the parents' deposition, the mother and father's

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[1] depositions, there was no need for the sibling to [2] receive antibiotic therapy to be treated to get [3] better from that illness.

[4] Q: It's your understanding she didn't receive [5] antibiotic therapy and she got better by herself?

[6] A: Yes.

[7] Q: At the 3:20 p.m. phone call to Dr. Litvak

191 A: Right.

[10] Q: - again, would you agree that there is a [11] difference in perception or accounts of what [12] happened between the mom's account and Dr. Litvak's [13] account?

[14] MR. LEINICKE: Objection to form.

[15] THE WITNESS: Let me just read my [16] notes as to what the mom's account was and Dr. [17] Litvak's account, and I'll answer your question.

[18] BY MR. RATZAN:

[19] Q: And you don't have to describe all -

[20] A: No, I won't. No, I won't.

[21] Q: Just answer it yes or no.

[22] A: Yes, I would say there is a discrepancy

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[1] between the mother's deposition testimony about how [2] the baby looked at that period and Dr. Litvak's [3] recollection of what the phone call contained.

[4] Q: If you assume that the mother's account, [5] that Russell was not drinking, that he hadn't gone [6] to the bathroom, that he hadn't changed much, that [7] he was still lethargic, listless or quiet, [8] starry-eyed, gazing about and had thrown up his [9] Tylenol and that the mother asked Dr. Litvak about [10] antibiotics at that point in time, should Dr. Litvak [11] at that point in time have suspected bacterial [12] meningitis?

13] A: Yes.

14] MR. LEINICKE: Objection to the [15] form of the question.

16] THE WITNESS: If those features [17] are present in a baby and, in fact, this goes [18] exactly to what we discussed a couple of hours ago [19] about Dr. Pearson's interaction with the mother, if [20] the mother now is coming forth with the answers to 1211 those sorts of questions

that say the child has no 1221 eye-to-eye contact, is starry-eyed, is extremely

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[1] lethargic, isn't drinking, isn't moving about at [2] all, absolutely any physician I think needs to [3] consider not only meningitis but a large group of [4] very serious or potentially serious and [5] life-threatening processes.

[6] BY MR. RATZAN:

[7] **Q:** If they're life-threatening processes, [8] these various diseases that the doctor needs to [9] consider, I assume it's an emergent situation?

[10] A: Given the description of a child like Mrs. [11] Litvak's - I'm ***sorry,*** Mrs. Wagner's description of [12] the 3:00 o'clock view that she thinks she remembers [13] talking to Dr. Litvak about, yes, it would be 1141 something that would have to be acted on in the [15] short term.

[16] ***Q:*** And what should be done?

[17] A: The child needs to be re-evaluated either [18] in the office or in the emergency room. I need to [19] take a break, I'm very *sorry.*

[20] THE VIDEOGRAPHER: Okay, we're now [21] off the record. The time is 5:29.

[22] (Thereupon, a discussion was held off the record.)

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[1] THE VIDEOGRAPHER: This is now [2] tape two, and the deposition is beginning at 5:36.

[3] BY MR. RATZAN:

[4] Q: Now again, Doctor, taking or assuming the [5] mother's account to be true and given that [6] requirement of Dr. Litvak, had he not responded the [7] way you just described, would that have been a [8] deviation from the standard of care?

[9] MR. LEINICKE: Objection to form.

[10] THE WITNESS: Had he not [11] responded, you mean Dr. Litvak had not sent this [12] child to the emergency room?

[13] BY MR. RATZAN:

[14] Q: Yes, sir.

[15] A: Yes, if that was the information [16] communicated to him and he didn't either send the [17] child to the ER or have the child come back to the [18] office for another evaluation, it would not be [19] within the standard.

[20] **Q:** And what would his differential diagnosis [21] have been at that point in time?

1221 A: I think his differential diagnosis at that

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111 point in time would have been extremely long and [2] very broad and included infectious disorders and [3] metabolic disorders and traumatic disorders, many, [4] many things.

[5] ***Q:*** Would the differential diagnosis include [6] bacterial meningitis?

[7] A: Yes, it would.

P| ***Q:*** Would it include bacteremia?

[9] **A:** Yes.

[10] **Q: Whendoesbacteremiarequire**[11] hospitalization?

[12] A: When it **is** associated with a [13] septic-appearing child.

[14] **Q:** And what is a septic-appearing child?

[15] A: It's a child who looks very sick, who [16] looks toxic, has poor eye-to-eye contact, is [17] listless, nonresponsive, non-interactive, a baby who [18] looked different than Dr. Litvak's description of [19] this child at 10:00 o'clock.

[20] ***Q:*** Let'stalk aboutthatfora second. If [21] you replace the words "alert" and "active" with the [22] words "lethargic" and "listless." what did the

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[1] standard of care require of Dr. Litvak?

[2] MR. LURY: I object to the form.

[3] MR. LEINICKE: Same objection.

[4] THE WITNESS: If Dr. Litvak's [5] description of the child had been lethargic and [6] listless?

