#6621

IN THE CIRCUIT COURT OF THE SIXTH
JUDICIAL CIRCUIT OF THE STATE OF FLORIDA
IN AND FOR PASCO COUNTY COUNTY
CASE NO.: 94-343-CA

CYNTHIA MESIEMORE, as
Personal Representative
of the Estate of
CHRISTOPHER SHELLEY, a
minor, deceased,

COPY

PLAINTIFF

vs. : DIVISION "Y"

EAST PASCO MEDICAL CENTER, :
INC., EAST PASCO EMERGENCY
CONSULTANTS, ELIZABETH :
DEMERS, D.O., AND ALICIA
FERNANDEZ-GARCIA, M.D., :

DEFENDANTS :

Washington, D.C.
Wednesday, October 25, 1995

DEPOSITION OF

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

an Expert Medical Witness, was called for examination by counsel for the Plaintiff, pursuant to notice, taken at Georgetown University Medical Center, 3800 Reservoir Road, N.W., Bles Building, Room 5036, at

FRIEDLI, WOLFF & PASTORE, INC.
1735 EYE STREET, N.W., SUITE 920
WASHINGTON, D.C. 20006
(202) 331-1981

beginning at approximately 2 P.M., before Brenda Hornstein, CSR, a notary public in and for the District of Columbia, when were present on behalf of the respective parties:

FOR THE PLAINTIFF:

Dennis A. Lopez, P.A.
BY: Dennis A. Lopez, Esq.
210 Pierce Street
Tampa, FL 33602
813-223-1977

FOR THE DEFENDANT EAST PASCO MEDICAL CENTER:

Cameron, Mariott, Walsh, Hodges and D'Assaro, P.C.
BY: Christopher C. Coleman, Esq.
18 Northeast First Avenue
Post Office Box 5549
Ocala, FL 34478-5549
904-351-1119

FOR THE DEFENDANTS DAVID WILCHER, D.O., ELIZABETH DEMERS, D.O., AND EAST PASCO EMERGENCY CONSULTANTS, INC.:

Shear, Newman, Hahn & Rosenkranz
BY: Glenn M. Burton, Esq.
201 E. Kennedy Boulevard
Suite 1000
Tampa, FL 33601
(813) 228-8530

FOR THE DEFENDANT ALICIA FERNANDEZ-GARCIA, M.D.:

Freeman, Hunter & Malloy
BY: C. Howard Hunter
Suite 1950
201 East Kennedy Boulevard,
Tampa, FL 33602
(813) 222-8200

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C O N T E N T S

E X H I B I T S

(Exhibits attached to transcript.)

Whereupon,

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

the Expert Medical Witness herein, called for examination by counsel for the Plaintiff, having been duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY MR. LOPEZ:

Q Would you state your full name, please.

A My name is Raoul **L.** Wientzen, Jr., **M.D.**

Q **Is** it pronounced Wientzen?

A Wientzen, yes.

Q Your occupation?

A I'm a pediatrician. I'm a physician who's a pediatrician that deals with infectious diseases in children.

Q Dr. Wientzen, my name is Dennis Lopez. I represent a lady named Cynthia Mesiemore's concerning the death of her three-year-old son in **1991.**

I'm going to ask you some questions today. If at anytime I'm not clear or you're not 100 percent sure what my question is seeking to elicit from you,

would you let me know so that I can repeat it rephrase it?

A Agreed.

Q Have you given a deposition before?

A Yes, I have.

Q Approximately how many times?

A Probably four or five times a year for the last few years. Prior to that, fewer.

Q Doctor, you indicated you're a pediatrician, did you say, with a specialty in infectious disease?

A Correct.

Q I noted on your C.V. that you did a fellowship in infectious disease. Is that right?

A Pediatric infectious disease.

Q I was curious that the fellowship was in two different locations, one year at each. Tell me about that, please.

A Actually, it wasn't. It's a single combined program. That's just the way the sheet appears to read, at the Parkland Memorial Hospital and Dallas Children's Hospital are co-joint hospitals

in it's a single program.

Q You listed it as one year at one and one year at the other. Is that right?

A I don't remember how it's listed, but it may be.

Q Do you have your C.V. handy?

A Actually, I brought a copy up and I don't know where it went.

Q Well, I've got a copy here.

A (Indicating.) Yeah, that's how it's listed, but it probably should be fisted as a single experience for two years in the same place.

Q One is the University of Texas Health Science Center at Dallas, Southwestern Medical School. That was the year '75 to '76. Correct?

A That's how it's listed, yes.

Q And then the '76 to 1977 listing is a fellow in pediatric infectious disease at Parkland Memorial Hospital and Children's Medical Center of Dallas. Correct?

A Right.

Q What does your fellowship certificate

indicate? Who awarded you a fellowship certificate?

A I think it's from the University of Texas Health Science Center in Dallas, Texas.

Q The reason I ask, most of my experience has been that fellowships of two years' duration usually take place under one moniker, if you will. Has that been your experience?

A And that's how mine was, yes.

Q But you prepared this?

A My secretary prepared it, probably, 15 years ago.

Q So there's nothing unusual about this fellowship?

A No.

Q You touched on your previous instances of depositions. Just let me get this cleared up out of the way. Approximately how regularly in your practice do you get involved in medical malpractice cases?

A Well, from the standpoint of reviewing cases, I probably review a dozen or 15 cases a year.

Q And of those dozen or 15, do you review

cases both on behalf of prospective defendants as well as injured people?

A Yes.

Q Do you keep records to indicate what percentage of each of those you get involved in?

A Just in my mind.

Q Tell me, in your mind, how that breaks down.

A Right now, it probably breaks down two-thirds, defense, one-third, plaintiff.

Q Have you ever been involved in a case as an expert in which a claim of a misdiagnosis of an infection of a child was the issue or one of the issues?

A Yes. You mean, against me?

Q Not personally against you.

A No, not personally against me, but I have, yes.

Q Approximately how many other cases of that type other than this one have you been involved in as an expert?

A Well, probably 95 percent of the work that

I've done over the years €or pediatric or, rather, for the medical/legal arena has been in some way, shape, or form involved with infectious diseases in children, so it's the vast majority of times that I've reviewed a case that has to do with an infectious disease that was misdiagnosed or mistreated or a problem with it.

Q Do you maintain a list of the cases and lawyers you've worked with and for?

A No, I don't.

Q Do *you* have anything other than your memory to rely upon to provide me with information about that?

A No.

Q When's the last time you've testified in court?

A The last trial that I went to, I would say, was probably March of this year.

Q Where was that, sir?

A That was in Florida.

Q And who was the attorney that you were employed by?

A I was a plaintiff's expert witness in a case in Naples, Florida, and the attorney was Mr. Marvin Weinstein from Miami, I think.

Q Do you remember, prior to that, when's the last time you testified in a trial?

A I don't. I couldn't tell you.

Q Was it within the last year or so?

A Probably.

Q You just don't recall?

A That's right.

Q You've told me about depositions. Tell ne how many times in your practice you've actua ly testified at a trial, in a medical malpractice matter.

A Probably 10 or 12 times in the last 15 years.

Q What was the issues in the case in which, I think you said, Mr. Weinstein --

A Yes.

Q -- hired you?

A This was a Haitian young man who developed a fever, was brought to an Emergency Room, had an

evaluation in the Emergency Room. A blood culture was obtained.

The child was sent home, I believe, on amoxicillyn therapy for a potential ear infection, And then the next day or two days later, the results of the blood culture came back positive for Haemophilus influenzae and no one notified the family.

The child went on to develop bacterial meningitis and had a serious neurologic injury. In the interim, the child was seen by a second ER, in a second ER in another city close to where the original visit occurred.

And I can't remember the specifics of what happened in that ER visit, but there was no, no identification of the prior blood culture made at that time either, so, basically, it was a misdiagnosis of meningitis.

Q At the original hospital?

A At the first. I believe it was the first. It's been almost a year as I read the information, but I believe it was the first visit, yeah.

Q Do you remember the name of the plaintiff in that case?

A The name of the plaintiff?

Q The one who you were testifying on behalf of?

A Yeah. Pierre, LaFortune Pierre.

Q Last name, Pierre?

A I believe his last name was Pierre.

Q LaFortune?

A Was his first name.

Q Was the antibiotic therapy that was prescribed in that case not appropriate the for the condition?

A No, it was. The initial antibiotic therapy was appropriate.

Q What were your opinions in that case?

A Well, my first opinion, as I read the case, was that the hospital, certainly, failed to notify the family.

Q That?

A That this child has a positive blood culture.

Q Even though they had already administered antibiotic treatment before he left the hospital?

A Before he left the Emergency Room, yeah, he was administered, I believe, oral amoxicyllin.

Q Was that oral amoxicyllin appropriate treatment for the condition which the hospital failed to notify the family of?

A No, it was not. The organism was resistant to amoxicyllin, but the amoxicyllin was appropriate to the initial evaluation of the child, the initial therapy.

Now, I may be wrong. It may well have been the first ER visit, there was no amoxicyllin given, and it was a second ER visit the amoxicyllin was given. I can't remember.

Q At another hospital?

A At the second visit. I don't remember how --

Q Okay. But you testified on behalf of the plaintiffs?

A Yes, I did.

And do recall that on of your testimonial

points was that, I take it, that the hospital erred in not notifying the patient there had been a positive blood culture. Is that correct?

A Right.

Q What were some of your other opinions, professional opinions, in that case?

A If I remember right, there was, at the time of the second ER visit, I think I was somewhat critical of the management of the child and I don't remember the specifics as to exactly what the second ER visit's management was lacking, but I thought there was.

THE WITNESS: Can I interrupt you? I'm sorry. I know you have a train of thought, but I just got paged. You know, I'm on service. I have people that's supposed to be covering for me. I'm not sure why they didn't get it, but can I answer this?

MR. LOPEZ: Sure.

(Break was taken.)

(Discussion off the record.)

(Exhibit No. 1 marked.)

THE WITNESS: Can I add just one quick question, one quick report about my C.V.?

BY MR. LOPEZ:

Q Certainly, Doctor.

A Not only is it poorly typed, but there are things missing on there that probably should he on there that will be on there the next time.

Q This is an exhibit. I don't know how I got an exhibit stamp. Is that from this deposition? Did you just put that on?

(Discussion off the record.)

Q Take a look at it and tell us what's incorrect or needs updating, please, as to your CV.

A Specifically, with respect to boards, I now am a diplomate of the subboard in pediatric infectious diseases that was given for the first time last year, and I took it and passed it successfully at Chapel Hill, North Carolina.

With respect to licensures, I'm now licensed in Virginia and Maryland, as well as D.C. With respect to awards, I was awarded the teacher of the year award again last year. And with respect

to --

Q '94?

A Well, let's see. It would have been in June of this year, so '95.

Q So you won it in '77 and '95?

A Right. And that's, I mean, from the standpoint of, I couldn't tell you about the publications, but they are the features that I would add to it right now.

Q You said a diplomate of the subboard of pediatric infectious diseases?

A Correct.

Q What organization confers that board status?

A The American Board of Pediatrics.

Q Is that a new board or subboard?

A Brand new board. It was just formulated and had given its first exam this past November.

Q November of '94?

A Correct.

Q And you took it then on the first time --

Yes.

Q -- and you passed both parts? It's written and oral?

A No. It's just an oral, oral exam. I passed it in the 90th percentile.

Q You've told me you can't recall any other cases that you've testified in court in other than the one in Naples.

A I don't think I said that.

Q I thought you did earlier.

A No.

Q Okay. Tell me other cases you've testified in court in.

A For the same firm, Mr. Weinstein's firm, I was an expert and appeared in trial in Florida a number of years ago on a child who had a misdiagnosis of pneumothorax, in fact.

Q Do you remember the name of that case?

A No, I'm sorry. I don't,

Q Okay. Approximately when was it?

A Probably 1983 or '84. And then I was an expert for Mr Carl Santone as a defens witness in a case of croupy stre meningitis and in one oth case

that's too hard to even describe what it was about.

I was an expert witness for a Mr. Watson, I believe, in a case of Haemophilus meningitis as a defense expert, and from the standpoint of Florida, that's all the cases I think I've done.

Q Okay. I appreciate you confining that to Florida for my benefit. My question didn't, but can you first tell me where Mr. Carl Santone is located?

A Right now, I think he's retired in Charlottesville, Virginia, living the life of a gentleman farmer.

Q Where did he practice prior, when you worked with him?

A I think it was West Palm Beach, but that's more of guess than --

Q Approximately when?

A The last time I appeared for him would have been, probably, 1991 or so.

Q You've worked with him on more than one occasion?

A As I mentioned, two times, yes.

Q I'm sorry. I misunderstood. You mentioned

a Mr. Watson. Was that the plaintiff's name in the second case or was that an attorney's name?

A He's an attorney. He's a defense attorney.

Q Where is he located?

A Again, I think it's West Palm Beach, but I don't know.

Q Do you remember his first name?

A I think it's Roy.

Q Have you worked as an expert in or been asked to review a case or given testimony or any involvement of that type in a case involving an infection in a patient that had chicken box or varicella, similar to this case, and when I say similar to this case, only in terms of infection with chicken pox?

A No, I don't think so. There was a prior case where the child actually had disseminated varicella, but no bacterial superinfection.

Q When were you first contacted about this case, Doctor, and by whom?

A Well, I have a cover letter to me dated December 8th, 1994, from Mr. Coleman, and it refers

to a recent telephone conversation, so m first contact would have been about that date, probably, from Mr. Coleman.

Q Do you know how Mr. Coleman obtained your name?

A No, I don't.

Q You never learned that or --

A Well, he may have told me when he first contacted me, but I certainly don't remember it right now.

Q Have you ever previously worked for this particular hospital as an expert in any capacity?

A Not to my knowledge.

Q How about the hospital corporation that owns this hospital?

A I couldn't tell you the name of that corporation to know whether I did or not, but I don't think so.

Q Before today, had you met or had any communications with any of the other lawyers or parties to this lawsuit?

A No.

Q When I walked in prior to today's meeting, I found, at 1:30 today, a half hour before the depo, I found you in a conference with Mr. Coleman and Mr. Hunter. Was that the first time you had any contact or discussions with Mr. Hunter?

A Yes.

