TRANSCRIPT OF PROCEEDINGS

IN THE CIRCUIT COURT

OF JOHNSON COUNTY, MISSOURI

- -x

NEVIN CARLYLE, et al.,

Plaintiff,

: Case Number CV486-564CC

v.

HSIEN E. LAI, M.D., et al.,

Defendants.

:

- -x

DEPOSITION OF RAOUL WIENTZEN, JR., M.D.

Washington, D. C.

Wednesday, August 31, 1988

ACE-FEDERAL REPORTERS, INC.
Stenotype Reporters
444 North Capitol Street
Washington, D.C. 20001
(202)347-3700
Nationwide Coverage
800-336-6646

IN THE CIRCUIT COURT

OF JOHNSON COUNTY, MISSOURI

- - - - - - - - - - - - - - - - - -x

NEVIN CARLYLE, et al.,

Plaintiffs,

v. Case No. CV486-564CC

HSIEN E. LAI, M.D., et al.,

Defendants.

- - - - - - - - - - - - - - - - - -x

DEPOSITION OF RAOUL WIENTZEN, JR., M.D.

Washington, D. C.

Wednesday, August 31, 1988

Deposition of RAOUL WIENTZEN, JR., M.D., called for examination pursuant to notice, at the Physicians Health Care Center, 2nd Floor, 3800 Reservoir Road, at 9:00 a.m. before KAREN N. ILSEMANN, a Notary Public within and for the District of Columbia, when were present on behalf of the respective parties:

JAMES BARTIMUS, ESQ.
Lantz Welch, P.C. and
James Bartimus, P.C.
City Center Square
Twenty-Ninth Floor
Kansas City, Missouri 64105
On behalf of the Plaintiff.

HAL D. MELTZER, ESQ.
Turner and Boisseau
Holmes Corporate Centre I
1001 East 101st Terrace
Suite 200
Kansas City, Missouri 64131

CONTENTS

EXHIBITS

P R O C E E D I N G S

Whereupon,

RAOUL WIENTZEN, M. D.

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

EXAMINATION

BY MR. MELTZER:

Q Would you state your name for the record, please?

A Raoul L. Wientzen, Jr., M.D.

Q Where do you reside, sir?

A My home is in Arlington, Virginia. My business address is Georgetown Hospital, Department of Pediatrics.

Q And we're taking your deposition here in your office today.

A Correct.

Q All right.

Doctor, is it Win'son, is that how you pronounce it? Is that right?

A Yes.

Q Dr. Wientzen, how long have you been in pediatric infectious diseases?

A Dating back to my fellowship in 1975. This will

be my 13th year, 14th year.

Q During the course of your practice, you have performed certain services as a medical-legal consultant, testified in various cases, have you not?

A Yes, I have.

Q During the past 14, 15 years, I have some idea of your prior history to 1985, but since 1985, how many cases have you consulted on?

A For medical-legal purposes?

Q Medical-legal purposes; right.

A I'd give an estimate that I probably review six to 12 to maybe 15 cases a year.

Q And in that regard since 1985, have you been called upon by the lawyers in this case for the plaintiff, either Jim Bartimus or Lance Welch or any of the members of that law firm, to review medical records in medical malpractice cases on their behalf?

A Yes, I have.

Q On how many occasions?

A Since 1985?

Q Yes.

I've got your history prior to that.

A The timing and the dates become very murky for me.

Q Then let's just do it this way. Just start, tell me all the cases that you have reviewed for them, whether you have actually testified in those cases or not, but cases which you have reviewed for them.

A All right.

The first case I reviewed, I believe was -- I'd be guessing on the year -- probably 1983, a case of meningitis with hearing loss. I don't remember the name. And I believe I gave a deposition in that case, but there was no trial.

I recall another case that I reviewed for the Lance Welch firm, a child with very severe meningitis who I believe went on to develop severe permanent sequelae, which I reviewed and I felt there was no merit in that case and told that to the court -- I'm sorry, to Mr. Bartimus.

There was a case of obstructive ventricular peritoneal shunt that I reviewed maybe two years ago or three years ago now, a child with VP shunt that was obstructed.

Another child whose records I reviewed was a

child who developed von Recklinghausen's disease.

That's four.

There's this case, which is the case of peritonitis and shock, appendicitis.

There's a case by the name of Wasserman versus Hammonds that I recently reviewed, which is a case of intussusception, missed intussusception.

And as I sit here now, I believe they are all the cases that I've reviewed.

Q About six cases then?

A I believe that would be about right.

Q In fact, the first of those cases was sometime between 1983 and your deposition was taken in about 1985; does that refresh your recollection?

A Sounds about right; yeah.

Q In addition to those cases for the plaintiff's firm in this particular case, have you reviewed any cases involving surgical abdomen peritonitis, with or without dehydration or shock, for any other lawyers?

A I don't believe that I ever reviewed any case like that. There was this intussusception case with Mr. Bartimus that you could argue, yes, had peritonitis and was

in shock at the time the baby was brought in for terminal care, and the baby died within about an hour of that period.

Q Have you testified in that particular case by deposition or --

A No, sir.

Q Have you rendered any written reports in that case?

A No written reports.

Q In this case, Carlyle versus Lai, that you've been retained to review records and ultimately testify, have you written any reports or correspondence --

A I'm sorry. I was not paying attention. Could you start over with that question?

Q In this particular case, Carlyle versus Lai, that you've reviewed for plaintiff law firm, have you written any reports, rendered any written reports?

A No, sir.

Q Everything has been done orally?

A Yes, sir.

Q Have you brought with you, sir, all of the materials that you reviewed in this case and any copies of any articles that you pulled that you rely upon?

A I brought with me all of the materials that I reviewed. I left them in the car because it's such a lengthy stack. I could retrieve them if you really feel it's necessary.

Q We might do that when we take a break.

Tell me what it is that you have reviewed in this case that was provided to you by the plaintiff law firm.

A I reviewed first the medical records of David Carlyle at the Johnson County Memorial Hospital, which included his ER stay and then subsequent hospital course.

I reviewed the outpatient records of Dr. Folkner, who was his family practice physician.

I reviewed the autopsy report on David Carlyle. I reviewed the life light record on David Carlyle. And then I reviewed a large number of depositions in the case, depositions of the mother, Mrs, Kramer; of the father, Mr. Carlyle; depositions of the defendant doctors, Dr. Hanna, Dr. Folkner, Dr. Lai.

I reviewed depositions of a large number of expert witnesses including Dr. Dunahue O'Brien and Dr. Fleisher, Gary Fleisher.

I reviewed the depositions of the plaintiff's

experts, Dr. Lauren Humphrey, Dr. Schwartz, Dr. Matthews, Dr. Wecht.

I reviewed the nurses! depositions from the ICU nurses.

Q Did you review any deposition or any statement or anything at all from the nurse that was in the Emergency Room Department between the time that the child was presented there and the time that the child was transferred to the ICU?

A No, sir; I don't believe I did.

Q At the present time, your primary responsibilities here at Georgetown University revolve around pediatric infectious disease and general pediatrics, do they not?

A That's correct, with an additional third responsibility this year as an intensive care unit attending.

Q What percentage of your time do you spend with the ICU?

A This past year was the only year that I've been required to spend time as a formal intensive care attending. Prior to that, by virtue of the kind of patients that I just

happen to have as an infectious disease consultant, a fair number of my patients and a fair amount of my time will be spent in the ICU taking care of patients.

But this year, as a formal ICU attending, I will spend upwards of five weeks or six weeks of my time as the ICU attending.

Q Five to six weeks a year.

A That's correct.

Q Okay.

Now, what percentage of your time do you spend on general pediatric rounds or general pediatric consultation not related specifically to pediatric infectious diseases?

A Until this year it was in the order of 20 or 25 percent of my time.

Q And this year?

A This year, as an ICU attending, I guess the one quid pro quo that those of us who have been asked to do this extra work is that during the time that I'm ICU attending, I will not have to do the clinics that I normally would do for pediatrics, so I will miss five or six clinics since I have one a week.

I don't know what fraction of that, if it would

be 10 percent of the 20 percent or 25 percent.

Q I gotcha. Okay.

And the rest of your time is spent in consultation where you are called upon by the attending physicians, treating physicians, to consult on infectious disease cases: correct?

A That's correct.

Q Now, with regard to the infectious disease specialty, as I understand it there is no such board certification in pediatric infectious disease; correct?

A Right now that's correct.

Q You have however, as I understand it, you did go through a fellowship which specialized in infectious diseases of pediatric patients.

A Correct.

Q Now, you're board-certified as I understand it, however, in pediatrics.

A Correct.

Q But you are not board-certified in infectious diseases under the Internal Medicine Board Certification which is available.

A That's true.

ki

Q And, of course, you're not board-certified in Emergency Room medicine.

A True.

Q And you do not spend any percentage of your time covering the Emergency Room on a regular basis, do you, sir?

A Only as it relates to what a general pediatrician does when he's on call for his patients on the off hours. They often times go to Emergency Rooms and --

Q Well, sure. You're --

A Let me just finish my answer.

-- and we're responsible for the care of those patients when they pop into the Emergency Room.

Q Okay, sure.

As a patient's physician, if you're the family physician or the family's pediatric physician, I should say, or you're called in to consult by the Emergency Room physician, why then you would go down and see the patient and take over the care of that patient; correct?

A Correct.

Q And what's happening in that regard is that the Emergency Room physician is contacting you because the patient has related to them that you are either the family

pediatrician or he's decided that he wants a pediatric consult, in which case you would be called in to serve one of those two functions.

Q Well, there would be a third. You're right in that, but there would be a third instance in which you would actually tell a patient that you would meet them in the Emergency Room and not really involve the ER physicians, and be their doctor in the Emergency Room for whatever the emergency condition might be.

A Sure.

In that regard, if you're the family's pediatrician or the family has been told that you might be available for pediatric services, they would call you ahead of even going to the Emergency Room, contact you as the family physician, and say gee, we've got a problem, and you would say, well, I'll meet you down at the Emergency Room and examine the child at that time.

A correct.

Q Now, in that regard -- well, let's go back a minute.

In this particular case, I assume that you have come to certain opinions or conclusions concerning the care

of the physicians involved in this case, having reviewed all of the records and the depositions, have you not?

A Yes, sir.

Q Have you been asked to limit your opinions or conclusions in any respect?

A No, not really.

I think it was stated to me to review the records and give Mr. Bartimus and Mr. Kavanaugh my opinions with the specific understanding that Dr. Lai was the one physician who still was remaining in the case, but that they would like to hear my entire opinion on the matter.

Q All right.

Sir, in that regard, do you hold opinions concerning the care of any physician other than Dr. Lai, considering what it was that was related to you by Mr. Bartimus or Mr. Kavanaugh? And I don't know which one it was, so you can tell me which one you talked to in that regard.

A I believe it was Mr. Kavanaugh. And, yes, I have formulated opinions about other physicians other than Dr. Lai.

Q Having reviewed all of the records during the

course of your review, I notice in other cases that you've testified in that you generally take notes or maintain notes about the significant aspects of the care and the facts involved.

A Correct.

Q That's part of your ordinary method of review, is it not?

A Yes, sir.

Q And not done specifically because some lawyer asked you to take notes, but because that's how you operate.

A That's absolutely true, especially in a case that has generated as much verbiage and page as this case has.

Q Have you brought with you, sir, all of the notes that you have made concerning your review that relate to the significant aspects of your analysis?

A Yes, sir.

Q Okay.

Let's have those, if we could, please.

(Document handed to counsel.)

THE WITNESS: This is a Xeroxed copy of the original of those notes. The reason it's a Xeroxed copy is you can see by looking closely at that it's a -- what's the

proper word -- it's a palimpsest, if you will, wherein I wrote as I sometimes do, I wrote the notes on the back of some correspondence. And that's what, in a way, shows through there, how a palimpsest is supposed to.

MR. BARTIMUS: Correspondence that doesn't relate to this case?

THE WITNESS: Well, it's correspondence that I believe was from your firm which stated, enclosed are some records with respect to the Carlyle case, and there was some mention of another case on that correspondence.

BY MR. MELTZER:

Q Do you have any other notes concerning your review and your work in this case?

A These are some handwritten notes -- let me see exactly what this refers to -- some handwritten notes that I made with respect to the different depositions listed here, on the time sequence and the historical aspects of the child's care before coming into the Emergency Room, and also a review of what I thought to be some pertinent information contained in the policies and procedures of Johnson County Memorial Emergency Room and Hospital.

(Document handed to counsel.)

ki

THE WITNESS: And there are some actually on the other side of that page, too.

BY MR. MELTZER:

Q Have you got copies of these here for us?

A I have a copy of this note here, but not of that. But I can make a copy if you want.

MR. MELTZER: Let's just mark these two.

(Wientzen Deposition Exhibit Nos. 1 and 2 identified.)

BY MR. MELTZER:

Q Sir, I'm going to hand you what has been marked Deposition Exhibits 1 and 2 and ask if you can identify these as the two documents that constitute your notes in this particular case?

A Yes, sir. These are the two documents that constitute the notes in this case.

I do want to, not to mislead you or in any way give you half-hearted answers, on the cover of the depositions and in the depositions I did make additional notes.

Q I was going to get to that. So you've anticipated. And, of course, that's why I wanted to have

all the materials here, and that's why we'll have you stop when we take a break and get all of those.

In addition to notes made in or on the depositions themselves and these two sets of notes that have been marked Exhibits 1 and 2, do you have any other notes at all that you took concerning your review and analysis in this particular case?

A Yes. Some notes on the covers of the various --

Q -- medical records?

A No, no. Pieces of policies and procedures from the Johnson -- but those notes in fact were the same as the notes that I wrote here.

Q Where are the policies and procedure materials?

A I believe that Mr. Bartimus has them?

MR. MELTZER: Counsel, if you would give him those back, because I think we're going to need those for use with his deposition since he reviewed those, and the court has ordered that all the materials that he reviewed need to be produced for the deposition.

MR. BARTIMUS: I'm sorry. The court ordered what?

MR. MELTZER: That all of the materials that he

reviewed need to be produced for the deposition.

MR. BARTIMUS: Do you have that order?

MR. MELTZER: He made it orally at the pre-trial conference.

MR. BARTIMUS: I know nothing about that, having not been present. But if he's recopied them on there -- I don't have them. They're not here with me. They were sent back to me.

BY MR. MELTZER:

Q Doctor, did you mail them back to Mr. Bartimus, the policies and procedures, or did you hand-deliver them to him this morning?

A I hand-delivered them this morning.

Q Thank you, sir.

MR. MELTZER: I'll ask counsel if you would, please, now that the doctor has advised that they were hand-delivered to you this morning, to please provide them back to the doctor since he did review those.

MR. BARTIMUS: Are those in the stack of materials that you returned to me?

THE WITNESS: Yes, sir.

MR. BARTIMUS: All right. Sure.

I think those are in your car.

THE WITNESS: Yes, they are.

MR. BARTIMUS: Well, that's fine. We have no quarrel with that.

MR. MELTZER: I'll tell you what; let's take a break now to get all that material up here so I can take a look at it and then we'll go on at that point.

MR. BARTIMUS: Sure. I have no problem with that.

(Brief recess.)

(Wientzen Deposition Exhibit Nos. 3 and 4 identified.)

BY MR. MELTZER:

Q Sir, before we go through all of the details in this case, I want to cover some of these materials that you brought with you or that you've reviewed.

We've marked Deposition Exhibits 2 and 3 which are boxes of material --

MR. BARTIMUS: Exhibits 3 and 4.

BY MR. MELTZER:

Q I'm sorry; 3 and 4. And I have pulled out of that a stack of loose documents which are some of the

policies and procedures that were provided to you from Johnson County Memorial Hospital; correct?

A Correct.

Q All the depositions that you've got, why don't we just identify them while I'm up here?

You've got Denise Kramer, Nevin Carlyle, George Schwartz.

A Actually I have two copies of George Schwartz. I only read one though.

Q While we're going through this, have you written all of your notes on the fronts of these depositions or have you made them throughout in the depositions themselves?

A The vast majority on the fronts, but an occasional note in the margin.

Q Okay.

To start out here, we have Denise Kramer, and the only note you have on the front of that is, "August 3, sick stomach" --

A Nausea.

Q -- "equals nausea."

A Correct.

Q If you have any notes that you would call on the

ki

front, it would be right here, plus the pages that you would identify up here.

A Yes, sir.

Q And apparently you've got up here, "missing pages 8, 9, 10, 32, 33, 34, and 36."

A Correct.

Q Do you have any reason why you weren't provided those pages?

A No, sir.

Q And then here you've got a note that says, "7:00 to 7:30, Dr. Hanna," up in the upper right-hand corner on Mrs. Denise Kramer's deposition.

A Yes, sir.

Q What does refer to, "7:00 to 7:30, Dr. Hanna"?