[7] BY MR. RATZAN:

[8] ***Q:*** Yes, Doctor.

[9] A: What about the next statement, responding [10] appropriately, would that be the same or would that [11] change?

[12] **Q:** Everything is the same. ***All*** I'm changing [13] is "lethargic" and "listless" in place of "alert" [14] and "active."

[15] MR. LURY: I object to the form.

[16] THE WITNESS: That would in [17] general put a lot of burden on Dr. Litvak to do a [18] more thorough and in-depth evaluation of why the [19] child would be lethargic and listless, and I say [20] that with the idea in mind that some children are [21] initially lethargic and listless with viral [22] diseases, with fevers, with a whole bunch of things,

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[1] but over a period of an hour in an office can wake [2] up and be very interactive and no longer be [3] lethargic and listless. So, assuming the degree of [4] those two conditions was significant and persistent, [5] there would be a responsibility on Dr. Litvak's part [6] to go ahead and evaluate that.

[7] BY MR. RATZAN:

[8] ***Q:*** In addition to the things that he did in [9] fact do, would, in the face of lethargic and [10] listless as an observation of Dr. Litvak's, would he [11] need to get a lumbar puncture done?

[12] MR. LEINICKE: Objection to form.

[13] THE WITNESS: If assuming the rest [14] of the physical exam did not disclose the reason for [15] the lethargy and the listlessness, and again with [16] the caveat that we're talking about significant [17] degrees of lethargy and listlessness as annotated by [18] a, you know, a physician who knows what those words [19] mean, then yes, I think that would ordinarily be [20] part of the evaluation, lumbar puncture.

[21] BY MR. RATZAN:

[22] **Q:** That's what the standard of care would

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[1] require; is it not?

[2] MR. LEINICKE: Objection to form.

[3] THE WITNESS: Yes.

[4] BY MR. RATZAN:

[5] ***Q:*** Did you notice that Dr. Litvak charted his [6] phone call with the mom at 3:20 p.m.?

[7] A: That's what I have written on my - yes.

[8] ***Q:*** It's right there in the bottom right-hand [9] corner of the page?

[10] A: Yes.

[11] **Q:** Was that appropriate for him to chart the [12] phone call that he had with the mother at 3:20 [13] p.m.?

[14] A: Yes, it was reasonable to do that.

[15] ***Q:*** He knew he was going to be off call later [16] on that day?

[17] A: I don't know the answer to that question. [18] I imagine he did.

[19] **Q:** Well, we know Dr. Betancourt came on call [20] to handle any calls from Russell Wagner's mother?

1211 A: Yes.

1221 MR. LURY: Is that a auestion?

Page 11*0*

[1] BY MR. RATZAN:

[2] **Q:** Are you aware of that?

[3] A: Yes, I am.

[4] **Q:** And Dr. Betancourt received a phone call [5] sometime between 5:00 and 6:00 p.m.; are you aware [6] of that?

[7] MR. LURY: I object to the form.

[8] THE WITNESS: My understanding is [9] about 6:00 p.m., yes.

[10] BY MR. RATZAN:

[11] **Q:** And again, there is another difference - [12] and I'm using the word perception or account, and if [13] you don't like those words, let me know. I mean, [14] there is a difference in someone's perception as to [15] what happened, and that someone is the mom and

Dr. Betancourt in this case at 6:00 p.m.?

MR. LURY: Is that another question or is that a statement?

BY MR. RATZAN:

Q: Do you agree with that?

A: Can you repeat it again?

Q: Sure. The phone call at 6:00 p.m., again

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we have a difference in perception or at least a different account of what was going on with Russell and what was reported between Dr. Betancourt and the mother?

A: Well, actually, I'm not sure -

MR. LURY: I object to the form.

THE WITNESS: I don't think the record really is supportive of that statement. I think the mother's deposition doesn't really add very much more to Dr. Betancourt's own recollection of that interaction.

BY MR. RATZAN:

Q: Are you aware of the difference in perception as to Dr. Betancourt's statement that he had been fully apprised of Russell's condition by Dr. Litvak or something to that effect and the mother's statement that Dr. Litvak was not aware or hadn't been fully informed about Russell?

A: Yes, I recall -

MR. LEINICKE: Excuse me, I think that might have been a misstatement by you, sir. I think you said Dr. Litvak had not been aware. I

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think you meant to say Dr. Betancourt.

BY MR. RATZAN:

Q: You're right, I'll clear up the question. Dr. Betancourt said he had spoken to Dr. Litvak?

A: Yes, Dr. Litvak said he had spoken to Dr. Betancourt.

Q: And the mother's recollection is that Dr. Betancourt was not aware of Russell's condition whether it be from Dr. Litvak or anybody?

A: That is true, as far as I recollect.

Q: Had Dr. Betancourt been aware of all the history starting with Dr. Pearson's phone call at 8:00 p.m. the night before and up until the point of 3:20 p.m., the last phone call to Dr. Litvak, and given these additional signs and symptoms of cramping and pulling the right leg up, should Dr. Betancourt have suspected bacterial meningitis?