Q And you understand that Mr. Hunter represents the pediatrician in this case. Is that correct?

A I did. I did after he told me that. Yes, I understood it.

Q How was it that Mr. Hunter was able to be privy here at your predeposition conference concerning this case?

A I think Mr. Coleman invited him in.

Q Did you and Mr. Hunter have any discussions?

A We had a trilateral discussion about the physiology of Group A strep sepsis.

Q When you say trilateral, yourself, Mr. Coleman, and Mr. Hunter?

Correct.

And how long did you all meet today?

A I met with Mr. Coleman, probably, for 15 or 20 minutes before Mr. Hunter popped his head in the conference room and was invited in, and so we met from then until, probably, 10 to two or something.

Q When did all that start, though?

A 1 o'clock.

Q When Mr. Coleman first called you on the telephone, what, if anything, did he ask you to do at that time or what did he discuss?

A I don't have a real recollection of that conversation, but I can presume that he told me about this case and asked me if I would review it, specifically with respect to the nursing care and the child's overall illness.

Q Okay, sir. You mentioned a letter. May I take a look at that letter?

A Sure. There are actually three letters. (Indicating.)

Q Okay. Thank you. (Indicating.) The red pen writing on the letter, September 8th, 1994, is that yours?

A Yes, and on the back, too.

Q Thank you. I appreciate that.

MR. LOPEZ: If we may, Madam Court Reporter, let's go ahead and, before I forget --

THE WITNESS: I took the liberty of making some copies of the letters and the handwritten notes so that I could keep my own, if it's okay with you.

MR. LOPEZ: That's fine. I appreciate that. Let's go ahead and mark as Plaintiff's next three exhibits in line, the letter of September 8th, 1994. That's a composite exhibit in that it's got handwritings on the back of the letter, and I believe the Doctor has indicated he's made a legible copy of that.

(Exhibit 2 marked.)

THE WITNESS: Not legible.

MR. LOPEZ: Well, I was presumptuous. You are correct. It is not legible. We'll work off of your copy, and the next exhibit in line, the September 27th, 1995 letter from Mr. Coleman to Dr. Wientzen. Am I saying that correctly?

(Exhibit 3 marked.)

THE WITNESS: That's fine.

MR. LOPEZ: And the next in fine, the July 31st 1995 letter from Mr. Coleman to Dr. Wientzen.

(Exhibit 4 marked.)

BY MR. LOPEZ:

Q Concerning this first letter, Doctor, dated September, 8th, 1994, all the red pen writings that's on the front and back, were those made at the same time by you?

A I'd say 98 percent of it was. I added, over the course of return visits to the records, various labs values that weren't apparent to me at the first go-round, but the vast majority of it was done at one sitting when I went through the medical records.

Q And, I take it, it was sometime close to receiving this letter from Mr. Coleman?

A It depends on how busy my life was in September of '94. I don't know. It could have been months after that.

MR. LOPEZ: May I take a moment, again, to see if I can --

BY MR. LOPEZ:

Q Doctor, would you be so kind as to read to us what your notes are in red there on that September 8th, 1994 letter.

A All right. On the front page of the letter --

Q Yes, sir.

A It's No. 1, charting in hospital by nurses, colon, problems and departures. Underneath it I have, no initial assessment on day shift. Underneath it I have, few notes from about 5 p.m. to 9 p.m., and then I have a question mark, emergencies ongoing. And then I have no I&O sheet, input and output sheet.

No. 2, survivability after admission to East Pasco at about 2. I have, colon, no standard intervention would have changed outcome.

Q Read No. 2, again, please.

A Survivability after admission to East Pasco at about 2 p.m. No standard intervention would have changed outcome. Do you want me to read the back,

too?

Q Please.

A It's going to take a very long time.

Q Well --

A Can I read the important parts?

Q Just go ahead and read through it, please.

A Christopher Shelley, 3 years, 9 months, East Pasco Medical Center ER. Dr. David Wilcher. I have 4/24/91, 7:11 a.m., and then crossed out underneath it, I have 4/23/91, 5:36 p.m., Tuesday. Onset of varicella-zoster Saturday. Intermittent fever since with vomiting. Unable to keep Tylenol down. Today, increased fever, hallucinations, and vomiting. Unable to ambulate this afternoon.

Q Can I interrupt you there?

A Sure.

Q These notes that you wrote down at this time, was this as you were going through the medical records that Mr. Coleman had sent you?

A Correct.

Q Prior to him sending you the records, had he provided you with any factual basis as to what

this claim was about?

A He may have over the phone call, but I don't know for sure.

Q Do you know if, do you recall if you expressed any preliminary opinions to him at that time during your phone conversation?

A I have no, no way to know if I did or didn't.

Q Okay, sir. Please continue with your reading.

A Then I have, physical exam, well nourished, well developed. Irritable. Cooperative and alert. Multiple varicella lesions, but no evidence of secondary infection. Neck, supple. Neurologic exam within normal limits. No joint effusions. Mucous membranes dry. Good skin turgor and capillary fill time. UA was 1030. White blood cell count, 14,700, 32 segs, 50 bands. 11.8 slash 35.3, hemoglobin and hematocrit.

Q Let me stop you. You mentioned the CBC and the segs and bands.

A Right.

Q What significance, if any, was that lab finding to you?

A To me, that lab finding shows a borderline elevated white count, but within normal limits, total white count, with a shift to the left showing an increased number of immature segmented forms, namely, bands.

Q When you say borderline white count, borderline to what, Doctor?

A Well, typically, 15,000 is the cutoff for true leukocytosis in children where one is concerned about identifying a bacterial infection.

Q So you say this is only a borderline indication of a bacterial infection. Is that right?

A Total white count, yes.

Q Yes, as to total white count?

A Well, I would, let me rephrase that. I'm not sure I would consider it an indication of a bacterial infection. It has not exceeded the threshold, that is, the threshold for a suspicion for bacterial infection.

Q Let's talk about the shift you mentioned.

Is that, in your opinion, the finding that was the preliminary lab value of April 23rd, 1991, indicative of a bacteriological infection, in your opinion?

A I think it's, it potentially is indicative of a bacteriologic infection and it's also indicative, it can go both ways, either a bacterial infection or a viral infection can induce a significant shift to the left.

Q You say that a viral infection can induce a significant shift to the left?

A Yes.

Q Could you provide me with the basis of that statement would be?

A I think it's a well-known fact. It's in textbooks of microbiology and infectious disease. It's certainly my clinical experience.

Q The viral infection in this case, of course, would have been the likely varicella. Correct?

A Right.

Q Is it your opinion that you would have

expected a 14,000 white blood count and the type of shift that was demonstrated in the differential of April 23rd, 1991, in a child with varicella and not a secondary infection?

A I think, to answer your question, I mean, the way physicians look at this is to say there a million or two million cases of varicella a year in the United States. And if you were to do white counts every day on those patients, you would not find a very large percent of children having this white count on the fourth day of disease.

But because there are so many such children with varicella, this white count is not a particularly abnormal experience; that is to say, there would be thousands and thousands of children with plain old varicella who, on the fourth day, would have this particular kind of white count.

Q And how about this particular kind of shift on the fourth day?

A I'm talking, I'm actually talking not just about the total white count, but the shift, also, on the fourth day.

Q Okay. So that's your opinion?

A Yes, sir.

Q Okay. Continue reading, please.

A Platelets, normal, 247,000. And then we have the electrolytes, which are 130 sodium, 3.7 potassium, 94 chloride, 20 CO_2, BUN of 9. And then I have some times which represent nursing times for vital signs. 5:05, pulse 180. Respiration is 52. Temperature, 105.6. 6:45, temperature, 103.54. 7:36, temperature, 102.3. Next to that, I have therapy.

Q Let ne interrupt you there, if I may.

A Sure.

Q You just gave sone temperature values that were taken by you off of the initial Emergency Room admission on the 23rd. Correct?

A Yes.

Q Do you have an opinion as to whether a temperature of 105.6 is consistent or likely to be caused by a fourth-day varicella in and of itself?

A Yes, I do.

Q What's your opinion?

A I think it's the same general sense about the white count, that it would not be a common finding in kids with varicella.

It would represent a small fraction of kids on the fourth day who would have that high degree of fever. But because there are millions of cases a year of varicella in the lifetime experience of a physician taking care of kids with chicken pox, he would see many such children who had 105 1/2 degree temperature on the fourth day and only due to varicella.

Q Do you currently treat children?

A Sure. Yes.

Q You have a pediatric practice?

A You mean, general pediatrics. Part of my job here is to be ward attending. And two or three months a year, I take care of all the children on the wards, no matter what they have.

The rest of the year, I see some general pediatric patients, but, in general, they are sort of special patients, the AIDS children that we take care of, some of the faculty children that use me as a

pediatrician, and a small cohort of children that was in a study of mine that I've given free care to for purposes of keeping them in their follow-up mode; but, in general, not much general pediatrics outside of my two or three months in patient ward attending.

Q As a patient ward attending for the two or three months, are you the only attending for that entire two- or three-month period?

A Well, there are two wards and so there would be two attendings, one for each ward, but I would be that ward's attending, yes.

Q And is that for a two- or three-month chunk at one time, so to --

A I thank God, no, no. It's usually broken up. You do it in the fall or the winter and then you do it again in the spring.

Q In your practice, Doctor, if a patient presented to you with a history of onset of varicella four days prior, seems to have gotten worse, unable to walk on the particular day they're brought, carried into the Emergency Room, and you obtained a temperature of 105, would you have suspected a

secondary infection?

MR. COLEMAN: Let me just raise one objection, and if I could have a standing one. Dr. Wientzen's here to testify on behalf of salvagability or survivability of the child and as to the nursing care, the standard of care.

He's not going to be testifying as to what he would have done or not have done or should have done. He's just purely in those two issues and I think we're going far afield.

And I want to object to the form and I'd like to have a standing objection that, you know, he's not here to give expert opinions as to standards of deviation of care of everyone else in this case and I think it's improper for the expert testimony that I'm proffering him for to give answers to scenarios on treatment modalities and other such factors.

So, with that caveat, I just object to the form and I'm not going to instruct him not to answer because we're up in D.C. here. So, anyway, with that caveat, I object to form.

I mean, the Doctor can answer if he wants to and if he feels comfortable.

MR. BURTON: But before he does, I, obviously, join in the objection to the extent that his answer may involve standard of care questions against someone that's not in his area of specialty and there hasn't been a predicate established as to expertise in that area.

MR. HUNTER: I've got nothing better to do, so I'll join in both objections.

THE WITNESS: Well, if someone could read back the question or restate the question because I don't really remember how it was phrased.

MR. LOPEZ: Sure. Madam Court Reporter will.

(Discussion off the record.)

BY MR. LOPEZ:

Q Doctor, in your practice, you've indicated to us that two or three months a year here, as a pediatrician, you attend to the pediatric ward patients. Okay?

A Right.

Q I'd like you to assume for purposes of my question that a three-year-old would present to you with a history of a four-day onset of varicella, vomiting, fever, and appeared to have gotten worse on now, the fourth day, to the point where the child is not walking and is carried into the ER and you obtain a temperature of 105 degrees, 105.6 degrees.

My question to you is, would you, under those facts, be suspicious of a secondary infection?

MR. BURTON: Same objection.

MR. COLEMAN: Same objection.

MR. HUNTER: Same objection.

A Based on that history, yes. Before examining the patient, I would be suspicious that one of the reasons for this problem could be a secondary bacterial infection.

Q Even though varicella is *obvious* and present for all the world to see?

A True.

Q Why would you be suspicious of a secondary infection?

A For a couple of reasons. One, there would

be only two ways that I could think of wherein varicella would eventuate in a child not walking, or three ways. I'll take that back; three ways.

One is a neurologic involvement involving either the spinal cord or brain. And No. 2 would be just general, an inanition and sickness, dehydration from the varicella. And No. 3 would be a localized infection in the area that the child is complaining of pain.

Q Doctor, how about assuming the same facts I just gave, and, in addition, add to that that there had been an increase in fever on this particular day, that the child was hallucinating, or the mother was giving a history that the child was hallucinating, vomiting, and unable to ambulate as of that afternoon, which I mentioned to you previously; would those factors, in of and themselves, strengthen your suspicious that a second infection is likely present?

MR. BURTON: Before you answer, Doctor, Dennis, did you give us that standing objection to the why in questions or not?

MR. LOPEZ: Certainly. But my response to that is, I believe, your proffer is, this expert's good for, Chris, as to survivability and what else?

MR. COLEMAN: As with regard to the standard of care in the nursing charting.

MR. HUNTER: Just for clarification, is he being proffered for the purpose that's set forth in the interrogatory answer?

MR. COLEMAN: Yes.

MR. HUNTER: Because the interrogatory --

MR. LOPEZ: Go ahead, Howard. It's probably going to help clear up the record.

MR. HUNTER: The interrogatory answer says that Dr. Wilson -- I'm sorry. Dr. Wientzen will testify as to the salvagability of Christopher Shelley and what actions of the nursing staff had any effect on the ultimate demise of Christopher Shelley.

THE WITNESS: I have your question.

MR. LOPEZ: Just for purposes of the record, I believe that the, though you made your statement as to why he's here, I believe the rules are very clear that any question that will reasonably

lead to the discovery of relevant evidence is appropriate because this is discovery, and that's all. And you guys, you can have a standing objection, so, yes.

BY MR. LOPEZ:

Q Do you still remember my question?

A Yes.

Q Go ahead, sir.

MR. BURTON: Okay. Wait a minute. I just want to make clear, that's not the basis that I'm objecting. I'm objecting that he is not an Emergency Room --

MR. LOPEZ: I didn't phrase my last question under Emergency Room.

MR. BURTON: I understand that.

MR. LOPEZ: Okay. So your objection on that basis is groundless.

MR. BURTON: And I don't mean to argue. I understand that you have not offered a sufficient predicate for him to be testifying as to the standard of care against other health care professionals, and that wasn't covered in Mr. Coleman's objection.

I just want to make sure that you have granted us a standing objection so I don't have to keep interrupting, which I don't want to do.

Glenn does in terms of predicate for my doctor, who is a general pediatrician. But, in addition, his answers to interrogatories indicate that this Doctor is here to testify that the Shelley child would not have been salvagable, even if the medication had been started at a particular point in time as well as that his nursing staff did not cause or contribute to the child's demise. That's what's in the interrogatory answer, I mean, an incomplete representation of it earlier.

