C-25222-vcl
NO. 99-2625-3
SEVERA DeLEON) IN THE DISTRICT COURT
)
Plaintiff(s),)
VS.) McLENNAN COUNTY, TEXAS
)
ROBERT W. GRAYSON, M.D.)
)
Defendant(s).) 74TH JUDICIAL DISTRICT

****

ORAL AND VIDEOTAPED DEPOSITION OF
ARMANDO G. CORREA, M.D.
DECEMBER 20, 2000

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ORAL AND VIDEOTAPED DEPOSITION of ARMANDO G. CORREA, M.D., produced as a witness at the instance of the Defendant, and duly sworn, was taken in the above-styled and numbered cause on the 20th day of December, 2000, from 2:08 p.m. to 7:02 p.m., before Velma C. LaChausse, CSR in and for the State of Texas, reported by machine shorthand, at the offices of Greer & Martin, 815 Walker, Suite 1447, pursuant to the Texas Rules of Civil Procedure.

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APPEARANCES

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ALSO PRESENT.
Ms. Dottie Lawrence, Videographer

THE VIDEOGRAPHER: This is the videotaped deposition of Dr. Armando Correa taken on December 20th, 2000, in the offices of Greer & Martin. The time is approximately 2:08 p.m. and we're on the record.

ARMANDO G. CORREA, M.D.,
having been first duly sworn, testified as follows:

EXAMINATION

BY MR. MARTIN:

Q. Doctor, would you please state your full name?

A. Yes. My name is Armando, my middle initial is G, and my last name is Correa, C-O-R-R-E-A.

Q. Are you a medical doctor?

A. Yes, I am.

Q. Briefly about your personal. Are you married?

A. Yes, I am.

Q. Where do you live?

A. I live in Pearland, Texas.

Q. Is that near Houston?

A. Yes. It's a suburb of Houston.

Q. And do you have any children?

A. Yes, I do. I have four children.

Q. All right. Tell me a little bit about your

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education in order to become a doctor.
A. Sure, Mr. Martin. I went to medical school in Monterrey, Mexico, where I trained for seven years. Following my completion of medical school, I did a residency in pediatrics at the children's hospital of Austin at Breckenridge. This is a pediatric hospital in Austin, Texas. I became the chief resident on my last year over there.
Q. Okay. Is -- what years would you have completed your residency?
A. I completed my residency in 1991.
Q. Did you -- what -- tell the jury what a residency is. Most people don't know what it is. They probably heard the term resident, but what is a residency?
A. Most certainly. A residency is the years following your medical training. Certainly when you become a physician you have general knowledge of many aspects of medicine, but the residency is a time period where you get further training into a specific field. In this case, to mention, in pediatrics.
Q. All right. Did you do anything, as far as training like that, beyond your residency, such as a fellowship?
A. Yes, I did.

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Q. And where did you do your fellowship?
A. I did my fellowship at Baylor College of Medicine here in Houston.
Q. And what fellowship program were you involved in?
A. Infectious diseases.
Q. What is your specialty today?
A. My specialty? I'm actually board certified both in pediatrics and in infectious diseases.
Q. Okay. Explain to the jury what a fellowship is.
A. A fellowship is further training, beyond the three years of residency, in my case. I had an additional two years of training, specifically with infectious diseases.
Q. After you got this fellowship, what did you do in terms of your career?
A. At the completion of my fellowship, I was offered a position as a teacher in Baylor College of Medicine, so I'm currently in the faculty at Baylor College of Medicine as an assistant professor.
Q. And how -- and when did that start?
A. That started in July of 1993.
Q. And when you -- what do you teach?
A. I teach pediatrics, infectious diseases and

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related topics to medical students, to other residents and to fellows.
Q. You mentioned before the term board certification. What does board certification mean?
A. Board certification means that you have completed the requirements to be board certified and that you have passed an exam in order to become board certified. That basically means that you're qualified to treat and give opinions regarding pediatric patients or patients with infectious diseases.
Q. When did you become certified -- board certified in infectious diseases?
A. If I remember correctly, I became certified in 1994.
Q. Have you been -- in your academic environment, have you been involved in giving lectures?
A. Yes, I have.
Q. How often do you give lectures?
A. Well, I have some formal lectures and teaching duties at the college, and that is on a regular basis, at least once or twice a month. In addition to that, I go and give lectures as an invited speaker. And that certainly varies from

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month to month, but on the average, about eight to ten times a year.
Q. And also as part of your academic background do you get involved in authoring articles and publications?
A. Yes, I do.
Q. Can you give us some examples of some articles and publications that you've been involved in relating to infectious disease?
A. Most certainly. I have, at this time, authored approximately 13 or 14 journal articles in peer review journal articles that deal with infectious diseases. In the same subject, I have written at least five or six chapters in different textbooks related to infectious diseases.
Q. Are you -- is your license on file with the State of Texas?
A. Yes, it is.
Q. And are you licensed to practice medicine here in Texas?
A. Yes, I am.
Q. Are you a member of any professional societies?
A. Yes, I am.
Q. Would you tell us about the professional

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societies that deal with infectious diseases?
A. Most certainly. I'm a member of the American Society of Microbiology, which is a national organization that deals with basically infectious -- infections and infectious agents. I'm also a member of the Infectious Disease Society of America, which is a nationwide society of people who specialize in infectious diseases, and I'm also a member of the Infectious -- Pediatric Infectious Disease Society and the Texas Infectious Disease Society.
Q. Let me hand you what we will have marked as Correa Exhibit No. 1 and ask you if you could identify what this document is.
(Exhibit No. 1 was marked)
A. Yes, sir. What we have here is a copy of -- an up-to-date copy of my curriculum vitae.
Q. (BY MR. MARTIN) And a curriculum vitae, is that short for C.V.?
A. That's correct.
Q. And tell the jury what a C.V. is.
A. Well, the C.V. is basically a compilation of all of my education, the different appointments and different participation that I have had with medical institutions, as well as the different talks, chapters, abstracts that I have prepared.

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Q. Concerning your current practice in treating patients, where do you currently practice when you're treating patients?
A. Well, as I mentioned, I'm currently an assistant professor at Baylor College of Medicine, so I participate in the care of patients in hospitals affiliated with Baylor College of Medicine, specifically will be Ben Taub General Hospital, Texas Children's Hospital, Women's Hospital of Texas, Shriner's Hospital for crippled children, and I think that covers the hospitals that I attend.
Q. Would it be fair to say that most of your current practice is in treating for infectious diseases?
A. Yes.
Q. Do you treat some adults for infectious diseases?
A. Yes, I do.
Q. Okay. Is there -- Doctor, I know your specialty is in pediatrics. Is there any difference in the training in the medical science that you learned with the specialty in pediatrics infectious diseases versus infectious diseases for adults?
A. With respect to the basic science of infectious diseases, there's no difference between

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adults and pediatric patients.
Q. Now, we've used that term infectious diseases, but why don't you tell the jury, what is the specialty that you call infectious diseases?
A. This specialty is basically a specialized care of patients who are known to have or are suspected to have an infection, whether it's a bacteria or a virus. This specialty also deals with preventing infections, understanding how infections occur, and finally, treating those infections.
Q. If a doctor has a serious question about bacteria, who do they go to?
A. Most commonly an infectious disease specialist.
Q. If a doctor has a serious question about the type of antibiotic to give, who do they go to?
A. It's the same answer. Typically an infectious disease specialist.
Q. Doctor, to the extent that I ask your opinions here today, will you give those opinions based upon reasonable medical probability?
A. Yes, sir, I will.
Q. All right. Have you reviewed the autopsy report for Gloria Bass?
A. Yes, I have.

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Q. Let me hand you the autopsy report. And I'm going to ask you if you could do this for me: Would you read the cause of the death under the conclusions -- well, read the whole conclusions section to the autopsy report prepared by the medical examiner.
A. Most certainly. "Based on the anatomic findings in autopsy and investigation information available at this time, it is my conclusion that Gloria Bass, a 34-year-old white female, died as a result of sepsis and bacterial peritonitis after a recent intraabdominal surgical procedure. Cause of death, sepsis and peritonitis.
Q. All right, Doctor. Do you agree with that opinion?
A. Yes, I do.
Q. All right. Now, first of all, some of the juries, they probably heard the term medical examiner, but explain what a medical examiner is.
A. Yes. A medical examiner is usually a physician who has been assigned by the State to determine the cause of death when the patient died under unusual circumstances.
Q. Who is the medical examiner, specifically her name, for Gloria Bass, when she died?