MR. LURY: I object to the form.

THE WITNESS: No, I don't think that the presentation of abdominal pain and abdominal cramping **is** something that typically calls to mind bacterial meningitis, and that wouldn't be

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- it wouldn't follow that one would jump to that diagnosis based on knowing the prior history and knowing **this** new complaint.

BY MR. RATZAN:

Q: Knowing the prior history - what about pulling the right leg up, what significance does that have to you?

A: Again, it well often is a sign of abdominal discomfort.

Q: What else can it be **a sign** of?

MR. LURY: Object to the form.

THE WITNESS: It would be a very unusual presentation for a seizure, but I imagine it could possibly be a focal seizure.

BY MR. RATZAN:

Q: Given the history of this baby that we've talked about at length and the possibility that pulling the right leg **up** could indicate a focal seizure, with that in mind, should Dr. Betancourt have suspected bacterial meningitis?

MR. LURY: I object to the form.

THE WITNESS: Again, to answer

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your question, no, I don't think so because I don't believe it would be a requirement on Dr. Litvak's part to go over with Dr. Betancourt the entire story of the shivering, was it convulsions, the physical exam and **so** on. I think what the requirement would be for Dr. Litvak to tell Dr. Betancourt, we saw this child. The child had a fever. We did an exam. The child looked okay. There was no focus. The white count was normal. I think it's a viral syndrome.

The rest of the history is I think not needed in a communication between physicians who are signing off on to the other. So, I don't think there would be any requirement for Dr. Betancourt to know anything about the shivering to put into perspective this next feature.

BY MR. RATZAN:

Q: Let's assume for - strike that. Assume for a moment that Dr. Pearson had taken notes the night before and recorded his history and Dr. Betancourt had the opportunity to see those notes, as well as discuss the *case* with Dr. Litvak, under

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those circumstances. should Dr. Betancourt have suspected bacterial meningitis?

MR. LURY: I object to the form.

THE WITNESS: Again, I think what you're really trying to get to is to leave open this question of shivering being convulsions, and I think a physician who would make a note about a patient from an evening conversation, should that be done wouldn't leave that open-ended.

He would say the child was having chills, not there was motor activity and the mother thought it might be convulsions and we **still** have an open-ended question, but rather that this child was having chills and then was seen because of fever; and again, that being the case, the activity of the leg raising and the abdominal discomfort would not raise the **issue** of that being a seizure.

BY MR. RATZAN:

Q: Well, let me ask the question a different way. Putting aside for a second whether Dr. Litvak had an obligation to tell about the entire history to Dr. Betancourt, assuming Dr. Betancourt did have

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the benefit of all that information and the information regarding pulling the right leg up, under those circumstances, did Dr. Betancourt - strike that - should Dr. Betancourt have considered or suspected bacterial meningitis as one of the possibilities?

MR. LURY: I object to the form.

MR. LEINICKE: I object to the form of the question.

THE WITNESS: You're going to have to read back the fist part of the question. It was kind of a convoluted question.

BY MR. RATZAN:

Q: I'm going to rephrase it, Doctor.

A: All right.

Q: Had Dr. Betancourt had the benefit of all of the history, putting aside whether Dr. Litvak had an obligation to tell him, had Dr. Betancourt had the benefit of all of that information and received this phone call regarding pulling of the right leg, should Dr. Betancourt have suspected bacterial meningitis?

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MR. LURY: I object to the form.

MR. LEINICKE: Objection to form.

THE WITNESS: No, the answer to the question would be there would **still** be no way to go from this abdominal leg complaint to bacterial meningitis even with the history that Dr. Betancourt could have had had every single

element of the [5] history been recorded and given to him on a piece of [9] paper.

[10] **BY MR. RATZAN:**

[11] **Q:** Is the fact that this is I think the fifth [12] contact that the mother has had with this pediatric [13] practice group over I guess a 15 to **20** hour period [14] significant?

[15] **MR. LEINICKE:** Objection to form.

[16] **MR. LURY:** Join,

[17] **THE WITNESS:** It's significant in [18] the sense that it represents the mother is very [19] concerned about her baby.

[20] **BY MR. RATZAN:**

[21] **Q:** If you add to that the fact that this [22] mother has never been known by this pediatric

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[1] practice group to call this many times and report [2] symptoms like this for Russell or any of her [3] children, is that also significant?

[4] **MR. LURY:** I object to the form.

[5] **MR. LEINICKE:** Objection to form.

[6] **THE WITNESS:** Again, it's as [7] significant as if a mother had called frequently. I [8] think a physician always listens to what mothers [9] have to say and does their best to get through the [10] history to see whether the anxiety is something that [11] is really focused on an observation that needs to be [12] acted on or not.

[13] **BY MR. RATZAN:**

[14] **Q:** Is it something that would raise or lower [15] a physician's suspicion?

[16] **MR. LURY:** I object to the form. [17] Is what something?

[18] **BY MR. RATZAN:**

[19] **Q:** Do you understand what I'm asking?

[20] **A:** I don't know what "it" is.