I have a standing objection to a lot of the questions as well. I don't think your statement regarding the law on discovery is correct with regard to discovery, an expert witness's opinion. I think your discovery is limited to the subject of the testimony and does not go beyond that and I object on that basis.

BY MR. LOPEZ:

Q Do you remember my question?

A Yes.

Q Go ahead, sir,

A You added two, two other features of the presentation, namely, the hallucinations and the heightened fever over that day and asked me whether or not that would increase my suspicion for a bacterial superinfection.

And the answer is that, probably, not truly increase my suspicision for a bacterial superinfection because both of these features would be seen in children, for instance, who would have neurologic injury as a consequence of varicella, so I would certainly think of a bacterial infection as potential etiology, but those features don't add weight to one side or the other.

back a value as was obtained in the Christopher Shelley case, namely, a 14,000 white blood count and a late shift on the differential, would that strengthen your suspicion that there was, in fact, a underlying or superimposed bacteriological infection?

MR. **HUNTER**: Object to the form, quoted on the basis previously stated.

A I would answer your question by saying, we would never do, nor would we teach residents or students to do a white count before we examined the patient. And the white count, really, only exists, in my judgment, in relationship to what the physical exam discloses in this child who comes in with fever and hallucinations and, quote, unquote, refusal to walk.

So it's hard to, you really, in my judgment, can't take the white count and stick it on as another piece of clothing on this animal and help identify the name of the animal. I need to do the white count after the physical exam.

Q Well, with the facts that I had put forth to you previously in this hypothetical question in

terms of your practice --

A Right.

Q -- would you have ordered a white blood and a differential?

A I would have.

Q Assuming you had done so and it had come back with the values of 14,000 on the white blood count and, I believe, what you referred to as a left shift on the differential, would that have strengthened your suspicion that there was a bacteriological infection?

A Again, I mean, the physical exam has to be done before the white count is done. I mean, if someone told me the white count without telling me what the physical exam showed, I would probably say, well, before we talk about the lab, tell me, what does the child look like?

Can *you* really identify a focus of infection on the exam? Does he really have a swollen knee, ankle, tenderness in the calf area, in the infected pox? Then the white counts means omething. But absent the physical exa he white count stands

there, in my mind, as a, as a, you know, a pigeon that's looking for a home.

Q You told me earlier that the left shift and the 14,000 white count, in your opinion, are both independently not particularly indicative of a bacteriological infection. Is that correct?

A I think I said, they point in two directions. They could be -- they are consistent with a significant viral infection, viremia, let's say, on the one hand, and they are consistent with someone who has now developed a bacterial process.

Q So it's your opinion that a 14,000 white count in a three-year-old child with a four-day history of onset of varicella is consistent with that varicella?

A True.

Q If you could remember where we stopped reading in terms of red notes on the back of Mr. Coleman's initial letter.

A Okay. I think we started with therapy, RX colon Tylenol and Advil, PO, 5:52 p.m., PO fluids, and then IV fluids at 9 p.m

Under that I have, 8 p.m., colon, walking and running in ER, acting normal, per mom. Having episodes of diarrhea, semicolon, repeat episodes of diarrhea.

And then underneath that I have, blood culture, arrow, Group A strep, right foot pox culture, no growth. Urine culture, no growth. Chest X-ray, negative, and then I have home at 11:10 p.m., and that concludes the notes on the 4-23 visit.

Q Injuries that you've mentioned about the patient laughing and running in ER, where do you obtain from the chart, and feel free to refer anytime to your records in front of you, as to who made that entry?

A I think it looks to me like the doctor's writing, although it's a little bit difficult to read, if I remember right, to read the signature. Let me see it I can find it. (Indicating.)

MR. COLEMAN: (Indicating.)

A You're quicker than me. Here it is. Let me just see, because I have my own. Yeah, here it is. I have it on the second page of the ER visit.

It's under the section called treatment and medications and, again, it looks to me like Dr. Demers' handwriting, but I don't see a specific signature right underneath that little note. It's underneath the Tylenol, Advil dose.

Q Do you indicate on the chart what time that entry was made?

A To me, it's looks like 2000 hours, which is a o'clock.

Q Doctor, let's finish with your notes from this, and, I take it, this was your initial review of the records. Correct?

A Correct.

Q Let's go ahead and continue with those, please.

A Then 4/24/91, 7:11 a.m., East Pasco ER, vomited all night. Now complains of left foot pain and can't bear weight. Spoke with Dr. Fernandez last night. Have ER care for patient, and I have a question mark after ER because I don't think I can read specifically the word. Spoke with Dr. Graves last night. Not his patient.

Q You said, spoke with Dr. Fernandez last night. Have ER care for patient?

A Yes.

Q Where did you obtain that from the chart, please?

A I believe it's in the nursing notes of the second ER visit (indicating). Let's see here. Yeah. It's the fifth line, two, four, fifth line of the second ER visit. It says, spoke with Dr. Fernandez last night, who stated -- I think it says ER care for patient and then, underneath, it says, spoke with Dr. Graves last night.

Q Let me show you a page and see if it's the same page because mine, fortunately, and the others we've put in evidence before are numbered.

A Yes.

Q And this is the line you're reading from?

A Yes.

Q And this is numbered at the top as to Page 17?

A I think it says 11.

Q But is there a No. 17 on the copy that I'm

showing you?

A Right.

Q And the same page?

A Yes.

Q Okay, sir. Continue with your notes, please.

A Then I have, left knee and foot, tender and swollen. Skin without secondary infection. Questionable increased liver size. Neck, supple. Then I have ESR of 25. 3800 white count. 36 segs. 58 bands. BUN of 22. And then the electrolytes, 135, 3.0, 98, and 18.

Q Let me stop you there. What were those values you started reading before you got to the 3800? Start above those, please, and tell us what those are. ESR, I believe?

A ESR is the erythrocyte sedimentation rate and 25 is a number that shows some mild amount of inflammation.

Q That's the sed rate, commonly referred to?

A The sed rate, yes.

Q 25, is that a normal finding?

A 25 is an elevated finding, but early in an illness, it doesn't necessarily mean anything.

Q Is four days, post chicken pox, early in the?

A For chicken pox?

Q Yes, sir.

A Yes.

Q Shouldn't it be resolving by the fourth day?

A Patients typically are better by the fourth day, but the average child with chicken pox with seven days, it's seven days with ongoing disease, so it's right in the middle.

Q But my question was, normally, by the fourth day, patients are typically getting better. Correct?

A Right.

Q And based on the records that you reviewed up to this point in your review, this was the fourth day and the patient was getting worse. Is that correct?

A I would say that's true.

Q Okay, sir. You mentioned the sed rate. What was next?

A 3800 white count. 36 segs. 58 bands.

Q Let me stop you there. That's the white blood count in the differential. Correct?

A Correct.

Q As of the first day?

A As of, this is the second visit.

Q Excuse me. As of April 21st, the second?

A 24th.

Q Did I say 21st? As of April 24th, the second presentation to the Emergency Room. Correct?

A That's right.

Q What, if anything, does the white blood count value of 3800 indicate to you?

A Well, to me, in context with the white count the night before --

Q Yes, sir.

A -- it is, again, raises two considerations. Could this be now typical leukopenia that we see with a severe viral process or could this be a bad prognostic sign for someone who has a very

aggressive bacterial process. They are the two ways of interpreting --

Q Okay, sir. Doctor, at anytime, has Mr. Coleman or anyone else provide? you with any information that, possibly, that 3800 value might actually be 38,000?

A The only information that was not provided by anybody, except what was given in the various depositions where that question came up, I went to the lab slip and it was, to me, very certain that there was 3800.

Q Assuming it was 38,000, would that change your impression as to the significance of that finding other than what you just told us a moment ago?

A I would say, if this white count were 38,000, it would be much, much stronger evidence for a bacterial process than any other process.

Q Than any other process?

A Right.

Q Does the fact that you've interpreted as 3800, is that of equal significance that it's

indicative of a bacteriological infection as it would be had it been 38,000?

A I think I understand your question.

Q Okay.

A But, no. If it was -- I guess, I don't really understand your question.

Q You mentioned in terms of a 3800 white blood count on the second day, a presentation at the Emergency Room, that in conjunction with the 14,000 that was taken the day before, you would interpret that 3800 as being indicative of two potential scenarios, as I understood them.

A Right.

Q One having to do with a viral complication.

A Right.

Q As a result of the varicella and the other being a indication that this child had a very serious bacteriological infection.

A Right.

Q Is that right?

A Correct.

Q And if, in fact, the 3800 white blood count

was being caused by a very serious bacteriological infection, would it be correct that this child's system, in terms of being able to produce those white blood counts, is about depleted at a very low point at that stage?

A That is true. Yeah, that's what happens.

Q In this case, have you reviewed all the medical reports and the autopsy report?

A Yes.

Q Do you agree with the cause of death?

A As I sit here, I don't remember what the autopsy says was the cause of death, but I know what the cause of death was.

Q What was the cause of death, sir?

A Well, the proximate cause of death was toxic shock syndrome from Group A strep.

Q Okay, sir. Would you have an opinion that this child was suffering from a bacteriological infection when he presented to the Emergency Room on the first day, that is, April 23rd of 1991?

A Oh, I don't think there's any question that we know he was. Postretrospectively, we know he

was. His blood culture was positive for Group A strep, so there's no question about that.

Q And on the 24th, when he had this 3800 white blood count, do you have an opinion that that white blood count, in retrospect, was, in fact, a reflection of the fact that he had a severe bacteriological infection?

A Knowing what I know about him now, in retrospect, there's no question in my mind the 3800 white count is definite evidence that this is now an infection out of control.

Q Okay, sir. In terms of the left side shift there that was taken, the differential on the 24th, give us the values and tell us, in your opinion, how marked a shift that is.

A The values of *36 segs* and 58 bands, and that is a very significant, very marked left shift. More, more than that, people don't usually characterize left shifts. I mean, this is a very hefty left shift.

Q And a left shift is consistent with a bacteriological infection. Correct?

A That's true.

Q Is it consistent with other things that this child was presenting with at that time to that degree of shift, in your opinion?

A I think the degree of the shift, again, is also consistent with a severe varicella infection that's now also getting out of hand. And, in fact, what one does is look at the patient to help determine what, what of those variables, which is the more likely one.

Q Explain what you mean by that, in order to look at the patient to determine whether it's a varicella problem or a secondary bacteriological infection. Is that what you're saying?

A Yes.

MR. BURTON: Well, wait. Before you answer that question, just let me make sure. We're still on our standing objection. Right?

MR. LOPEZ: Absolutely.

MR. BURTON: Is there any confusion about that?

BY MR. LOPEZ:

Q I'm asking this Doctor, based on his experience as a pediatrician, to explain that last comment in terms of what he stated.

A Well, what I think one does is look at the patient to see several features. One, how sick or toxic does this child appear?

A child who's very ill appearing and has a white count like that, the evidence suggests that you should treat that patient for a bacterial infection.

Secondly, when you've gone beyond the general overview, is this child toxic or not, you look for *foci* of infection.

If a child has cellulitis, septic arthritis, a pneumonia on examination, a horrendous pharyngitis on examination, and then you look at this white count, you say, in context, this white count is probably telling us this is aggressive infection.

So the focality, you identify the source that's probably a bacterial infection or the overv ew of the patient, how sick the child is, in a way, determines how you interpret that white count.

Q On the 24th, the child's presentation in

to see more than one joint with septic arthritis, and, by description, there are two anatomic regions here that are swollen, the ankle and the knee, so, statistically, it's not likely.

No. 2, characteristically, children who have septic arthritis only have pain, at least, initially, when they're moving their extremity. They don't have spontaneous pain when they're at rest.

And by, what I glean from the mother's deposition, and, certainly, after the child was admitted, this child was having real marked pain, spontaneous pain, and that is the hallmark of necrotizing fasciitis, but not the clinical hallmark of septic arthritis.

Thirdly, if you just want to look at the microbiologic, or, rather, the biochemical markers, the child also had hypocalcemia, which is, again, a feature of necrotizing fasciitis because of the saponification, the making of soap.

And then, lastly, if one looks at the autopsy, one sees under the skin pathology evidence for a necrosis and bacteria, so I think the pathology

is there and the clinical presentation and. I believe, strongly, this was necrotizing fasciitis

Q Was this necrotizing fasciitis caused by the strep bacteria?

A Yes.

Q So whether it's a septic or a necrotizing fasciitis, it's your belief that it was caused by the streptococcus?

A Oh, absolutely. It was even seen at the time of post they found cocci in the skin, yes

Q Did you note in the autopsy report that there were no active varicella lesions obtained by the pathologist?

A I don't remember seeing that

Q Assume that that is the final autopsy report, is that of any particular significance to you in terms of indicating what this child was suffering from on the 24th or the 23rd that was causing this fever and that sort of thing?

A I don't think I would dare to -- I mean, in retrospect, I certainly wouldn't want to know that that was suffering or causing this child to suffer

fever and so on. We have the culture of the blood from the 23rd and then we have the subsequent courses of events on the 24th.

Q I guess what I'm asking is, do you have an opinion as to whether the varicella actually had resolved by the 23rd or the 24th?

A If, in fact, the pathology description of the skin lesions are that they are all crusted over, then they would have all, in fact, resolved.

Q Doctor, I know I'm interrupting as you go along when you hit relevant areas. If you would continue reading your notes, please.

A All right. I think we had gone over the electrolytes, BUN and CO_2, the hemoglobin and hematocrit, 11.5 and 33.5.

Q Let's do this. If you come across things in the notes that you wrote them down that you felt, that you feel bears mentioning as to their significance, please do so and I won't have to interrupt you.

A Okay,

MR. BURTON: I don't understand what you're

asking him to do.

Q He does.

MR. BURTON: Well, I don't --

A He wants me to --

MR. BURTON -- understand what the question is. I mean, you're asking him, are you asking him to --

(Simultaneous speaking.)

MR. BURTON: I'm sorry. I have my objection, so I'm just going to sit, sit back and --

MR. COLEMAN: I don't want *to* like waive anything by him volunteering these opinions, so we still have a standing objection, which I think I do. I'll let him go ahead so we can speed this thing up.