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A. In this particular case the medical examiner was Dr. Peacock, Elizabeth Peacock.
Q. Have you read Dr. Peacock's deposition?
A. Yes, I have.
Q. Have you read where she talks about her training and experience?
A. Yes, I have.
Q. Is she -- is Dr. Peacock a specialist in infectious diseases?
A. No, she is not.
Q. All right. In the medical examiner's report where they talk about the cause of death, they're talking about tubal ligation surgery?
A. That is correct.
Q. And when did the tubal ligation surgery occur?
A. The tubal ligation surgery occurred in June of 1997.
Q. And let me try to be more specific with you, and let me see if I can find the document. I want to know the exact date that this surgery occurred, if I -- if I could find that, Doctor. Do you have any records that might show that?
A. Yes, I do.
Q. Let's try to get that for the jury. Let me

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help you with that. Let me hand you the operative report for this particular surgery. Does that say the date of this surgery?
A. Yes, sir. It says that the surgery was performed on June 6th of 1997.
Q. And who performed the surgery?
A. The surgery was performed by a physician by the name of Robert W. Grayson.
Q. And what date -- looking back to the autopsy report, what was the date of Gloria Bass' death?
A. Looking back at the report, that day that she died was June the 8th of 1997.
Q. So this is -- she died two days after the operation?
A. That is correct.
Q. All right. Now, the words used to describe the cause for the death of this --
MR. MARTIN: Can you hear?
THE VIDEOGRAPHER: (Moving head up and down)
Q. (BY MR. MARTIN) The words used to des-- why don't we take a minute and put that back on, Doc. Is that coming off?
A. Thank you.

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Q. The words used by the medical examiner to describe the cause of death, the first word used was peritonitis. Is that right?
A. That's correct.
Q. Well, let's talk a little bit about peritonitis. Tell the jury what peritonitis is.
A. Well, let me explain by explaining to you what the peritoneum is. The peritoneum is a tissue that lines the abdominal cavity, and the peritoneum is basically the space where the gut and other organs are.
Q. Okay. And that space is called -- Does it have a name, that space?
A. Yes. It's called the peritoneal cavity.
Q. Or the abdominal cavity?
A. That's correct.
Q. And the surgery that Gloria Bass had on June 6th was in what part of her body?
A. It was in the abdominal cavity.
Q. Okay. And exactly what is peritonitis then?
A. Peritonitis means that this lining and this space has now become infected. Now there is inflammation and infection of that surface.
Q. And infection inside the abdominal cavity?

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A. That is correct.
Q. Okay. What is the infection? Is there a specific type of infection that it has to be? Can it be bacterial or viral?
A. The vast majority of peritonitis are bacterial in origin.
Q. Okay. Let's talk a little bit about bacteria, then. What are bacteria?
A. Bacteria are microscopic organisms that are capable of causing disease in humans.
Q. Can bacteria be deadly?
A. Absolutely.
Q. What about if treated?
MR. AUSTIN: Objection; form.
A. In the majority of the cases, they are not.
Q. (BY MR. MARTIN) Okay. How do you treat bacteria?
A. Bacteria is commonly treated with antibiotics.
Q. All right. And let's talk a little bit about antibiotics. What are antibiotics?
A. Antibiotics are chemical products that have been found to destroy or stop the bacteria from causing serious injury. Antibiotics are probably the most important discovery of the 20th century.

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Q. They save a lot of lives?
A. Absolutely. Before antibiotics, a patient with a condition such as this would have certainly died, but since the introduction of antibiotics, the survival rate is almost a hundred percent.
MR. AUSTIN: Objection; nonresponsive.
Q. (BY MR. MARTIN) Tell me the types of conditions that after discovery of antibiotics saved lives.
A. Well, certainly any infection of the blood stream, sepsis, sepsis syndrome, septicemia, all of those infections have certainly -- the outcome of those infections has certainly improved. Same situation with intraabdominal infections, such as appendicitis or perforated gut. Infections in the lungs, pneumonia, respiratory tract infections, meningitis. There's a vast number of infections in which the outcome has really changed since the introduction of antibiotics.
Q. Last thing I want you to teach us a little bit about is how bacteria grows. Tell the jury, just in infectious disease terms, as easy as you can for these -- for the people on the jury, how bacteria grow.
A. Yes. Bacteria are typically obtained from

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a tissue sample, and what we do is we put them in a special media where there's enough nutrients and perfect conditions for them to grow. The most common thing that we use is blood. It's something called a blood agar, A-G-A-R. It's a plate that has the nutrients that allow the bacteria to duplicate and reproduce.
Q. How do they grow inside the body?
A. Well, in the body, obviously they grow in -- under ideal circumstances, in a place that is moist, that is warm and a perfect temperature. For example, in the blood.
Q. Does fecal matter from the bowel have bacteria in it?
A. Yes, it does.
Q. What kind of bacteria does it have?
A. This bacteria are usually -- we call them enteric bacteria, and some of the examples I can give you is bacteria like the one called E. coli, Klebsiella. These are bacteria that normally live in our GI tract.
Q. All right. And what caused Gloria Bass' peritonitis was bacteria?
A. That's correct.
Q. Tell us, Doctor, based upon what you have

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reviewed, the reasonably plausible sources for the bacteria getting inside of Gloria Bass' abdominal cavity during the surgery.
A. Mr. Martin, there's --
MR. AUSTIN: Object to form of that.
MR. MARTIN: What's your objection?
MR. AUSTIN: He has no basis for knowing that.
Q. (BY MR. MARTIN) Go ahead.
A. Mr. Martin, I believe that there's just a few ways that the bacteria --
Q. Let me stop you for a second so that I -- so we don't have to repeat it. His objection was to form. I think he's saying no predicate, so I need to establish that with you.
In your training and experience, have you been involved in identifying sources of bacteria for patients who have undergone operations?
A. Yes, I have.
Q. Have you been involved in identifying sources of bacteria via punctured bowels?
A. Yes, I have.
Q. Are you familiar, based upon your training and your experience, are you familiar with the various ways that infections can develop in an

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abdominal cavity?
A. I certainly am.
Q. All right. Tell us the reasonably plausible sources for how bacteria can get inside an abdominal cavity, such as in the surgery that Gloria Bass had.
A. Yes. The possibilities include perforation of the gut.
Q. When you say the gut, what are you talking about?
A. The bowel.
Q. Okay.
A. The GI tract.
Q. All right. What else?
A. You can also have translocation of bacteria, bacteria that migrates from inside the gut, out into the peritoneal or abdominal cavity because of the excessive handling of the gut, as it occurred in this case.
Q. And again, when you say gut, you're referring to the bowel?
A. Yes.
Q. I just want to be that clear for the jury.
A. Yes, sir.
Q. What else?

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Q. Now, the appearance of the bowel upon autopsy, when she was looking inside, was there pus around there or -- describe that for us.
A. Yes. Her description is that the bowel was covered with pus.
Q. Could she get a clear view of the bowel surfaces?
A. No, she could not.
Q. Did she do the type of test that would be necessary to determine whether there was a puncture in the bowel?
MR. AUSTIN: Object to the form.
A. Based on the records, she did not.
Q. (BY MR. MARTIN) Let's talk about your opinion where the bacteria came from that caused Gloria Bass' peritonitis and the likely type of bacteria. First of all, do you have an opinion?
A. Yes, I do.
Q. And what is your opinion?
A. My opinion is that the bacteria that caused Gloria Bass' death -- infection came from her gut, came from a puncture of her gut, and that the type of bacteria was the bacteria that normally live in the gut, called enteric bacteria.
Q. That's from fecal matter?

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A. That's correct.
Q. And when you say gut, again, you also refer to that as the bowel?
A. That's correct.
Q. Tell us -- tell this jury why you believe the bacteria came from a punctured bowel.
A. Well, as I had mentioned, it is a known risk, it's a known complication of this procedure. We know that Dr. Grayson had introduced a laparoscope in order to visualize the surgery that he was doing, and the type of bacteria that would produce this type of infection must have come from the gut.
Q. Okay. Is there anything about the amount of the pus found inside the abdominal cavity by Dr. Peacock that you find significant?
A. Yes, it is, Mr. Martin. The amount of pus was over a hundred cc's. That means -- I'm sorry.
Q. Was it a hundred?
A. Over a thousand cc's. That means over one liter. So just to give you an idea, we're talking about roughly a quart of pus. In order for that amount of pus, you would have had to have a large amount of bacteria, probably a visible amount of bacteria, escape from the bowel and then set in to create this infection.

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Q. In your opinion, could microscopic bacteria that could have gotten in from an unsterile instrument have resulted in that much pus?
A. No.
Q. In your opinion, could microscopic bacteria that could have gotten in during the surgery from such bacteria that lives on the skin have caused this amount of pus?
A. No.
Q. What is -- what is the only source that you opine could've resulted in this amount of pus being in her abdominal cavity on autopsy?
A. In my opinion, the only source was a perforation, a puncture of the bowel.
Q. Now, is there any significance -- I'm sorry. Strike that.
You've read the medical examiners's deposition. Right?
A. Yes, I have.
Q. Is there any significance to her finding that the severed -- the ovarian artery was severed in terms of the development of bacteria?
A. In terms of developing of peritonitis?
Q. Yes.
A. No.

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Q. Well, I mean, in terms of -- in terms of how bacteria grow.
A. Oh, most certainly. As we had mentioned earlier, bacteria grows in an ideal media, where you have nutrients, where you have blood, where you have warm temperature, and in this case, the fact that the artery was severed created the perfect place for bacteria to grow at a faster rate.
Q. How do you know that Dr. Grayson severed the ovarian artery during that surgery?
A. Well, it's not only described in the autopsy where -- and in Dr. Peacock's deposition where she describes that the artery was severed, but in addition, in her report, she talks about necrotic tissue in the ovaries. That means that the blood -- blood was not flowing to these ovaries. These ovaries were dying from lack of blood supply.
Q. In part, as your opinion, are you relying upon that of Dr. Peacock?
A. Yes.
Q. All right. I'm going to ask you to read from Dr. Peacock's deposition, if you could, beginning on Page 30, Line 6, down to Page 30, Line 22. If you could read that for the jury, what she says.