[21] **Q:** The number of phone calls the mother has [22] made and the history regarding this mother.

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[1] **MR. LURY:** I object to the form.

[2] **MR. LEINICKE:** Same objection.

[3] **THE WITNESS:** I think absent a [4] physical examination during the course of the day [5] had this just been repetitive phone calls, that [6] would raise the need for the patient to be seen [7] because it would raise a physician's concern that [8] this unknown patient still has a problem that's very [9] worrisome to the parent.

[10] In the face of an examination that had [11] been done eight hours earlier, seven hours earlier, [12] and in the face of a planned follow-up phone call, a [13] planned one, this was executed based on the [14] follow-up plan that Dr. Litvak put into operation, [15] then the next phone call I don't think rises to the [16] level of concern that, for instance, a mother who [17] had called **six** times during a day about a problem [18] that no one had seen and no one had followed up on. [19] I hope that answers your question.

[20] **BY MR. RATZAN:**

[21] **Q:** Is it your understanding that the mother's [22] plan according to Dr. Litvak was to call again

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[1] around 6:00 o'clock to Dr. Betancourt?

[2] **A:** No, I was talking about –

[3] **MR. LEINICKE:** Objection to form, [4] mischaracterization of testimony.

[5] **THE WITNESS:** No, my reference was [6] to the 3:00 o'clock phone call that Dr. Litvak had [7] planned to have with the mother to get more feedback [8] about how Russell was doing in the afternoon hours.

[9] **BY MR. RATZAN:**

[10] **Q:** Okay. Should Dr. Betancourt have [11] considered bacteremia at 6:00 p.m.?

[12] **MR. LURY:** I object to the form.

[13] **THE WITNESS:** Again, based on the [14] deposition that's written or that's taken from the [15] mother and the father, I don't think bacteremia [16] would have been a likely diagnosis for Dr. [17] Betancourt to consider because the baby's [18] temperature was markedly lower than the 105 fever [19] that was the presentation fever and because as the [20] mother states in her deposition, she basically went [21] right to the issue of the raising of the leg and the [22] abdominal discomfort, and actually Mr. Wagner

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[1] corroborates that by saying he recollects the phone [2] conversation between Dr. Betancourt and his wife, [3] and in that conversation what was discussed was the [4] abdominal complaints and the leg moving but not the [5] baby's color, not the baby's irritability, not the [6] baby's cry. It was basically for the abdominal [7] complaint and the leg. So, that wouldn't raise an [8] issue of bacteremia to me.

[9] **BY MR. RATZAN:**

[10] **Q:** Did Dr. Betancourt ask any of those [11] questions to elicit any of that information?

[12] **MR. LURY:** I object to the form.

[13] **THE WITNESS:** His recollection of [14] the deposition – his recollection in his deposition [15] of that conversation is he only remembers talking [16] about the abdominal complaints and doesn't have any [17] more recollection, so I don't know.

[18] **BY MR. RATZAN:**

[19] **Q:** Should he have asked questions to elicit [20] information like that regarding the color, lethargy, [21] fever, vomiting, listlessness, starry-eyed look, [22] laying around, any of those kinds of observations?

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[1] **MR. LURY:** I object to the form.

[2] **THE WITNESS:** No, I don't think he [3] has at that point another independent duty to go [4] back overall the history. He basically I think can [5] rely on a parent to say here's where we are with [6] this baby, been seen by Dr. Litvak, phone call at [7] 3:00 in the afternoon, viral **syn**drome, and now the [8] baby has what I think to be abdominal discomfort, [9] he's raising the legs up and crying with that.

[10] **BY MR. RATZAN:**

[11] **Q:** Do you agree with Dr. Betancourt's [12] diagnosis of the flu?

[13] **MR. LURY:** I object to the form.

[14] **THE WITNESS:** I don't remember [15] where he made that diagnosis or if he made the [16] diagnosis in his deposition, but I think what I [17] would think had I been called by a mother like this [18] that this could be the persistent ongoing evolution [19] of an intestinal viral process.

[20] **BY MR. RATZAN:**

[21] **Q:** Looking back on it now knowing what you [22] know now, do you agree, assuming he made the

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[1] diagnosis of the flu and prescribed Donnatal Elixir [2] for abdominal cramping as part of that flu –

[3] **A:** Right.

[4] **Q:** – do you agree with that diagnosis and [5] form of treatment?

[6] **MR. LURY:** I object to the form.

[7] **MR. LEINICKE:** I object to the [8] form.

[9] **THE WITNESS:** Oh, in retrospect –

[10] **BY MR. RATZAN:**

[11] **Q:** Yes, **sir.**

[12] **A:** – this baby had certainly more than [13] abdominal complaints. This baby did have I'm sure [14] esophagitis and duodenitis, GI bleeding, probably [15] had an ulcer based on the autopsy and based on the [16] presence of blood later on in the baby's stool and [17] blood in the gastric acid, coffee-ground vomitus. [18] Chis baby was having the beginning of GI bleeding [19] and probably was having abdominal pain.