THE WITNESS: Bun of 22, I think, is significant. It shows a worsening of his hydrational status compared to the night before and it shows, basically, kidney involvement in whatever process we're dealing with.

CO_2 of 18 is, to me, significant because it is suggestive of an underlying metabolic acidosis that has developed since this child left the ER the

night before, since his intravenous infusion of fluids, which was given, in effect, to help combat some of the causes of metabolic acidosis,

The SDOT of 145 and SGPT of 52 and bilirubin 1.8, I think, are significant. They show liver involvement in whatever process this is.

The child also had a, skipping to the bottom of the page, but just tc keep it all under the same rubric of laboratory, had a pro time, a PT 14.7, which was prolonged. He had a platelet count of, it's in here somewhere and I just don't see it, I think, 148,000, which is low.

All of these are evidences of a very aggressive bacterial process which has gotten out of control and, in fact, this child is showing fairly multisystem organ involvement with whatever process this is as we look at it prospectively.

Q Okay, sir.

A The rest of the note says, consult Dr. Fernandez. First call at 9:16, then at 10:21, and then here at 11:25. And then this is from Dr. Fernandez's typed note, physical exam, oriented

and appropriate. Liver is 3 fingerbreadths below the right costal margin.

Q significance?

A Hepatomegaly is significant in a child with varicella for many, many reasons; toxic hepatitis disseminated, bacterial disease, viral hepatitis, Reye's syndrome. I mean, it raises a whole bunch of issues for a physician.

Q Swollen liver?

A Swollen liver. Left knee and ankle swollen and red. And then I have here, varicella with hepatitis, arthritis, fever, and I think I have the word tender underneath swollen in red, knee and ankle, but it doesn't, like my C.V., I have it on the wrong line.

Then I have, admit, diagnosis, varicella-zoster. Rule out Reye's syndrome, varicella, hepatitis, encephalitis.

Then I have some vital signs taken at 7:13, temperature 99.6, pulse 124, respiration is 44.

9:05, temperature, 101.4. 10:25, temperature, 102.6. Pulse, 160. Respiration's 44.

Then I have nurse's notes. Vomited 45 minutes post home last night. Complained of stomach and left foot pain and swelling. Acting like he doesn't know where he is.

8:45 a.m., therapy IV with D5 half normal saline, 50 ccs an hour, and I have a line drawn. And I have, admitted to East Pasco at 2:10 p.m.

Then I have, Dr. Fernandez orders negative antibiotics. Nurse's notes, 5:15 p.m., patient's mother called. Complain of change in the skin in neurologic exam, dark purple to bluish colors of ears and toes. I have a PTT of 31.2 and then the PT of 14.7 seconds. And then the last line is 7:13, arterial blood gases. Dr. Fernandez called 9:50 p.m. All Children's Hospital and then arrested and died 3 a.m.

Q Those are your initial notes after your review of the records. Correct?

A Again, a few of the things that are on here were added with subsequent reviews.

Q Is there any way for you to tell which ones are which?

A I can point out a few of them for you. For instance, the notation Tuesday in brackets on 4-23-91, I believe, came after I read Mrs. Mesiemore's deposition and she timed the days,, the days of Sunday, Saturday, when things were happening.

Q In terms of the four-day onset?

A Right. And the rest of it, I think I probably circled some of these lab values this morning when I was reviewing my notes so that I could highlight them when I gave you my discourse.

Q Okay, sir. And those are the ones that are circled now?

A Yes.

Q Please tell me, Doctor, what in its entirety have you reviewed or relied upon in order to reach the opinions which you, apparently, prepared to express here today?

A I reviewed the East Pasco Medical Center ER visits of the 4-23 and 4-24. The All Children's Hospital hospitalization of 4-24, 4-25, The autopsy report. The depositions of Mrs. Mesiemore's, Nurse

Paula Leach, Nurse Patricia Ann Johnson Dr. Warren Andiman, and Dr. Howard Franklin.

Q Do you know or know of Dr. Andiman?

A No, I don't.

Q You're not familiar with him?

A No.

Q Anything particular in terms of the

Mrs. Mesiemore's, the mother of the boy, Paula Leach, and Pat Johnson, firstly, that strike you as particular significant as it pertains to this case? And you can take them one at a time, if you wish to.

A Well, again, my main concern, as I was going through the records was, was largely to identify what the eventual outcome of this child could have been or would have been had things been done differently.

Q Yes, sir.

A So with that concept in mind, one of the

issues that, that addressed, I addressed was, when did the tissue infection really become well established, and that has serious importance as I look at a case like this.

Q Let me ask you this question. Did I ask you specifically what Mr. Coleman had requested you to do in terms of reviewing these records and what opinions he wanted you to -- let me start again.

Have I asked you what Mr. Coleman had asked you to review for what purposes?

A I don't think so, at this point.

Q Please tell me, when Mr. Coleman engaged you and sent you these records and had you review them, what, if anything, did he tell you to do at that time?

A He, basically, told me to review the records and see whether or not I thought there was a problem with the nursing care and whether or not that problem with the nursing care in any way prejudiced the outcome of this young boy.

Q Okay. Now, you've done that?

Yes.

You've completed your work?

Yes.

Q Is there any materials which you had requested which weren't provided to you for whatever reason?

A Well, I don't know if I would use the word requested, but I do think I spoke with Mr. Coleman after I had read Dr. Andiman's deposition and, in there, realized through some questioning that he was addressing that Dr. Fernandez's deposition had been done, had been taken.

And I believe when I discussed Dr. Andiman's deposition testimony with Mr. Coleman, I made mention of the fact that I hadn't gotten Dr. Fernandez and he basically said, well, we're interested in your opinions for the nursing care and so you don't need to do it, so I haven't seen Dr. Fernandez.

Q Have you formed any opinions concerning the standard of care as it pertains to Dr. Fernandez?

A Without reading her deposition and the other doctors involved, I wouldn't want to do that.

No, I have not.

Q Okay. Do you plan on doing so prior to trial?

A Not unless somehow I have to.

MR. COLEMAN: No. That's fine.

Q Same question as it pertains to the Emergency Room care that was administered in this case. Have you formed any opinion as to whether or not there was an appropriate standard of care administered in the Emergency Room by the physicians?

A Same answer. I would want to find out more what their thought processes were before making any judgment about that.

Q In terms of what Mr. Coleman had asked you to do, basically, to determine, in your opinion, whether, I think you stated, there was a problem with the nursing care?

A Right.

Q And whether, if there was a problem with the nursing care, it would have made a difference in the ultimate outcome of this child. Is that right?

Correct.

Q With that mind, I asked you about the significance of the depositions. Firstly --

A Right.

Q -- Ms. Mesiemore, Paula Leach's, Pat Johnson's, the ones you said you reviewed, and we can take them one at a time.

A Right.

Q And you started telling me, you wanted to make a determination concerning the tissue?

A Right.

Q Please tell us about that.

A This goes to, I think, primarily, Ms. Mesiemore's deposition and that is, my basic, and just to give you a whole paragraph and maybe it'll shorten this, my basic opinion in this case is that children who have invasive Group A strep disease with the kinds of strep that happen to be circulating in the United States right now, it has been well proven that when this particular infection is well established in tissue, that is to say, it's gone on for 12 hours, 24 hours, untreated in tissue, antibiotic therapy no longer is very effective.

And that when you have such a circumstance, a well-established, reasonably longstanding tissue infection, the outcome in these patients is universally poor.

So I looked at Mrs. Mesiemore's's deposition to see whether or not there was a way of timing when the necrotizing fasciitis or even septic arthritis, if that's what it really was, was really beginning and how Long it might have been there before any physician saw it and identified it, could have treated it.

In that regard, I noted in Mrs. Mesiemore's's deposition that there was fever on Monday, which would have been the 22nd, which, later on, was associated with knee pain, and that on Tuesday, her sister, who was taking care of Christopher that day, contacted her late in the afternoon about the knee pain or the leg pain and the fever, suggesting to me that there was probably some ongoing tissue involvement as early as late Monday or, perhaps, during the course of the day on Tuesday.

Q Tuesday the 23rd?

A Yes, Tuesday the 23rd. That, to me, was, was the beginning of the question of, when did this problem really start?

Q Okay. You're reading from your notes that you've made and read on this time on the page of Ms. Mesiemore's's deposition.

A That is right.

Q Madam Court Reporter, let's mark the cover page as the next exhibit in line.

And did you do that, Doctor, for each of the depositions?

A Right. Right.

MR. LOPEZ: And we will mark, in line, the cover pages of each of the respective depositions where Dr. Wientzen has recorded his notes.

(Exhibit Nos. 5-9 marked.)

(Discussion off the record.)

BY MR. LOPEZ:

Q Doctor, you even listed page numbers. Correct?

A That's right.

Q Please, go there. You mentioned that you

determined from Ms. Mesiemore's's deposition that he had a fever on Monday?

A Right.

Q And that was associated with some knee pain?

A Yes.

Q Did you reference a page number?

A No, I did not, not on those notes.

Q Would the fever have been consistent with varicella in and of itself?

A Yes.

Q Continue on with your notes, sir, if that helps refresh your recollection. Basically, what I asked you was, in terms of Ms. Meisiemore's deposition, what significance did that have to you?

A The second series of issues that would be significant to me from this deposition is her statements about the course of events after leaving the ER, the first time, late on the night of the 23rd going through the morning hours of Wednesday the 24th.

And by her description the child, during

the course of those hours, was hallucinating, had high fever, and was very restless and not sleeping, and those were the reasons why she took him back to the Emergency Room.

Prior to that, he had complained, after getting home, of leg pain and vomited soup, so suggesting that this leg pain was persisting and the process was, in fact, continuing and getting, getting worse.

Q Okay. Let me see if I understand you here. You obtained from the deposition statements from Ms. Mesiemore's that she indicated that her son was complaining or there was some reference to knee pain on the 22nd, that is, the date prior to first presentation to East Pasco Emergency Room.

A Right.

Q And you also mentioned hallucinations on the night of the 23rd after returning from the Emergency Room. Is that correct?

A I think it's early morning hours of the 24th. I mean, she got home, probably, at midnight or close to it, so we're talking about the 8 hours or

7 hours between getting home and then returning to the ER.

Q Now, you had already noted there was a recorded history of hallucinations on the first presentation --

A Right.

Q -- at the Emergency Room on the 23rd. Correct?

A Although she has no recollection of that now, but I don't have any doubt about that.

Q Who has no recollection of it now?

A I believe, Mrs. Mesiemore's in her deposition doesn't remember about the hallucinations leading up to the first ER visit.

Q Okay. But they're reflected in the records --

A Absolutely.

Q -- are they not, sir?

A Exactly. I'm saying, I have no, I have no debate about that.

Q Okay.

A If they're there, they're there.

Okay. So they were recorded by whatever physician or person took that history on the 23rd. Right?

A Right.

Q You noted, though, that the patient had more hallucinations after returning back from the Emergency Room on the 23rd. And what I'm trying to determine is, of what significance is that to you since the presentation on the 23rd has it recorded in the chart that the child had hallucinations?

MR. BURTON: I object to the form of the question. I believe that was a history given, and not a finding of hallucinations by the medical staff, so I think you unintentionally mischaracterized what that record really reveals, but go ahead.

A It truly was a history of hallucinations and children with very high fever can hallucinate.

Q Okay.

A There's a very, in fact, probably, the most common cause of children talking out of their head is a high fever from any cause.

The reason I note it in here is that it

tells me that this process is continuing.

Q Okay.

A It is not something that really was starting and stopping, but it's now a continuation of the same process that was in effect Tuesday, let's say, now on Wednesday.

Q Okay. So in review of that deposition, you found a reference to knee pain by Ms. Mesiemore's on the 22nd or the date prior to admission to the Emergency Room or presentation to the Emergency Room on the 23rd?

A Right.

Q Okay. You assert or believe that that knee pain was indicative of the same inflammation that later manifested itself in the chart at East Pasco Hospital?

A Yes.

Q Do you have any opinion as to when the infectious process started because you, in your paragraph that you mentioned earlier, you used terms like reasonably long period of time, 12 hours, 24 hours, etc.? Do you have any feeling as to when the

infectious process started?

A Well, I think, whenever the knee pain was first complained of, in my judgment, would be when this process was in the tissues, whenever that was.

She doesn't time it. I don't think she was asked the time. I don't think whoever was taking the history from Ms. Mesiemore's understood the significance of that line of questioning to me, but whenever that was, in my judgment, the infection was there at that time.

Q Okay.

A How many hours earlier was it there before the pain occurred, I don't know.

Q Well, let me ask you that, sir. You have indicated you're board or subboarded in infection disease?

A Right. Pediatric disease.

Q Do you have any opinions as to when a Strep A bacteria would likely be in the tissue before it manifested itself in terms of pain?

A No.

Q Is there any way to determine that?

A I would not know. I mean, the animal models that are used for this process don't allow you to ask those questions.

Q Based on your clinical experience with patients and the histories you've obtained and the things you've learned in your practice, you don't have any opinions about that?

A I can give you a very general opinion, which is just the opinion of a reasonable man, and, that is, Group A strep is a reasonably aggressive pathogen. And so my judgment would be, the pain commenced within a reasonably brief time after the introduction of the bacteria into the tissues, but I didn't mean to pick a number of hours, but, certainly, not days.

Q My question to you was, have you formed any impression, do you have an opinion as to when the infectious process started?

A Yes.

Q And when is that?

A It was certainly, it would have started not long before the first notification of pain that

mother described on Monday the 22nd.

Q Okay. Can you indicate where that was stated or do you have a page number or anything like that, and we don't have to waste a lot time going through the deposition if you have a page number, but the problem is, I can't read your writing on the cover page.

A Well, for that group of, for the group on the top here, I didn't put a page. But, if I recollect, I think it's towards the end of the deposition, strangely enough. Let me see (Indicating.) So you went me to just look through this for a minute?

MR. LOPEZ: Yes, sir.

(Discussion off the record.)

(Short break taken.)

BY MR. LOPEZ:

Q Doctor, you were attempting, as we went off the record here, we've taken about a five-minute break to try to find the portion in Ms. Meisiemore's deposition that appears to support the testimony you gave me earlier as to when, based on that deposition,

Ms. Mesiemore's had stated that her son Christopher had first shown knee pain to her. Is that right?