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A. And finally, contamination.
Q. Contamination from what sources?
A. Well, the contamination could occur if a -- the equipment that we use was not properly sterilized. Sometimes, also, in a long procedure and despite conditions of sterility from the surgeons and the hospital, bacteria may actually find a way of getting into the operation, or into the site that is being operated.
Q. Okay. Now, explain -- I want to go over each of those to explain how that results in bacteria, and I think you just did it for the contamination part, but explain how bacteria can get into an abdominal cavity with a punctured bowel. Explain that to the jury.
A. Well, it is a known risk of surgery, such as the one that Ms. Bass underwent. And what it basically is, is you're using a blunt object that has certain degree of sharpness, and as it goes through the surface of the abdomen, it can go and perforate and cause a hole, basically, in the bowel.
Q. You've read Dr. Grayson's deposition?
A. Yes, I have.
Q. Has -- has he punctured a bowel in another surgery that's similar to one like this?

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A. Yes, he has.
Q. Explain to me -- we've talked about punctured bowel, then, how the bacteria gets in. Let's explain how it gets into the abdominal cavity via excessive handling of the bowel. That was another possibility.
MR. AUSTIN: Object to the form.
A. Yes. In cases where the gut is manipulated for a long period of time, it is possible that the union, the joints between cell and cell may become open, and so you have a little gap from which a few amount of -- a few bacteria can actually go from inside the bowel to the outside of the bowel.
Q. All right. And then explain to the jury how contamination -- how bacteria can get into a wound during surgery from contamination.
A. Well, typically in a surgery you have a sterile media, so -- and the -- that occasionally, the instrument that is being used, may not have been properly sterilized and the bacteria may actually be living or be colonizing the instrument, and when it's introduced into the abdominal cavity, it will become an infection.
In a similar matter, as we described, sometimes if a wound is left open for a period of

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time, bacteria may find a way of getting access to that cavity.
Q. When Dr. Peacock, the medical examiner, did the autopsy on Gloria Bass, was she able to determine the exact source of the bacteria and what kind of bacteria it was?
A. No, she was not.
Q. Why not?
A. Well, in -- her duty was to determine the cause of death, and in her opinion, the cause of death was explained by the findings as she described. She was not able to determine the exact source of that bacteria.
Q. What is the best way for -- for Dr. Peacock to have determined the exact type of bacteria that was involved?
A. Well, in that case, culture is the definite way of determining which bacteria is involved.
Q. And explain to the jury what a culture is.
A. It's basically taking a sample of that pus that was seen in the autopsy and growing it in a plate, as I mentioned, a plate that usually contains blood, that will allow it to grow, and then we stain it and we identify it under the microscope to determine which bacteria it is.

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Q. Well, why didn't she perform a culture?
A. My recollection from her deposition was that she did not have the facilities to culture at the place that she was performing the autopsy. It would have required her to send them to another facility.
Q. Did she trust the other facility that she would send it to? Did you get -- did you get any implication from her testimony as to that?
A. When I was reading her testimony, is that she did not. This autopsy apparently happened during the weekend, and this would have implied waiting until the next working day to send the cultures, and her interpretation was that this would have been unreliable.
Q. To establish that the bacteria did not come from a punctured bowel, what would Dr. Peacock have had to do?
A. Well, she would have either had to do a very extensive microscopic examination of the whole gut, of the whole bowel, and so we're talking about more than ten or twelve yards of gut that she would have had to examined, or she could have introduced a dye or water into the gut to see if it was leaking at any place.

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A. "Your report seems to find that there was a severed ovarian artery." Her answer is, "Yes." "Is that right?" "Yes. Interruption." "Interruption means that it was apart, wasn't connected, not intact." "Right." "All right. And you – do you know when that became severed, or I guess, not intact?" Her answer, "I don't have independent knowledge of it, but with the recent operative procedure to that area, it would be my strong opinion that it occurred during the procedure." "And what runs through the ovarian artery, what material?" The answer, "Blood."

Q. Okay. All right, Doctor. We've talked about peritonitis in detail and your opinions relating to that. Have we talked about the second part of the medical examiner's opinion on the cause of death, sepsis?

A. No, we have not.

Q. All right. Let's talk about sepsis. First of all, what is sepsis?

A. Well, sepsis is a term, it's a medical term that we use to describe a group of symptoms, a group of signs that are the result of a bacteria of an infection getting into the bloodstream.

Q. Okay. And so how are you saying that

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sepsis develops? Does it develop from bacteria?

A. Yes, it does.

Q. And the way it develops is it gets in the blood?

A. That is correct.

Q. Is sepsis what killed Gloria Bass?

A. Yes, it is.

Q. Okay. Explain how the sepsis killed Gloria Bass.

A. Yes. As I was mentioning, sepsis means the -- not only that the bacteria has gained access to the blood, but now it has created a chain reaction. It has created the body to respond in different ways, and one of the things with sepsis is that it starts affecting other organs. It starts affecting the lungs, it starts affecting the heart, it starts affecting the kidney, and it starts causing all of these organs to shut down, to stop being effective. So in this case, it was the development of this failure of the heart, of the lungs, of the kidneys, that ultimately killed her.

Q. Does the medical examiner agree that sepsis caused Gloria Bass' death?

A. Yes, she does.

Q. All right, Doctor. Do you have an opinion

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whether the punctured bowel caused Gloria Bass' sepsis and death?

A. Yes, I do.

Q. And what does –

MR. AUSTIN: Object to the form.

Q. (BY MR. MARTIN) And what is that opinion?

MR. AUSTIN: Object to the form.

A. My opinion is that the puncture of the bowel was what ultimately caused her death. This is by causing the sepsis that led to her death.

Q. (BY MR. MARTIN) All right. Let's specifically talk about your opinions as to how the bacteria, from whatever source, whether it be a punctured bowel or from unsterilized instruments, whatever source, how it got into the blood. Do you understand that?

A. Yes, I do.

Q. All right. First, do you have an opinion as to how the bacteria, whether it would be from the bowel or from any other source, got into Gloria Bass' blood?

A. Yes, I do have an opinion.

Q. And what is that opinion?

A. My opinion is that that bacteria gained access to the bloodstream from the severed ovarian

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artery.

Q. All right. Now, explain that opinion to the jury, if you would.

A. Yes, most certainly. Normally the blood is -- let me back up.

The abdominal cavity is not open to blood. There's no blood flowing directly into the cavity. It's flowing to the organs, but not into the cavity. That is protected by the walls of the blood vessels. Now all of a sudden you have a blood vessel that has been severed. The wall has been severed, that's been cut, and now there is basically an open door for the bacteria to gain access into the bloodstream and cause the sepsis.

Q. How does Dr. Peacock describe the area where the ovarian artery was severed?

A. She basically describes this as necrotic tissue.

Q. And that means what?

A. That means that the tissue is dead, that the tissue is shrinking, is dead, because it has not received the proper blood supply, and by that, the oxygen supply.

Q. All right. So regardless of whether the bacteria was caused – was from the bowel -- and I

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want you to set that aside -- or whether it was from any instruments or from any other source, do you have an opinion as to what caused the sepsis in Gloria Bass' death?
A. Yes, I do.
Q. And what is that opinion?
A. My opinion is that the sepsis was caused by the severed ovarian artery.
Q. If the ovarian artery had not been severed by Dr. Grayson during that operation, do you have an opinion as to whether Gloria Bass would be alive today?
A. Yes, I do.
Q. And what is that opinion?
MR. AUSTIN: Let me object to the form?
A. My opinion is that she would have survived.
MR. MARTIN: What was your objection to form?
MR. AUSTIN: Predicate.
MR. MARTIN: What particular aspect of predicate?
MR. AUSTIN: He's not qualified because he's not a surgeon, in particular, a --
MR. MARTIN: Okay.

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MR. AUSTIN: -- gynecological surgeon.
Q. (BY MR. MARTIN) One last area of questions, Doctor. From an infectious disease standpoint, what should have been the treatment for Gloria Bass if Dr. Grayson had discovered that he had severed the ovarian artery and consulted with an infectious disease expert, such as yourself?
A. Strictly from an infectious disease standpoint, would have been the administration of antibiotics.
Q. Is there any literature that you can point us to that supports your opinion that in that situation, with a severed ovarian artery, the administration of antibiotics is appropriate?
A. Yes, there is. In fact, I submitted to you a copy of the medical letter regarding the use of antibiotics in surgical procedures.
Q. We'll go ahead and have this marked as Correa Exhibit No. 2. And let me hand it to you. Is this the medical letter you're talking about?
(Exhibit No. 2 was marked)
A. Yes, sir, it is.
Q. (BY MR. MARTIN) Do you find this medical letter reliable -- a reliable authority to support your opinions?