[20] So, I think Dr. Betancourt and I think he [21] mother, if this was her observation to Dr. [22] Betancourt, I think hey were both right. There **was**

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[1] an abdominal process going on at that juncture that [2] she was picking up correctly on, but I'm also sure [3] that the baby had more than that at that juncture. [4] The baby had meningitis and sepsis at that point.

[5] BY MR. RATZAN:

[6] *Q:* How do you account for Dr. Betancourt's [7] missing the diagnosis of meningitis and sepsis?

[8] MR. LURY: I object to the form.

[9] MR. LEINICKE: Objection to form.

[10] THE WITNESS: I think unless a [11] physician is given the appropriate history and [12] enough history, he can't come to a diagnosis of [13] meningitis or sepsis.

[14] BY MR. RATZAN:

[15] **Q:** Do you fault the mother for not giving Dr. [16] Betancourt enough history or information at that [17] point in time?

[18] A: No, I don't fault either party.

[19] *Q:* How do you account for it in this case?

[20] MR. LURY: I object to the form.

1211 THE WITNESS: In this case, I [22] account for it based on the mother's deposition and

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[1] the father's deposition that they both were focused [2] now on this child's abdominal complaints and wanted [3] to discuss specifically that with the doctor who was [4] on call, and again, according to the father, the [5] mother didn't offer as a complaint anything else to [6] Dr. Betancourt, and when that's the case, a [7] physician who already begins with the idea that this [8] is a viral syndrome seen by his partner, the white [9] count is normal, the exam is normal, a phone call [10] was satisfying enough to his partner to say we're [11] not going to do anymore, the next step is abdominal 1121 pain, hey, the baby is going to have diarrhea in [13] three hours. I don't think you need to go beyond [14] that as a practicing pediatrician.

[15] BY MR. RATZAN:

[16] **Q:** Do you fault the mother at all for not [17] telling Dr. Betancourt about the entire history of [18] the night before and her visit to the doctor and her [19] impressions of what happened and how each doctor [20] responded to her?

1211 A: No.

[22] *Q:* Meningitis, we talked about non-specific

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[1] symptoms. So, meningitis often presents like many [2] other illnesses?

[3] A: Correct.

[4] **Q:** What do you see as the first line approach [5] with respect to meningitis?

[6] MR. LURY: I object to the form.

[7] MR. LEINICKE: Same objection, [8] vague and ambiguous.

[9] THE WITNESS: The first line [10] approach meaning the antibiotic therapy that we 1111 would offer?

[12] BY MR. RATZAN:

[13] **Q:** Do you understand what I mean when I use [14] the word "first line approach?"

[15] A: That's why I tried to clarify your [16] question. No, I don't.

[17] **Q:** Have you ever heard of that type of [18] phraseology before?

[19] **A:** Probably, but I don't know how it applies [20] to this case and what you mean by this case, first [21] line approach.

1221 **Q:** When you're confronted with this

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[1] presentation, non-specific signs is the term you 121 used earlier –

[3] **A:** Right.

[4] **Q:** – what is the first line approach with [5] respect to reaching or excluding a diagnosis of [6] meningitis in the face of those non-specific signs?

[7] MR. LURY: I object to the form.

[8] THE WITNESS: The first line [9] approach is to do an examination of the patient [10] after you've taken the adequate history and make a [11] judgment whether the patient looks sick or not. The [12] trouble with meningitis, traditionally looks sick. [13] As we talked before, there are occasionally children [14] with meningitis who don't look sick enough yet to [15] warrant the lumbar puncture, but they have [16] meningitis and we can't know it. So, the first line [17] approach is an examination of the patient if the [18] presentation speaks loudly enough about the [19] possibility of meningitis to warrant the [20] examination.

[21] BY MR. RATZAN:

1221 **Q:** Well, what do you teach residents nr

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[1] interns or fellows here at Georgetown regarding the [2] appropriate circumstances for a lumbar puncture?

[3] A: The appropriate circumstances for a lumbar [4] puncture are many. One such circumstance is a baby [5] who looks sick or toxic or septic. Those babies [6] need lumbar punctures. A second approach would be [7] babies who have physical findings on examination [8] that speak to nuchal irritation, to meningeal [9] irritation, stiff neck, positive Kernig's sign, [10] positive Babinski's sign, focal neurologic signs.

[11] A third indication would be in the newborn [12] period basically fever at any time, and there are [13] many others. I don't know that I could sit here and [14] list for you each and every indication for a lumbar [15] puncture, but the basic one is a sick-looking child [16] in the eyes of the physician who spends time [17] evaluating that child for toxicity.

[18] **Q:** Have you ever ordered or performed a [19] lumbar puncture on an infant or child Russell [20] Wagner's age, plus or minus a few months, who was 1211 not lethargic or listless?

[22] MR. LEINICKE: Objection to form.

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[1] THE WITNESS: Who was not [2] lethargic or listless, yes, I think the opposite of [3] lethargy and listlessness would be irritability, and [4] a baby who was irritable but not lethargic or [5] listless would be an indication for, in some [6] instances, for a lumbar puncture.