A Let me think about it.

It probably refers to the time Mrs. Kramer felt that she first saw Dr. Hanna.

Q All right.

The next one we have is Nevin Carlyle, and you make a note in the upper left-hand corner, "page 11 missing."

And then this note here, page 36, is that missing

also?

A Correct.

Q And pages 66, 67, 68, 114 and 115 are missing.

A Yes, sir.

Q Do you have any knowledge or information as to why those pages were not provided to you?

A No, sir.

Q On the front of that deposition you have a notation here, "August 6, early evening hours, complaining of nausea."

A Uh-huh.

Q "August 3, nausea and vomiting. August 4, nausea and 'vomiting and questionable fever."

A Correct.

Q Meaning that the information in the deposition from this witness, Nevin Carlyle, was that there was some concern about fever on August 4th, but there had been nausea and vomiting on both the 3rd and the 4th.

A Correct.

Q On the 5th, he says the child was normal or appeared to be, had improved.

A Right.

Q And this is without --

A -- pain, fever --

Q -- pain, fever and vomiting.

A Correct.

Q The entire day of the 5th.

A Correct.

Q And then on the 6th, nausea. And at 11:30 p.m. on the night of the 6th, there was persistent pain --

A No, that says "periumbilical."

Q "Persistent pain" is what it says right there.

A You're right.

Q And that he was apparently taken to the Emergency Room at 1:30 a.m. on August 7th.

A Correct.

Q That's at least, of course, what Nevin Carlyle has testified to.

A That's correct.

Q You know, of course, from reading the medical records that the Emergency Room personnel, the h spital staff, recorded that the patient came to the Emergency Room at about 2:30, 2:28 a.m. on the morning of the 7th of August.

A Correct.

Q Then on George Schwartz's deposition you have made no notes, but there is a --

A This is a superfluous copy, a second copy of this, and I don't think I even reviewed or looked through that.

Q You have not read this deposition of Dr. Schwartz, or you simply read another copy?

A I read another copy of Dr. Schwartz deposition, and it's in there.

Q All right.

Then here is a copy of the deposition of Lauren Humphrey.

A Correct.

Q Did you read this deposition?

A Yes, sir.

Q Just kind of briefly thumbing through it, I don't see any notations in it or on the front of it; correct?

A Let me just check.

Yes, correct.

Q At least that you made.

A Yes, sir.

All the pages that I dog-eared are the pages that I felt might have some interesting, if not important, information.

Q All right. Tell you what we'll do, is after the deposition we'll arrange to just identify those pages. We won't do it right now. We'll do it at a break or something.

A I can tell you right now, sir, that's going to take hours.

Q Okay. I'll go pretty fast through it.

Now, Cyril Wecht, he's the pathologist from Pittsburgh, and you've read his deposition?

A Yes, sir.

Q And the only notation on it is "pathologist." And then you have dog-eared some pages.

Incidentally, with regard to the pathologist Dr. Wecht's deposition, what information from his deposition did you rely upon in coming to any of your opinions or conclusions, if any?

A None.

Q How about with regard to Lauren Humphrey?

A None.

Q And how about with regard to Dr. Schwartz?

A None.

Q Here we have the deposition of Dr. Schwartz, the other copy. The only notation on the outside of it is "ER medicine" and "153."

A Which is page 153.

Q Let's take a look here. It must be that page 153 was missing.

A No, sir; 153, to alert myself that there was some information I wanted to review before my deposition.

Q All right.

And did you review that?

A Yes, sir.

Q What was significant about page 153 to you, sir?

A Let me read it before 1 answer.

The question that I believe somebody from your firm asked was: "We're going to change the loading dose. It's going to go in at 3:10 as opposed to 4:15. Is it your testimony that that, in and of itself, all other clinical signs and symptoms being equal, that would have changed his outcome"?

The answer is no, but I have to explain that, that his surgery did not occur.

Si

Basically, I believe Dr. Schwartz's opinion is that this child was going to die, even if they had changed the fluid management, absent surgery. And I disagree with that opinion.

Q Then we have Dr. Matthews, and on the front cover you simply have made the notation, ER medicine, or ER md., and you put page 75 and following for deviations from standard of care.

I assume that what you are referring to there is that's the part in the deposition where he identifies the specific deviations that he contends exist.

A Correct.

Q Any aspect of Dr. Matthews' deposition upon which you rely, either his testimony or any of his conclusions or opinions?

A No, sir.

Q How about Dr. Schwartz, any of his opinions or conclusions? --

A No.

Q The next deposition we have is Janice Koetting, K-o-e-t-t-i-n-g. I see no notations on the outside of the deposition, and it doesn't look like you dog-eared any

ki

pages. And as best I can tell, it doesn't even appear that you have read it.

A Oh, I've read it.

Q You've read it but made no notations, dog-eared no pages.

Is there any information in this deposition that you recall that you relied upon in this case?

A Not to my recollection at this time, no.

Q Certainly it's nothing significant or you would have made some notation about it.

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A That's probably true.

Q Next we have Marian Mecca, and again no notations on the outside of the deposition, no pages dog-eared, and nothing -- it doesn't appear that you've made any notations inside,

In that regard, is there any information from this deposition upon which you relied in coming to any of your opinions or conclusions in this case?

A Not that I recollect.

Q Again, the same thing would be true: if there had been anything significant, you would have made some type of notation on it.

A Yes, sir.

Q Next we have the deposition of Amy Harris, again no notations on the outside, and I don't see any pages dog-eared, and no notations at least that appear as we thumb through the deposition.

A Correct.

Q Would the same thing be true about this deposition as with the prior two nurses' depositions?

A Right.

Q Next we have the deposition of Joe Whistler Chase. The notation on the outside is "Director of Medical Records." And I note here that there is a notation here that says "from Lisa." It says, "Dr. Wientzen, we have provided you summaries for all the depositions in this box."

Do you have those summaries here?

A No, I don't.

Q What happened to those summaries?

MR. BARTIMUS: I have them.

BY MR. MELTZER:

Q Go ahead and answer.

A Mr. Bartimus has them.

Q When did you give him the summaries?

A This morning.

Q Have you read the summaries of those depositions in this case?

A Yes, I have.

Q Again, with regard to Joe Whistler Chase, no other notations on the front of the deposition and no pages dog-eared.

Would the same thing be true of this deposition as is true of the prior three depositions of the nursing staff?

A Yes, sir.

Q Next we have the deposition of Susan Dockery. No notations on the front, no pages dog-eared, and no apparent notations inside the deposition.

Would the same thing be true of this deposition as was true of the previous depositions of the nursing staff?

A Yes, sir

Q Deposition of Dr. Lai. You have dog-eared some pages and you have some notations out on the front.

A Yes, sir.

Q All right, let's go through the notations in the upper left-hand corner.

As best I can read it, it says "Dr. L" for Dr. Lai, "has strong recollection of phone call attempts and beeper attempts to contact Dr. H," meaning Dr. Hanna," before the first chart entry of such attempt at 4:30."

A Correct.

Q Then at page 122, it says "no recollect of talking with Dr. Hanna."

Page 97, "called PMD Folkner" -- P stands for pediatrician?

A Private medical doctor.

Q Private medical doctor Folkner "at 3:16 a.m."

A Correct.

Q Page 174-178, 3:16, Dr. Folkner told Dr. Lai to give Claforan and call surgeon --

A As soon as possible.

Q -- call surgeon as soon as possible.

Then it says, "approximately 4 a.m., Dr. Lai

ki

called Dr. Folkner with lab results. No Hanna yet."

A Correct.

Q Then to the left of that it says, "did not ask Dr. Folkner to come in either time, did not tell Dr. Folkner at 4 a.m. no Hanna."

A Correct.

Q Then at least in that regard, from pages 174-178, that's your interpretation of the testimony which is a function of both questions and answers; correct?

A Correct.

Q Page 183, "Doctor Hanna, a surgeon, 5 a.m. came to --"

A It's repetitious. "5 a.m., came at 5 a.m."

Q "Told nurse to take patient to ICU."

A Correct.

Q And those were the significant aspects of the testimony of Dr. Lai as far as you were concerned?

A Some of them, yes.

Q Are there any others that you recall at this time upon which you relied in coming to any of your opinions or conclusions in this case?

MR. BARTIMUS: Object to the form of the

question.

THE WITNESS: Not that I recall offhand at this time.

BY MR. MELTZER:

Q Now, you have dog-eared some pages, and based at least on what I've seen in other depositions that you have testified in and what you've told us here today, when you find something that is significant, generally speaking, the testimony of a witness or medical record information, you make some type of notation either on the front of the deposition of the medical record or in some other notes that you have, do you not?

A Yes, sir.

Q So that although we have a number of pages that have been dog-eared in this deposition, the most significant aspects of the testimony of Dr. Lai which you thought were significant are recorded on the front of the deposition, are they not?

A Especially since some of those pieces of information would not be found in the medical record per se.

Q Okay

You wouldn't expect them to be found in the

medical record per se.

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I don't think I understand the question.

BY MR. MELTZER:

Q Well, you said they would not be in there, and a what I'm understanding you to say is you would not expect them to be in there.

A These pieces of information?

Q Yes.

A Yes.

Some of them; yes.

Q And by "these pieces," we're referring to the notes on the top of the deposition or the front of the deposition of Dr. Lai?

A Yes.

Q Now, the deposition of Dr. Hanna. Let's start with the notes on the outside, "page 15, arrived at ER" --

A -- "and saw" --

Q -- "and saw Dr. Lai 20 minutes after police aroused him."

A "Roused" him. No "a," just "roused."

Q Oh, "roused him."

A Correct.

Q All right.

"Doesn't know if he saw David in ER or not."

A Correct.

Q If the police, in this case the medical records will indicate that the police went out to see Dr. Hanna or to rouse him around 4:45 a.m. and, assuming that they got there within 15 minutes or so -- Warrensburg is not that large a town -- incidentally, have you ever been to Warrensburg?

A No, sir.

Q Do you know where it is?

A No, sir.

Q Do you know what size hospital the Johnson County Memorial Hospital is?

A No, sir.

Q Do you have any idea how many beds that hospital has --

A No, sir.

Q -- in the ICU?

A No, sir.

Q Or the Emergency Room, how many patients they can take on in terms of beds in the Emergency Department?

A I believe in some of the depositions of the nurses and some of the depositions of the physicians, some of those pieces of information were brought to light, but I don't recollect right here, only to say that it seems to be a very small community rural hospital.

Q Sure.

Incidentally, you in your practice, you've been practicing at Georgetown for the last, what, 15 years?

A Thirteen.

Q Thirteen years; okay.

And prior to that, where did you do your internship and residency?

A Georgetown.

Q And you got your medical degree from --

A Georgetown.

A From Georgetown.

Basically, your entire medical career has been here at this tertiary care center and teaching hospital, Georgetown University Medical School and Medical Center;

correct?

A Well, only in part, in that Georgetown's Department of Pediatrics has a community-based program. And one of the reasons I elected to do my residency at Georgetown is that it would give me, and still does provide residents with a very well-balanced program of pediatric training, a program that includes tertiary care here at the medical center, but as well primary care in community hospitals, such as Arlington Hospital which is a very small community hospital, Fairfax Hospital which used to be, Shady Grove Hospital which is a very small community hospital, and from time to time, other community hospitals have been involved in the program.

Q Sir, during your internship or residency -- did you do an internship or just a residency?

A Well, in fact, it was three straight years of postgraduate pediatric training, and the term "internship" was sort of lost in vogue at that time, so PL-1, PL-2, and PL-3 years in pediatrics.

Q In that regard, during the course of your pediatric residency, did you ever spend a period more than a month on a regular basis at any of these community hospitals

that you've identified?

A Yes, sir

Q And how many beds did those hospitals have?

A Right n I don't know Back then, when I was doing my residency, the Arlington pediatric ward would have 10 or 12 beds

Q The pediatric ward alone w ld have 10 or 12 beds?

A Yes.

Q How about the Emergency Department? How many beds would it have?

A I can visualize the Emergency Room physical setup and I would judge by its size and what I recollect that maybe it had six or eight examining rooms

Q I see.

And that in the Washington, D C area, in the area that George n pr ides a tertiary care center for, would be known as a c mmunity hospital in this part of the country; correct?

A Yes

Q And as to how that compares with what s call a rural community hospital out in western Missouri, you are

not familiar, are you, sir?

A Well, let me say this; that being a tertiary care hospital, we do in fact get referrals from some of these very small community hospitals -- Woodbridge Hospital, far out in Virginia, Leesburg Hospital -- many of which, years ago, were very tiny. And we would see the patients here, but they would be referred from the care rendered initially there.

So I have a judgment as to how care should be rendered in different parts of the country, at different times, in different hospitals.

Q Did you actually provide any type of Emergency Room coverage at any hospital other than here at Georgetown?

A Southern Maryland Hospital for a time, yes.

Q And Southern Maryland Hospital has how many beds? At that time that you were practicing and providing Emergency Room coverage, how many beds did that hospital have for the Emergency Department?

A Again, it would be a judgment. This was years ago. Eight' perhaps.

Q And how many beds on this pediatric ward?

A A dozen.

Q And in the ICU?

A I don't even think they had an ICU for pediatric patients,

Q What about an ICU for all patients?

A I don't know.

Q All right.

Going back to the deposition of Dr. Hanna, we were talking about page 15 and -- okay, we've read that.

Well, let's go back. We were talking about Dr. Hanna coming down, and if the police notified Dr. Hanna sometime between 4:45 a.m. and 5:00 a.m. and he got down to the ER, as he testified, then he would have been down to the ER within, say, 20 minutes. That would be between 5:00 and 5:20 a.m.; correct?

A That's about right. Yes.

Q Now, page 84, 80 cc's of measured urine, 50 cc's at 8:30 and 30 cc's at 9 a.m.

Q And it says "void in ER"?

A Correct.

Q What does the reference to "void in ER" refer to?

A I believe there's a sheet in the hospital chart, a flow sheet which makes that statement. At 7 o'clock or

8 o'clock it says "vd in ER." That is, the patient voided a urine specimen in the Emergency Room.

Q And if it was recorded as the patient having voided in the ER at 7 o'clock a.m., you and I both know that that statement is inconsistent and can't be true in all respects; correct?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A I think 1 would certainly not judge from that, that the patient voided at 7 o'clock in the ER. We know the patient was not in the ER at 7 o'clock.

I think it was a nurse's attempt to say that the patient did void once sometime in the Emergency Room. She didn't specify the specific time. She could have written it anywhere, but decided to put it at 7 o'clock.

Q Having reviewed the nurse's depositions, did you attempt to learn what nurse it was that would have had personal knowledge of the patient voiding in the Emergency Room?

A I made the judgment as I read through all of

these materials that it was probably one of the Emergency Room nurses.

Q Well, as a matter of fact, sir, haven't you reviewed and determined that none of the nurses that were deposed in this case were every in the Emergency Room in this case?

A Yes, sir.

Q So therefore if none of nurses were in the Emergency Room in this case, and they were all ICU nurses, none of them would have personal knowledge of the patient having voided in the Emergency Room; correct?

A Only in terms of what might have been said by an ER nurse to the ICU nurse at the time of switching services from the ER to the ICU.

Q And, of course, that switch occurred at 5:15, did it not?

A Correct.

Q Ordinarily, when nurses, when they have a switch like that, the information that's coming from the ER is recorded in the initial set of notes or the transfer set of notes from the ER to the ICU; correct?

A Ordinarily that's true.

Q And that would be what you would expect. You would expect them to be there if it in fact had occurred in the ER; you would expect it to be recorded in that transfer note or the series of notes relating to the transfer; correct?

A Not only that, but it should have been recorded by the ER nurse at the time the patient voided, in the ER notes.

Q Sure.

In fact, one *of* the responsibilities of the nursing staff, whether it's in the ER or the ICU or anywhere else, is to record when a patient voids, the fact of the voiding, and to estimate the amount of urine voided; correct?

A I would say in this particular circumstance, I wouldn't even allow an estimation to be adequate for the patient. The nurse should measure the amount of urine.

Q Well, either estimate or to measure the amount.

A Again, I would not allow an estimation of a patient that is in shock, of his urine output. It should have been measured.

Q I didn't ask whether you would allow it or not,

sir. I move to strike as being nonresponsive.

My question is this: You would expect the nursing staff to record, number one, if a patient voided, you would expect them to record when they voided and to record the amount of urine that was voided either by estimation or, if they had measured it by a catheter of some sort, they would record the amount that was measured; correct?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q I'm talking about the recordation process, sir.

A Now, if you're talking hypothetically all patients, I would say yes. Non-acutely ill patients, one could estimate the amount of urine voided.

If we're talking specifically about this patient in an Emergency Room in shock, I would say the standard of care requires that the strict I&O be kept and a nurse measure the amount and not estimate the amount.