A Correct.

Q In an effort of brevity, hopefully, why don't we go to your notes, your red written notes on that first page of that deposition, and let me ask you, did you read that entire deposition?

A Yes, I did. Several times.

Q Several times?

A Yes.

Q How about these other depositions; you've read them in their entirety?

A Yes.

Q Okay. Madam Court Reporter, let's copy them all, the entire depositions, because you've made underlined notations on these depositions. Correct, Doctor?

A Right.

Q When they came to you, were they not marked in any way?

A No.

Q So we can assume that all the marks were

yours?

A Yes.

MR. LOPEZ: Okay. Mark those as the next prospective exhibits.

(Exhibits 5-9, previously marked, include entire depositions, not just cover pages.)

BY MR. LOPEZ:

Q If you would, sir, please read to us your notes from the cover page of Ms. Mesiemore's deposition.

(Discussion off the record.)

THE WITNESS: So read what's on my cover?

BY MR. LOPEZ:

Q Please, sir.

A Fever on Monday. Fever stayed high and associated with left knee pain. Then, underneath it, I have Tuesday with a dash. And what we've now discussed is that it seems like the fever stayed high and it was associated with knee pain that began on Tuesday. So the knee pain began on Tuesday and I stand corrected based on my missreading of my handwriting notes.

Q Just so we're clear, that's Tuesday, the same day of initial presentation to the Emergency Room?

A Correct.

Q I.e., April 23rd?

A That's right.

Q Okay.

A Contacted by sister at 4:30 p.m. about this. Had had diarrhea prior to coming to ER.

Page 53, Dr. W exam, dehydrated plus chicken pox, IV fluids for 2 to 3 hours. Re-evaluated patient. Sent the patient home. Chris was calm in bed at ER. Was unable to walk post IVs.

Page 56, D/C instructions did not contain information concerning complications to watch for. Carried Chris from the Emergency Room. Complaint of light pain at home. Vomited soup. Wednesday, early a.m., hallucinating. Had had high fever, very restless, not sleeping. Arrow back to the ER.

Saw Dr. Demers in ER. She called pediatric consultant, Dr. Fernandez. And then I have crib, comma, no bed. Then bed. IV backed up and fixed.

Noted pox to be purple; skin and nails with color change.

Page 98, first ER visit. Mom noted the left knee swollen, but not overly swollen, in quotes. Wouldn't move it. No color change.

Page 132, denies CS, which is Christopher Shelley, was walking or running in the ER and denies

Q Those are the notes that you made on the cover page of Ms. Mesiemore's's deposition which you felt were significant in terms of her deposition testimony?

A Right.

Q As it pertained to what Mr. Coleman had asked you to do. Is that right?

A Well, some of them were important for what Mr. Coleman asked me to do, but some of them were just generally important.

Q Okay. We're clear that based on your review of that deposition, the mother of the child first noted that her son was complaining of knee pain the very day she took him to the Emergency Room. Is

that right?

A Yes.

Q Okay. Do you have an opinion or impression as to when this infection, in your professional opinion, might be started in this child?

A If the knee pain began on Tuesday, my judgment is, the invasion of the tissue began shortly before the complaint of knee pain on Tuesday, whatever hour that can be timed at by the sister whose deposition I haven't read either.

Q I don't think it's been taken, sir. In terns of the invasion of the tissues, that phraseology that you use, does that mean that that's when the infection started?

A Yes.

Q So the infection, in your opinion, started on Tuesday the 23rd?

A Right.

Q Can you tell us, based on -- strike that. Assuming that the child complained of knee pain as reflected in Ms. Mesiemore's deposition, whenever that might have been, can you quantify for us as to

when you think the infection started in terms of time prior to that that knee pain manifesting itself?

A Again, I would only be able to quantitate that by saying, within a pretty brief period of time, a reasonably brief period of time.

Q Okay. Are we talking --

A Hours.

Q A few hours?

A Yes.

Q Okay. Doctor, what was the next, or take any of these depositions. We can take them in line, in the manner that we've marked them that you reviewed for purposes of this case.

A Right.

Q And whose deposition was that and what are you notes reflecting there, please?

A Paula Leach's deposition, and I'd have to read my notes to see why I took them, but would you like me to read them into the record?

Q Please, sir.

A Staff nurse, third floor, 3 to 11 shift, was charge nurse 3 to 11 shift, April 1991. Took

oral report on Chris Shelley from outgoing charge nurse. Had varicella, plus vomiting at home.

Page 77, 78, saw Christopher Shelley on rounds at 3 p.m. Alert, talking, and pink. 30 to 45 minutes later, went back to see Christopher Shelley with Dr. Fernandez at about 4 p.m.

Dr. Fernandez was upset. The labs had not yet been done, especially the ESR. Asked Dr. F if patient could be transferred because of being covered with varicella-zoster and swollen knee. Dr. Fernandez left the hospital at 4:30. At 5:19, though, it might be 5:15.

Q Can I interrupt you a minute?

A Yeah.

Q That last entry you read from your notes prior to Dr. Fernandez leaving the hospital at 4:30, what was that entry, please?

A The one prior to that?

Q Yes, sir.

A It says, asked Dr. Fernandez if patient could be transferred because of being covered with varicella-zoster and swollen knee.

Q Okay, sir.

A Dr. F left hospital at 4:30. At 5, either 15 or 19, Mrs. Mesiemore asked the nurse to check Christopher. He was lethargic, had blue nails, and slightly labored respirations.

Someone paged Dr. Fernandez at about 5:20 to 5:25. She returned the call at 7:10 and gave orders for an arterial blood gas, etc., and then in parentheses I have O_2 tent.

Saw Christopher Shelley at about 6 p.m. Again, he remained the same. Dr. Fernandez arrived about 7:25. Nurse Leach recruited from role of charge nurse to work only with one patient, Christopher Shelley, and work with Nurse Dixon, getting vital signs and establishing second line.

Q Okay, sir. The particular significance of that deposition as it pertains to what you were asked to do by Mr. Coleman?

A Just flushing out of what other things might have been, being done for Christopher while he was on the ward before he was transferred, before his situation got critical.

Q Okay, sir. What do you make of Nurse Leach's statement that you read in your notes that the patient was alert, talking, and pink sometime prior to, what, 3 o'clock in the afternoon? Is that correct?

A Yes. I think that's on rounds at about 3 o'clock. That's compatible with a child who's got any one of a number of serious problems that are going to present, even fatally, in the next few hours.

Q Alert, talking, and pink?

A Yes.

Q That phraseology in and of itself that you wrote down as being significant to Ms. Leach's deposition is indicative of a child that's going to die in the next few hours?

A No. I'm saying, I guess, I was trying to jump ahead to maybe answer the second question that you were going to ask after your prior question.

That is a notation that describes a child with reasonably normal neurologic functioning. That child could be on a baseball field, playing baseball,

or that child could have necrotizing fasciitis, be bacteremic, as we know he was at this time, and be in shock, florid shock, two hours later. That is how this disease can progress.

Q Okay. My question to you was the fact that you wrote down in your notes as a significant finding in Nurse Leach's deposition was that the child, allegedly, at 3 o'clock was alert, talking, and pink --

A Right.

Q -- was answered by you, I believe, that in the next three hours or so, something bad could happen. Is that right?

A I think your question was, what is that compatible with or what does that tell you?

Q What does that tell you?

A At the precise moment you make this determination, that this tells you the child's neurologic status appears intact.

Q Okay. The next deposition, Doctor, and its significance, and I believe that would be No. 7. And before we get to that, and I've got it right here,

it's Nurse Johnson's, let me ask you a question

I believe, based on your review of Ms. Mesiemore's deposition, and correct me if I'm wrong, I think you were under the mistaken impression that the child had given a history or that knee pain had been noted the day prior to the hospital admission. Is that a fair statement?

A Yes.

Q So you were under the impression that the knee pain that manifested itself on Monday the 22nd when, in fact, it had manifested itself on Tuesday the 23rd. Is that right?

A That is correct. I misread my notes.

Q So are we correct that everything has moved forward now 24 hours from what your previous opinions would have been as far as salvagability?

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

A No. Regardless of whether this process began on Tuesday or whether this process began on Monday, my opinions on salvagability are not moved forward because the crucial question is whether or

not there has been a 12-hour interval for these organisms to establish themselves in tissue.

And if there is a 12-hour interval, conventional and microbial therapy has minimal effect on the serious consequences that these organisms are going to wreck on the cardiovascular system and the pulmonary system by virtue of production of the various toxins that they produce.

Q Was there anything particularly different about this type of Group A strep that Christopher Shelley had?

A I think this particular strain of Group A strep was never tested for the production of the various toxins that have been associated with the organisms that produce toxic shock syndrome and necrotizing fasciitis and other varieties of invasive Group A strep disease.

But based on the clinical disease that Christopher Shelley had with rapid progression to fulminant shock, irretrievable shock associated with chicken pox, I think the odds are overwhelming that this was a variety of strep that produced

streptococcal, pyrogenic X with Toxin A and probably proteas and other toxins that are very poisonous to human beings.

Q Regardless of the type of strep that it was back in 1991 when this child presented, do you have any opinions that this particular type of strep, whatever it was, would have been very easily controlled and treated by antibiotic therapy had it been instituted in a timely fashion?

A I think we would disagree with what a timely fashion might mean for this variety of Group A strep.

Q Well, do you know what variety of Group A strep it is?

MR. BURTON: Well, hang on a second. I don't think the Doctor was finished with his answer.

MR. LOPEZ: Well, he wasn't. I'm sure he wasn't, but I wanted to clarify.

MR. BURTON: Well, no, no.

MR. HUNTER: He gets to finish his answer.

BY MR. LOPEZ:

Q Go ahead, Doctor. I'm sorry I interrupted

you.

A For strains of Group A strep that produce necrotizing fasciitis and that produce toxic shock syndrome, which is what this child had, timely institution of antibiotics has to be very, very early in the evolution of the process.

No. 2, antibiotic therapy is fruitless, unless it's cojoined with aggressive surgical debridement of these patients.

So unless a physician was willing to take this child to the operating room and, essentially, flay this child, this child was going to have continued production of toxin and disruption of his cardiovascular and pulmonary circuits.

So antibiotics are only one part of the story. They must be given very early and, even in that circumstance, alternative or, what's the word I'm looking for, adjuvant therapy needs to be given, namely, surgery.

Q Okay. I want to back up a little bit because I'm confused about something. You said, in these types of patients, in order to treat them

effectively, some type of surgery would have to hav been done. Is that right?

A Right.

Q When you say these type of patients, what specifically are you referring to, the previous diagnosis that you've given as to what you think was actually going on in the knee and ankle? Is that what you're referring to?

Well, certainly, there's no question that necrotizing fasciitis would need to have a very major debridement, and, often, repetitive debridements.

Children who have suppurative arthritis and had two joints involved, one would need to get the material that was infected out of the knee joint. That would be less surgery, but it would still be surgery.

Q Okay. You don't think he had septic arthritis?

A That's right.

Q You think he had necrotizing fasciitis?

A Correct.

Q And you would say that for treating

necrotizing fasciitis, that surgery would have to done rather rapidly?

A Right.

Q Now, is it your testimony that in all cases of necrotizing fasciitis, that surgery is necessary to save the patient's fife? Is that what you're saying?

A In the majority of cases, yes, and if you don't do surgery, there's a very grave chance that you will sacrifice the extremity. The patient may live, but the extremity is gone.

Q You mentioned earlier in this last exchange here, before I interrupted you, and I'm sorry, that you believe, and you used the term, a 12-hour interval is what is the time frame that you've utilized in terms of if the bacteria has a opportunity to establish itself for that length of time, I believe, you said that it becomes futile to treat it?

A Refractory to therapy. The antibiotic, beta lactam antibiotic therapy like penicillin and the ceftriaxone that was used here.

Is there any antibiotic therapy that, in your opinion, if administered more than 12 hours after onset of this infection, would be able to stop the infection?

A Yes.

Q Which ones?

A Clindamycin.

Q Was that available in 1991?

A It was available. Very few people knew that it was potentially life preserving and it was not standard therapy, but it was available.

Q Okay. I'm trying to understand what you've stated here, and maybe you can help me through this. It's your testimony that this child, if not given correct antibiotic therapy within 12 hours of the onset of this infection, which you've indicated first manifested itself by the pain in the child's knee sometime on the day of admission of the 23rd?

A Okay. Let's say date of visit rather than admission.

Q Excuse me. Date of admission to the Emergency Room on the 23rd That would have been

within 12 hours of that time period. It's your opinion that if that was not done, this child was doomed?

A That is right.

Q That's your opinion within a reasonable degree of medical probability?

A Absolutely.

Q And you base that on the fact that all we know about this is that it was Group A strep. Correct?

A Well, that's not we all know about this. We know that this is a Group A strep strain that caused toxic shock syndrome with intreatable shock and multisystem organ involvement and soft tissue infection that I think was necrotizing fasciitis.

Q Let me ask you this. There's many different strains and varieties of Group A strep. Correct?

A That is true.

Q Let's take your garden, hypothetically, a garden variety of Group A strep that's present in anyone in this room's bloodstream or the tissues of

anyone in this room who's afflicted with it.

A You mean, if someone were to be afflicted with it?

Q Yes, sir.

A Okay.

Q Okay. And let's assume this garden variety Group A strep is not treated with any antibiotic therapy. Do you have any opinion as to whether that garden variety Group A strep would lead to the same type of result that happened in the Christopher Shelley case?

MR. BURTON: Object to the hypothetical. It's incomplete.

MR. HUNTER: Same objection.

Q If I understand your hypothetical, you're positing, you induce necrotizing fasciitis, or let's not even say necrotizing fasciitis; let's just say a bad cellulitis with Group A strep and then don't treat that patient with antibiotics. What will happen to him?

Some fraction, which would probably not be insignificant, of people would die. The majority of

people probably would not die. They would suffer vitally for a long time and get better.

Q. Are you assuming for purposes of your opinions that this was a particular type of Group A strep that we have no empirical proof that it was, but you're assuming that it was a particular proof that existed in Christopher Shelley?