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A. Yes, I do.
Q. Specifically, what does the letter show in terms of antibiotic therapy for a patient with a severed ovarian artery?
A. Well, in this letter it talks about the use of antibiotics in vascular surgery involving the abdominal aorta. The ovarian artery is a branch of the ovarian -- I'm sorry -- of the abdominal aorta, and in this case, it indicates that antibiotics should be administered.
Q. All right. Let me ask you this: Assume for a second that if this ovarian artery had been discovered that it was severed and the decision was made to simply remove the ovary, from an infectious disease standpoint, if you were consulted what would you have recommended in terms of antibiotic therapy?
A. Well, Mr. Martin, in fact, in this same publication, they talk about antibiotic usage in gynecologic and obstetric procedures. And for practical purposes, removing the ovary would fall in the same category as hysterectomy. And again, in this case, the recommendation is to administer antibiotics in those situations.
Q. If antibiotics, in either of the situations, either, in any situation where it was

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discovered that that ovarian artery had been severed by Dr. Grayson during this surgery, if that had been discovered, what would have been your recommendation for treatment?
A. The administration of broad-spectrum antibiotics.
Q. And would that administration, that particular treatment, have saved Gloria Bass' life?
A. In my opinion, yes.
Q. Thank you, Doctor.
A. Thank you.
MR. MARTIN: Pass the witness. You want to take a break?
MR. AUSTIN: Yeah, let's do that.
THE VIDEOGRAPHER: We're off the record at 2:49 p.m.
(Recess taken from 2:49 to 2:57)
THE VIDEOGRAPHER: We're back on the record at 2:57 p.m.
EXAMINATION
BY MR. AUSTIN:
Q. Dr. Correa, my name is Bob Austin, and I represent Dr. Grayson. You understand who I am and who I represent?
A. Yes, sir, I do.

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Q. You understand that Dr. Grayson is the defendant in this case and the party whom Ms. Bass' family has sued?
A. I am aware of that.
Q. Okay. Before we get started here, I want to talk about some of the materials that you brought with you, and I saw you brought a large notebook -- well, semi-large notebook with you. Are you able to look through this notebook and tell me when you received any of the documents in here?
A. Not specifically.
Q. Okay. For example, there's a large stack of medical records which appears to be the hospital records for Ms. Bass in this case, and it also appears to have records from Dr. Grayson's office and also another doctor named Dr. Salinas, Dr. Ralston. Did those all come together?
A. Yes, they did.
Q. Was that the first thing that you got in this case?
A. No, it is not.
Q. What is the first thing you got in this case?
A. The first thing I received was the medical examiner's report.

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Q. Okay. Let's just start from the very beginning. When did Mr. Martin first -- when did Mr. Martin or someone from his office contact you about this case?
A. It was sometime in 1999.
Q. Do you recall when, early or late, 1999?
A. Towards the early part of the year.
Q. Did you actually speak to Mr. Martin?
A. Yes, I did.
Q. Was that by telephone?
A. No. I met him in my office.
Q. He came to your -- I assume some contact had to be made before he just showed up at your office.
A. Yes.
Q. Tell me how that came to pass.
A. Well, we had been working in another case, and so he came to my office to discuss the matters of the -- of the case, and he then gave me the records that I have mentioned for me to review.
Q. So he was there to discuss another case that you were reviewing for him?
A. That's correct.
Q. Was that a case where Mr. Martin represented a plaintiff?

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A. Yes, sir, it was.
Q. And while he was there talking with you about that case, he handed you the records pertaining to Gloria Bass?
A. That's my recollection.
Q. And you say the first thing you got was the autopsy report?
A. That is correct.
Q. And that was in -- sometime in the early part of 1999?
A. That's correct.
Q. What did Mr. Martin tell you about Ms. Bass' case during that meeting?
A. He gave me some broad ideas of what the case involved, basically that it was a lady that had undergone a laparoscopic procedure, a tubal ligation, and that she had died a couple of days later from infection.
Q. Did he tell you anything else during that meeting about this case?
A. Not that I can recall.
Q. Okay. What were your instructions from Mr. Martin at that point?
A. He asked me to review those records and determine if I felt that there was a cause that could

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have been -- a cause for her death and what -- and the explanation for that cause would have been.
Q. And you agreed to do that?
A. Yes, I did.
Q. Okay. When was the next time that you received any records?
A. It was probably also in 1999, and it's -- if I remember correctly, that it was included in that letter dated October 25th of 1999.
Q. Okay. Did you speak with -- well, I see there's also a letter in your materials dated August 17th in which Mr. Martin asked you to prepare a report. Do you see that?
A. Yes, that is correct.
Q. Up to this point, August 17th, had you received -- had you reviewed any records other than those autopsy records?
A. Yes, I have.
Q. Okay. What had you reviewed up to August 17th of 2000?
A. I basically had reviewed all the documents that you have here, which includes the medical examiner's report, the medical records from Gloria Bass and the depositions of Dr. Grayson and Dr. Peacock.

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Q. Do you recall when it was -- it was obviously before August 17th that you got those records. Correct?
A. That's correct.
Q. Do you know when you received those additional records? And I mean by that the records above and beyond the autopsy report.
A. Yes. Those were received, some of them on October 25th of '99. I think that's where the confusion is.
Q. Yeah. Forgive me. I didn't look at the year. I was thinking that was -- October 25th was after August, but '99 would be before 2000, wouldn't it?
A. Yes, sir.
Q. All right, then. So in early 1999, you reviewed the autopsy report, or at least received it?
A. That's correct.
Q. And by the fall of that year, 1999, you got the other materials that are sitting here before us?
A. With the exception of the deposition of Dr. Peacock and Dr. Grayson.
Q. Okay. And then at some other time you received the depositions of Dr. Peacock and Dr. Grayson?

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A. I believe I received them later on.
Q. Do you have -- do you know for certain when you received the depositions of Dr. Peacock and Dr. Grayson?
A. If I may look at the envelopes.
Q. Certainly.
A. I may be able to find the date they were marked. The postmark is July 14 of this year.
Q. Okay. Sorry for the confusion. Let me see if I understand what you received and when. At some point in early 1999, Mr. Martin and you had a personal visit, at which time he gave you the autopsy records on Gloria Bass?
A. That's correct.
Q. And then on October 25th of 1999, he sent you a packet that contained some medical records pertaining to Gloria Bass?
A. That is correct.
Q. And then on July 14th of 2000, he sent you the depositions of Dr. Peacock and Dr. Grayson?
A. For sure the deposition of Dr. Grayson. I do not recall if the deposition of Dr. Peacock came with the October '99 package or with the --
Q. Or with the July 14th?
A. That's correct.

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Q. Did you speak with Mr. Martin after you had reviewed the autopsy records but before you received the October 25th of '99 packet?
A. I about this specific case?
Q. Yes, sir.
A. Not that I recall.
Q. Did you ask for those additional medical records or was that something that Mr. Martin just sent to you?
A. I believe that's something that he sent to me.
Q. Okay. And then had you formed an opinion in this case prior to receiving the medical records and possibly Dr. Peacock's deposition in late October of '99?
A. No, I had not.
Q. Had not formulated any opinions?
A. That is correct.
Q. Okay. After you reviewed the material -- the autopsy report that you got in early '99, and then after you reviewed the materials that were sent to you in October of '99, after reviewing all that material, had you prepared -- had you formed an opinion in this case?
A. I believe I had.

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Q. And what was your opinion at that point?
A. My opinion at that point was that the cause of Ms. Bass' death was a sepsis episode related to an intraabdominal infection.
Q. Those are, in a nutshell, the same opinion that you expressed to Mr. Martin earlier in this deposition?
A. That is correct.
Q. Okay. And then it was after -- sometime after you had formulated that opinion that you received and reviewed Dr. Grayson's deposition?
A. Yes.
Q. Okay. Did -- did Dr. Grayson's deposition testimony affect your opinions at all, one way or the other?
A. If anything, it just helped to solidify my opinion.
Q. In other words, you did not form any additional opinions after reviewing Dr. Grayson's deposition but became more confident in the opinions that you already had?
A. That would be a fair statement.
Q. Okay. Have you received anything from Mr. Martin's office since you received Dr. Grayson's deposition in July of this year?