[7] BY MR. RATZAN:

[8] *Q:* Have you ever performed a lumbar puncture [9] on a child, same general age, whose symptoms were a [10] fever of 105 degrees and irritable but who did not [11] have nuchal rigidity, upon whom the white blood [12] count was either normal or hadn't even been ordered [13] and was pale?

[14] MR. LURY: Object to the form.

[15] MR. LEINICKE: Objection to form.

[16] MR. KING: I object to the form, [17] incomplete hypothetical.

[18] THE WITNESS: I think it would [19] depend on the level of irritability. The answer to [20] your question would be sure, I'm sure there are 1211 patients that I have seen who are pale and are [22] irritable and have a temperature of 105 in whom the

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[1] rest of the examination shows enough global change [2] in their level of interactivity that I would do a [3] lumbar puncture.

[4] BY MR. RATZAN:

[5] **Q:** Do you have the opportunity to view their [6] level of activity over a certain amount of time when [7] you do that?

[8] *A* Usually, yes.

[9] **Q:** And again, that goes back to the [10] importance of either a physical exam or on-site [11] evaluation by the doctor of the patient?

12] MR. KING: I object to the form, [13] incomplete hypothetical.

14] THE WITNESS: Well, if you could [15] co-join it with the original need to see :he patient [16] in the first place, yes.

BY MR. RATZAN:

Q: How many lumbar punctures do you think you perform a year or order a year?

A: Or order, I'm glad you said or ordered.

Q: Perform or order.

A: I don't perform any anymore. I'm probably

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involved with, I don't know, more than 50, more than 100 children a year who get lumbar punctures.

Q: Over the last how many years?

A: 20 years.

Q: And of the lumbar punctures ordered, based on your training and experience, of the lumbar punctures ordered in accordance with the standard of care, what do you estimate the ratio is between the lumbar puncture that reveals or indicates meningitis and those that are negative for such disease?

MR. LURY: I object to the form.

MR. LEINICKE: Objection to form.

THE WITNESS: I mean, there is some guessing to this because I've never done a study of that, but I would probably say it's on the order of 10 or 15 percent that are positive for meningitis. The majority are negative for meningitis.

BY MR. RATZAN:

Q: So, it would be about 10 to 1?

A: 7 to 1, 8 to 1, 9 to 1, yes.

Q: What do you attribute that ratio to?

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A: I attribute that ratio to the fact that the majority of children who look sick or toxic do not have meningitis. They have viral diseases. They have gastroenteritis. They have viremia, which is enough to make them look sick enough that we don't know whether it's bacterial or viral.

Q: So, why do the lumbar puncture?

A: We do the lumbar puncture because when you get to a certain level of illness, the risk for meningitis has risen to a high enough level that the yield is reasonable and the importance of making an early diagnosis is well-known.

Q: Well, I guess what I'm asking you is if there is - do you think it's appropriate that there's such a high ratio?

A: Yes.

Q: Why do you think so?

A: I think because there's no way to know bacterial meningitis from a serious viral illness that can mimic bacterial meningitis, and when you get to a certain level of disease, the risk for bacteremia and meningitis goes up to 10 or 15

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percent, and that's a high enough risk to act on.

Q: Is that because it's a life-threatening illness?

A: To some degree, yes.

Q: If you don't do the lumbar puncture and you leave it to chance, the baby could die?

MR. LURY: I object to the form.

MR. LEINICKE: Objection to form.

THE WITNESS: If you would take out "leave it to chance," I would answer your question affirmatively. I think this issue of leaving it to chance, the jury needs to know that physicians when they practice medicine always leave something to chance. There is no 100 percent certain way of ruling out meningitis.

BY MR. RATZAN:

Q: I understand, but to do the lumbar puncture, the risk of doing the lumbar puncture versus the benefit of doing a lumbar puncture in the face of bacterial meningitis, a life-threatening disease, makes it appropriate to have a ratio of 9 negatives for every 1 positive?

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MR. LURY: I object to the form.

MR. LEINICKE: Same.

THE WITNESS: When the risk of meningitis being present is in that neighborhood, 10, 15 percent likelihood, then you're right, the risk factor ratio favors doing extra lumbar punctures to find that 15 percent that have meningitis.

BY MR. RATZAN:

Q: Do you have, as you sit here now, any reason to believe that any of the doctors, Dr. Litvak, Dr. Betancourt, Dr. Pearson deviated from the standard of care in this case in any way?

A: Again, taking each one by name, Dr. Betancourt I really don't see any concern for him deviating from the standard of care based on the mother's deposition, the father's deposition, his deposition and so on.

Dr. Litvak, assuming his record is the proper record and a real description of the child, he practiced well within the standard of care in his determination to do a blood count, to watch the

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child, to have a phone call back. No, I don't think he deviated from the standard of care.