A. Well, the empirical proof as to what kind of Group A strep this was is the syndrome that he presented with. This syndrome is due to, is caused by these strains of Group A strep that are toxogenic Group A strep.

They produce these enzymes, this whole cocktail of enzymes called SPEA and proteas and a number of other chemicals that cause horrendous disruption to the cardiovascular stability of human beings and a very high mortality rate.

This particular variety of strain of Group A strep has become more common in the last five years in Canada, the United States, in other parts of the world. It had disappeared, largely disappeared in the 30 or 40 years prior to now and now has made a

resurgence in the world, in fact, and no one exactly knows why.

But, in fact, the truth of the matter is, more and more people are becoming infected with this variety of strep and, hence, the reports of the, quote, unquote, flesh-eating bacteria, that is what this child had.

Q Okay. I'm glad you stated that. It's your opinion, Doctor, that Christopher Shelley has the so-called flesh-eating bacteria type of strep that's been talked about in the press in the last couple of years?

A Yes, sir.

Q What do you base that opinion on?

A Based on the presentation of a child with a very classic presentation of necrotizing fasciitis for me. The organism in the blood. Multisystem organ involvement. Shock that's impossible to treat.

Q Based on the opinion you just stated, Doctor, under any scenario, would a child who presented with a symptomatology that Christopher Shelley presented with to the Emergency Room on

April 23rd, under any scenario, should that child have been allowed to go home?

A If one --

MR. BURTON: I have a standing objection. That's the standard of care question with regard to the ER people, and, obviously, I renew my objection. Go ahead.

A If one knew that he had this particular syndrome, there was no way to send that patient home within the standard of care.

Q Would the appropriate standard of care of a pediatrician when presented with the symptomatology and history that Dr. Fernandez was presented with on the 24th, would the appropriate standard of care, in your opinion, as a pediatrician been to begin aggressive antibiotic therapy?

MR. HUNTER: I object to the question. Lack of predicate and the fact this Witness has already indicated, he's not reviewed Dr. Fernandez's deposition and has no opinion regarding the standard of care.

A I can answer the question?

Q Yes, sir.

A The answer would be, yes, aggressive antibiotic therapy should be given in that instance.

Q Let's go to the next deposition, please, the ones you reviewed that you felt were significant in terms of --

A I'm not sure what number we're up to now. Does anybody know?

Q You just finished Paula Leach.

MR. BURTON: That was 7.

A That was 7, so 8.

Q No. Paula Leach is 6. 7 is Patricia Ann Johnson.

A On top, it says, R.N. who was administrative assistant at East Pasco responded to Nurse Leach's call at about 7:30 p.m., 7:35 p.m. on 4-24. No. 8 is --

Q Before we leave Pat Johnson, what was significant about that deposition, from your perspective?

A From my perspective, it was sort of a nullity. I mean, by the time she got involved in

this child's ongoing care, things had really progressed so extensively that I just didn't even think it was much of a factor and I did not review this deposition for today, to answer that.

Q Did you note or were you told by Mr. Coleman or did you note in your prior reading of the deposition that Nurse Pat Johnson had seen fit to include into the medical record of East Pasco Hospital a handwritten notation or letter or report, if you will, and I'm showing that to you now as part of this deposition?

A I think that's also in my packet of records for East Pasco, and I think I read that at the time I saw this.

Q Well, find it and let's talk about that a moment, please.

A I found it and it's on Page 00043.

Q Okay, sir. And you've made some red underlinings there?

A That's right.

Q What have you underlined, sir?

A Next to, approximately, it looks like 7 5,

but it's not quite clear. I underlined, Dr. Fernandez arrived approximately 20 minutes after being called and then, underneath that, I've underlined, it says, Marge Preston from ED came and did start IV in the right foot. D5, abnormal saline hung approximately normally 8:30, and then I've underlined, and Dr. Fernandez asked for a surgeon to do a cut-down. Dr. Demers called from ED.

Q Okay. That's what you've underlined?

A Yes, sir.

Q Doctor, do you note from that letter there by Nurse Pat Johnson as to what antibiotic therapy was attempted to be administered to the child at approximately 7 or so p.m. that evening?

A Yes.

Q What was it?

A Rocephin.

Q Okay. Do you know what antibiotic therapy was instituted at All Children's Hospital?

A Again, I don't absolutely recollect, but, I bet you, Rocephin.

Q Okay. Now, is it your opinion that the

Rocephin that was administered at 7 a.m. here or attempted to be administered at East Pasco Hospital and later was administered at All Children's Hospital was not the appropriate antibiotic to treat this infection?

A No, that's not my opinion at all It was not an effective antibiotic, but it would be the antibiotic that almost everybody would have chosen to administer to a child like this.

Q All right So if I understand your testimony, it's your opinion that everybody who would have chosen that antibiotic to treat this infection, including the doctors at All Children's Hospital, were incorrect in choosing that, Rocephin Is that correct? Is that your testimony?

A No, that's not truly my testimony.

Q Well, why don't you tell me what it is

A It has been shown --

Q As of 1991, we're talking about, Doctor.

A It has been shown recently and, again, I'd have to call the date to find out what year it was, that the so-called Eagle effect, which was proven to

occur in Group A step infections that are tissue infections by Dr. Harry Eagle in 1951, can be surmounted or subverted by using Clindomycin rather than a beta lactam.

The Eagle effect is an effect wherein, if you give Group A strep a head-start in tissues and let Group A strep grow for 12 hours, in some cases, even 6 hours, but 12 hours, to pick a fair end point, the effectiveness of penicillin is gone and instead of dying 24 hours after a dose of antibiotic, the Group A strep is still alive and well in the tissues of this, of this animal, which is how Dr. Eagle did the study.

I believe it was in 1991, but I'm not sure, a researcher repeated Eagle's studies and proved that if you used Clindomycin, it was markedly superior to the use of beta lactams and, in fact, overcame the Eagle effect, the Group A strep dying quite nicely in tissues, even if they've been given a 12-hour head-start on antibiotic therapy.

Now, does that make it standard care? That's the question that you've stuck me with and the

the answer is, no. I warrant you, even a big hunk of pediatric infectious disease and board certified physicians don't know anything about the Eagle effect.

I warrant you, Dr. Andiman doesn't know anything about the Eagle effect because it didn't come out in his deposition when he said penicillin or ceftriaxone would be what we should use. I don't disagree with it, that physicians would use penicillin or ceftriaxone.

But when he reads this article, and he probably will after he reads my deposition, I believe, if he's a fair-minded scientist, he will agree that Clindomycin offers a specific theoretical survival advantage to patients who have invasive Group A strep strains.

Q I'm asking you, as of April of 1991, is it your opinion that Rocephin was an inappropriate antibiotic to give to this patient?

A It is not my opinion that it was inappropriate, nor is it my opinion that it's inappropriate now.

Q Is it your opinion that to give Rocephin for what Christopher Shelley had was a deviation from the acceptable standard of care?

A It is not a deviation from the standard, acceptable standard of care.

Q So what I'm getting from your testimony is that you think Rocephin is okay, but Clindomycin is better. Clindomycin is better?

A Rocephin is what people use and it's not very effective. Clindomycin, more and more people are using, and it is effective, but I don't think Clindomycin has become the only antibiotic one could offer and still be within the standard of care.

Q Okay. But I want to confine your answers to 1991, April. What was available to physicians at that time, okay, and Clindomycin was available to physicians at that time?

A Yes, it was.

Q Was it widely used?

A Not for soft tissue infections due to Group A strep like, but for other things, yes.

Q Okay. Was the Rocephin that was

administered at All Children's Hospital shown to have had any effect in combatting the strep?

A In fact, no, it was not shown to have any effect in combatting the strep and I say that because at autopsy, this is now, I can't remember when the autopsy was done, but let me just pick a number, 12 hours, after he was given a dose of Rocephin, they still identified bacteria from his tissues.

Q So it's your opinion, after reviewing the medical records of All Children's Hospital and East Pasco Hospital concerning Christopher Shelley and everything else you reviewed as to this case, that the Rocephin was given admittedly much too late. Correct, Doctor?

A Right.

Q Did not have any effect in combatting this strep bacteria. Is that right?

MR. HUNTER: Object to the form.

A Well, we're talking about different things. I think the tissue phase of this infection, no. Did it potentially sterilize the blood after 12 hours? I don't know if it was cultured or not, but

it may well have been able to do that

as what's shown to be, in fact, an effective antibiotic to treat that bacteria?

A I think if you were to test the bacteria against Rocephin in a test tube, is that what you're talking about?

Q No, sir. I'm asking you, in terms of your review of this case and the Rocephin that was administered to this child, albeit, admittedly, much too late, do you have an opinion as to whether anything in the record showed that the Rocephin, in fact, was combatting this bacteria, but it was just too little too late?

MR. HUNTER: Object to the form.

A As I sit here, I don't recall anything in the record that I even looked at to address that question.

Q Okay. Do you have any opinions or impressions as to what the purpose was of Pat

Johnson, the nurse at East Pasc Hospital, since you've been retained by East Pasco Hospital to render opinions as to whether the standard of nursing care, as I understand it, is one of the things you've been retained to give an opinion on, do you have any opinions or impressions concerning what the significance of this letter by Nurse Pat Johnson to the file is, from your perspective?

A I can't read into this what significance it has with respect to why she wrote it. To me, it would be just what a nurse would do, post facto, who wanted to keep the records straight. Excuse me.

(Discussion off the record.)

(Break was taken.)

(Discussion off the record.)

(Testimony was read back.)

BY MR. LOPEZ:

Q Doctor, you've been asked by Mr. Coleman, as I understand it, correct me if I'm wrong, to do a couple of things; to render an opinion as to whether the nursing care was appropriate?

A Right.

Q That's one of the things?

A Yes.

Q And, No. 2, to give an opinion as to when the child, Christopher Shelley, would not have been able to have been saved. Is that correct?

A That's right.

Q As to the first question, do you have an opinion as to whether the nursing care at East Pasco Hospital, as it pertains to Christopher Shelley, was appropriate care?

A I do. If one looks at the nursing, and we've read these into the record, or very early in this deposition, but if one reads the record, I believe, the record is short in terms of the notations that are put into the record with respect to vital signs and input and output and the typical, normal nursing component that one commonly sees in children who are hospitalized.

That is, to me, a deviation from the standard of nursing care. There is, perhaps, more to it in the sense that, even though there may be deviations from the bookkeeping or the recordkeeping

here. it is even Mrs Meisenhorn's remembrance that nurses were coming in and going things very frequently with various problems over the time as well as it is Nurse Leach's recollection that she was in repetitively and, yet, didn't write notes

I think they should have written notes The care may have been better than the notes suggest, but the notes suggest less writing about the care than you would expect to see so that you can objectively assess what the care really was like

Q In your medical training and experience, have you ever encountered the phraseology, if it's not charted, it didn't happen?

A I've heard, I've heard people talk about that That's certainly not the way I practice medicine, but I've heard people say that that's a nursing overview.

Q When you say that's not the way you practice medicine, tell us what you mean.

A I think I'm a middle-of-the-road person with respect to putting things in the chart and I'm not the kind of person who makes a handwritten

notation about every phone call that I get about every one of my patients and then runs it over to the medical record department to have it stuck into the chart. And I may order or recommend Tylenol for fever or whatever and it doesn't get in the chart, but it did happen and it did get done, and I think it's reasonable care.

Q Okay. Based upon your review of all the records that have been provided by Mr. Coleman and any other information that he's provided to you, and feel free to refer to the hospital chart in front of you at anytime, what's the last notation as to the child, Christopher Shelley, in the Emergency Rcom on April 24th of 1991? What's the time or entry of those please, sir, and, again, refer to the chart at your leisure?

A (Indicating.).

MR. BURTON: And the page you're reading from, Mr. Lopez, is?

A The last notation, let me look here. (Indicating.) I see two notations that would be juxtaposed. There's a 1310, sleeping quietly, no

distress noted, and then there's a 1410, time admitting called notation, so it appears here, 1410, someone called admitting to notify them that this child was to be admitted to the hospital.

Q That's at 2:10, correct, 2:10 p.m.?

A That is 2:10 p.m, yes.

Q What's the first -- you mentioned some specifics earlier, just so we're, hopefully, on the same page here. You do agree that the charting that's performed by the nurses at East Pasco Hospital, in your words, was a deviation from the acceptable standard of care. Is that right?

A Well, my view on that is, certainly, after this child was admitted, in-hospital charting, the in-patient charting was scanty and was subpar.

Q Okay. It was unacceptable, you're saying?

A Yes.

Q And an unacceptable deviation from what good charting should have been. Correct?

A In my medical judgment about nursing standards, yes.

Q Okay. And that's what Mr. Coleman has

asked you to do?

A Yes.

Q And however the offshoot of your opinion is, though, the charting was poor, it didn't have any effect on ultimate outcome. Is that right?

A That's right.

Q In terms of the last notation in the Emergency Room at 2:10 p.m., which is just a call saying it's time to get him up to the floor. Is that right?

A Right.

Q You mention some specific items that are missing from the hospital chart or record pertaining to the child's admission up to the floor. Could you specifically tell us what's not there that normally should be there?

A The initial nursing assessment. When a patient is admitted to a hospital, there's usually a pretty significant nursing form that's filled in.

Q Okay. Did you ask Mr. Coleman where that might be or --

A When we talked about it, I don't know if I

asked him where it might be, but 1 stated, it should be there and I don't recollect any retort to him, well, we have one, but it's out of the chart. I don't know anymore than that.

Q You're assuming it's non-existent?

A That's my assumption.

Q What else, sir, other than the initial nursing assessment?

A Dr. Fernandez ordered an I&O to be kept on this child, a strict I&O, and I don't see an I&O sheet to determine what his fluid intake was hour to hour and his output was time to time.

Q Okay. There's no I&O sheet.

A As far as I could see.

Q Doctor, what are you using as the basis that Dr. Fernandez did, in fact, order a strict I&O?

A His order, that's like the fourth or fifth order, as he admits this child to the hospital. It says I&O, strict.

Q And what page are you reading from, sir?

A It's not noted.

Q Those aren't noted, and that's

Dr. Fernandez's orders?

A Yes.

Q What else, Doctor? You mentioned absence of an initial nursing assessment. No I&O sheet.