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A. I had received the -- a number of faxes that include requests for dates for a potential deposition and this other request for certain documents to be presented during deposition.
Q. Okay. I understand you had received a letter asking you for dates for deposition and you received a letter pertaining to our trial date in this case. Is that correct?
A. That is correct.
Q. And then looks like in August 17th of 2-- on August 17th of 2000, you got a letter that asks for a report?
A. That is correct.
Q. Were you provided with any additional records or materials from Mr. Martin's office after July 14th of 2000?
A. I do not recall having received any other records after that time.
Q. Okay. So the last thing -- the last thing you got that you reviewed that would have any impact on your opinions in this case would have been Dr. Grayson's deposition, which you got sometime in July of this year?
A. That is correct.
Q. Okay. When you received the letter from

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Mr. Martin on August 17th asking for a report, what did you do? Did you sit down and write a report?
A. No, I did not.
Q. Did you call Mr. Martin and tell him you didn't want to prepare a report or didn't have time, or how did you handle that?
A. Well, no. What I did was have a telephone conversation with him.
Q. Okay.
A. August happened to be a very busy month for me. I was in charge of the clinical service at Texas Children's Hospital. So I did not have the time to sit down and formulate a full report, and what we basically did was, I -- I asked Mr. Martin if he could use a subpoena -- I'm sorry, I apologize -- a affidavit, rather than a report.
Q. Okay. And by that, did you mean that after you discussed your opinions with Mr. Martin that he would put together that affidavit?
A. Not he would put it together. We put it together over the phone.
Q. His office actually prepared the affidavit?
A. I don't know if his office -- I know it was typed in his computer.
Q. This document that's in front of us, it

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says the "Affidavit of Armando Correa," you didn't type that up and your secretary didn't type that up?
A. That's correct.
Q. Somebody from Mr. Martin's office prepared this and then sent it to you?
A. That is correct.
Q. And then I assume you reviewed it and felt comfortable with it and signed it?
A. That is correct.
Q. Did -- after you received this affidavit, did you have any conversations with Mr. Martin about any modifications you'd like to make?
A. I think we did the modifications on the phone. We went through it together, and I expressed what my opinions were and we made the modifications necessary.
Q. You and Mr. Martin worked on it together over the phone?
A. That's correct.
Q. Do you recall -- well, I guess you're not aware if there's in existence anywhere a draft of they way this affidavit read originally?
A. I am not aware.
Q. If that existed, I assume that would be in Mr. Martin's computer system somewhere?

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A. That's correct.
Q. It may not exist at all, as far as you know?
A. As far as I know.
Q. Are you --
MR. AUSTIN: Let's go ahead and mark this.
(Exhibit No. 3 was marked)
MR. AUSTIN: Do you have a paper clip or something?
THE REPORTER: No, I don't.
MR. AUSTIN: Stapler?
THE REPORTER: No, I don't have that either.
MR. MARTIN: I'll staple it, if you want.
MR. AUSTIN: Thank you. Thank you.
Q. (BY MR. AUSTIN) Dr. Correa, we've marked your affidavit as Exhibit No. 3 to your deposition. Would you look that over for a second?
A. Most certainly.
Q. Does Exhibit 3 appear to be a true and correct copy of the affidavit that you signed in this case?
A. Yes, it does.

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Q. As you look over Exhibit No. 3, are you able to recall which items you requested that Mr. Martin change, as he -- as you and he worked together on the affidavit?
A. If you'll allow me for a second to go over it.
Q. Sure.
A. I don't recall any specific changes. It is my recollection that I wanted to make sure that transposition of bowel -- transposition from the bowel could have been the source.
Q. When Mr. Martin -- well, I assume he read it to you over the telephone?
A. That is correct.
Q. Did he do that sentence by sentence and then you either approved or suggested changes or did he review it all at once -- read it all at once and then you went back and told him what you'd like to change?
A. No, I think it was section by section.
Q. And in that original affidavit that Mr. Martin read to you over the phone, did it contain any statements about transposition?
A. Yes, I think it did.
Q. What was it that you requested be added or

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modified?
A. The line that says that the most likely source was bowel perforation.
Q. Okay. It formerly -- the former version did not say that the bowel puncture was the most likely source?
A. I don't know that we can call it the former version. I remember I wanted to stress that my opinion is that the perforation was the most likely source.
Q. Did the original version -- what do you want to call it, just for purposes of this deposition to make it easier? Former version, original version?
MR. MARTIN: Objection; form.
A. His original reading?
Q. (BY MR. AUSTIN) Did -- okay. Did the original reading have any statement in there about the transposition?
A. Yes, I do believe so.
Q. And it also had something in there about a possibility of a bowel puncture?
A. Yes, it did.
Q. And to your recollection, you wanted to stress the bowel puncture was the most likely source?

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A. That is correct.
Q. I guess at that point it was not your feeling that the affidavit expressed that to your satisfaction?
A. That is correct.
Q. Do you recall, as you look at Exhibit No. 3, anything else that you changed as you and Mr. Martin read over the deposition -- excuse me -- read over the affidavit over the telephone?
A. The original reading used the term septicemia, and I asked Mr. Martin to change it to septic shock.
Q. What's the difference?
A. There's really no difference. It's just the septic shock is a more widely accept term.
Q. Are the terms interchangeable?
A. For practical purposes, yes.
Q. Is there anything else in your affidavit that is different from the original reading?
A. Not that I can recall.
Q. Let's talk about -- we've talked about when you received various sets of documents.
Let's now talk about conversations that you've had with Mr. Martin about this case, and you've told me that you had this first conversation

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in early '99, when he was in your office to discuss another case. Is that correct?
A. That's correct.
Q. To your recollection, when was the next time you spoke to him about this case?
A. I will not be able to give you specific dates. I know that in my invoice, I have dated July 14 as one of the times when I met with Mr. Martin, but I'm sure I have discussed it with him on other occasions.
Q. Do you typically bill -- well, in this case, would you have billed Mr. Martin? Had you spoke to him about a case -- about this case?
A. Would you ask the question again? I'm sorry.
Q. Would you have billed Mr. Martin, had you spoken to him, whether in person or on the telephone?
A. Not necessarily.
Q. Is there a cutoff, like a five-minute conversation doesn't get billed but a ten-minute conversation does, anything like that?
A. No. It's -- it has to do sometimes with -- more with convenience, and on occasions, we have met to discuss two cases at a time and is for both I think my convenience and his convenience that I would

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bill it to the one case that we discussed at length, rather than dividing the number of minutes for the different cases we discuss.
Q. Okay. So you -- in a given conversation, you may discuss more than one case. Is that what you're telling me?
A. That's correct.
Q. And you would bill him for the conversation that is the longest?
A. That's a fair statement.
Q. Let's say you had a 30-minute discussion on the telephone and you talked about the Gloria Bass case for five minutes and you talked about another case for 25 minutes. Are you with me?
A. Yes, sir.
Q. Would you bill for the entire 30 minutes?
A. Yes, I would.
Q. And you'd bill it to the case that you discussed for 25 minutes?
A. That's correct.
Q. All right. So are the only two discussions that you know you had with Mr. -- well, the only two discussions that you're able to give me specific dates or a specific date range would be this first discussion in early '99, and then again on July 14th?

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A. Yes, as well as the discussion that we had in August, when the affidavit was produced.
Q. You said August. Do you mean October?
A. I'm sorry. October.
Q. Without recalling the date, are you able to give me the substance of any of those discussions that would have happened prior to July 14th of 2000?
A. Yes. Basically the discussion was what my opinions were based on the records that I had reviewed.
Q. What did you talk about on July 14th where your statement says, "Meeting with Mr. Martin"?
MR. MARTIN: Objection; form.
A. I do not recall the specific topic of discussion. We probably basically talked about the opinions that I had formulated on this case. The one thing I specifically recall is Mr. Martin taking note of my opinions.
Q. (BY MR. AUSTIN) Can you explain what you mean by that?
A. Yes. Basically he had a notebook similar to the one you have, and as I was giving him the different opinions that I had, he was just writing them down.
Q. Okay. Okay. On your invoice, this first

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entry says that you reviewed various medical records, the autopsy report and the depositions of Dr. Grayson, Peacock and had a meeting with Mr. Martin. Does that mean that you did all those things on July 14th, or did you just bill for it on the 14th, or can you explain that?
A. No. It means that I had reviewed those medical records throughout this time, from when I first received them and that I had specifically met with Mr. Martin to discuss this specific case.
Q. You didn't necessarily do all of these tasks on the same day?
A. That is correct. I know for sure that I did not.
Q. But from the time that you received those records in October of '99, up through July 14th of 2000, it took you four hours to do all of the tasks denoted here?
A. That is correct.
Q. Do you know how long you met with Mr. Martin during this -- on this -- on July 14th?
A. If I remember correctly, about an hour.
Q. So it would have taken you three hours to do the other things?
A. That is a fair statement.

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Q. Are you telling me, then, that it took you three hours to review the medical records pertaining to Gloria Bass from Hillcrest Medical Center, Hillcrest Family Clinic, Dr. Gerald Salinas, the autopsy report and the depositions of Dr. Grayson and Dr. Peacock?
A. That's what I billed for, yes.
Q. Would there be a time that you spent reviewing the case that you did not bill for?
A. It is quite possible. I am known to underbill.
Q. You -- okay. In your estimation, do you have any idea how much time, if, in fact, you underbilled, how much time you would have underbilled on this case?
MR. MARTIN: Objection; form.
A. No, I do not.
Q. (BY MR. AUSTIN) And then on October 25th of 2000, you had this telephone discussion with Mr. Martin where you went over the affidavit with him. Is that correct?
A. That's correct.
Q. Did that conversation and reviewing and signing the affidavit take a full hour?
A. Yes, it did.