Dr. Pearson, again, depending on a belief that he did involve the parents in a conversation or the mother in a conversation about the things he says he did and determined in his mind that the level of irritability was not so high that meningitis or sepsis or some other life-threatening illness was pressing enough to be acted upon right then, again, I think he was within the standard of care. Now, you give me a different hypothetical, and I'll give you a different answer as we've already gone through.

Q: I understand, I meant as you sat here now given what you understand to be the facts of the case.

A: Yes.

Q: Going back to the white blood count for one moment, the neutrophils, we talked about a shift to the left, and neutrophils, without knowing more like about band cells or other types of polymorphonuclear leukocytes, when neutrophils are

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elevated that could suggest a shift to the left?

A: Yes.

Q: Looking back on it now with the retrospective scope, do you have reason to believe that the neutrophils in this case actually were elevated?

MR. LEINICKE: I object to the form.

MR. LURY: I object to the form.

THE WITNESS: Well, the neutrophils were 65 percent. I would have to look at Oski's book to see what the, you know, the two standard deviations around the mean is for a child this age with respect to the percent polys. That could be a slight increase in the number of polys, but if it is, it's very trivial and not something that strikes you as a physician that this is a raging bacterial process. If anything, this is commensurate with a viral disease that has just begun.

BY MR. RATZAN:

Q: What I meant, and I want to make sure you

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understand the question, is looking back on it now, not at the time that Dr. Litvak looked at it, but looking back on it now and knowing what we know now and in your opinion that the baby had bacteremia at presentation, is it likely that the neutrophils at 65 percent was elevated?

A: Again -

MR. LEINICKE: I object to the form.

MR. LURY: I object to the form.

[11] THE WITNESS: Again, I think I [12] answered your question that way. My answer would be [13] I would first check Oski's Textbook of Pediatric [14] Hematology to make sure that the range of normal [15] does not extend to 60 percent or 65 percent in a [16] baby this age, because this may in fact be normal, [17] in which case one could not say this is a shift to [18] the left in response to a bacterial sepsis picture.

[19] BY MR. RATZAN:

[20] **Q:** How do you spell Oski?

[21] **A:** O-S-K-I. If it turns out these numbers [22] are elevated above the range of normal, two standard

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[1] deviations from the norm, from the mean, then I [2] would answer your question affirmatively. This in [3] retrospect was the bone marrow's response to a [4] bacterial infection.

[5] **Q:** And under those circumstances, if there [6] were a study of the band cells done, do you have [7] reason to believe that that would have indicated an [8] elevated count of band cells?

[9] MR. LURY: I object to the form.

[10] MR. LEINICKE: Objection to form.

[11] THE WITNESS: I don't think [12] there's anyway to make that judgment. It may [13] have. It may not have. There's no scientific way [14] to say yes or no on that. Just to go beyond this, I [15] think maybe we're not communicating on a level that [16] we want to be. The risk for bacteremia anyway has [17] nothing to do with the number of bands, at least as [18] physicians practice general pediatrics.

[19] The total white count **is** what determines [20] the risk for bacteremia. The band count, the shift [21] to the left, other things that might be done with a [22] white count is not commonly used in the algorithm

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[1] for determining who might be bacteremic and who [2] might not be.

[3] BY MR. RATZAN:

[4] **Q:** Is it ever used in the algorithm for [5] determining who might be suffering for bacterial [6] meningitis?

[7] A: No, the white count, no, no correlation [8] between the white count and directly with bacterial [9] meningitis. There is a correlation -

[10] *Q:* Have you ever heard of -

[11] MR. LURY: Let him finish his [12] answer.

[13] BY MR. RATZAN:

[14] **Q:** I agree, I apologize.

[15] A: There is a correlation obviously between a [16] high white count and bacteremia, and bacteremia does [17] lead to meningitis. So, indirectly there **is** that [18] correlation, but directly there **is** no correlation.

[19] *Q:* Is there any correlation to the percentage [20] of immature versus mature neutrophils in peripheral [21] white blood at all and bacterial meningitis?

[22] **A:** Well, there is what's known as the I/T

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[1] ratio, which is I think what you **just** described, the [2] ratio of immature to total white count - the total [3] poly count, rather, and that ratio has been most [4] commonly used in the newborn period to determine [5] which babies might be at risk for group B strep, [6] sepsis and disease.

[7] I'm not aware of there being an [8] application of the I/T ratio in children with [9] bacterial meningitis outside the newborn period, but [10] certainly in the newborn period there is. You know, [11] I got paged about ten minutes ago, and I've been [12] putting it off.

[13] MR. LURY: Before you go, Stuart, [14] how much more do you have?

[15] MR. RATZAN: A bunch,

[16] MR. LURY: Then we're definitely [17] not going to finish tonight because we've got three [18] attorneys that are going to catch a flight out.

[19] MR. RATZAN: Are we **still** on the [20] record?

[21] MR. LURY: Yes, we're still on the [22] record. I told you earlier that we would make

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[1] arrangements for you to complete this deposition by [2] telephone. You were unwilling to accept that. You [3] have been going I'm not sure, you know, with the [4] breaks, I apologize for the breaks. I think it's [5] unfair that you expect three attorneys -

[6] MR. KING: Why don't you let the [7] Doctor go while we're talking.