Q I move to strike the last portion of the response as being nonresponsive.

A Mr. Meltzer, it was fully responsive.

Q We'll let the court worry about that. The latter portion of your response in my view was not responsive and I move to strike it as being nonresponsive.

Incidentally, didn't Dr. Lai in his orders direct the nursing staff to record and to monitor the input and output on this patient?

A I believe Dr. Lai made that order as he admitted the patient to the ICU. I don't see a written order, I don't recall a written order in the ER for him to do that, although it's standard procedure in an acutely ill patient to do it by the nurses.

Q In other words, the nurses either would or should do it, wholly apart from whether the doctor specifically ordered them to do it anyway; correct?

A Correct.

And if the nurses are not doing it, they should be told by the doctor to do it.

Q Of course, you agree that the primary responsibilities of both nursing staff and the physician is to take care of the patient and that recordation, particularly in the Emergency Room in the emergency setting, is not of the same nature and degree as it is in other

aspects of patient care; correct?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A I don't know if I can agree with you generically with that statement.

Q Okay.

Do you recall having testified in a case for Mr. Bartimus previously, by deposition, and your deposition was taken by a Mr. Wagenstaff or Wengstaff? Do you remember him?

A I 'can't recall.

Q I'll get to that a little later.

All right, sir, first of all, going back here, the other notation that you have is page 64, "David was in shock at 6:30 a.m. in ICU," and that's Dr. Folkner saying that the patient was in shock at 6:30 a.m. in the ICU.

A No, sir. It's Dr. Hanna.

Q Oh, I'm sorry. I said Dr. Folkner.

Dr. Hanna determined that the patient was in shock at 6:30 in the ICU.

A Yes, sir.

Q And then, page 72, "Dr. Folkner was the attending physician." That's Dr. Hanna saying Dr. Folkner was the attending physician.

A Correct.

Q Any other significant testimony from Dr. Hanna upon which you relied in coming to any of your opinions or conclusions?

A I don't believe so.

Q Incidentally, if Dr. Hanna is correct that he arrived at the Emergency Department about 20 minutes after he'd been roused by the police, that would be consistent with Dr. Lai's testimony that Dr. Hanna was there and examined the patient, evaluated the patient at least initially, at 5:15 or so; correct?

A Yes, sir.

Q All right.

This is the deposition of Dr. Mingle, Ralph Mingle, and I note other than making a notation that he was the Medical Director for Spectrum and relieved Dr. Lai in the a.m., in the morning, there are no other notations on the outside and no pages dog-eared or any other notations in

the deposition; correct?

A Correct.

Q I assume from that, that there was nothing significant from the testimony of Dr. Mingle upon which you relied in coming to any of your opinions or conclusions.

A Correct.

Q Then you've got the deposition of Dr. Folkner and you make notations on the outside of the deposition, "page 30, Dr. Lai called Dr. Folkner and said David needs surgical consult, and Dr. Folkner agreed."

A Correct.

Q Page "51-52, essentially gave no orders to Lai over the phone."

And "page 58, second call from Dr. Lai was about the inability to get Dr. Hanna." Right?

A Yes.

Q Do you recall, sir, what time it was that Dr. Lai's secretary's call was to Dr. Hanna, at least as indicated by Dr. Folkner?

A I believe it was shortly after 4 a.m.

Q So it would be before 4:30 a.m.; correct?

A I believe so; yes.

ki

Q What that tells you, then, is that Dr. Folkner at least recalls a telephone call coming from Dr. Lai, which Dr. Lai is calling back sometime around 4 o'clock saying, look, we're having difficulty getting ahold of Dr. Hanna; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Again, I don't know what words were spoken, but the sense of Dr. Folkner's deposition was that they could not find Dr. Hanna as of 4:00 or 4:15; yes.

BY MR. MELTZER:

Q "Page 59, second call, Dr. Folkner suggested send dispatch out to get Dr. Hanna."

A Correct.

Q Which was ultimately done in that regard. After they tried to call again and beep and everything else, they sent the police out.

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A That's true.

Q Anything else significant in the deposition of Dr. Folkner other than what you have noted on the front cover?

A With respect to the formulation of my opinions, no.

Q Then you have reviewed the deposition of Dr. Fleisher, I note you have on the front cover, "ER for Emergency Room physician.!!

A Correct.

Q Or "for Emergency Room care." And you have no notations on the front of that deposition.

A Correct.

Q Did you rely on any of the information elicited during the deposition of Dr. Fleisher?

A To formulate my opinions?

Q Yes.

A No, sir.

Q Incidentally, do you know Dr. Fleisher?

A No, I don't.

Q Do you know who Dr. Fleisher is?

A Yes, I do.

Q Do you recognize him as one of the leading

authorities in the field of pediatric fluid management?

A No, sir.

Q Do you recognize him as one of the leaders in pediatric care in any respect?

A I don't know that I would call him leader in any respect.

Q Incidentally, I note you have a copy of Dr. Fleisher's work on Pediatric Emergency Medicine.

Was that book provided to you by the plaintiff law firm?

A No, sir.

Q You had that in your own library?

A Not in my library. It was in the Pediatric Library.

Q Here at Georgetown?

A Yes.

In fact, it was in an associate's library, in his office.

Q Then you've reviewed the last deposition that we have here of Dunoff O'Brien.

Do you know Dr. O'Brien?

A No, sir.

Q In the front of the deposition, the notes that you have there say -- what's this?

A "No change."

Q "No change, standard of care for Dr. Lai."

A No deviation.

Q No deviation. All right, that's what you are referring to.

"Onset Friday by history. Ruptured Sunday by pathology and history. Discounts parents'" -- what's that?

A "Deposition history."

Q -- "deposition history. Accuses parents of neglect, page 124. Page 127, CVP for qualified ER doctor or surgeon. 129, Claforan."

What's this?

A "Ahead of his time."

Q "Ahead of his time in 1984, using the single initial antibiotic for ruptured appendix."

And "128, overly cautious fluid administration."

Any other significant information that you found in the deposition of Dr. O'Brien other than what we have identified on the front cover?

A Not as it relates to my opinions.

Q All right, fine.

Now, having gone through all of that, I note here Deposition Exhibit 1, which are the notes from some depositions and the ones that you at least have recorded, you start out -- so we'll go through them here -- "ER nurse." And I assume what you're talking about here is significant findings from the Emergency Room nurse or historical information, one of the two?

A From the ER nurses' historical recording in the ER sheet.

Q In the ER sheet. Okay.

And V, I assume is vomiting?

A Yes.

Q D is for diarrhea?

A Correct.

Q And you've got "vomiting and diarrhea for four days. Constant sharp" --

A "Periumbilical.

Q -- periumbilical pain, onset August 5 evening." And then you've got approximately equal to 30 hours?

A Correct.

That's my own notation. That wasn't in the

record. That was my addition.

Q And the approximately 30 hours, what does that relate to? How did you determine the time on that?

A From the time of onset of pain in the evening of 8/5, 6:00 or thereabouts, until 2:30 or so on the morning of the 7th is about 30 hours.

Q In that regard, I assume that you are interpreting the ER sheet of the nurses' notes to mean that the onset of the periumbilical pain was on August 5, the evening of August 5, as opposed to during the prior days; correct?

A Let me just look at the note itself.

(Pause.)

Well, I'm not interpreting it, Mr. Meltzer. It specifically states the onset of 8/5 in the evening. So I mean that's not an interpretation. That's a literal rendition of what the nurse said.

Q Okay, let's take a look. Just a minute.

(Pause.)

Okay. It talks about the constant sharp pain at umbilicus. Then it says "onset August 5 in the evening, gradually worsening." Right?

A Yes, sir.

Q Then you've got Dr. Lai, referring to the ER sheet again. You say, same on ER sheet, something on consult sheet to Dr. Hanna.

A "And on consult sheet to Dr. Hanna."

Q "And on consult sheet to Dr. Hanna, plus" -- is that "plus fever," temperature?

A Yes.

Q All right.

I assume what you're referring to there is that the notes of Dr. Lai were the same in the Emergency Room runner or in counter sheet as they were, essentially the same as they were in the consult request to Dr. Hanna?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: In part, yes; that Dr. Lai's history was, on the ER sheet and on the consult to Dr. Hanna, the same information, plus the fever on the consult sheet, but it was the same as what the ER nurse had written above.

BY MR. MELTZER:

Q Then you've got Dr. Folkner, "diarrhea and

vomiting for four days. Constant abdominal pain and fever since August 5."

A Right.

Q And then Dr. Hanna, "vomiting, diarrhea, times four days, with fever, constant pain since August 6, yesterday."

A Yes.

Q His historical information is slightly different.

A Yes.

Q And then you've got the notations of Mr. Carlyle and Mrs. Kramer. Essentially these are similar to what was previously discussed that were on the front sheets of the depositions; correct?

A Correct. That's where they came from.

Q That's where they came from. Okay.

Now, then the next set of notes below, you talk about the Emergency Service Physician Privileges Form, and I assume you're talking about a number of documents that are here, and we will go through them individually.

The first point that you make a notation of, at least on Exhibit 1, is -- what's that, plus or minus? Is that equivocal?

A I don't see where you see that.

Oh, that's I.B. It's Roman numeral I.B.

Q Oh, I.B. All right.

"He will care for the life-threatening situation," ellipsis.

A Dots.

Q Well, that's ellipsis.

A Would you like me to read it and save some trouble?

Q I'll get it.

A Ellipsis -- "in the hospital's Emergency Service until such time as appropriate staff specialist arrives."

Correct?

A Correct.

Q In that regard, what was it that you thought was significant about that particular statement in the Emergency Service Physician Privileges Form?

A I was trying to determine what the hospital requires of the Emergency Room physician with respect to his duties for the patient.

And it's stated right there in that Physician Privileges Form that the ER physician, in the face of a

life-thr atening is situation, is responsible for the patient until the appropriate staff specialist arrives. That's very well spelled out.

Q So that we're clear, what you're talking about is on this document that is part of Deposition Exhibit 8 from some deposition taken March 16, 1987.

You have underlined, under Roman numeral I.B. that statement which says, "He will care for the life-threatening situations with the facilities and staff available in the hospital's Emergency Service until such time as the appropriate staff specialist arrives."

Right?

A Yes, sir.

Q Now, that limits, in effect, his responsibilities to the time that the patient is in the Emergency Department and until the time that the appropriate staff specialist arrives.

MR. **BARTIMUS:** Object to the form of the question.

BY MR. MELTZER:

Q That's what it's referring to, isn't it?

MR. BARTIMUS: Object to the form of the

question.

THE WITNESS: Would you repeat your question because I'm a little bit confused about some of your phraseology.

BY MR. MELTZER:

Q Sure.

The statement itself in the Johnson County Memorial Hospital Emergency Service Physician Privileges Form refers to the care to be provided in the hospital's Emergency Service Unit, which is the Emergency Department; correct?

A Correct.

Q And it talks about that the responsibility of the Emergency Room physician or Emergency Department physician is for patients in life-threatening situations in that department while they are there and until such time as the appropriate staff specialist arrives; correct?

A I would agree with you in part, but add that to me that also means that a physician in the Emergency Room, the Emergency Room physician, would not release from the Emergency Room a patient who is in life-threatening circumstances until the appropriate staff specialist arrives

to take care of that patient.

Q In this case, the information that we have from Dr. Hanna and Dr. Lai is that Dr. Hanna arrived between 5:00 and 5:15 and the patient was transferred to the ICU, so he's no longer in the Emergency Department, correct, at that time?

A Correct.

Q And also Dr. Hanna has arrived sometime in that time frame between 5:00 and 5:15 in that regard.

A If that's the time Dr. Hanna arrived, he fulfilled this part of the responsibility.

Q You mean in that regard, Dr. Lai fulfilled his responsibility in that regard?

A Specifically Dr. Lai, if he did not discharge this patient from the Emergency Room until Dr. Hanna arrived and was there to take care of this patient, then Dr. Lai fulfilled the wording of this responsibility I.B.

He may not, I would add, he in my view did not really care for the patient appropriately while in the Emergency Room, but at least he did not release the patient from the Emergency Room until Dr. Hanna was there, which was proper.

ki

Q Move to strike that portion of the response concerning what you thought he did or didn't do during the course, during the time that he was in the Emergency Department.

My question related to up until that point in time, that he had fulfilled the responsibilities as required by Section I.B insofar as once Dr. Hanna arrived, discharging him to the ICU.

A Let me just add to that, sir, that this specifically says he will care for the life-threatening situation, and I stated that he did not appropriately care for the life-threatening situation.

Q Your quarrel, then, is with the fact of the treatment, the care and treatment of Dr. Lai between the time that the patient arrived at the Emergency Department at about 2:30 a.m. and the time that the patient went to the ICU for at about 5:15.

A That's correct.

Q Now, the next notation here is on page 2. You say "venous cut-down requested as a privilege."

And, looking at Deposition Exhibit 8, you're referring to the fact that venous cut-down has been

ki

requested as a privilege by Dr. Lai?

A Yes, I am.

But as it states on the first page of this form that you were just now reading to me, it says "see completed application by Dr. Lai," which is a different copy of the same thing.

Q Okay, that's fine.

Dr. Lai had requested privileges to do venous cut-down.

A Correct.

Q What was significant to you about the fact that he requested privilege to perform venous cut-down?

A Several things; one being if he requested privileges to perform venous cut-down, it seems to me that he feels proficient in doing that when it is necessary.

Number two, I believe in this case that there was a need for additional intravenous lines to supply sufficient fluid at a sufficient rate than Dr. Lai had the expertise to provide those additional lines, even if it came to doing a cut-down.

Q Incidentally, Dr. Hanna you would expect to he proficient and qualified to do a venous cut-down as well;

ki

correct?

A Yes.

Q As a surgeon?

A Yes, sir.

Q Then you've got the next notation, "Summary of medical staff members' responsibility for Emergency Service coverage. Page 3, CVP not allowed. Page last, treatment of shock."

A Yes.

Q You, of course, are aware that the Johnson County Memorial Hospital policies and procedures prohibited the emergency staff physicians and nurses from performing or placing CVP lines; correct?

A There is that notation in some of the records; yes.

Q Well, it's part of their policies and procedures that they don't want CVP lines being placed in the Emergency Department; correct?

A That's what it states; yes.

Q Then the last item, "Page last, treatment of shock." Let's see if we can find that particular item.

Did you find it there?

A In Emma·y of Staff Medical Responsibility, no. Let me have mine. Maybe I'm more familiar with these than you are.

Q I hope so. I mean I hope you're familiar with the records that you have and the notes you've made.

A I try to be.

It's right here, the last page of the form entitled Summary of Medical Staff Members Responsibility for Emergency Service Coverage. "Procedures: Life Saving and Stabilizing such as CPR, IV's and Medications, Insertion of Chest Tubes, Tracheostomy, Control of Major Bleeding, Lavage of Ingestion of Toxic Substances, or Treatment of Coma and Shock."

Q All that really is saying is that they expect the Emergency Room personnel to provide treatment for shock.

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A Yes, sir.

Q Then you have a notation here: ''Emergency treatment of pediatric patients - do weight of all pediatric

patients under one year and all pediatric patients 10 years and under with fever."

A Correct. It's right here.

(Document handed to counsel for defendants.)

BY MR. MELTZER:

Q In that regard, of course, you're well aware of the fact, are you not, that the addition of that particular notation was in February of 1987, are you not?

A I don't know when it was.

Q Well, take a look at it, sir.

MR. MELTZER: In fact, let's mark that, if you would, please.

(Wientzen Deposition Exhibit No. 5 identified.)

BY MR. MELTZER:

Q Sir, I'm going to hand you what has been marked Deposition Exhibit 5 and ask if you can identify that as a copy of the Emergency Treatment of the Pediatric Patient Sheet that you're referring to with regard to the last note that you have on Deposition Exhibit 1, where you state, emergency treatment of pediatric patient, "Do weight of all pediatric patients under one year and all pediatric patients

10 years and under with fever."

A Yes, sir.

Q On Exhibit 5, you see that at the very bottom of the listing of procedures, there is a handwritten addition which says, "Do weight of all pediatric patients under one year and all pediatric patients 10 years and under with fever."

Correct?

A Yes, sir.

(Whereupon, a discussion was held off the record.)

BY MR. MELTZER:

Q And in the lower left-hand corner, in the same handwriting, are the words "revised," some initials, and the date 2/87.

Do you see that?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Yes, I see that.

BY MR. MELTZER:

Q Now, what that tells you is that this addition, where it says taking the weight of all pediatric patients

was an addition to the procedures of the Pediatric Patient Care in the Emergency Department, was an addition made in February 1987; correct?

MR. BARTIMUS: Object to the form of the question. It assumes facts not in evidence and calls for conclusions and speculation on the part of this witness.

BY MR. MELTZER:

Q Go ahead and answer, sir.