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Q. How much of that time would you have been on the phone with Mr. Martin going through this first reading of the affidavit?
A. Oh, it's hard to estimate, but maybe 25 to 30 minutes.
Q. Where did the other 30 minutes come in?
A. From getting the papers -- after it was finalized, he sent it to my office, and I had to go and get it notarized at a different facility. I do not have the public Notary in my office.
Q. So that 30 minutes involved receiving the fax, reviewing it and taking it to get notarized?
A. That is correct.
Q. And then I assume faxing it back to Mr. Martin?
A. That is correct.
Q. There's a fax header on Exhibit No. 3 that says 10-12 of 2000. Do you know if you actually received a copy of this affidavit before the 25th of October?
A. Well, that's what the stamp says. It may have been that I received it on the 12th of October. It was not signed until the 25th of October. I don't recall the specifics, if I was out of town or I couldn't find a public Notary, but at least if we

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believe what this stamp says, it says that it was sent on October 12th, 2000, and the signature is on the 25th of October.
Q. If I understood your testimony, you did not see a hard copy of the affidavit before your conversation with Mr. Martin. Is that true? This telephone discussion where you had the first reading?
A. This telephone discussion was when it occurred, on -- well, that is correct.
Q. Does that refresh your recollection, that that conversation probably happened on October 12th, instead of the 25th?
A. To be honest with you, it does not.
Q. Okay.
A. I do not recall the timing of the -- of the conversation, versus the timing of the signature of this affidavit.
Q. At any rate, whenever you received this, you did not actually get a hard copy to look at as you were talking to Mr. Martin on the telephone about it. Is that true?
A. I could not tell you "yes" or "no." I may have had a copy faxed to me at the time of the conversation.
Q. And then you would have gone through it

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with him while he made changes on his computer?
A. That is correct.
Q. All right. Your invoice -- your first entry is for four hours and the extended amount is $1200. Does that mean that you charge $300 per hour?
A. That is correct.
Q. And then your telephone discussion and your review of the signature -- review and signature of the affidavit also contains an entry of one hour at $300?
A. That is correct.
Q. Do you charge the same amount for services like reviewing -- reviewing documents and preparing reports as you do for attendance at trial or deposition?
A. No. The -- when I do depositions or attend trial it's $400 an hour.
Q. So as we sit here today, you're charging Mr. Martin $400 per hour?
A. Yes, sir.
Q. And if you were to come to Waco to testify at trial, you would charge $400 per hour?
A. That is correct.
Q. When does the clock start running for you? Let's say if you were to go to Waco and testify in

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this case, when would the clock start running?
A. When -- it's a difficult situation, because it be honest, it's not something that I do for a living, and I -- it's very hard to really determine. For sure the time that I'm on the stand or getting ready to be on the stand will count, and what I typically do is bill for an eight-hour day if this deposition takes the whole day.
Q. So you would -- sometime before the day you would testify, you would prepare for your testimony, I assume?
A. That's correct.
Q. And then would you bill from the time that you got in your vehicle to drive to Waco or left for the airport or however you got to Waco?
A. I wouldn't necessarily count the time. I would just bill it as a day of work. I would say to Mr. Martin, "Okay. I spent, you know, one day, it would have been eight hours of work. This is what I billed."
Q. I see. Even if you're on the stand for an hour and then travel time rolled in there, Mr. Martin would get billed for eight hours?
A. No. It would depend on what time I would come back and -- I want to specify that when I mean a

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full day, I don't mean a full day at a rate of $400 an hour. The $400 an hour would be for the time that I'm on the stand or at the deposition. If it implies other travel time, the rate is considerably less, $150 an hour.
Q. Oh, I understand. All right. So once you get on the stand, then your rate is $400 per hour?
A. That is correct.
Q. But as you're -- let's say you were to drive from Waco back to Houston, that time -- your driving time would be billed at $150 per hour?
A. That's reasonable.
Q. Or if you're on an airplane, same deal?
A. Yes, sir.
Q. You mentioned eight hour -- the figure eight hours. Is that a minimum or a maximum?
A. No. It's just a -- what I'm trying to say by eight hours is, let's say this would take me actually ten or 12 hours, I would not go over an eight-hour billing time, unless, you know, the circumstances so demanded. Let's say that the trial was up in the east coast or someplace like that. But what I meant by eight hours is I would not consider billing for more than that.
Q. Even if the whole day, from your door to

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Waco to testify and back to your door at home, took you, say, 13 hours, you wouldn't bill for more than eight?
A. That's correct.
Q. Is this invoice dated November 10th of 2000 the last invoice you sent to Mr. Martin for your work in this case?
A. That is indeed the only one that I have sent to him.
Q. Okay. I assume you've done some work to prepare for your deposition today?
A. Yes, I have.
Q. When did you begin preparing for your deposition?
A. Well, I did not receive the notice of the deposition until last week, so I -- actually, Mr. Martin mentioned it to me, that he was going to try to get the deposition done this week. I gave him some potential dates, and when I received the notice that it was going to be today, I started preparing, particularly gathering the documents that you requested and rereviewing the documents that I had reviewed in the past.
Q. Prior to last week, let's say from October 25th of 2000, up until last week, did you do

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any work on this case?
A. Not that I recall.
Q. And so you picked it up again last week?
A. That is correct.
Q. How much time have you spent on this case since November 10th?
A. Other than this deposition, probably about two hours.
Q. Two hours to prepare for today's deposition?
A. That is correct.
Q. Would that include meeting with Mr. Martin before the deposition?
A. Yes, sir, that's correct.
Q. How long did you meet with Mr. Martin before the deposition?
A. Approximately an hour.
Q. So one hour to review the materials and then one hour to meet with Mr. Martin?
A. Yes, sir.
Q. Have there been any materials in this case that you've asked Mr. Martin to provide to you that you have not been provided with?
A. No.
Q. Now, in this stack of records that we've

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got in front of us, we've got records from Dr. Salinas, for example, was there anything in Dr. Salinas' records that you found pertinent to this case?
A. No, I did not.
Q. Was there anything in the records of Dr. -- anything in Dr. Grayson's office records, other than those pertaining to his -- to the tubal ligation he performed that you found significant or important in this case?
A. Not that I can recall.
Q. There's some records in this stack from Dr. Ralston. Do you recall if you've reviewed those?
A. Yes, I do recall reviewing those.
Q. Is there anything in Dr. Ralston's records that bear on your opinions at all?
A. Not that I recall.
Q. I've noticed in this stack that there are a number of copies, three, maybe four or five copies of the medical examiner's report in this case.
A. That is correct.
Q. Do you know why there would be numerous copies?
A. Because as I had mentioned to you, Mr. Martin had provided me with an initial copy. If

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I remember correctly, he said that all of the copy may not have been complete, and that's why he sent the second copy that was included with all those documents on October 25th of '99.
Q. Do you know why you would have had a third and fourth copy of that report of those records?
A. It is possible that they were attached to one or the other deposition as part of the exhibits.
Q. If we were going to make a list of the items that you reviewed that form the basis of your opinion, that would be, one, the Hillcrest Hospital records pertaining to Ms. Bass?
A. That is correct.
Q. And I say Hillcrest Hospital. I mean only those relating to her tubal ligation. Is that correct?
A. That is correct.
Q. Okay. On that list, would I also include Dr. Grayson's office chart?
A. Yes, that is correct.
Q. The medical examiner's report and records?
A. That is correct.
Q. The deposition of Dr. Peacock?
A. Yes, sir.
Q. And the deposition of Dr. Grayson?

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A. Yes, sir.
Q. Are there any other materials besides those five things that I just listed that you have reviewed to prepare your opinions in this case?
A. The one thing to add was the document that Mr. Martin just produced, a copy of the medical letter.
Q. Anything else?
A. If you allow me a second to --
Q. Certainly.
A. -- go over these records to make sure we're not missing anything.
As part of the records from Hillcrest Baptist Medical Center, there is an attachment, a record from the Rural Metro Ambulance.
Q. Is that the only thing you would add to my list of things that you reviewed in coming to your opinions?
A. Yes, I believe so.
Q. You may need those medical records. I guess I should put them over there.
A. Thank you.
Q. Sure. Okay. Let's talk about the medical letter. Is this something that you provided to Mr. Martin?

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A. That is correct.
Q. Did you -- did he ask you to do some research or did you take that upon yourself?
A. Well, if I remember correctly, we were discussing in my office this case, and he asked a question, is there any publication that addresses the issue. This is a publication that I have at the top of my desk, and I immediately pulled it out and gave him a copy.
Q. Was that -- was that just coincidental that this particular edition of the medical letter would have information that you believe was pertinent to this case, or did you have to sift through a couple of editions to find this?
A. No. This is a -- this is one that I keep on file in my most active articles, if that makes sense. Those are articles that I frequently have to make reference to because of the nature of my specialty.
Q. Would these be kept in a notebook of some fashion?
A. They're kept in a drawer.
Q. So Mr. Martin asked you if you had any literature or knew of any literature to support your opinions?

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A. That is correct.
Q. And then you turned to your drawer, your file drawer, and pulled out this copy of the medical letter?
A. That is correct.
Q. Is your file drawer organized or divided in some fashion as to the topics in the medical letter?
A. No, it is not. In fact, that is the -- one of two or three articles from the medical letter that are in my file. There's only three of them.
Q. Oh, I see. Do you take the medical letter on a -- how is it published, weekly, monthly?
A. If I remember correctly, it's published weekly.
Q. Do you take it weekly?
A. That is correct.
Q. And then you throw away the ones that aren't pertinent to your practice?
A. No. I put them in a separate file.
Q. And the ones that go in your desk drawer are the ones that you believe are pertinent to your practice area?
A. That's correct.
Q. And of those, this was one?
A. That is correct.