[8] MR. LURY: - okay, who need to [9] get back to Florida for depositions and hearings [10] scheduled for tomorrow morning to continue with this [11] deposition until all hours. You're telling me [12] you've got a bunch more which doesn't mean we're [13] going to get out of here at 7:00 or 8:00 or 9:00 [14] o'clock tonight, and we all have flights.

[15] We understand that you don't have a flight [16] tonight. Therefore, I'm making the offer that the [17] Doctor will make himself available by telephone to [18] complete the deposition, but for all intents and [19] purposes, this deposition is now over.

[20] MR. RATZAN: Well, if that's your [21] position, that's your position, but I can tell you [22] that this deposition has been interrupted numerous

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[1] times by the Doctor. It was scheduled to start at [2] 2:30. He wasn't here. It started at 5 to 3:00.

[3] He's been out for several, I don't know [4] how many pages. He spent a half an hour downstairs, [5] and for the early part of this deposition, there [6] were countless speaking objections which interrupted [7] me and interrupted the procedure here, and we're [8] going to move to strike this witness and to prevent [9] him from testifying at trial unless I can go forward [10] right now and complete this deposition. I'm here. [11] He's here. We're all ready to complete it, and [12] that's just the way it is.

[13] MR. LURY: Okay.

[14] MR. KING: Let me put this on the [15] record. I don't have a dog in the fight with [16] respect to the Doctor's availability or with respect [17] to the circumstances that called him away today from [18] time to time. However, the last flight out that we [19] can catch back to Fort Iauderdale is at 7:00 [20] o'clock. It's now 5 minutes after 6:00. I suppose [21] we could go for another 10, 15 minutes tops, but [22] then we're going to still have to leave

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[1] The point being that we're not going to [2] complete this deposition today anyway. I think in [3] all fairness it's going to have to be reset Again, [4] I don't have a dog in that fight, but it cannot go [5] forward today.

[6] MR. RATZAN: Well, let's go 10 [7] more minutes and you guys gotta go. I mean, I don't [8] have brains. I can't keep you from getting on an [9] airplane. I'm just telling you my position. Can we [10] go 10 more minutes and get 10 more minutes done?

[11] MR. LEINICKE: Why go 10 more [12] minutes if you're not going to get done? That's the [13] only question I have.

[14] MR. RATZAN: Because it's 10 more [15] minutes now, get 10 more minutes done now, and then [16] you can go.

[17] MR. LURY: No, because we're [18] talking Washington, we're talking traffic, and we're [19] still talking 20 or 25 minutes to the airport, plus [20] we all have to change tickets. I'm not going to [21] miss and these gentlemen aren't going to miss taking [22] their flights back to Florida. It would be one

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[1] thing if we could just jump on a plane, but we can't [2] do it.

[3] MR. RATZAN: I mean, that's our [4] position.

[5] MR. KING: We're going to have to [6] redo it anyway.

[7] MR. RATZAN: I don't know, I think [8] that we'll see what Judge Moe (phonetic) says about [9] it. I mean, I don't know if this witness is going [10] to be available to testify at trial after what [11] happened today.

[12] MR. KING: It's not your fault I [13] don't think that the depo necessarily can't be [14] completed, but I do think you could have maybe [15] gotten to the point a little quicker, but it's not [16] our fault either that the deposition couldn't be [17] completed, and the Doctor has been trying to deal [18] with certain emergencies that he has here. I don't [19] think it's anybody's fault, and it's just something [20] we all have to deal with. I don't think he should [21] be stricken because of that. Anyway -

[22] MR. RATZAN: I have nothing to

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[1] say. That's it. We're going to move to strike the [2] guy.

[3] THE WITNESS: One thing I want to [4] say is I think your clock is a lot different than my [5] clock. I'm **sorry,** I was here at ***25*** of, and I was [6] here waiting for you before that after **my** conference [7] with Mr. Lury. So, I don't think it was 5 to 3:00 [8] when we really started.

[9] MR. RATZAN: It was. She's got it [10] on her machine.

[11] THE WITNESS: I was here at 25 of, [12] and I'm not sure why we didn't get going.

[13] MR. LURY: I don't know why we [14] didn't get started.

[15] THE WITNESS: We were waiting for [16] one attorney on the phone and so on, but 1 was here [17] very close to the time we were supposed to start. I [18] definitely apologize for all the interruptions. I'm [19] very *sorry* for that.

[20] MR. RATZAN: I understand. I [21] mean, no one is going to be in the court blaming [22] you, at least not here.

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[2] (Thereupon, with the consent of the witness, reading [3] and signature waived.)

[5] Whereupon, the deposition was adjourned at [6] 6:12 p.m.)

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CERTIFICATE OF NOTARY **PUBLIC**

I, Justina M. Consoiazio, 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 in stenotype 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 lo the action in which this deposition **was** 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** the action.

Notary Public in and for the District of Columbia

My commission expires: August **31, 1997**

Lawyer's Notes

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Lawyer's Notes