A I think one way of looking at this would be the way .youjust suggested; *yes.*

Q Sir, are you attempting to tell us that there's another way to look at that?

A You know, there may have been a verbal policy to do weights on different categories of patients that was formulated differently at this time.

Q Are you aware, from any of the information that you have read, of any policies, written or unwritten, concerning taking the weights of pediatric patients under lo years of age with fever, that had been formulated by the hospital staff at Johnson County Memorial Hospital as of August of 1984?

A Only in the sense that it's standard procedure

and it's standard care to take the weights of all acutely ill pediatric patients.

Q Move to strike as being nonresponsive.

I'm asking specifically if you're aware of any written or verbal policies that have been established specifically by the Johnson County Memorial Hospital staff concerning the emergency treatment of pediatric patients in which one of their specific policies or procedures was to take the weight, do the weight of the pediatric patients under 10 years of age with fever.

A No, sir.

I don't know of any written or verbal policy by this hospital Emergency Room which stipulates that patients should be taken care of, via having them weighed, according to standard procedures and standard care.

Q I move to strike the last portion of that as being nonresponsive.

Then on the back side of that page of notes, you have "Introduction, Johnson County Memorial Hospital, Emergencies-Outpatient Department." Then you have "Philosophy."

With regard to those four items, the Introduction

down through Philosophy, what are you referring to there?

A That's one document that is entitled that way. I believe that's it.

Q Then what you say there is to refer to the third page from the last.

And I note here, in your handwritten notes on Exhibit 1, you say, "ER physician will 'attend' any in-house patient in a crisis situation until the attending physician arrives on the scene."

A Correct.

Q And then you have the same notations here. On the third page from the last of the document that you have referred to it says, "until Dr. H or Dr. F arrived, Dr. L was still attending patient in ICU."

A Correct.

Q Sir, you're aware of the fact, are you not, that the rules and regulations of the Johnson County Memorial Hospital prohibited physicians like Dr. Lai from being an attending physician or participating in the care of a patient outside the Emergency Department:'

MR. BARTIMUS: Object to the form of the question. That misrepresents the evidence in this case.

THE WITNESS: I think there was an exception to that general rule stated in the line you just read, which is a very commonly done exception and a very reasonable one which states you should not let a patient die just because the hospital says usually you shouldn't admit patients to the hospital!

If there is a patient who is in crisis situation and his physician is not there, you as the ER physician will be responsible until the patient arrives.

Q The physician arrives.

A Until the attending physician arrives; that's correct.

Q By crisis situation, isn't it a fact that most hospitals interpret the term "crisis situation" to refer to Code Blues that are called?

A That would certainly be one such crisis situation.

Q Assuming that Dr. Lai and Dr. Hanna are accurate when they recall Dr. Hanna coming down to the hospital to see the patient and see Dr. Lai at some time between 5:00 and 5:15 or so, then this particular sentence and the reference that you've identified to the ER physician waiting

till the attending physician arrives or handling crisis situations in the interim elsewhere in the hospital would not apply; correct?

A That's correct.

I wrote this specifically with the idea in mind that were the trier of fact in this case in the end of September to determine that Dr. Hanna wasn't available and wasn't in the hospital at 5:15 or whatever time we have agreed he might have been available, then Dr. Lai really still had responsibility to this patient.

But if Dr. Hanna were there, then I agree with you; Dr. Lai's responsibility ended at that point.

Q In that regard, do you contend that this patient was in a crisis situation from the time that he arrived in the Emergency Department until the time of his death at around 11:00 a.m. or 12:00?

A Yes, sir.

Q So as far as you're concerned, this patient was always in a crisis situation and -- all right.

When is the latest time, sir, that you acknowledge would be the time that Dr. Hanna would have been there at the hospital?

A I believe one of the Emergency Room nurses has a notation that he was there at 6:30 or thereabouts, so I would think that would be the latest that we could say he was there.

Q Incidentally, between 5:15 and 6:30, was there any indication in the record that this patient went into cardiac arrest or cessation of breathing or any other Code Blue type situation?

A No, sir.

Q As a matter of fact, from about 5:15 to 6:15 or 6:30, the nursing notes from the ICU generally reflect that the patient's condition remained about the same, did it not?

MR. BARTIMUS: Object to the form of the question. Misrepresents the facts in this case.

THE WITNESS: If you're finished with this one, could I take a quick break?

MR. MELTZER: Sure.

(Recess.)

BY MR. MELTZER:

Q Sir, on Deposition Exhibit 2, the other notes that you made, at least you've got the times noted. On August 7, '84, you start out with 2:21 a.m., patient checks

into the ER.

A It would help probably if I quickly went and made another copy of that so I could follow along with you, because that's the only copy that's existing here right now.

Q Have you got your original here?

A Mr. Bartimus has the original.

MR. MELTZER: Why don't you just let him look off the original.

MR. BARTIMUS: Make a copy.

(Brief recess.)

BY MR. MELTZER:

Q You've got a copy of Deposition Exhibit 2. You've made notations of some of the times. 2:21 a.m., checks into the ER. You've also got out to the side, approximately 2:30 a.m. to 5:15, transferred to ICU.

A Correct.

Q And then you've got 3:16, referring to 3:16 a.m., Folkner notified.

That's the time that Dr. Lai called Dr. Folkner?

A Correct.

Q And 2:30, Dr. Lai notified. Okay.

Then it looks like you've recorded the vital

signs, charted the vital signs yourself. And the first vital sign that you have noted is at 2:28 the temperature is 97 -- is that 97.8?

A Correct.

Q Pulse at 172, respiration is 20, and no blood pressure.

A Correct.

Q And that would have been recorded by the nurse?

A Correct.

Q Incidentally, do the nurses record vital signs here in your hospital?

A Yes, they do.

Q And also in the Emergency Room, nurses keep track of the vital signs?

A They record them and keep track of them; yes.

Q At 4:10, the vital signs are next recorded at that time with a temperature of 101, pulse of 180, respiration is at 24, and the blood pressure 80 systolic.

A Correct.

Q And no diastolic recorded.

A Correct.

Q Then you have a note over at the side and you

can't read it. You might tell me what that says there.

A It says "peripheral pulses weak and thready." This is the nurse's notation of 0228, talking about the quality of the patient's pulses.

Q Okay.

Now, at 5:10 a.m., no temperature is recorded but the pulse is recorded at 176, respiration is at 24 again, and blood pressure again at 80 systolic; right?

A Yes.

Q Now, at least insofar as those recordations are concerned, with the exception of the increase in temperature from 97.8 to 101, the remaining vital signs remain essentially the same, do they not?

MR. BARTIMUS: Object to the form of the question. The best evidence is the record itself.

BY MR. MELTZER:

Q Go ahead and answer, sir.

A I think I would answer your question by saying that you're right. The fever did change, basic temperature did elevate at 4:10, but also the pulse elevated and also the respiratory elevated. So I would say there has been a change in this patient.

Q You consider the increase in respirations from 20 to 24 to be marked?

A I would say marked might not be the word I would I would use. I would say "worrisome."

Q Are the respirations of 24 for a patient with abdominal pain and ongoing peritonitis, is that respiratory rate abnormal?

A That respiratory rate, since it's in the presence of a child with shock and it's elevated from the time the child was first tested in the Emergency Room at 0228, is worrisome and it probably is abnormal.

Q It's consistent with the patient, though, who has peritonitis, is it not?

A Yes, it is.

Q Since the blood pressure is not recorded at 2:28, we don't know what it was at that particular time, do we?

A That's correct.

Q We do know that at 4:10 and at 5:10, the blood pressure remained the same or essentially the same, do we not?

A Correct.

Q We also know that from 4:10 to 5:10 respiration

remained the same, as did the pulse rate.

A Yes, sir.

Q Now, were there any other vital signs that were taken during the course of this child's hospitalization that you thought were significant with regard to either his care and treatment at any stage or with regard to his ultimate outcome?

MR. **BARTIMUS**: Object to the form of the question.

THE WITNESS: Well, you're talking now about the in-hospital record as well as the Emergency Room? You said "during the course of his hospitalization"?

BY MR. MELTZER:

Q Yes.

A I think, sure, the values recorded in the Intensive Care Unit are very important.

Q At 5:15 when the patient was first admitted to the **ICU**, what was the -- oh, **I** see. You've got it written down there, that the temperature was 102.8; right?

A Correct.

Q Isn't there also another temperature recorded at about the same time for that patient that is different than

102.8 within the records, that was recorded by a nurse who recorded the same -- the same nurse recorded the temperature at approximately time and have two different values?

Do you recall that?

A I'm not aware of the two values that you're talking about with respect to the temperature at 5:15. I know there was no temperature recorded at 5:10 in the Emergency Room, and I don't recall that there was a temperature on the flow sheet at 5:15.

There may be. We could look. I just don't know that there was. If there was, 1 normally would have put it down.

Q At 5:15 in the nurses' notes it says 100. Take a look at the nurses' notes. I think you've got it right there. Look at 5:15.

The patient was alert and coherent and cooperative. Temperature was 100.2 PO, which I assume is an oral temperature.

A Right.

Q And you've got it's 102.8.

A I don't know whether this temperature of -- let me see now -- that's PO -- I can't explain why they would

have at the same time two temperatures this discordant, except to say that this temperature of 100.2 orally was taken at some different time.

Q Sir, where did you get the temperature of 102.8?

A I got that temperature from the -- I'll give you the name of the sheet in a second. It's called the Johnson County Memorial Hospital Admission Nursing Assessment, 8/7/84, 0515. And it's signed by A. Wise, and it has temperature 102.8.

Now, it may be 102.3, but on my Xeroxed copy I thought it was 102.8.

Q And who signed off on the nurses' notes for the 5:15 exam where the nurse determined the patient was alert, coherent, cooperative, and a temperature of 100.2?

A Same nurse.

Q Which one is right, sir?

A They could both well be right if they were taken at different times. If one was taken at 5:15 and one was taken at 5:50 and they were just charted this way, they could certainly both be right.

Q You said 5:50 is when the other one was taken; right?

A Which one? The 102.8?

Q 102.8.

A No, sir. The time on the sheet is 0515.

Q And the other time is also 0515.

A Well, the time 0515 on the sheet that contains the 100.2 oral temperature is written next to a different notation than the temperature.

That 0515 is written next to a line that says "alert and coherent and cooperative," and then there is no line next to the temperature of 100.2.

Q Sir, you know, of course, that each line that's contained under the nurses' notes relates to the time that is recorded up above on the left-hand side until you get to another time, do you not?

A Well, not necessarily.

Q That's a standard of practice, isn't it, for nurses to record it in that fashion, isn't it?

A Nurses record items in blocks of time in charts very frequently. So to have a notation of 0515 and then a block to write in, and then a notation of 0630 could mean that all those things occurred at 0515 that's written there by that nurse, or that some occurred at 0515 and some

occurred sometime after that, but before 6:30.

Q And you don't know which one it is?

A No, sir.

Q At any rate, if the temperature was 102.8 at 5:15 and sometime thereafter dropped to 100.2, you don't know when that time was that it dropped, or you don't know which one of those came first?

A I would think that the 0515 102.8 was the true recording at 0515, because it's on a separate sheet, an individual sheet that was the admission sheet.

Q The fact of the matter is, you don't know which one of those is correct and you would have to speculate with regard to which one is correct.

A I think again they both could well be correct.

Q Also at that time, at 5:15, you found the systolic blood pressure was 78 by Doppler; correct?

A Correct.

Q That's essentially the same as what it had been previously, correct, when the pat ent left the Emergency Room?

A Again, I don't know whether or not they were using a Doppler machine in the Emergency Room and whether

the blood pressure was now harder to find and the Doppler had to be used.

But, even so, I think just as the temperature being worrisome, the respiratory rate elevation being worrisome, in a patient in shock when the blood pressure slips from 80 to 78, it's worrisome.

Q But essentially if it's between 80 and 78, there is not a marked difference in the blood pressure.

A Again, from the numerical standpoint, 80 to 78 is a small difference.

From the human standpoint, 80 to 78 could be worsening shock.

Q Now, the respirations at 5:15 are 52.

A Correct.

Q And the pulse is 168.

A Correct.

Q And you obtained those from what particular document?

A The same document I mentioned a minute ago, the Admission Nursing Assessment, signed by A. Wise.

Q Then you went from there to the flow sheet which is the nursing flow sheet, and you've made notations about

ki

5:15; correct?

A Yes.

Q There, you make a notation the patient is drowsy.

A Yes.

Q Any particular reason why you didn't record the fact the patient was alert as well, which is also recorded in the flow sheet?

A Well, the child was known to be alert from the time of his admission to the Emergency Room. That was his baseline.

The reason I circled drowsy is that this is a sign of change from the baseline, and again it's very worrisome in a child who has been in shock for three hours.

Q Do you know, sir, whether or not Dr. Folkner was notified of that change in condition?

A I know Dr. Folkner, 1 believe Dr. Folkner in his deposition stated he was notified about the fever and ordered a blood culture. I don't know that he was notified about the change in his mental status.

Q Take a look at the nurses! notes at 5:15 where it says "alert and coherent, cooperative, temperature 100.2, Dr. Folkner notified and ordered blood cultures to be

drawn."

A That's correct.

As I just stated, most of the time a febrile episode would require a blood culture. I think Dr. Folkner did the right thing.

Q Also at the same time, at 5:15, the nurses recorded the fact that the patient was alert, and then says drowsy. You see that?

A Yes.

Q Do you have any knowledge or information as to whether the nurses notified Dr. Folkner of the patient's change from alert to drowsy?

A No, sir; I don't have any information.

Q Now, pulse is 150 to 190, a fairly broad range in terms of recordation; correct?

A I'm trying to find -- yes, on this flow sheet and on my notes I see that. Yes.

Let me just add to that, that notation is a suggestion that -- is it Ms. Wise -- yes. What Ms. Wise is doing here is, in a way, a range of different findings over a period of different times with respect to that heart rate.

Q Variation in that regard.

A That's correct.

So that would suggest that some of these notations in this block of handwritten notations were not all entered at **0515**, but in fact some were entered at **0520**, 0530, and **so** on.

Q On the other hand, where she puts with regard to the heart, regular, 150-190, she could be talking that she has estimated the pulse at between **150** to 190 on a particular occasion; correct?

A That's possible, although I can just state that Emergency Room nurses and ICU nurses, in my experience, would never estimate a pulse rate in that range. I mean they would count it and know it because it's so crucial for the care of the patient.

Q Move to strike the last portion of the response as nonresponsive and speculation.

Now, if the heart rate is 150 or pulse is 150, do you consider that to be markedly abnormal, or marked tachycardia?

A Yes, sir.

Q And certainly at 190, that's marked tachycardia, isn't it?

A Yes, sir.

Q Do you have any knowledge or information as to whether Dr. Hanna or Dr. Folkner went in to see the patient at 5:15 when Dr. Folkner was notified of the temperature and may or may not have been notified concerning these other findings?

A I don't know. I know that Dr. Folkner was not there by his own admission. Dr. Hanna may have been there by virtue of the timing that we've gone through prior in this deposition. And if he was there, he should have known, either by review of the records or by the nurse telling him of these changes.

Q You would expect the nursing staff to contact the physician that they understood to be in charge at that time, to let them know of these changing conditions; correct?

A absolutely, sir.

Q And failure of the nursing staff to orally notify the physicians who they knew or understood to be responsible for the care of the patient would be a departure from standard accepted nursing practice on the part of the hospital staff, the nurses; correct?

MR. BARTIMUS: Object to the form of the

question. It's outside the scope of the deposition for which this expert has been named.

BY MR. MELTZER:

Q Go ahead and answer, sir.

A I would agree with you.

Q Incidentally, sir, isn't it a fact that to your knowledge, no member of the nursing staff contacted Dr. Lai after 5:15 in the morning after the patient went to the ICU?

A I believe that's stated in some of those depositions. *Yes.*

Q Then at 5:15 you make a particular notation that the patient is not on any oxygen; right?

A Yes.

Q Why was that significant to you?

A Well, again let me state that my notation that the patient was not on oxygen is merely a copying of what the nurses noted, and that's significant to me because it's standard care for a patient with shock to be on oxygen.

Q Is there anything that prevented the nursing staff from administering oxygen to this patient when the heart rate started varying between 150 and 190 and the temperature rose to in the neighborhood of 102.8? Any

reason that they would not have been capable of making the determination that oxygen should be given, and giving oxygen?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A The answer is that a patient who is recognized to be in shock by the flow sheet in the hospital policies and procedures should be supplied oxygen, and the nurses should have done that. And if the nurses didn't do that, the physician should have ordered it.

Q Of course, Dr. Folkner was notified, at least he was telephoned sometime around 5:15, had a conversation with the nurses according to the records, and would have been in a position had the nurses given him information concerning this patient's changing condition and the vital signs, that he could then have ordered the oxygen if he thought it was appropriate at that time; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Correct. At that time and in prior

conversations in the Emergency Room, he could have and should have ordered oxygen.