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Q. You said you had about, what, two or three besides this one in your drawer?
A. That is correct.
Q. Do you know what topics those cover?
A. The other one is on therapy for parasitic infections, and the third one is on advice for travelers.
Q. What is the one about parasitic infections? What does it say? Can you paraphrase that for me?
A. The choice of antimicrobials for parasitic infections. That's probably the closest.
Q. Can you describe what you mean by parasitic infection?
A. Infections caused by parasites, which unlike bacteria that are microscopic, parasites are usually, not always, but usually, tend to be of a larger size than bacteria.
In addition, bacteria is a very simple form. It's just a cell. Parasites tend to be made of a number of cells.
Q. Okay. Are parasites organisms? I mean, they're more complex than bacteria?
A. That's correct.
Q. Okay. And this particular copy of the

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medical letter, which has been marked as Exhibit No. 2, is this the only medical letter that you believe is pertinent to your opintons in this case?
A. I believe so.
Q. Do you intend to support your opinions with any other medical literature, other than the medical letter that is found as Exhibit 2 to your deposition?
A. No, sir.
Q. When you had this telephone discussion with Mr. Martin where you went through this first reading of the affidavit, was it your understanding that that had already been -- it was already in existence, as opposed to something that he was typing or writing as you went along?
A. Yes.
Q. And to your assumption, I guess, was that something that he had probably prepared based on his previous discussions with you?
A. That is correct.
Q. Had you reviewed the medical letter before preparing -- or before signing your October of 2000 affidavit?
A. Yes, I had.
Q. Have you reviewed any materials after signing your October 2000 affidavit?

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A. No, I have not.
Q. And you do not intend to, do you?
A. That is correct.
Q. Did you review the deposition of the plaintiff, Severa DeLeon?
A. No, I did not.
Q. Did you review the deposition of Gloria Bass' sister, Minni Guerra?
A. No, I did not.
Q. Did you review the deposition of Dr. Halbridge?
A. No, I did not.
Q. Did you review Dr. Halbridge's report in this case?
A. No, I did not.
Q. Forgive me here. I'm going to skip around and try to hit some of the areas that Mr. Martin talked about with you earlier.
I believe you listed out the hospitals where you practice. Is the Baylor College of Medicine considered a hospital?
A. No, it is not.
Q. How about Ben Taub? That's a hospital, is it not?
A. That is correct.

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Q. Is that a children's hospital?
A. No. It is a general hospital.
Q. Texas Children's Hospital?
A. It is a pediatric hospital.
Q. And then you said you had -- you practice at -- is it called Texas Woman's Hospital?
A. That's correct. It's actually -- it's Women's Hospital of Texas.
Q. Women's Hospital of Texas. Is that in Houston?
A. Yes.
Q. And you work at Shriner's Hospital, as well?
A. That is correct.
Q. Is Shriner's Hospital a hospital for children?
A. That is correct.
Q. Maybe I misunderstood. Do you actually treat patients at the Baylor College of Medicine?
A. No, we do not. That is just a medical school.
Q. Those four hospitals that you listed are somehow affiliated with the Baylor College of Medicine?
A. That is correct. And if I may take the

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opportunity, I want to add the Methodist Hospital. It's another hospital where I have privileges.
Q. Okay. I want to talk about your privileges. You currently have active privileges at Ben Taub?
A. Yes, sir, I do.
Q. Active privileges at Texas Children's?
A. That is correct.
Q. Same at Women's Hospital?
A. No. Women's is consulting privilege.
Q. Do you have active privileges at Shriner's?
A. No. Also consulting, as it is the case with Methodist.
Q. What does consulting -- what do consulting privileges mean?
A. It means that if a treating physician feels the need of the opinion of an infectious disease doctor, he can call me and I can go and see patients that I have the authority to go and make recommendations.
Q. Diagnoses and treatment alternatives?
A. That is correct.
Q. Recommendations?
A. Recommendations regarding diagnosis and treatment.

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Q. What's the difference between consulting and active privileges?
A. I think that it comes down to what your obligations are to the hospital. If you are part of the active staff, you also have certain obligations, such as attending a number of medical staff meetings and serving in committees of the hospital. When you are only a consultant, you do not have to attend those meetings or serve in any of their committees, if you wish not to do so.
Q. Is that the reason that you have not -- well, have you sought active privileges at Women's or Shriner's or Methodist?
A. No, I have not.
Q. Is that why, because you don't want to be involved in the staff meetings and that sort of thing?
A. That is part of that. In addition, it -- it also involves, in some places, an additional cost.
Q. What does that mean, you have to pay to get privileges there?
A. That is correct.
Q. Is that a yearly fee that they assess?
A. I -- since I do not have it, I don't know.
Q. Does that mean there's no fee to be -- to have consulting privileges at these places?
A. That is correct. And that's specifically for -- the one that I'm aware is Women's Hospital.
Q. Are there limits on the number -- strike that.

As a physician with consulting privileges at Women's and Shriner's and Methodist, are there limits on -- numerical limits on the number of cases that you can consult on in a given month or year, for example?
A. No, there are not.
Q. So you could be just as, quote, unquote, active in that hospital with consulting privileges as you could with active privileges?
A. You sure can.
Q. As a practical matter, are you as active in Women's and Shriner's and Methodist Hospital as you are the others?
A. Not with Shriner's or Methodist, but certainly with Women's. We sometimes are actually busier than with our other hospital.
Q. Let's talk about your -- the breakdown of where you spend most of your time, and let's first talk about just patient care.
A. Sure.

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Q. Can you tell me what percentage of your work is done with Ben Taub?
A. In general terms, about 60 to 70 percent of my time is patient care, and out of that time, about 30 percent is at Ben Taub, 60 percent at Texas Children's Hospital and another ten percent at Women's, with very occasional visits to Methodist or Shriner's.
Q. Okay. And those would be so minor that they wouldn't even account for one percent?
A. Probably Shriner's one, two percent, but no more than that.
Q. Shriner's and Methodist together make up the one to two percent?
A. Yes.
Q. You indicated that 60 to 70 percent of your time is spent on patient care. Is that right?
A. That is correct.
Q. Have you ever testified that your -- the time you devote to patient care is closer to 50 to 60 percent?
A. It is possible.
Q. Which one is more accurate? Is your patient care time spent more closer to 50 percent or 70 percent?

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A. Sometimes it depends on if they're asking me about my teaching duties, also, because some of my patient care is at the same time I'm doing teaching, and some of them is independent of that. I think a more accurate estimate is the one I have given you today.
Q. Okay. How much of your time since 1993 has been spent with direct patient care as opposed to some sort of academic and/or administrative function?
MR. MARTIN: Objection; form.
A. There's no way of doing an estimate. It varies from year to year and sometimes even month to month.
Q. (BY MR. AUSTIN) Are you aware that in June of 1999, you answered that question, "Approximately 50 percent of my time is direct patient care"?
MR. MARTIN: Objection; form.
A. I do not recall my answer, but certainly it seems that you have a copy of a deposition where I -- I certainly could have said that.
Q. (BY MR. AUSTIN) Do you dispute that answer today?
A. No, I do not.
Q. So is it true that your time, since 1993, has been spent with direct patient care, as opposed

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to some academic or administrative function, has been closer to 50 percent of your time?
MR. MARTIN: Objection; form.
A. Would you be kind enough to rephrase the question -- or reask the question?
Q. (BY MR. AUSTIN) Sure. Is it true that since 1993, your time spent with direct patient care, as opposed to some sort of academic and/or administrative function has been approximately 50 percent of your time?
A. I would agree that from 1993 to the time of this deposition, 50 percent would have been a reasonable estimate.
Q. Now, you also have some, as you alluded to earlier, some academic responsibilities?
A. That is correct.
Q. Would that make up the additional 50 percent of your time, or is there some other obligation that you spend your time doing?
A. I -- I believe I left an additional 30 to 40 percent.
Q. I thought you just said that 50 percent of your time was spent with direct patient time.
A. No. Up till 1999.
Q. Oh. And that has changed since 1999?