A Then, my other handwritten note to myself says, there were a few notes from about 5 p.m. on the 24th to 9 p.m. on the 24th.

Q Find that part of the chart, Doctor, that reflects those notes from 5 p.m. to 9 p.m. I think Mr. Coleman has the page here.

A Yes. I see them right here. I have a note and I don't see a number on my --

Q Doctor, let me show you, just for purposes of keeping the record straight, is this the page, the same page you're looking at now?

A (Indicating.) Yes.

Q And it's numbered Page 42 at the top?

A Your notation is 42 at the top.

Q Okay, sir. You mentioned to me that there's few notes from 5 p.m. to 9 p.m., but, actually, it's from 3:30 p.m. to 9:50 p.m. Is that correct?

A Well, I think I keyed on the 5 p.m. to 9 p.m. because it was at this point that Christopher went into florid clinical shock and, in those patients, typically, there's a lot of nursing information that's gathered as the problem unfolds.

Prior to that, again, recollecting Ms. Leach's statement that this child was pink and awake and talking, I could see the need for less nursing hour-to-hour notes then after a child becomes cyanotic, let's say.

Q Do you know who wrote these nurses' notes there on the pages before you, which is numbered Page 42 at the top?

A Well, the handwriting is hard to read, but from my recollection of Nurse Leach's deposition, it was Nurse Nixon or Dixon.

Q Okay. Do you know or have an impression as whether all these notations -- firstly, have you read them?

A Yes.

Q Okay. Do you have an impression as to whether they were all done contemporaneously, sir?

A I don't know if they were done all at one sitting or hour to hour.

Q Okay. Do you have an impression?

A I would think they would be done hour to hour. I would find It hard to recollect a six-hour period with the kind of detail this person had retrospectively.

Q Well, by reading them, sir, where the time entries are placed in, does the time entries give you any indication that that's starting a new entry or does it just seem to flow one to the next?

A It seems to flow one to the next.

Q With that statement, do you have an impression whether they were done all at one time?

A Again, I would, I would find it hard to understand how anybody could recollect this kind of detail in sitting down and doing it all at one time.

It might have been and I just -- you know, I would judge not, but if Nurse Dixon says differently, she wrote them.

Q That's fair. What information, if any, other than this entry here, do you have to make an

assessment as to what the patient's condition was from, I believe, 1:10 or 1 o'clock in the Emergency Room when he was allegedly resting quietly till 3:30 in the afternoon, when we have the first entry on the floor? What information do you have to make any assessment as to what the patient's condition was during that period of time?

the record to give such a assessment.

Q And do you feel that such an absence of such a record is a deviation from the acceptable standard of care as it pertains to nurses?

A Well, we're talking about a two-hour period or two-hour-and-20-minute period and, to me, the real question is, is there a requirement for a nurse to make a note every hour or hour and a half on such a patient, and I don't think there really is. It's a function of how sick the patient is.

Q Okay. Well, let me ask you that, sir. Is it your testimony then that the absence of a record for 2:10 to 3:30, using 2:10 as the last entry, even though, in the Emergency Room, even though that has

nothing to do with the patient's condition, till 3:30, based on what you have gleaned from these records as to Christopher Shelley, the fact that there's a 2-hour-and-20-minute gap with no indication or no entries at all as to what the patient's condition was; do you feel that that is or is not a deviation from the acceptable standard of nursing care?

A No, I don't believe that is a deviation from the acceptable standard of nursing care to go two hours without making an entry on a child who's being admitted from an Emergency Room where he's been monitored all morning.

Q Do you know what the particular nursing requirements of East Pasco Hospital are as to charting?

A No.

Q Have you asked or been afforded that information?

A No.

Q In terms of your opinions as to the nursing standard of care, I think we've covered that and,

basically, correct me if I'm wrong, yes, the nurses were negligent in the recordkeeping and that was a deviation from the acceptable standard of care in terms of no initial nursing assessment, no input and output sheet, few notes from 5 p.m. to 9 p.m., the lack of vital signs in certain parts of the chart. Is that correct?

A Yes.

Q What else, if anything, have I left out?

A As I sit here, that's all I can recollect as to what should be there.

Q What significance would the vital signs have had to you, sir?

A Well, clearly, this child was in clinically diagnosable shock by 5:15 and vital signs sometimes change to the worst before the patient, apparently, changes to the worst on physical inspection, so the importance of the vital signs is it could have potentially allowed for a somewhat earlier diagnosis of cardiovascular compromise.

Okay. Prior to 5:15 when is the last notation of blood ressure, pulse and temperature

prior to 5:15 that you were able to determine or from any materials supplied to you by Dr. Coleman?

A Temperature was taken sometime between 3:30 and 4, according to this block charting by Nurse Dixon, taken twice, in fact And then the prior also and respiratory rate that I could find, the last one was -- I have to look through here (indicating) where was a pulse and respiratory rate taken at 11:25

Q Okay How about blood pressures?

A I don't see any blood pressures

Q At all?

A Well, not during the course of the early unfolding of this process, no

Q Okay When was the first blood pressure that you noted in the chart?

A (Indicating) As I sit here, I don't recollect ever seeing a blood pressure in this chart There might be one after the shock was clinically diagnosed, but, by then, I didn't continue to track what was missing.

Q In terms of the progression that this child

took from the time he came to the ER on the 24th to the time he was air lifted to All Children's Hospital and later expired that morning at 3 a.m., would it have been important, in your opinion, to have taken blood pressures on this child?

A Yes.

Q For what reason?

A Again, it gives some assessment as to cardiovascular stability of the patient.

Q Can you be more specific as it pertains to what was plaguing Christopher Shelley as to why a low blood pressure would have been particularly important?

A Well, a low blood pressure would correlate with shock and it would be an indication for more aggressive fluid and electrolyte management and, perhaps, earlier transfer.

Q Okay. When he was noted to be molted and his fingernails were blue --

A Mottled.

Q Mottled, excuse me, and his finger nails were blue and his skin had changed color, does that

clinical description signify a person in shock to you?

A Yes, it does.

Q In your opinion, from what point in tine prior to that, Doctor, would a blood pressure reading likely have indicated that the child was severely compromise?

A I don't think any, I don't think I certainly can predict when his blood pressure would have been low, vis-a-vis, the clinical determination.

It could have been hours. It could have been minutes. I would, I would say that a child with hypotension would not be a child who looks pink and awake and alert and talking, as Nurse Leach describes him at 3:30, so one could use that and say, probability not then, but it could have been anytime after that.

Q Okay. Did you review parts of the chart where the IV wasn't working or there had been difficulty inserting the IVs?

A Uh-huh. Yes.

Q Could a low blood pressure have, would have been consistent with that in that the child was suffering from low volume or things of that nature at that point in time?

A If I understand your question, no, I don't think it works that way I don't think an IV stops functioning properly because a child goes into shock

It has nothing to do with shock In fact, low venous pressure would be a reason to keep, would be a reason for the IV not to come out All right? That's what happens in shock There's low venous pressure, so there's nothing there exerting any vis a tergo, force backward on the catheter, so I don't think there's any relationship between those two features

Q Okay In terms of the starts the line and having difficulty finding the vein --

A Yes.

Q -- would that condition, in your opinion, if a blood pressure was taken, likely signify h do, what's the term I'm looking for?

A Tension.

Q Hypotension, low blood pressure?

A I think you mixed two metaphors there. If you're asking, do children in shock sometimes have a hard time getting an IV starting because they have poor circulation, the answer is, yes, if that was your question.

Q Okay. Do you form an impression and, from the records, as to whether or not the child was, in fact, receiving any IV therapy from 1 o'clock or so, when he was last noted to be sleeping in the Emergency Room, till the note you were looking at at Page 42 as reflected on the 3:30 block charting?

A It was my sense that the child had the IV in place until, while he was on the ward until the time when the IV was noted to be backed up, and the nurse had to go in and either restart it or fix it.

Q And when was that, sir?

A I don't think I see it in the nursing notes as a timed entry, so I would have to look in the deposition of Nurse Leach to find that out.

Q Okay. Well, you read the deposition of the

mother and didn't she not discuss what was happening up there on the floor during those hours before the child, obviously, turned to the worst and everyone came running into the room? Did she describe that in the her deposition?

A Did she describe what, that the IV had backed up or something?

Q Or that it didn't appear to be working, yes, and the blood was running up the tube?

A Right.

Q Do *you* remember that?

A Yes.

A Fluid.

Q Well, I used the medication. The hydration in the IV solution was not being administered to the patient at any point in time when there's blood running up the tube. Is that right?

A This is true. Um-hum.

Q Did you form an impression from the records as to how long the child went without any hydration therapy?

A No, I did not.

Q Do you feel that's significant in terms of assessing the nursing care as it pertains to East Pasco Hospital?

A Well, I think the, I mean, there are two issues here. IVs blow all the time in pediatric patients.

It's the bane of having a child in the hospital is for the IV to be occluded and back up and clotted and out and it had to be restarted, so the mere fact of that happening, to me, is not at all a reflection of the adequacy of nursing care.

When it comes out, if it's needed as therapy, it should be started, or at least attempted to be started in a reasonably fast way. So, to me, the issue would be, how long did they wait before they started the effort of putting the IV back in?

Q Okay. That's exact --

A And I don't know how long that was. I

can't reconstruct it here from an of the notes and I don't remember from the depositions.

Q Okay. Well, that's exactly my question. How long, did you form an impression how long the child went without any IV therapy while he was on the floor, and is your answer, no, you didn't form an impression?

A I read through the information in the depositions, but did not structurally think about that to determine how long it might be that he was without an IV.

Q Okay. If, in fact, I want you to assume that the, from the time that the mother arrived with the child on the floor, and do you know how the child arrived on the floor?

Evidently, the mother carried him.

Q Okay. From the time the child arrived on the floor and for a period of hours thereafter, I want you to assume the child was not receiving any antibiotic therapy in that, as you've indicated, if the blood's running up the tub , the chi not getting any of the solutions. Right?

A Antibiotics weren't ordered, though.

Q Excuse me. I'm sorry. I apologize. I'll start again. I'd like you to assume for purposes of my question that the child, from the time he arrived on the floor and for a period of hours thereafter, according to the mother's deposition, which you've indicated you've read, was not receiving any IV therapy in that the blood was running up the tube, the mother and other persons in the room noted this and were telling the nursing staff that it didn't appear to be working prcperly and that nothing was really being done until the point in time where the child's condition notably and visibly changed and all the nurses came running in the room.

I'd like you to assume that for purposes of my question. Assume that to be the facts, would you feel that that would be a deviation from the acceptable standard of nursing care as it pertained to Christopher Shelley?

MR. COLEMAN: I just want to object. I think it's a mischaracterization of his testimony.

MR. LOPEZ: If the hypothetical is

incorrect. You are correct. Mr. Coleman. But I'm asserting it on facts presented to this doctor

MR. COLEMAN: Okay.

THE WITNESS: It would be a deviation from the standard of nursing care, assuming the admitting orders by the physician required or requested the administration of a fluid volume of a certain amount per hour.

BY MR. LOPEZ:

Q Okay, sir.

A And I can check the orders to find out what that was

Q Please do

A And there was an order and, so, consequently, if that IV was not working for several hours and no one --

Q Hold that, hold that page Okay?

Q And no one was attending to it, then it would be a deviation from the nursing standards

Q What were the other orders that were made a part of the chart there, and those are Mr. Fernandez's orders? Is that correct?

A Yes.

Q Please indicate what those orders were that you have before you.

A You mean, read them all? There's a whole series of orders here that anybody could read, if they want it.

Q I want to talk about, since you've been given a, you've given an opinion here as to the deviation from standard of nursing care. I want to ask you about the orders that Dr. Fernandez gave and whether those orders were carried out or not.

A Okay.

Q Can you tell us?

A Well, again, the order for fluid, you want me to go through every order?

Q Yes, sir.

MR. COLEMAN: And let the record reflect, he has not seen Dr. Fernandez's deposition.

MR. LOPEZ: I understand.

THE WITNESS: Respiratory and contact isolation, that's no way for me to know in that nurses don't usually even note that in the record, so

it would be something on the door.

Vital signs, Q2 hours times 24 hours. Vital signs were done intermittently during the course of the first few hours, probably, at a two-hour interval, although I don't see the full vital signs at 2-hour intervals, so I would say, no, the vital signs were not done in their fullness every two hours.

Next order is observe for change in sensorium or lethargy. Notify M.D., P.M.D. I think that was done based on Nurse Leach's deposition and what I can glean from the nursing records.

There are indications about the child being awake and alert and when this child did have the change of color and lethargy, Dr. Fernandez was called at 5:15.

BY MR. LOPEZ:

Q You believe that that order was adequately carried out, based on your review of the records?

A Yes.

Q The observe for change and sensorium?

A Yes.

Q Next Go ahead

A It says, weight to chart I believe that order was done

Q What's that, weight?

A Weight to chart

Q Meaning, the child's weight?

A Right.

Q Is it reflected in the chart? Have you seen it anywhere?

A It's in the ER record, which is, I'm sure, part of the record of this child as he comes into the ward, and I believe it's also written right next to the order, weight to court, 14 5, and circled on the page

Q About those or. Fernandez's admitting orders?

A Yes, they are

Q Wouldn't that have been something that she wanted done arrospectively?

A I think that order is ambiguous in the sense it could mean, make sure we know what this patient weighs, in any way, and if the patient has

been weighed three hours ago let's use that weight.

Q Go ahead, sir.

A I&O, strict, and, again, we've already talked about that note. I don't see a I&O sheet. Urine specific gravity Q shift. There was one in the Emergency Room and I don't see a second one done during the course of this shift, but the shift hadn't ended by the time the child was transferred, so it's a nullity.

Q Doctor, is your opinion then that that order was or was not carried out at the urine specific gravity Q shift?

A I'm trying to remember when the child actually left East Pasco. Was it before 11 o'clock at night?

Q Well, when he leaves by being air lifted in very critical condition, I mean, if they haven't done one prior to that time, has that order been carried out or not, in your opinion?

A Well, the shift hasn't ended, though, but it hasn't been carried out, but there would have been time to do it had not events intervened.

Q Okay.

A PO, cleared diet times 24 hours. Yes, the child is drinking, according to the nursing notes and 7-Up or, yeah, 7-Up.