BY MR. MELTZER:

Q Incidentally, the absence of oxygen under these circumstances, what effect did that have in your opinion, probability based upon a reasonable degree of medical certainty, on the heart or the renal function of this patient?

A To answer your question, I think oxygen is, crucial in patients with shock because it preserves organ function. It preserves cardiac function, renal function, cranial brain function.

And so the absence of oxygen, supplemental oxygen to this patient, worsened his shock over time.

Q When did this patient first start having signs that his heart or brain was having the effect of insufficient oxygen?

A To take the heart first, I think we can't just sort out the oxygen alone. I think this patient was in shock, dnd that's a multifactoral insult to the body, to the heart, to the brain.

But certainly at the time he arrived in the

Emergency Room a 2:30 in the morning, this child was suffering from the multitudinous effects of shock, including the hypoxia associated with shock, and should have been given oxygen.

Q Move to strike as being nonresponsive.

My question was: When did the patient's heart first start having the effects, adverse effects of lack of supplemental oxygen?

MR. BARTIMUS: I think he just answered it. The question has been asked nd answered.

BY MR. MELTZER:

Q Go ahead and answer.

A To clarify my answer a little bit, I don't know when that started in terms of before he came to the Emergency Room, but certainly at the time of arrival in the Emergency Room would be when I would say we have documentation that he needed oxygen.

Q When was the time that the patient's condition with regard to lack of oxygen irreversible? In other words, when would the administration of oxygen, supplemental oxygen, when was the last time that that would have been of no benefit to this patient?

A I think again it's hard to answer that question in terms of the last time. I think he would have benefited from the administration of oxygen through seven or eight in the morning.

As you get closer and closer to the time at which he actually arrested, had a cardiopulmonary arrest, it gets more and more difficult for me to say that any modality or therapy would have prevented his demise.

But I think certainly through the time we've already spoken, and probably until seven or eight in the morning, oxygen would have benefited this child and increased his chances of survival.

Q Do you contend that the failure to give oxygen caused, the failure to give supplemental oxygen caused the death of this child?'

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer.

A I don't think there's a one-to-one relationship, between his not getting oxygen and his death, but I think it contributed to his death because it exacerbated the shock.

Q Incidentally, at 6 o'clock in the morning when Dr. Folkner was seeing this patient, between 6:00 and 6:30 at least, when there is at least a record or notation from the nurse that Dr. Folkner was seeing the patient in the ICU, sometime in that time frame the patient's respirations are 44, are they not?

A Yes, sir.

Q The pulse is 172?

A Correct.

Q And at that point in time, the temperature is now 102 and the pulse or the blood pressure by Doppler is 74.

A Correct.

Q At that point in time, is the patient still in need of oxygen?

A Yes, sir.

Q And is the patient's shock worsening at that point?

A Yes, sir.

Q Is that based on the respirations increasing?

A Yes, sir.

Q Okay.

Certainly they have almost doubled from the time

the patient was discharged from the Emergency Department, from 24 to 44; correct?

A Correct.

Q Do you have any knowledge or information as to why Dr. Hanna did not administer supplemental oxygen?

A No, sir. I think he should have.

Q Do you consider his failure to administer supplemental oxygen between 6 o'clock and 7 o'clock a departure from standard approved medical practice on his part?

A Yes, sir.

Q The same, of course, would be true for the nursing staff at that point in time.

A Yes, sir.

Q Now, at 9 o'clock, the patient's fever or temperature has increased to 104.4; right?

A Yes, sir.

Q And the blood pressure at 6 o'clock went to 70. I'm sorry; at 7 o'clock it went down to 70, and at 9 o'clock it's up to 74.

A Correct.

Q Do you consider that improvement or essentially

remaining the same?

A I think I would look at that blood pressure of 74 in conjunction with a pulse of 200 and say that this boy is doing absolutely everything he can to whip his myocardium to the point of maintaining as much cardiac output as possible.

Q And, of course, his respirations have increased again to 48.

A Yes, sir.

Q Between 7 o'clock and 9 o'clock, there are no other vital signs taken, are there?

A No, sir.

Q And, of course, the patient is becoming markedly worse in that time frame, is he not?

A I think that he's been worsening throughout the time that we've been talking about.;yes.

Q But between 7 o'clock and 9 o'clock, he becomes markedly worse, does he not?

A He's getting ready to arrest; yes.

Q All right.

When you have a patient who is tachycardic and with a blood pressure of 74, he would be hypotensive, would he not?

A Yes, sir.

Q With a patient who is tachycardic and hypotensive, one of the things that you do not do with that patient is administer Inderal. That's a fact, isn't it?

A I would agree with you there.

Q As a matter of fact, you would agree, even though you have no notes about it, that Dr. Folkner's orders to give Inderal to this patient was a gross departure from accepted medical practice, do you not?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Yes, I do.

BY MR. MELTZER:

Q And, of course, the administration of Inderal certainly hastened this child's death, if it didn't cause it; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Yes, sir.

BY MR. MELTZER:

Q As a matter of fact, you would agree with me, would you not, that the administration of Inderal was a

ki

primary cause of the child arresting at the point in time, that he did?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I don't know if I really have a judgment on that. I think the child was getting persistently more and more sick and he may well have arrested anyway, even without the Inderal -- though, if forced, I would say that the Inderal speeded things up by some finite amount.

BY MR. MELTZER:

Q Also, at some time between 7 and 9 o'clock, Dr. Folkner ordered the fluids cut in half, did he not?

A Yes, sir.

Q You would agree with me, would you not, that certainly the reduction of fluids at that point in time would constitute a departure from accepted medical practice on the part of Dr. Folkner, wouldn't you?

A Yes, sir.

Q And that certainly we can see the effects of reducing fluids at that point in time in the vital signs, can't we?

A I haven't studied them specifically with that in mind, but I don't doubt that he got worse at that point; yes.

Q And that reduction of fluids certainly caused and contributed to the child's ultimate demise, did it not?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: It certainly contributed to his ultimate demise; yes, sir.

BY MR. MELTZER:

Q At 5:15 a.m., assume that Dr. Folkner has been to the Emergency Room and is determined that this is a patient that needs surgery for the surgical abdomen.

A Could you start again? You're giving me a hypothetical situation that Folkner was there at 5:15?

Q Sure.

A Okay, this is a hypothetical.

Q Well, sir, let's do it this way.

Have you made a determination in your own mind as to what time Dr. Hanna arrived or are you going to --

A You had said Folkner.

MR. BARTIMUS: Yes, you said Folkner four times,

so let's get our apples and oranges straight.

THE WITNESS: Folkners and Hannas straight.

Hanna?

BY MR. MELTZER:

Q Yes.

A Okay.

Q First of all, have you made your own evaluation or determination as to whether Dr. Hanna did or did not arrive at the Emergency Department at around between 5:00 and 5:15?

A I don't think I've made a judgment as to whether he was there or not. Certainly it's possible that he was there.

Q Assume with me that Dr. Hanna did arrive, as he said he did, at 5:15 and made the determination that this was a child that was going to have to be operated on for the surgical abdomen, but that he didn't feel like that he could operate because the child was too dehydrated at that point.

Certainly at the time the child goes to the ICU, if Dr. Hanna or Dr. Folkner, under whose service the child is admitted under, believes that the fluids are not adequate for proper rehydration, they certainly are in the best

position to increase those fluids, modify the fluid, management in that regard; correct?

A Being the physician there, yes, I agree with you.

Q Of course, even if Dr. Hanna didn't arrive until between 6:00 and 6:30, he still was in a position at that point to modify the fluid management at that point in time if he thought it was necessary in order to put this patient a in a condition that he would then feel comfortable operating on.

A True.

Q Now, at what point in time, sir, did you conclude that this patient, because of either the peritonitis or the dehydration, the shock, was no longer salvageable, could no longer be saved?:

A I can't, you know, as I stated initially, I can't point to a precise minute in this chart and tell you okay, this is where he would have died no matter what they did before this, he would have been salvageable.

I do think though that he was salvageable through the 7, 8 o'clock time frame that we've been talking about till now, so that any of these modalities or changes in therapy that we have now talked about, I think would have,

with some degree of medical certainty, eventuated in his survival had they been effected.

Q Okay.

And, of course, the determination of whether to increase fluids, decrease fluids, take other courses of treatment, would have been under the control of Dr. Hanna and Dr. Folkner at that point in time; correct?

A True.

Q Certainly you would agree that, although you may disagree with the amount of fluids that were given by Dr. Lai, you would certainly agree that at least the administration of fluids was the correct approach.

You may disagree with the amount and timing of those in terms of how quickly those fluids were administered, but you would agree that the administration of fluids was the correct approach, do you not?

A I would agree that the administration of fluid in the right amount is the only standard therapy for shock: yes.

Let me add to that, it's not the only modality that you use. You use oxygen and pressors, and a whole bunch of other things. But fluid is the mainstay of the

therapy of shock and needs to be given in the right amount.

Q In that regard, you of course recognize that different people have -- that there are different schools of thought on how aggressive the fluid management must be and how quickly the fluid management and the aggressive nature of it must be; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I think with respect now to the therapy of shock, not simple mild dehydration, but with respect to the therapy of shock, there is pretty much a unanimous opinion about how aggressive to be with the fluid management.

We quibble about a few features of the management of shock but, in general, I think there is unanimous opinion about the aggressivity and the nature of the aggressivity with the therapy for shock.

Q In that regard, what degree of shock would you consider this child to have when he came into the Emergency Room at 2:30 a.m.? Based on the physical findings, do you considerate it to be mild, moderate, extreme? What degree?

A Between mild and moderate I would say.

Q At 5:15 when the patient left the emergency room, do you consider the nature and degree of his shock to have remained essentially the same?

A I think he had been progressing during that period of time from the mild-moderate to the moderate variety of shock.

Q Certainly shock at that point in time was not critical in nature.

MR. **BARTIMUS**: Object to the form of the question.

THE WITNESS: Shock is always critical in nature. It's a medical emergency.

Q Left untreated is what you're referring to, isn't it?

A Even during the course of therapy it's a critical emergency, and we treat it aggressively because it is a medical emergency.

Q In that regard, that's regardless of whether the shock is mild or moderate in nature or extreme in nature.

A What are you referring to when you say "that is"?

Q When you talk about shock is always a critical emergency, you do not differentiate in that regard between

whether the shock is of a mild degree, moderate degree, or extreme degree; correct?

A The initial therapy of that shock situation does not differentiate between mild, moderate or severe. In the case of severe shock, *you* may be more correct in a more invasive therapy right from the start with respect to placing various lines in the patient, central venous catheters and so on, which you would not be required to do in the face of mild to mild and moderate shock.

But the initial steps in the management of all varieties of shock are the same.

Q When did this child go into what you would refer to or characterize as severe shock?

A I think towards the periods of time that we were talking about a few minutes ago, when the fluid was cut, the propranolol was given. I think at that point the bottom dropped out.

Q Propranolol is the same as Inderal. That's the generic name for it?

A Correct.

Q In that regard then, Dr. Hanna, the surgeon, you would expect him to be competent and qualified to provide

ki

care and treatment for shock, would you not?

A Yes, sir.

Q And the same thing with Dr. Folkner?

A Yes, sir.

Q As a surgeon, you would expect Dr. Hanna to be able to place a CVP line.

A Yes, sir.

Q' And expect him to be able to do a venous cut-down if necessary.

A Yes, sir.

Q How about Dr. Folkner? Would you expect him to place the CVP line or be able to place one?

A Not necessarily.

Q Or do a venous cut-down?

A Not necessarily.

Q Do you contend, sir, that between 2:30 a.m. and 5:15 when this patient left the Emergency Room and went to the ICU, you contend that in that interim period, that 2-1/2 hour period or so, that Dr. Lai was obligated to do a venous cut-down on this patient?,

A Only if he could not start enough peripheral IVs to give the patient the quantity of fluid that shock therapy:

requires.

Q Do you contend that he was obligated, regardless of what the Johnson County Memorial Hospital rules and regulations say, that he was obligated to attempt a central venous pressure line, placement of a central venous pressure line?

A No, not for the initial therapy of this patient's shock. No. If that was properly managed, that would not necessarily be one of the first things done.

Q Even up until 5:15, he would not have been obligated to place a central venous pressure line; do you agree?

A Let me say this. As this patient was mistreated, as he gets closer and closer to the 5:15 point and is starting to progress with his shock, one could argue that a central venous pressure line became more important.

But to answer your question, I think you could either make an argument as of 5:00 or 5:15 that the child was not yet in that severe a shape that a CVP line would be mandatory, especially since he never received an adequate bolus of fluid, an adequate fluid administration.

These are the steps that make you decide to put a

CVP line in or not.

Q Move to strike those portions of the response that are nonresponsive.

My question to you was this: As of 5:15, even the treatment considered that was given in this case and considering the patient's condition as of 5:15, Dr. Lai was not obligated, it was not mandatory for him to place or attempt to place a CVP line, regardless of the fact that Johnson County Memorial Hospital rules and regulations prohibited him from doing so in the Emergency Department.

MR. BARTIMUS: Object to the form of the question for several reasons. First I object to the form in general. Secondly, it's been asked and answered. And, third, it's a compound question.

THE WITNESS: As best as I understand your question, I would agree Dr. Lai did not have a responsibility. It was not part of the standard of care at 5:15 to have inserted a CVP line.

BY MR. MELTZER:

Q Thank you, sir.

Now, from 2:30 to 5:15, what do you consider was the minimum amount of fluids that should have been given

khat would still comply with the minimum standard of carp required for this patient who started out in somewhere between mild to moderate shock, with the other findings that this child had?

MR. **BARTIMUS:** Object to the form of the question.

THE **WITNESS:** Not knowing his weight, I can't give you a milliliter amount but **I** can give you a guideline per kilogram amount.

That is to say, I would say that the minimum therapy this child should have received initially was 20 milliliters per kilogram as an IV bolus over a very brief period of time, as fast as one could run it in, 15 minutes, **20** minutes, would be ideal as the initial bolus.

One then would calculate for this patient, based upon his ideal weight, the fluid requirement for maintenance, in deficit, as has been discussed ad nauseam in the many depositions, for between **a** 10 and 15 percent and, probably in this case a 15 percent, dehydrational status would be the best way to start, and then run that in.

But the most important thing, having done those two calculations and started that fluid therapy, would be

ki

ongoing monitoring of a patient to assess whether or not your therapy is sufficient, because it may not be sufficient. And if it were assessed not to be sufficient based on poor response to the hydrating fluid, blood pressure didn't go up, the pulse didn't come down, the color didn't get better, urine from a Foley catheter didn't start to flow in a period of half an hour or 45 minutes, one would then reassess the situation and re-bolus the patient and, with that second bolus, do the same thing again: How did the patient do? Did the patient get better or not?

And if the patient doesn't get better with the second bolus administration of IV fluids, it's at that point that the surgeon comes in and puts in a CVP line and one has the need for very aggressive therapy in an Intensive Care Unit that is used to managing these kinds of problems:

Q In an Intensive Care Unit that is used to managing these problems.

A Yes, sir.

Q Okay.

Certainly when Dr. Hanna saw this patient at 5:15, there wasn't anything that prevented him from increasing the fluids and ordering a bolus to increase the

rehydration rate; correct?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q And to deal with the shock.

A That's correct. And to weigh the patient and to do many of the things we just talked about now. Yes.;

Q You would agree with me that there is literature in the field that discusses the preliminary bolus, the guidelines for preliminary bolus, to be anywhere from 10 to 20 cc's; correct -- per kilogram?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: If you're talking about the initial bolus therapy for dehydration, yes, there is such literature.

If you're talking about recommendations for the initial bolus of therapy for patients in shock, I don't know of any such recommendations. If they exist, I would certainly quarrel with them.

BY MR. MELTZER:

Q All right.

Is it your position that with regard to shock, the initial bolus must be, and the literature all reflects, that it must be a minimum of 20 cc's per kilogram?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Again, the initial bolus in a patient who doesn't have contraindications for that fluid therapy, yes, that would be the initial bolus.

BY MR. MELTZER:

Q My question is a little bit different than that. My question was: Is it your contention that all the literature indicates that the minimum amount of fluid to be given for the treatment of shock is at 20 cc's per kilogram?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q Again, the initial bolus.

A That's correct, as long as you add the initial bolus.

And I would add the caveat once again that there would be some patients who were known to have certain underlying conditions which might make you not give 20

milliliters per kilogram.

Q What underlying conditions would those include?

A Severe myocardial problems. That is to say, cardiogenic shock where the heart is not working and might not be able to tolerate a fluid load.

Q Any others?

A That's the one that comes to mind right now.

Q Are there some others that you know exist but can't think of them off the top of your head?

A If I knew they existed, I probably could think of them. So I have to answer no, I can't think of them.

Q What is the significance of the BUN results in this case of about 62?

A It shows poor perfusion of the kidneys. The kidneys are not putting out urea nitrogen into the urine and so it's accumulating in the serum.

Q What does that tell you?

A It tells you that the patient is either severely dehydrated or, worse, in shock.

Q With regard to the other laboratory studies that were done, the lab tests, the CBC of 16,000 that was obtained, I think the blood was drawn around 3:45 or so the

ki

results back around 4:15 or so.

In that regard, what is the significance to you of the blood results? Anything?

A The white count results to me suggest infection or stress. It doesn't necessarily have anything to do with the shock or dehydration, however.

Q It does tell you that this patient, 16,000 white cells, you agree there was a left shift, do you not?

A A very significant left shift.

Q It tells you that there is significant infection ongoing at the time, does it not?

A It tells you that that is one possibility. The other possibility is any serious stress could produce that.

But I would agree with you in this particular instance that physical examination of the patient, showing peritonitis, and this white count go hand in hand very nicely.

Q Have you come to any opinions or conclusions, sir, as to what point in time the patient's appendix ruptured in this case?

A I haven't really even thought about that seriously in terms of my opinions about the case. I would

judge, sitting here right now, that it was more than just several hours before the patient arrived in the Emergency Room. I would expect that we are dealing in terms of a day or more that this patient's appendix ruptured?

Q When you say several hours, several hours to one person can mean one thing, and several hours to somebody else could mean something else, couldn't it?

A Yes.

Q In your view, though, in this particular case, you think the appendix had to rupture a day, maybe even two days before?

A I think that's my best judgment on that.

Q With a patient who, at the time of initial presentation has a white count of 16,000 and a dramatic left shift with the findings of peritonitis, and later at autopsy shows up with 200 cc's of purulent exudate, that tells you that this patient has severe ongoing infection, does it not?

A Yes, sir.

Q What, sir, in your opinion, what was the primary, cause of death in this child?

A Shock.

Q And it's your view that the shock caused the

child to go into cardiac arrythmia or cardiac failure?$

A Correct.

Q Is it your contention that the infection played no role in the death of this child?;

A Oh, I think the infection contributed in part to the shock, so yes I do think it played a role in the death of the child.

Q How did it contribute to the shock?

A I think in several ways probably. Certainly one way is by third spacing. He had lost fluid into his peritoneal cavity. That fluid was no longer available for circulation in his circulatory system, and that contributed to the shock.

And, secondarily, this question of endotoxin-mediated shock, septic shock, is a possible contributing factor to his shock state.

Q When did this child first show evidence or signs of being in septic shock?

A It's hard to answer that question. I don't know that I can give you again a specific minute where I think that was the major operating feature of his disease, except to say that as he presented to the Emergency Room, to me

looking at the records he appeared to be more in hypovolemic shock than in septic shock based on the physicai examination khat Dr. Lai gave.

That's about as good an answer as I can give.

Q What aspect of the presentation at the Emergency Room was it that suggested to you that it was hypovolemic shock as opposed to septic shock, at least as the primary component?

A The sunken eyeballs, the turgor of the skin, the dry mouth. Well, those would be the three major components.

Q What were the first signs that you recall from the records that would indicate that the child was going into septic shock?

A Again, as I answered before, I can't look at the record and give you a specific minute to say this is --

Q I'm not asking for a specific minute. I'm asking for the findings that would suggest septic shock.

A Let me answer by saying this. Since this patient's shock, hypovolemic shock, wasn't treated as hypovolemic shock in my view, it's hard to know -- and in my view, this child certainly never got to a point where his intravascular volume was repleted so that one could judge

that he now had third spacing in capillaries, intravascular third spacing if you will, which is the hallmark of septic shock$

I can't tell you for sure that this patient even had septic shock. I would say it's likely, given the pathology report of all this pus in his peritoneum.--

Q Sure. With 200 cc's --

MR. BARTIMUS: Let him finish his answer.

Go ahead.

THE WITNESS: But since they never corrected the fluid deficit for the hypovolemic component, which you would have to do before you could then say why isn't this patient now responding to this fluid therapy -- well, maybe he has septic shock, and go *on* with that algorithm -- I can't tell you for sure that this patient had septic shock, except to say he had a lot of infection and many patients with a lot of infection have some component of septic shock(

BY MR. MELTZER:

Q Certainly with 200 cc's of purulent fluid and the white count with the increased white count left shift, the probabilities are that this patient did have septic shock at that time.

ki

A Let me just answer by saying that patients with pneumococcal pneumonia, who are better in 12 hours, have a white count a hell of a lot worse than what we see in this case, so I wouldn't look on the white count as any indication that this is septic shock.

Q I didn't say that. I said in combination, the white count left shift, and the 200 cc's of purulent fluid in the abdomen, certainly the probabilities are that that patient was in septic shock.

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

a You would agree with that, would you not?

A No, sir.

Q Are you telling me, sir, that you have no opinion or that in your opinion the child was not in septic shock.

A I'm telling you this, and I think I stated already that it's likely that sometime during the course of this child's hospitalization, septic shock became part of this shock picture.

But I can't tell you when it was, since they never corrected or treated appropriately the hypovolemic

component to his shock, which would then allow you to say hey, there's something more going on, and -- I'll just stop right there.

Q In your notations on Exhibit 2 on the right-hand side of the page, you have listed a number of items, most of which you say "no," and then you itemize certain things.

Are those the items that you contend are the failures or departures on the part of the physicians in this case?

A Yes.

Q All right.

The first one you indicate is no weight.

I assume you are referring to the fact that no weight -- that this patient was not actually formally weighed.

A Correct.

Q The next one was no blood pressure taken or at least no pressure recorded at 2:28; correct?

A Correct.

Q Now, you would agree that normally it's the nurse who is responsible for recording the blood pressure when it's taken on admission, do you not?

ki

A That's true.

Q And I take it that from all of these items, you haven't attempted to differentiate particularly which health care provider it was that failed to do what: correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Correct.

BY MR. MELTZER:

Q Also, nursing staff can certainly weigh the patient. In fact, typically the standard of care is for the nursing staff to weigh the patient; correct?

A The standard of care is for the nursing staff to know to weigh the patient and for the physician to order it if the nursing staff overlooks it.

Q And it may be that the nursing staff has weighed a patient and has simply forgotten to write down what that weight is; correct?

A That's possible.

Q But particularly in Emergency Room emergency situations, nursing staff will orally advise the physician of the weight in that regard; correct?

MR. BARTIMUS: Object to the form of the

question.

THE WITNESS: I think in emergency situations, there is a place for rapid oral transmission of information to allow a physician then to act within the standard of care and deliver, in this particular instance, the correct amount of fluid for his patient, based on that oral documentation of the patient's weight.

BY MR. MELTZER:

Q All right.

Further, physicians often times will estimate what the patient's weight is; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I would say yes, that a lot of physicians estimate what the patient's weight is.

BY MR. MELTZER:

Q And then rely upon that estimation in calculating their fluid management in the care and treatment of the patient; correct?

A I would say they would rely on that estimation for calculating fluid management for the very beginnings of the fluid management, but the standard of care would require

that physician to get an accurate weight on the patient as soon as possible so that he could tailor fluid therapy to that patient's true weight.

Q That tailoring occurs in many instances after the patient is out of the Emergency Room and in the ICU; correct?

MR. BARTIMUS: Object to the form of the question as hypothetical and not assuming sufficient facts on which this expert can base an opinion.

THE WITNESS: In specific regard to this patient, I would say that no, one could not allow a patient to spend three hours in the Emergency Room being treated as this patient was treated, without any fluids, and well enough to be sent to X-Ray for an x-ray, and not obtain a simple weight on the patient,

BY MR. MELTZER:

Q Was this patient, while he was in the Emergency Room, alert and coherent and cooperative?

A There are very scanty nursing notes in that regard. What I read of this child's mental status while in the Emergency Room would suggest that yes, he was alert and coherent.

a What does that tell you about his condition?:

A With respect to this patient's illness, it would tell me that his shock is early enough such that one could expect a good outcome if therapy is appropriately applied.

Q It also tells you that his condition at that time is more toward the, like you say, early stage and more toward the mild degree of shock: correct?

A I think we're saying the same thing; yes.

Q And, of course, in that regard, then the amount of fluids that would be necessary if they were maintained over the course of time, would perhaps be less than what would be needed for a patient who is in, say, severe shock: correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I wouldn't look on the differentiation of mild versus severe shock and draw a conclusion as to the total amount of fluid required to resuscitate those two different patients, at least initially.

I would rather look on those two varieties of shock as a way of discriminating between those patients who

can undergo a trial period of aggressive fluid management without invasive monitoring -- that is, a Schwangantz catheter and a CVB catheter on the one hand -- versus those patients who are going to have treatable shock that will be reversible in six or eight hours and who never need to have that invasive monitoring.

But it does not differentiate, again as I stated before, the initial stages of the management of the fluid resuscitation of those two varieties of shock.

BY MR. MELTZER:

Q So that we're clear, are you saying that the patient's condition of being alert, cooperative, and coherent do not affect the amount of fluid that would be administered for the treatment of mild shock, early mild shock, as opposed to severe shock?,'

MR. BARTIMUS: Object to the form of the question. It's been asked and answered.

BY MR. MELTZER:

Q Go ahead and answer.

A Again, the initial stages of the fluid resuscitation of both varieties of shock that you've just laid out in your question would be identical.

Whether the patient in severe shock would be sicker longer in the hospital, and require more fluid over the next three or four days, perhaps that would happen. But we're talking in this three, six, 12-hour period, no difference in the amount of fluids that we would give to those two varieties of patients.

Q Then you report no BUN, approximately 6 a.m.

A Correct.

Q You're referring there to the fact that at 6 o'clock a.m. no BUN was ordered; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I'm referring here to the fact that Dr. Lai did not order a BUN with his laboratory evaluation of the patient, that the BUN was subsequently ordered I believe by Dr. Hanna, although it might be Dr. Folkner -- it's in the record -- at about 6:00 or 6:30 through a verbal order, I believe.

BY MR. MELTZER:

Q And that wasn't accomplished until 8:45.

A The results of that.

Q The results of that.

A I believe that's correct.

Q Do you contend that the failure to obtain a BUN caused or contributed to the death of this child?

A Yes, it may well have.

Q And how is that?

A One of the ways of knowing whether or not you're getting ahead of a patient in shock is to see whether or not the BUN is in fact diminishing with therapy.

So to get a BUN at 2:30 in the morning, when I think it should have been obtained, that is -- we'll pick a number that's not in this record, but just for the sake of argument -- that's 100, and then to repeat that BUN two hours or three hours later as you've gone through the initial stages of fluid resuscitation and see that it's now 60, is a good evidence that you're doing better for the patient.

Whereas if that BUN is still 100 or it's 97 or it's 102, you'll reassess the situation much more aggressively and say, wait a minute, this is not the way it's supposed to be; we've either miscalculated the fluids, we've misweighed the patient, or he's got another process such as septic shock going on and we need to do X, Y, and Z

now.

BY MR. MELTZER:

Q Do you have an opinion, sir, probability based upon a reason degree of medical certainty, as to what you,

which was the result of the BUN being ordered at 6 a.m.?

A Again, it would be a judgment based on my* knowledge of how much fluid this child was getting, that the BUN probably was not much different than 62 at the 2:30 or 3:00 time frame that we're talking about now;

Q Previously you were talking about the BUN being in the range of 100.

A That was a hypothetical. I'm just making it easy as a number.

Q All right.

If the BUN is at 62, what does that tell you about the nature and degree of the shock and the condition of the renal system of the child in terms of its ability to function?

ki

A Again, that's one of the reasons we measure BUNs over time, because one single BUN does not differentiate between a kidney that's not working because it's infarcted or severely infected or absent -- you know, you could go on with a long list of things that would be intrinsic renal disease that would cause an elevation in the BUN -- versus what's known as pre-renal azotemia, which means an elevated BUN because the blood is not getting to the kidney in sufficient quantity for the kidney to extract the BUN from it and put it into the urine.

And so one of the other reasons one measures repetitive BUNs is specifically to answer the question that you just posed: Is this patient's elevated BUN because of the shock, or is this patient's elevated BUN because of some underlying serious renal problem that will in fact complicate my management of this patient's shock as he gets towards normal volume repletion?

Q Based on the autopsy in this particular case, did you find any evidence of necrosis or ischemia related to the renal system?

A I believe the kidneys were reasonably normal at the time of autopsy.

Q So that regardless of the BUN being 62, there was no indication of pathologic abnormality of the renal system; correct? Of the kidneys?

A Can I answer by saying there was no intrinsic renal disease?

Q No, that's not my question.

My question was: Was there any evidence of necrosis or ischemia, lack of blood to the kidneys, and their inability to function at that time?

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q On autopsy.

A On autopsy, I believe -- and we can look at the record -- but I believe the autopsy showed no injury sustained by the kidney by virtue of this child's shock, as well as no intrinsic renal disease which would explain an elevated BUN.

Q You have also indicated here, at least you've criticized or apparently criticized the administration of -- what's that, potassium?,

A Yes.

Q -- before urine.

And I assume you're talking about obtaining a urinalysis?

A No, sir.

Before -- the cardinal rule of giving potassium, to a patient is to be sure that a patient, especially a patient in shock, is capable of making urine. That is to say, you're trying to be sure not to give potassium to a patient who has intrinsic renal disease, because elevated potassiums are very difficult to deal with.

So the standard of care is to give IV fluids without potassium until you have assured yourself that the urine -- that the kidney can make adequate amounts of urine and eliminate potassium from the serum, should it become elevated.

Q Do you have any evidence that the potassium level in this child ever became markedly abnormal?

A No, sir. I don't think this contributed to his demise.. I just think it was a deviation from the standard of care.

Q A deviation that had no cause or contributing effect on the outcome.

A Yes, sir.

Q Then the next thing you note is no oxygen. We've talked about that to some extent.

Between 2:30 and 5:15, do you have any notations or do you see any notations in the record that would indicate that the child's condition deteriorated as a direct result of the absence of supplemental oxygen?

A Again, as I stated before, I don't think the record could show a one-to-one correlation between deterioration and only the absence of supplemental oxygen, since there were many other things going on with this patient that were not being addressed properly.

Q Then the next is the QNS fluids.

Again, that relates to the fluid management.

A Correct.

Q You then make a note about no colloids?

A Colloid.

Q Colloid. Okay.

You're talking about the expanders?

A Yes, sir.

Q In that regard do you contend that the use of normal saline in this particular case constituted a

departure from accepted practice?:

A No.

I think to expand on what I meant by no colloid in this list that we're now reading, if a patient doesn't respond to the initial fluid challenges, the initial boluses of fluid -- if the pulse doesn't come down, the blood pressure doesn't drop, all the things we've spoken of before -- one has to go through a series of thoughts as to what next to do for the patient, one of which would be to give colloid, plasma, fresh frozen plasma, a whole bunch of possibilities.

I can't really look on this as a strong criticism of the care. That is to say, I don't believe that not giving colloid was a deviation from the standard of care because in fact Dr. Lai did not go through the initial proper steps with crystalloid. But I did list this because it wasn't given or even considered that I saw in the record.

Q In that regard, so that we're clear, do you, contend that the failure to have administered colloids constituted a departure from accepted medical practice in this case?

A It's a very hard question to answer because if

Dr. Lai felt strongly he was treating this child's shock properly with the fluid he was administering, and the patient wasn't any better after a period of an hour, then he should have said, oh, my goodness, I think I'm going to give this child some fresh frozen plasma.!

Now, I don't 'think he was treating the patient properly, and so from the proper medical perspective the answer to your question is -- directly as I can -- no, it was not a deviation from the standard of care to have not$ given colloid to this patient.

Q Thank you.

The answer to my question is no then: it was not a deviation.

A That's right.

Although within Dr. Lai's intrinsic reasoning process it should have been given, but it would not be a violation of the standard of care.

Q Move to strike that portion of the response from the former answer and from the last answer that were nonresponsive to the question.

I only asked whether it was a departure or not a departure.

Now, do you contend, sir, that the failure to administer colloids caused or contributed to the ultimate demise of this patient?

A No.

Q Then the next notation here is substandard -- is that a-b-d or -

A a-b-x, antibiotics..

Q Antibiotics.

First of all, are you familiar with Claforan?

A Yes, I am.

Q Being in infectious diseases, I assume that you have studied all of the various antibiotics that have ever been marketed; correct?

A No, sir; that would not be correct.

MR. BARTIMUS: Object to the form of the question.

BY MR. MELTZER:

Q With regard to Claforan, you recognize it to be a third-generation cephalosporin, do you not?

A Yes, sir.