Q Okay.

A So that order was carried out. And then it says, and then advance to requiar diet for age. Well, he had not been there for 24 hours, so that order could not be carried out. We have CBC and diff in a.m. and 8 p.m. tonight. I believe that order was carried out.

Q The CBC at 8 p.m.?

Q Yes.

A You believe it was?

A If I remember right, there was an 8 p.m. CBC.

Q Okay.

A And then it says, repeat liver function test with ammonia in a.m. Obviously, it couldn't be done. It says, ammonia and glucose, Q shift. I know there was a dextrose stick for glucose that was done, and I believe there was another ammonia done.

Q Doctor, you say you believe, and I don't mean to be -- well, you don't have at your disposal the benefit of Dr. Fernandez's deposition as .to whether, in the specifics, as to what order she gave in addition to what you're reading there on the chart. When you say you believe it, are you just going from recollection here?

A Yes, recollection that there was a dextrose stick that was done, that was discussed in one of the depositions, and it was an opportunity for the nurses to come in and interact with the child. And I may may be wrong. I've read a lot of things on this case.

Q I understand. Okay.

A Next order was, notify PMD with results. I don't know whether she was notified with results or not.

Q Notify primary medical doctor with results?

A Right.

Q Regarding the liver function test that you think were done, the repeat liver test, do you remember something from Paula Leach's deposition that

when Dr. Fernandez cane to the floor supposedly at 3 or 4 o'clock, that she was very ang -- or she was upset over the fact that certain tests had not been performed at that point in time?

A Well, I think the repeat LFTs were to be in the morning.

Q My question is, do you recollect something from Nurse Leach's deposition about Dr. Fernandez being bothered by the fact that certain tests had not been performed?

A Yes.

What test was it that she had wanted done and hadn't been done at that point that?

One that was not back on the chart. Whether it had been done or not was the issue, but one that was not back on the chart was the sed rate.

Are you saying there was even a chart when Dr. Fernandez came up to the floor, supposedly, at 3:30 or 4 o'clock?

My recollection of Nurse Leach's deposition is that they went back to the nursing area and reviewed the chart.

Q Okay. What chart is there that reflects that time period?

How do you mean, what chart?

Q Well, we have all the records here and the only thing we have from 3:30 to 4 o'clock, from my understanding, is the 2 or 3 inches of the page you've been reading to.

A Well, a chart, when it's made up in the hospital, has the admission sheet that the admitting office makes up. It has insurance information. It may well have had, and typically would have had, a copy of the ER record put into the chart. It would have the nursing notes. It would have Dr. Fernandez's handwritten admitting orders as part of the chart and any progress notes or admitting notes that she made to that time.

Q The same handwritten orders of Dr. Fernandez that you're reading right now?

A Yes.

Q Again, my question to you is, is it your understanding that when Dr. Fernandez went up there, she actually had accessibilit to the chart?

A From Nurse Leach's deposition, yes.

Q Okay.

A As you know, I didn't read Dr. Fernandez's deposition to know whether that's in debate or not.

Q Okay. Any other orders that Dr. Fernandez had given as to whether they were carried out or not?

A E5, half normal saline at 51 ccs an hour, and we talked about when that might have fallen through with respect to the IV coming out. Pediaprofen. If temperature greater than 102.5 Q6 hours, and I looked in the, I looked at the medical record or medical treatment record, drug treatment record, and I don't see any notation that the Pediaprofen was given in that record.

Q Okay.

A And it was for a threshold temperature of 102.5, so I'd have to look through here and see whether the child made that threshold, and, in fact, at 3:50 p.m., the temperature was 102.6, and we'd have to look on the ER record and see whether they gave Pediaprofen within 6 hours, which would block the administration of Pediaprofen at that time, and

you probably know the answer to this, so tell me.

Q What's the question?

A Was Pediaprofen given in the ER?

Q Not to my recollection or knowledge. Gentlemen? I don't know.

MR. HUNTER: I can't remember.

MR. COLEMAN: If it wasn't Tylenol, then I don't know.

THE WITNESS: It wasn't given in the ER or within 6 hours of the 3:30, 102.6. Then, by Dr. Fernandez's order, it should have been given at about that time, and I don't see a record where it has been given because it's not checked off as a given medicine on the med sheet. Next order is Aveeno bath soaks. I don't know if they were given soaps. Next order is calamine lotion to skin PRN. I don't know if they were given.

Q Is that it?

A There's a bunch more here. I'm trying to read this one. Please notify doctors of immune compromised patients on the floor. If a patient with varicella for appropriate VZIG administration, I

don't know if that was done. Then we have stat, this is a 1910 order, stat ABGs, and they were done 30 percent phase ten.

Q That was after the child had gone into shock?

A Correct.

Q Did you denote from these records that a code was ever called?

A No. I didn't denote anywhere in these records of East Pasco Hospital that a code was called. It was called at All Children's.

Q All right. Maybe it's a difference in terminology. Did anything come to your attention in review of these records that when the child's condition was noted to be as serious as it was sometime in the afternoon or early in the evening of the 25th, that something was called in that various doctors and nursing personnel all convened in that room on a stat basis?

A Yes.

Q Is there a term for that that you are familiar with or you use?

A Well, I wouldn't use the word code because then that gets too strong, but I think it would be a, you know, a stat cry for help to establish IVs and to help maintain the patient.

Q Okay. Did we finish with the orders?

A Yes.

Q Okay. Doctor, let's talk about your opinions concerning the child's chances of surviving this, a varicella and strep that he had. Okay?

A Right.

Q Do you have an opinion as to whether on April 23rd, Christopher Shelley, if given appropriate medical treatment, would have survived?

A My answer is, if the timing of the sister's recollection of the onset of this disorder's pain was such that there would have been less than 12 hours from the time the antibiotics could have been started, then, yes, he probably would have survived.

Q All right. Less than 12 hours of the onset of the knee pain?

A Right.

Q Okay. Is it your professional opinion that

if appropriate antibiotic therapy would have been started within 12 hours of the reported onset of the knee pain, which, according to what you have before you, was sometime on April 23rd. Is that correct?

A Correct.

Q That Christopher Shelley, in your opinion, would likely, more likely than not, have survived?

A That is true.

Q Is that 12 hour a time period that you're giving, Doctor, in your opinion, inflexible or etched in stone, so to speak?

A Pretty much so.

Q And what do you base that opinion upon?

A I base it on Harry Eagle's studies of 1951 where he showed that a 12-hour interval of tissue infection with Group A strep made it essentially impossible to treat that patient and sterilize the tissue rapidly with a beta lactam.

Q What's a beta lactam? What's that?

A Penicillin, ceftriaxone.

Q Rocephin?

A Ceftriaxone is Rocephin.

Doctor, you mentioned a more subsequent study, and I'll talk about that in a minute, but do you consider the 1951 Dr. Harry Eagle is still authoritative?

A I don't know. What do you mean by still authoritative? I think it's --

Q Well, you've cited it in the basis of your opinion and I would think that the question answers itself. But for purposes of this deposition, do you consider Dr. Harry Eagle's's 1951 study that you've made reference to authoritative in this area?

A I'm always reluctant to say anything is, by definition, completely correct in it's entirety, which is how I take to mean authoritative. But you could quote any sentence from that study and not disagree with it 50 years later, so I would not claim that the study is, in its entirety, authoritative.

I would tell you that I believe the scientific principle that he identified that, namely, when you get to the resting phase of tissue infection with Group A strep, you no longer have potency of beta lactam therapy. That is authoritative. That

has been studied and proven by many other investigators, so that point, yes, is authoritative,

Q You read Dr. Andiman's deposition?

A Yes.

Q Do you agree with Dr. Andiman's findings in this case?

MR. BURTON: Object to the form of the question. That's a little broad.

A There are 200 findings. Which finding do you want to talk about?

Q Well, let's talk about his opinion. What do you recollect his opinions to be and do you agree with him?

A As soon as I get this page all typed.

(Short break was taken.)

(Discussion off the record.)

BY MR. LOPEZ:

Q Doctor, I don't think I have too much more, believe it or not, and I know it's been rambling and I appreciate your patience.

We were going to talk about Dr. Andiman and you expressed some reluctance about the term

authoritative.

A Um-hum.

Q You cited Dr. Harry Eagle's article in support of your opinion.

A Right.

Q You agree with the article?

A In general, yes.

Q Okay. That's fair enough. What individuals in this field, pediatrics or pediatric infectious disease individuals do you feel are authoritative?

A How do you mean, authoritative?

Q In terms of their writings, their textbooks, their studies, things that you rely on in your practice as a physician. That's what I mean as authoritative.

A Specifically, with respect to this disease?

Q No. Pediatrics, in general. I'd like you to be as broad as possible, please, and things that you rely upon that you consider authoritative in your practice, textbooks.

I'm very confused by you asked people; now you want textbooks.

Q Well, we're going to do both, but you equivocated about Dr. Eagle, so I'm asking you about individuals.

I didn't equivocate about Dr. Eagle.

Q Well, okay.

A about a lot of illnesses that had been proven true and some things were said that were proven false. Not having read Harry Eagle's work in some weeks, I couldn't sit here and vouch for everything he said being true today, 40 years later.

Q Okay.

A All right. But there's one feature of his work, which is, you get to postlog phase growth in tissue with Group A strep, and beta lactam doesn't work anymore. Everybody accepts that. That is authoritative information. That is truth, medical scientific fact.

Q And that's the so-called Eagle effect?

A Yes.

Q So you cite the proposition of the Eagle effect as supportive of your opinion, professional opinion in this case, that 12 hours from the onset of that knee pain, if Christopher Shelley did not get appropriate antibiotic therapy, he was a goner. Is that correct?

A Why do you have to have to use terms like that?

Q Because, sir --

A Why can't you say, he would have died? I mean, when you say a goner, you're bringing this down to a street level.

Q All right. Let's, let's -- I apologize. I apologize and your point's well taken. It's your opinion, professionally, that within 12 hours of the onset of the knee pain, Christopher Shelley, if not given appropriate antibiotic therapy, would have expired?

A Secondary to this given conventional therapy, yes.

Q Okay. When you say given conventional therapy, does that mean he could not have been saved?

A Well, I think what it really means that if he had been lucky enough to have been treated with Clindomycin, he probably would have had a better than 50/50 chance of surviving, even 12 hours after the onset of his knee pain.

If given intravenous gamma globulin and Clindomycin, that would have further increased the chance of his survival, but none of these are standard treatments and, in 1991, no one really knew about them.

Q I want to definitely confine your analysis of my questions to what was available in 1991, April of 1991.

A The problem with that is these these were available and, maybe, a select few people in the country knew about them, but they weren't general knowledge nor standard care, so if you mean by available, what was standard treatments, then we could proceed.

Q Okay. Is Rocephin still prescribed for strep?

A Yes.

A Right.

Q And what I still don't understand is, if Christopher Shelley was first treated with appropriate antibiotics as of what was available and known to a generally competent pediatrician in April of 1991, some 12 or 18 or 24 hours after the onset of knee pain, do you have an opinion as to whether the child's life could have saved?

A I've already expressed that opinion and the answer is, no, I don't think it would have been saved.

Q Not past 12 hours?

A Correct.

Q So in the 13th hour, it's your professional opinion, after the onset of knee pain, that Christopher Shelley would not have been able to have been saved?

A Correct.

Q Do I take it that anytime prior to the 12 hours then, it's your professional opinion that Christopher Shelley could have been saved?

A Yes.

Q Other than the Dr. Harry Eagle 1951 article and the so-called Eagle effect, can you provide me any other basis for that opinion, whether it be other publications, your own practice, etc.?

A Well, certainly, other publications, as I talked to you three hours ago, at the beginning of this deposition. The Eagle effect has been reprised and a group of researchers have repeated the Eagle using beta lactams compared to Clindomycin. I'm sure Dr. Andiman can get you the reference.

Do you know the name of th article and

when it was done?

A I believe it was 1991. I already told you this.

Q Yes, sir, you're correct, but you didn't have the name.

A No. I still don't have a name. My experience has been that Clindomycin outperforms beta lactams in my patients that I've treated with this particular problem, so my own judgment is that it really is a feature of survivability to use Clindomycin.

Q What percentage of children, in your opinion, that have varicella present with an underlying infection, bacterial infection?

A It's a significant percent on the order of 10 percent, 15 percent. There's actually data in the preantibiotic era which show 30 or 40 percent.

Q Okay. Do you agree with the proposition that a bacteriological infection is the most common serious complication of varicella?

A Yes.

Q Has that been the case since the time you

began practice of medicine?

A Yes.

Q And that's still the case today?

A Yes. It's also the argument for the use of the varicella vaccine.

Q How effective is the varicella vaccine?

A Very effective.

Q Percentage-wise, are you able to say?

A 80 to 90 who get it will not get varicella, and the ones who get varicella will have a very mild disease.

Q You do not have, nor do you plan on expressing any opinions in this matter concerning the standard of care as to the Emergency Room physicians, Dr. Wilchers and Demers, nor should the standard of care of, at this trial, of Dr. Fernandez-Garcia, Is that correct?

A That is right.

Q Have you told me all of the professiona opinions you have concerning this case that Mr. Coleman has retained you in order to do a review of, basically, two, as I understand it?

A I believe so.

Q Lastly, have you ever been a party to a medical negligence action?

A No.

MR. LOPEZ: Congratulations- I have nothing further.

MR. BURTON: No questions.

MR. HUNTER: No questions.

MR. COLEMAN: No, we don't have any and, if it's ordered, we shall read.

(Deposition concluded at 5:02 p.m.)

I HAVE READ THE FOREGOING DEPOSITION, WHICH CONTAINS A CORRECT TRANSCRIPT OF THE ANSWERS GIVEN BY ME TO THE QUESTIONS THEREIN RECORDED.

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

Certificate of Notary Public

I, Brenda Hornstein, a notary public in and for the District of Columbia, do hereby certify that the foregoing Witness, whose testimony appears in the foregoing deposition, was duly sworn by me; that the testimony of said Witness was recorded

transcribed from my stenographic notes and electronic tapes to the within typewritten matter in a true and accurate manner; that said deposition is a true

Notary Public

My Commission Expires:
April 1, 1996