Q Do you contend that the administration of Claforan itself constituted a departure from standard

accepted medical practice as one of the reasonable alternatives to antibiotic therapy for the initial phases of a patient with peritonitis and surgical abdomen?

MR. BARTIMUS: Object to the form of the question. It's a hypothetical and does not assume sufficient facts on which this expert can base his opinion,

BY MR. MELTZER:

Q Go ahead and answer, sir.

A I think in this particular instance, Claforan was an acceptable antibiotic, although perhaps a reasonably poor choice, but within the standard of care.

Q All right, fine.

In that regard, we talk about th'e spectrum of the standard of care going from the ideal to the substandard.

This fit within that category that is within the standard, but not ideal and not substandard; correct?

A I'd say it's about as poor a choice as you can make and still say you're doing okay for the patient.

So, yes; towards the end of the spectrum that gets towards substandard, but not substandard.

Q Certainly you don't contend that the administration of Claforan as opposed to -- I'll withdraw

ki

that question.

We've already talked about the CVP; right?

A Yes.

Q And with regard to antibiotics, you're aware, of course, that Dr. Lai discussed the administration of antibiotics with Dr. Folkner, are you not?

A I think there are two different variations of what conversation really existed with respect to the antibiotic. There was a discussion that went on.

(Whereupon, a discussion was held off the record.)

BY MR. MELTZER:

Q Certainly when Dr. Hanna started caring for this patient, if he thought another antibiotic would have been better and more useful under the circumstances, he had not only the opportunity but also the right and responsibility to change the antibiotic therapy and fine-tune it in that regard; correct?

A Yes, sir.

Q The next item that I'm reading here says no -- is that b-l-d?

A Blood culture".

ki

Q No blood culture.

Q How long does it take to obtain a blood culture?

A A minute.

Q But how long does it take to have a result from that blood culture that will give you any information that would be beneficial to the care and treatment of the patient?

A Twenty-four to 72 hours.

Q The failure to order a blood culture at 2:28 or 2:40 a.m. didn't have one iota of effect on this particular patient, did it?

A In terms of eventual outcome?

Q Yes.

A No, sir; it did not;

Q Also, the antibiotic that was administered does provide for a broad spectrum coverage of gram-negative as well as other types of bacteria; correct?

A With the exception of enterococci, Pseudomonas, and bacteroides species, Claforan is a broad-spectrum antibiotic that's effective against the organisms you mentioned.

THE WITNESS: Can we take a quick break?

(Brief recess.)

BY MR. MELTZER:

Q The next item that we have is the reference to no monitoring. You've got, it looks like "clinical" and then --

A Electronic.

Q -- "electronic." Okay.

Do I understand you to refer to that there was no monitoring of any type?

A No; that there was insufficient monitoring.

Q Relative to clinical monitoring in terms of vital signs, things like that, that's typically left to the nursing staff to monitor that and to record that information, or certainly at least to report it to the physician orally; correct?

A In patients who are not in shock, I would think, that is very often the case. In patients who are in shock, the response to the IV fluids that the physician is giving is such important information that I think it's the physician's responsibility to either take those measurements himself -- that is, the quality of the patient's pulse, his blood pressure and so on that we talked about before -- or

to give a verbal and/or written instruction to the nurse to let him know everything he wants to know at the intervals he wants to know it.

Q Do you have any knowledge or information to the effect that Dr. Lai did not request that the nurse that was there in the Emergency Room advise him of the patient's clinical status and vital signs during the course of the 2-1/2 hours that the patient was in the Emergency Room?

A All I see in the note from the Emergency Room are three partial recordings of the patient's vital signs, which I think in a case of a child in shock is insufficient monitoring by any stretch of the imagination.

So to answer your question, while I don't have any deposition from the nurses in the ER to say what Dr. Lai ordered them to do, if he ordered them to do hourly vital signs, it was Dr. Lai's failure not to have gotten enough vital sign information, specifically because he had infused a bolus of fluid and needed to know the effect of that bolus over the next short period of time on this patient's cardiac situation.

Q What period of time do you contend to be the minimum acceptable period of time for obtaining information,

the intervals for obtaining information on the vital signs?

A I think in the first several hours in the Emergency Room setting of a child in shock, it should be done every 15 minutes as a minimum, if not continuously on a monitor.

Q And by "monitor," you're talking about the cardiac monitor, an EKG monitor?

A Right; and/or an A-line monitor to see what the instantaneous blood pressure is for the patient.

Q In that regard, your criticism relates to the failure to monitor the pulse. Anything else?

A Respirations.

Q Pulse, respiration.

A Blood pressure, color, urine output, mental status.

Q Well, a cardiac monitor doesn't monitor the urinary output, does it?

A No.

I was giving you a generic answer.

Q My question relates to monitoring that a cardiac monitor would provide. The concern there relates to the pulse; correct?

ki

A Correct.

Q Respirations would be monitored by the nursing staff at any rate; correct?

A Many monitors in Intensive Care Units and ERs now have a respiratory monitor that will tell you minute to minute, second to second, what the respiratory rate is.

Q But typically that's done in most Emergency Rooms, typically that is done by the Emergency Room nursing staff; correct?

A I would agree that it certainly would be reasonable and within the standard of care for the ER nurses to record this patient's respiratory rate every minutes; yes.

Q Of course, when you get down to talk about recordation, the key in Emergency Room care, as in the rest of medicine, the key is the monitoring or the care, and recordation is a secondary matter; correct?

MR. **BARTIMUS:** Object to the form of the question.

BY MR. MELTZER:

Q Go ahead and answer. . . .

A I would agree with you in the sense that when

things are happening so quickly in an Emergency Room setting for an acutely ill patient, if you have to judge between writing a note and taking care of the patient, for certain you take care of the patient and do what needs to be done, and then write the note when you have time.

As it relates to this patient, I just don't see it as being that busy in the Emergency Room, from my recollection of Dr. Lai's deposition, or that this patient's needs were so great they couldn't in fact have done the monitoring that I think should have been done and recorded that information.

Q Again, it is the nursing staff that you generally rely upon to make those recordations of the vital signs;' isn't it?

A Again, the answer is yes. If the doctor orders vital signs, the nursing staff has a responsibility to record them$

If the nursing staff doesn't record them, tiie physician should say please put them down, record them!

Q Of course, if the nursing staff doesn't record them at the time, and .then the doctor says at a later time, where are the vital signs recorded, and the nursing staff

says, well, we forgot to record them or we didn't get them recorded and I forgot what they were, there's not a lot that can be done in that regard, is there?

A Well, the situation you described, where the patient has already left the unit, let's say, sure, you can't -- unless the nurse made the notes on her uniform or something -- you can't recreate those records.

But specifically, not to talk in a vacuum but to talk about this patient before the court today, if Dr. Lai undertook to give this child a fluid challenge at 2:40 in the morning, he should have known, he should have sought to know the response of this patient's vital signs every 15 minutes thereafter. And that would have given him multiple opportunities to tell the nurse, I told you take the vital signs; what are they; and please write them down because you haven't written them down.

He would have had three such hours to do that, or almost three such hours to do that.

Q Certainly the most important thing would be for him to ask what the vital signs were.

You would agree with that, would you not?

A I think the most important things would be to

know what the vital signs were; yes, sir.

Q And that can all be communicated orally in that regard; correct?

A That's true.

Q You also have a note here that says "MS, thready pulse, pallor and I&O."

A Correct.

Q What does the MS stand for?

A Mental status.

Q Mental status: okay.

This patient, from the time that he came in until the time he left the Emergency Room remained in essentially the same condition of being alert, cooperative, and coherent, did he not?

A Except for the one notation I am aware of in the Emergency Room about this patient's mental status -- maybe there are two, but I believe there's only one -- I don't know of any other notation about his mental status until he arrives in the ICU at 5:15 and he's noted to be drowsy by Nurse Wise.

So whether he was drowsy for some time before that, I don't have any information.

Q Sir, as a matter of fact, the very first thing in the 5:15 note by Nurse Wise says "alert," doesn't it?

A And right underneath that it says "drowsy."

Q Now, the patient, as you have previously discussed, the patient can't be alert and drowsy at the same time, can he?

A In fact, a patient can have waxing and waning mental status and be alert for 15 minutes, and then be drowsy for 15 minutes, and then be alert for 15 minutes. And that is in fact one of the ways in which we see shock present and progress, with waxing and waning mental status.

Q The nurse who recorded the condition of the patient at the time he was transferred from the Emergency Room to the Icu indicated that the patient was stable; correct?

A Yes, sir.

Q And did not indicate the patient being drowsy or incoherent or unresponsive, did she?

A There was no notation of that.

Q That would be a significant positive finding that you would expect to be recorded if, in fact, that was the condition; correct?

A We just went through a whole list or a whole long several pages of questions and answers about whether a nurse needs to note everything in the record and when the nurse needs to note it, but I would agree with you; yes, it certainly should have been put into the record.

Q I note here you indicate that at "4:15 did not tell Dr. Folkner that unable to reach Hanna for one hour." And then you have something about "transfer."

You are concluding that Dr. Lai did not tell Dr. Folkner that he had been unable to reach Dr. Hanna?

A That's his statement in his deposition; yes.

Q You recall Dr. Folkner indicating that he was aware from his conversations with Dr. Lai that he had not been able to reach, that Dr. Lai had not been able to reach Dr. Hanna as of shortly after 4 o'clock.

A Yes, sir; I do.' There is a discrepancy between the two physicians' recollections of those events.

Q Right.

Dr. Lai simply indicated that he didn't recall whether he told Dr. Folkner about being unable to reach Dr. Hanna, and Dr. Hanna said, I do recall him mentioning that, or words to that effect.

A I'll let the deposition stand as it is. When I read the deposition, this is what I extracted from it. We can check. I probably have the page notation on the front of the cover.

Shall we check, just so we can clarify this now?

Q I don't need to ask any further questions. I'll go on to something else, because the depositions will speak, and the witness will testify at trial in that regard.

Now, the next item, this note about transfer." What are you referring to there?

A That if a physician is taking care of a patient in shock and it's everybody's opinion that a surgical consultation is urgently needed, after a period of trying to get the surgeon for an hour, if the surgeon can't be reached, the next logical step would be to say, let's get this patient to a facility where we can get a surgical evaluation as well as care, in this particular patient's case, of the patient's shock.

Q Sir, at 4:15, do you have an opinion as to whether this patient could have been operated on at that time?

A No, sir.

ki

Q And that's because you are not a surgeon in that regard.

(Pause.)

A Oh, do I have an opinion? Yes, I have an opinion. I'm sorry; I misanswered your question.:

I have an opinion. No, I don't think this patient could have been operated on at 4:15.

Q Do you have an opinion as to whether this patient could have been operated on at 5:15 in the morning?

A Yes, I do.

Q What is that?

A No.

Q Do you have an opinion as to whether there was any point in time that this patient could have been operated on?

A No, sir. I think the shock was so persistent and worsening that I think it would have been improper to have operated on this patient, given the way this child was treated for his shock.

Q As we have already discussed, once Dr. Hanna got there, certainly knowing what condition he needed the patient in to do surgery and knowing how to treat shock, or

presumably knowing how to treat shock, he certainly was in the best position in the ICU from the time the kid was in the ICU on, to know what to do to improve the child's condition and put him a condition to be operated on: correct -- as far as he was concerned?

A Again, I'm not sure I understand your question. I don't know that I would agree that he was in the best position to know how to improve the patient's situation --

Q No, I don't mean that.

A -- because obviously you and I have agreed that Dr. Hanna deviated from the standard of care in improving this patient's situation for surgery.

So that's my answer to that question.

Q But what I'm getting at is that Dr. Hanna would be in the best position to evaluate whether this child could be operated on and what needed to be done in his view to bring the child to the condition that he would be willing to operate; correct?

A I think Dr. Hanna or any competent surgeon would be able to make a decision that this child's shock was too severe to allow an operation now: let's get the shock better.

ki

Q Other than the items that we've talked about that are on your list here, and ones that we talked about regarding the reduction of fluids by Dr. Folkner, and the administration of the Inderal, are there any other departures from accepted medical practice that you have identified in this case by any health care provider?

A No.

I don't know that we really discussed the item I listed on the sheet on 3/16 in terms of Dr. Lai's departure from the standard of care in not demanding Dr. Folkner to come to manage the patient with shock.

Q In that regard, you're saying that here's Dr. Lai with this patient in the Emergency Department, and he calls Dr. Folkner and describes the condition but does not say, Dr. Folkner get your body down here and take care of this patient who needs your attention.;

You consider that to be a departure on the part of Dr. Lai.

A Again, assuming that he -- let me go back.

I think the major departure on the part of Dr. Lai was not to have diagnosed shock, which I don't think he did. But I also believe that a physician should be able

to diagnose shock and, having done that, should demand that the private physician, whoever is responsible for this patient's care, come in and manage this patient.:

Q Based on the findings that Dr. Lai had, assume that he related the essential findings that he had to Dr. Folkner, would you expect Dr. Folkner to recognize that this patient was in the early stages of mild shock at that time?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: It's a hard thing. A physician who's woken up in the middle of the night from a deep sleep and who gets -- I've never heard Dr. Lai talk, I don't know what kind of accent he has -- but who gets a rapid summary of a patient over the phone, I would think there would be instances where some of that would be lost in the fuzziness of grogginess of sleep, which wouldn't be the case in the normal daytime hours when you would expect the guy to really know where his brain his.

So one of the things that happens, I think, often times in the case of a phone call in the middle of the night to a physician, is a rehashing or a repetition or a more

structured approach to what you want done or what should be done with the patient than you might request during the course of a daylight hour.

And I'm not here to defend Dr. Folkner with regard to this, but it certainly is possible that he heard very quickly, the pulse is 172, the blood pressure is 80, the patient's dehydradated, and didn't process the information because he was still recovering from his sleep.

Which is why I think a physician such as Dr. Lai in seeing such a sick child should say, this kid is really sick and, shock or not shock, he's so severely dehydradated with peritonitis, come on down and have a look at him because he's going to be hospitalized and he's going to be your patient, and go on from there.

Q When he describes the condition of the patient and he talks about the fact that the child is dehydrated and he appears to have a surgical abdomen of sorts, peritonitis, that you would expect the physician, particularly if it's a family physician for the patient as opposed to a consultant, you would expect the family physician to come down and see the patient who is described as having this acute illness, would you not?

A I would answer your question yes. If a physician is notified that this patient is as this patient presented, the responsibility would be then for that physician to come in and see the patient and take over.

If the physician doesn't do that, the only determination I believe the referring physician, Dr. Lai in this case, the ER physician could make is that he didn't understand what I really was talking about initially. I'm going to tell him right now, this child is real sick; you should come in.

Q Isn't it a fact that during the phone conversation between Dr. Lai and Dr. Folkner, Dr. Lai obtained from Dr. Folkner the instructions about some of the treatment to be provided and about the admission of the patient to the hospital and things of that nature.

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: Again, it depends on which deposition is the one you want to look at.

Dr. Folkner says he gave no recommendations to Dr. Lai. Lai outlined the plan of approach for the patient and he said, sounds good; whereas I believe in Dr. Lai's

ki

deposition he states, listen, I got the recommendation for the antibiotic from Folkner and some of the other things.

So I don't know which is the proper story, but either way, however you cut it, I believe it was a requirement on Dr. Lai's part to demand someone come in now and take care of this sick patient. And if it didn't jar Folkner at 2:30 or 3:16 in the morning enough when he heard the presentation, I think Lai should have said, this child is so sick I think you should come in and see him and take care of him.

Q In that regard, though, Dr. Lai -- if you will' recall what you just said about Dr. Lai relating information and, according to Dr. Folkner, Dr. Lai made certain recommendations or suggestions of approach, and Dr. Folkner, said, sounds good to me -- and one of those things was to get Dr. Hanna in. In fact, Dr. Folkner told Dr. Lai to get ahold of Dr. Hanna.

A Correct.

Q Then in that regard, if Dr. Hanna does not come in when Dr. Folkner talks to Dr. Hanna at 4 o'clock, as Dr. Folkner recalled, wouldn't you at that time expect Dr. Folkner to come in and participate in the care of this

patient?

MR. BARTIMUS: I'm going to object to the form of the question. There's no evidence that Dr. Folkner talked to Dr. Hanna as you've just indicated on the record.

MR. MELTZER: I didn't say he talked to him. I said --

MR. BARTIMUS: Would you read back his last answer?

MR. MELTZER: If it will help, I'll rephrase it.

MR. BARTIMUS: If you'll rephrase it, I will withdraw the objection.

BY MR. MELTZER:

Q Sir, you will recall that Dr. Folkner indicated that he had talked to Dr. Lai and told Dr. Lai to get ahold of Dr. Hanna, and that at around 4 o'clock or so, Dr. Folkner recalled having a conversation with Dr. Lai in which Dr. Lai indicated to him he hadn't been able to get ahold of Dr. Hanna,

Now, with that in mind, don't you agree that Dr. Folkner at that time should have come down to participate in the care and treatment of this patient when the consultant that had been recommended, this Dr. Hanna,

ki

wasn't there to provide there to provide the care and treatment that Dr. Folkner had talked to Dr. Lai about?

A That would be certainly one way of satisfying the standard of care. The other way would be for Folkner to day, get Life Light and transfer this patient.

Q You are aware, of course, are you not, that Dr. Lai did 'not have the authority to transfer the patient without the -- that he did not have the authority to transfer the patient. That authority had to come from Dr. Folkner or Dr. Hanna, one of the staff physicians;

You're aware of that, are you not?

MR. BARTIMUS: Object to the form of the question. That is absolutely a misrepresentation of the evidence in this case.

MR. MELTZER: No, it's not.

BY MR. MELTZER:

Q Go ahead.

A I can't answer your question. I don't remember the policies and procedures well enough for that question to answer.

But whatever the policies and procedures of the hospital are, that's what they are.

Q Certainly neither Dr. Folkner nor Dr. Hanna ever suggested that this patient be transferred until such time as the patient had already gone into cardiac arrest; correct?

A That's true.

Q And if anybody thought that this patient needed to be transferred because they were unable to handle the patient, it would have been Dr. Hanna or Dr. Folkner who was seeing the patient after 5:15, knowing what their surgical skills were and what the skills were available to them by their hospital staff; correct?

MR. BARTIMUS: Object to the form of the question.

(Whereupon, a discussion was held off the record.)

THE WITNESS: You're going to have to go over that question again.

MR. MELTZER: Would you read that back?

(The reporter read the record as requested.)

THE WITNESS: To answer, I wouldn't necessarily agree with your question in its entirety. I think Dr. Lai was equally as capable of making a judgment for this

judgment that transfer was indicated as Dr. Hanna or Dr. Folkner; the more so, given the fact that when Dr. Hanna finally did see the patient at whatever time it was, surgery was no longer a consideration, and what was really the consideration was everybody's skills in managing this patient's shock, which appeared to be, in my reading of the record, very substandard.

And I think they should have recognized, all three of them -- Dr. Lai, Dr. Hanna, Dr. Folkner -- should have recognized that they were not capable of managing this patient's shock, and that was an additional reason for getting this patient to a facility where shock could be well managed.

BY MR. MELTZER:

Q Sir, at 5:15 the patient was transferred to the ICU under admitting orders of Dr. Folkner to his service, and Dr. Hanna to be seeing the patient; correct?

A Correct,

Q Certainly at the time the patient left the Emergency Room, the patient's shocked condition was not such, that it was severe at that point in time and untreatable at that time; correct?

ki

A I would agree with you: yes.

Q And Dr. Lai was entitled to assume that Dr. Hanna or Dr. Folkner could make the assessments about whether or not they were capable of taking care of the patient and whether any fine-tuning or modification of the therapy that had previously been given was necessary: correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: I think you're correct in part, but I don't think that absolved Dr. Lai from an independent responsibility for him to say, my goodness, I have treated this patient for shock as best as I know, or for severe dehydradation as best as I know how, and here it is two hours down the line of my treatment, and this child is no better and may getting worse; which would be an independent assessment he had to make, since he was the doctor on the scene from 2:30 to 5:15, the only doctor on the scene, and which would require either a change in therapy that he effected or a recommendation to transfer the patient, or a recommendation to Dr. Folkner, get your body in here and help me with this patient because things are not going the way they should be going. And none of that was done.

BY MR. MELTZER:

Q When Dr. Hanna came in, if Dr. Hanna indicated to Dr. Lai that he had no problems and did not see anything wrong with the treatment that was being provided at that time, your testimony is, as I understand it, that Dr. Lai was not entitled to rely on Dr. Hanna as the surgeon who would be performing the surgery in that regard.

A I don't understand the question.

Q Well, if Dr. Hanna is in, and tells Dr. Lai in effect that he doesn't see any problems with the treatment that's being provided, and the patient is going up to the ICU, it is your testimony that Dr. Lai isn't entitled to rely on Dr. Hanna and his assessment that the patient is getting the things that the patient needs at that point in time and assume that Dr. Hanna will change the therapy if Dr. Hanna deems it appropriate in order to put the kid in the condition that Dr. Hanna deems necessary in order for him to perform surgery?

MR. BARTIMUS: Object to the form of the question. It's a misrepresentation of the evidence in this case directly, the rules and regulations of the hospital.

THE WITNESS: I would answer your question by

saying that any physicians who holds himself out to be an ER physician needs to know what kind of response he can expect from fluid therapy from shock and needs to know what to make as the next step if that kind of response is not forthcoming.

Dr. Lai undertook what he thought to be appropriate therapy for this child's condition, did not get any effective clinical response. And regardless of who says things are going fine, Dr. Lai, I believe, had an independent responsibility to this patient until Dr. Hanna took him to the Emergency Room, took him to the ICU rather, to say things aren't going well, we have to change therapy or transfer the patient.

And it was not sufficient for him just to let things go over two or three hours and go on with life -- because he went on with his iife, but this boy didn't go on with his.

MR. MELTZER: I would move to strike the last portion of the response as being argumentative and unnecessary --

THE WITNESS: But true.

MR. MELTZER: -- and nonresponsive.

THE WITNESS: But true.

BY MR. MELTZER:

Q Now, sir, is a patient in shock, or the acute nature of a patient in shock similar to the acute condition of a patient with meningitis? In other words, the needs of the patient may be different, but they're all acute in that regard, need immediate attention and therapy.

MR. BARTIMUS: Object to the form of the question. It's irrelevant and immaterial. Anything that has to do with meningitis is not involved in the issues of this case and is clearly outside the scope of this deposition.

BY MR. MELTZER:

Q Go ahead and answer.

A Both acute bacterial meningitis and shock are medical emergencies, and because they're both medical emergencies, there are some overlapping of the ways in which medicine needs to respond to those two conditions.

Q Do you recall, with regard to medical records and recordation of information, do you recall testifying in a case involving acute meningitis in October of 1985, in Bissett versus Sawyer, for Mr. Bartimus here?

ki

A I recall. That was probably the first case I reviewed for Mr. Bartimus; yes.

Q Do you recall testifying, page 133, line 8: You are responding and you say:

"I mean I also think it is important to note that in taking care of an acutely ill child who has meningitis and who knows what else ongoing, probably the least important thing a resident or even an attending doctor thinks of is to record every piece of information that the mother wants to give or has given in the exact sequence that it has been presented, because you have a lot more important things to do with respect to taking care of the baby. It doesn't mitigate a physician's responsibilities to have a reasonably accurate approach to a medical record, but I don't think we need to say that every piece of information has to gibe with every other piece of information."

Do you recall testffying in that regard, to that effect?

A With respect to the way a history is taken and

recorded, yes. And I would agree with that today, in an emergency situation.

Specifically with respect to meningitis, the first line of approach is to get the spinal tap done and the IV started and the antibiotics going, and then monitor the patient with appropriate laboratory studies and so on.

Q Incidentally, with regard to a child who has bacterial infection, which peritonitis would be a type; correct?

A Correct.

Q You would agree that generation time of bacteria is very, very small, very few minutes; correct?

A Yes, it can be, depending on a whole bunch of features.

Q And that toxin production of bacteria is very significant over even very short periods of time; correct?

A Again, depending on where the organism is growing and what kind of organism you're talking about, it may well be very important over even a very brief period of time; yes.

Q In the peritoneum, the growth of bacteria occurs very rapidly and can have a major adverse effect on the

patient if allowed to grow for periods of 24 to 36 hours; correct?

MR. BARTIMUS: Object to the form of the question.

THE WITNESS: My answer is yes, it can in some instances; yes.

BY MR. MELTZER:

Q Now, in this particular case, the parents of this child did not bring the patient in for approximately a period of a total of four days; correct?

A Correct.

Q We know that during approximately, by your evaluation, approximately two of those days, a day and a half to two of those days, this patient had a ruptured appendix; correct?

MR. BARTIMUS: Object to the form of the question. You have once again misrepresented this doctor's testimony.

BY MR. MELTZER:

Q Go ahead and answer.

A I don't know that I ever stated as to when I thought the appendix ruptured. All I stated was that about

ki

30 hours before this child arrived in the Emergency Room, he started to complain of a sharp periumbilical pain.

Q In fact, on the Sunday before he went to the Emergency Room, he had had some pain, then felt like he got better, and then got worse; correct?

A Correct.

Q That's a sign of the appendix having ruptured, isn't it?

A It may be; yes.

Q If the patient's appendix ruptured on Sunday, that means that from that period of time up until the time he got to the Emergency Room, there is bacteria that is growing in his belly; correct?

A That's true.

Q The delay of the parents in taking the patient to the Emergency Room certainly contributed to the ultimate outcome of this child, did it not?

MR. BARTIMUS: Object to the form of the question. Assuming facts not in evidence.

THE WITNESS: Well, how can I answer your question? If these parents had brought this patient into the Emergency Room before the appendix was ruptured, and if

the diagnosis of appendicitis were made, and if the patient were operated, he would be probably alive today.

I can only say that amongst 7-year-old children, more than half have ruptured their appendix before the parents bring them to the physician, so it's not at all an uncommon circumstance for parents to bring to the physician a child who's had appendicitis obviously for some time, and then had ruptured his appendix.

BY MR. MELTZER:

Q Okay.

But it's the delay of 30 to 48 hours that is unusual, isn't it, sir?

A I don't know if I would say that it's unusual. I don't think I have a very firm opinion on how usual it is. I've never done a study or even reflected on it, as to how, usual it is for a child to present with peritonitis 30 hours, let's say, after a ruptured appendix..?

I know I can recollect cases where that has been the situation, but whether it's usual or not I don't really have an opinion.

Q Certainly the number of cases in that regard that you've had where the patient has been brought in with 30 to

ki

48 hours between the time of rupture and the time that the patient is brought in, a 7-year-old child by parents, has been relatively rare.

A I would have to answer your question by saying one of the reasons it's hard even to talk about this issue is that it's very hard to know when in fact the patient's' appendix ruptured.

In this case, we have some evidence that maybe it did rupture Sunday, by virtue of the mother's and father's history.

The patients that I can recall don't give us that nice history. And whether this is really meaningful for the ruptured appendix or not is, in a 'way, a debatable question.

So I really can't help you with respect to that issue. I would say that the early diagnosis of appendicitis without a rupture would be a very good thing for this child and would have allowed for his survival.

Q Incidentally, do you contend that Dr. Lai failed to timely diagnose the surgical abdomen?

A No, sir.

Q Any other departures that you contend on the part of Dr. Lai, other than those that you have related to us

here today?

A Just what I've written on my sheet that we've gone through.

Q We've gone through all of them, haven't we? You're talking about on Deposition Exhibit 2?

A Yes, sir.

Q We've gone through all of them, haven't we?

A Yes, we have -- as far as I can see.

Q And there aren't any other departures that you can identify at this time?

A Not that I can recall; no, sir.

Q Incidentally, can you determine from the records what time it was that Dr. Folkner reduced the fluids in this particular case?

A I'd have to look at the records maybe to do that.

(Pause.)

I have a note here at 9 a.m. to reduce IV rate to 50 cc's per hour and call Dr. Folkner, but that's a verbal* order of Dr. Hanna, so it was Dr. Hanna who ordered the reduction in the fluid according to this verbal order.

Q Is that in the same time frame that you believe that -- or approximately the same time frame that you

believe that this patient's condition deteriorated to the point that it was approaching or at the point where the child was not going to be salvageable, that his condition would be irreversible?

A Yes, I think that's about right.

Q Of course, that is followed then shortly by the order for the Inderal or the propranolol at about 9:45; correct?

A Correct.

Q Sir, previously you testified that you thought at 5:15 the patient was drowsy based on the ICU nurse incoming records.

A No, it wasn't the incoming nurse records; it was the flow sheet of the ICU nurse.

Q You know that on the incoming assessment, Nurse Wise recorded that on objective findings, that the patient's pupils were equal and reactive and that the patient was alert and cooperative; correct?

A Yes, sir. More evidence that that --

MR. BARTIMUS: Let him answer the question.

MR. MELTZER:, I can already tell he's going to go on and make a statement.

MR. BARTIMUS: I don't care what you can tell.

Finish with your answer. If he wants to move to strike it -- but he's not going to interrupt you.

THE WITNESS: I think it's not contradictory to have two notations of level of consciousness written side by side at the same time, since it's often the case that the time period that one is dealing with is not specifically 0515, but 0515 and then following.

And it goes to the same evidence about the pulse rate being a range over a period of time, so that these two levels of consciousness were one at one minute and then one sometime later.

BY MR. MELTZER:

Q At 5:15, based on Nurse Wise's initial assessment, the admission nursing assessment at 5:15 to the ICU, the patient at that time was alert, cooperative, and pupils were equal and reactive to light; correct?

A That's what she states. Yes, sir.

Q Sometime thereafter is when the patient apparently became drowsy, and that level of consciousness changed or maybe varied thereafter; correct?

MR. BARTIMUS: Object to the form of the

question. The best evidence of the record is the record itself.

BY MR. MELTZER:

Q Go ahead and answer, sir.

A I would agree. I think that's true.

Q Incidentally, part of the plan of care, according to Nurse Wise, her note was that the nursing staff was to assess the vital signs; correct? To monitor the vital signs?

A I can't find the page in question, but I certainly think that's probably right; yes.

Q With a patient who has peritonitis and dehydration, would you expect to see an oxygen tension of approximately 76?

A You're talking about a patient such as this patient in shock?

Q With or without shock.

MR. BARTIMUS: I object to the form of the question. It's a hypothetical. It's not assuming sufficient facts in evidence. It's irrelevant and immaterial if it involves some other instance.

BY MR. MELTZER:

Q What would you expect, sir, to be the range of oxygen tension for a patient with peritonitis and infection in the abdomen, with dehydration?

A If the patient doesn't have a component of septic shock, and just has dehydration because of poor intake of fluids, vomiting and diarrhea and so on, and the patient is again not in shock from hypovolemia, I would expect his oxygen range to be in the normal range.

Q A range between, what, 90 and 100?

A 92, 95, and 100. Yes.

Q A minute ago you used the term "not in septic shock," and then you said "not in hypovolemic shock."

A patient who is in septic shock may have the same oxygen tension that a patient who is in hypovolemic shock would have; correct?

A Correct.

Any kind of shock will cause hypoxia.

Q Do you consider an oxygen tension of 76 for a patient who is in, whether it's septic shock or hypovolemic shock, to be a mild, moderate, or severe oxygen depletion?

A Because of the co-joined presence of shock, I

would consider that to be at least a moderate depletion of his PO-2, and the reason I believe that's the case is that while his hemoglobin concentration, his hemoglobin saturation may be reasonable, even in the face of a diminution of his PO-2 to 76, patients in shock, by definition, are not delivering blood to the various pools of the circulation. Consequently, there is already ongoing anaerobic metabolism and you are worsening it by allowing the 0-2 to be lower than normal.

Q In this case, the hemoglobin was within reasonably normal limits, was it not?

A The hernoglobin was elevated because of the dehydration and shock. It was not within normal limits.

Q It was not markedly elevated, was it?

A The hemoglobin was markedly elevated. It was 17.2, I believe, and for a boy this age it should be 12 or 13.

Q Incidentally, what is hypokalemia?

A Would you spell that for me? Hypokalemia?

Q Hypokalemia.

A Hypokalemia is low serum potassium.

Q And treatment for that would be the increasing or

administration of potassium would be one of the appropriate therapies for that?

A If you're asking the question in vacuo, the answer is yes.

Q Sir, you plan to return to Kansas City to testify at trial, or actually the Warrensburg area to testify at trial in this case?

A If required to do so, yes.

MR. MELTZER: That's all I have at this time.

Oh, I have got a couple other questions. I just saw something.

BY MR. MELTZER:

Q Incidentally, sir, with regard to the procurement of laboratory evaluations, you don't contend that the failure to obtain the laboratory workup until 3:45 a.m. constituted any kind of departure that caused or contributed to the ultimate outcome of this child, do you?

MR. BARTIMUS: Object to the form of the question. He's already told you about the BUN. Th t's laboratory value.

BY MR. MELTZER;,.

Q I'm talking about the timeliness of obtaining the

other laboratories outside the BUN.

A No, sir. I don't have any major criticism of the way this hospital operates its laboratory.

I recollect when I was a resident, taking my own x-rays on patients because the X-Ray Department was closed at night in some of the community hospitals that I worked in, and developing and reading them myself. So I think that's okay.

MR. MELTZER: That's all.

(Wientzen Deposition Exhibit No. 6 identified.)

(Whereupon, at 1:04 p.m. the deposition was concluded.)

_____

Raoul Wientzen, Jr., M.D.