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A. That is correct.
Q. Why is it that after June of 1999 you increased your direct patient care responsibilities?
A. It's a number of factors. Number one, I have not spent any time doing research since that time. In addition, one of my colleagues recently retired, and I have taken a big part of his load in my practice.
Q. What kind of physician was that that retired?
A. An infectious disease physician.
Q. Pediatric or just general infectious diseases?
A. Pediatric infectious diseases.
Q. So his patients now that you picked up are predominantly minors?
A. I won't say that it's necessarily his patients. It's the time that he devoted to clinics or patient care. But, yes, it is mostly minors.
Q. In the pedi-- what defines the pediatric field? Is that birth to what age?
A. It depends on different places, but in general, most of us consider it birth to 18 years of age.
Q. In the patients -- in the pediatric

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patients that you see, do you find that those patients are pretty evenly distributed throughout that age range, zero to 18?
A. I guess overall there's a reasonable distribution. Because of the nature of our hospital, I would think that we may be a little bit skewed towards the neonates, in general. A good number of our practice has to do with newborns.
Q. You said neonates. Can you explain what you mean by neonates?
A. Well, neonates is a term that we use for children less than 28 days of life. That's the strict definition. For our purposes is really newborns less than three months of age.
Q. What percentage of your practice is spent treating neonates?
A. I don't know that I could even guess. I would say it's among an even distribution. Again -- it's hard for me to estimate.
Q. Okay. Do you see more neonates than ten years old?
A. As in strictly a ten-year-old category, yes.
Q. Do you see more neonates than any other age group, meaning one year olds, two year olds, three

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year olds, on up to 18?
A. I don't know that I could say that.
Q. Besides -- well, the neonates take up a heavier percentage than the other -- than the rest of the group. Is that what you're telling me?
A. Yes.
Q. But you can't estimate what that percentage would be?
A. No, I could not.
Q. Do you find that as the patients -- the older the patient gets, the less percentage of time that takes from your practice?
A. I think that outside of the first year of life, I don't think I see that tendency. I do not see that tendency.
Q. Okay. So there may be just as many two year olds as 18 year olds?
A. Well, I think I used 18 -- I guess till the time they turn 18, so maybe 17 year olds.
Q. Okay.
A. There may be as many. I just couldn't really tell you.
Q. Okay. What is the -- how do you spend the other 30 to 40 percent of your practice time? Or maybe I -- let me rephrase that. How do you spend

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the additional 30 to 40 percent of your time?
A. Mostly either administrative or teaching duties.
Q. When you say administrative, what do you mean?
A. Administrative, I mean answering phone calls, returning -- writing papers, writing chapters, preparing for talks. And by teaching, I mean giving lectures to the medical students, preparing lectures for the medical students or the residents, for the fellows.
Q. Does that comprise what we just talked about, your private practice and your administrative and teaching duties, does that comprise a hundred percent of your professional work?
A. I want to clarify. I do not have a private practice. All this time is part of academic practice affiliated with Baylor College of Medicine.
Q. Okay. Let me rephrase that. Would the 60 to 70 percent that you have -- that you told me you spent in patient care, plus the teaching responsibilities and the administrative responsibilities, does that all comprise 100 percent of your professional time?
A. Yes, it does.

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Q. Would you agree that one to two percent of your practice is adult in nature?
A. Yes, I would.
Q. When we talk about adults, are we talking about people who are 18 and beyond?
A. That's correct.
Q. How much of your adult patients -- how much of your work with adult patients involves surgery patients?
A. I would say the majority of it.
Q. Greater than 50 percent?
A. Well, I guess patients who have had surgery, is that...
Q. Let me be more specific. Of the one to two percent of your patients that are adults, how many are in the postoperative period?
A. About half of them.
Q. Is it fair, then, if my math is correct, that somewhere from half of one percent to one percent of your patients are adults in the postoperative period?
A. That's a fair statement.
Q. How many of those are typically women?
A. Half and half, probably.
Q. So somewhere from one-quarter of one

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percent to half a percent of your patients are female adults in the postoperative period?
A. That's fair.
Q. And of those, how many of the postoperative patients have had tubal ligations?
A. I would not be able to give you a number.
Q. Half and half, somewhere less than that?
A. I don't -- I wouldn't guess. You know, it's -- that are there that I'm seeing them because of a postop tubal ligation.
Q. Let me rephrase it. I'm wondering how many of your -- well, you said that a quarter of one percent to a half of one percent are adult female patients in the postop period. Is that correct?
A. Well, I think you said that and I agreed to it.
Q. Is that correct?
A. That's correct.
Q. And how many of those patients are you treating after a tubal ligation?
A. Probably none.
Q. How many of those are you treating after gynecological procedures?
A. Probably none.
Q. Have you ever treated a patient in the

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postoperative period like Gloria Bass?
A. Yes, I have treated patients in the postoperative period.
Q. Have you ever treated a patient like Gloria Bass, who was a 34-year-old woman, who underwent a tubal ligation?
A. No, I have not.
Q. Is it true that when you have privileges at a hospital, that's something that you have to apply for?
A. That is correct.
Q. And when you fill out an application for privileges at a hospital, do you have to specify what privileges you want?
A. Yes, that is correct.
Q. In other words, a surgeon might on his application for privileges request privileges for general surgery?
A. That is correct.
Q. What -- what sorts of -- how would you describe your privileges as a physician at the hospitals where you have active privileges?
A. At the two hospitals where I have active privilege, I requested the privilege to admit, diagnose and treat common and uncommon diseases of

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childhood and in adults. It also includes requesting appropriate tests, interpreting those tests and requesting appropriate consulting services, or appropriate consultations. If I may also say, it wouldn't be surprising if at both places I also requested privileges for diagnosing and treating infectious diseases.
Q. Okay. You said that the privileges that you requested at these places would be admitting, diagnosing and treating common and uncommon diseases of childhood and adults, including requesting tests, interpreting tests and requesting appropriate consultations?
A. That's probably a fair statement.
Q. At the hospitals where you have active privileges being -- and again, that's Ben Taub, Texas Children's, it's those two?
A. Yes, sir.
Q. At those two hospitals, were you granted the privileges that you requested?
A. Yes, I was.
Q. The full privileges that you requested?
A. Yes, I was.
Q. They didn't cut you short in any respect?
A. Not that I know.

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Q. Have you ever had your privileges at any hospital suspended?
A. No, I have not.
Q. Revoked?
A. No, I have not.
Q. Have you ever voluntarily relinquished any privileges at any hospital?
A. No, I have not.
Q. Where did you do your medical -- where did you go to medical school?
A. I went to medical school in the Monterrey Institute of Technology in Monterrey, Mexico.
Q. Do you graduate from that school like you do here in the States?
A. Yes, I did.
Q. Did you graduate?
A. I sure did.
Q. And was it after that graduation that you decided to come to the States?
A. No. I think I -- earlier in my medical career, I had decided that I wanted to come to the United States. In fact, I took the first part of my exams before completing medical school.
Q. Exams that are required in the United States?

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A. That is correct.
Q. Is that -- that's called a FLEX exam?
A. I think that's the current name. At the time it was called the ECFMG.
Q. And that's a college -- excuse me -- that's an exam that foreign medical graduates have to take before they're allowed to come and train or practice in the United States?
A. That is correct.
Q. And I assume you passed that test for foreign-trained medical graduates?
A. Yes, sir, I did.
Q. And then you came to the United States, where you performed your residency?
A. That is correct.
Q. Now, there's an internship involved in going to medical school, as well, isn't there, or at least in the medical training?
A. That is correct.
Q. Had you performed your internship in Mexico, or is that something that you did in Texas?
A. I did it here in Texas.
Q. So first would have been an internship and then the residency?
A. Yes. And in the case of pediatrics, it is

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really the first year of the pediatric residency. That is called internship.
Q. So it's -- for that first year, the terms are interchangeable?
A. That's correct.
Q. And your residency, is that the one you did at Breckenridge?
A. Yes, sir, I did.
Q. That would be a residency in what? Was it called pediatrics?
A. In pediatrics, yes, sir.
Q. And that qualified you -- after you completed that residency -- strike that.
After you completed that residency at Breckenridge, did that, then, qualify you to become a pediatrician?
A. Yes.
Q. And you could have gone out and hung out a sign on a building that said, "Dr. Correa, Pediatrician"?
A. Yes, sir.
Q. And you completed that in 1991?
A. That is correct.
Q. Did you immediately, after that, go into the fellowship at Baylor?

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A. Yes, sir.
Q. There was no time in between, during which you practiced solely as a pediatrician?
A. No, I did not.
Q. Now, your fellowship at Baylor was in infectious diseases?
A. That is correct.
Q. Was it in infectious diseases generally or was it more specified in pediatric infectious diseases?
A. It was more specified in pediatric infectious diseases.
Q. So those additional two years where you did that fellowship at Baylor was in pediatric infectious diseases?
A. Yes, sir.
Q. After -- when did you complete that fellowship?
A. 1993, June of 1993.
Q. Since June of 1993, have you had any other formal medical education?
A. No, I have not.
Q. And I'm not talking about hours that you need to do to keep your license current.
A. I understand. No, I have not.

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Q. Now, you are -- I believe you testified earlier that you are board certified in pediatrics?
A. That is correct.
Q. And you are board certified in infectious diseases?
A. In pediatric infectious diseases.
Q. Okay. So you are board certified in pediatrics and pediatric infectious diseases. Is that correct?
A. That is correct.
Q. Is there a separate board certification for adult infectious diseases?
A. Yes, there is.
Q. Do you hold that?
A. No, I do not.
Q. Now, if there are different boards for pediatric and adult infectious diseases, does that mean that there are differences between treatment of pediatric and adult patients with infectious diseases?
MR. MARTIN: Objection; form.
A. Yes.
Q. (BY MR. AUSTIN) Can you tell me, what are some of the differences in treating pediatric infectious diseases versus treating adult infectious

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diseases?
A. The basic differences have to do with the antibiotics or antimicrobials that are approved in adults as compared to children. There are a number of antimicrobials that have gained approval to be used in adults that are not approved for use in pediatric patients. And the other has to do with how children metabolize those antibiotics or those antimicrobials. It may be that children require higher dosages or a different dosing schedule, but in general terms, those are the main differences.
The other difference -- you asked specifically about treatment, but the other difference is that some diseases may be more common in one age group than the other.
THE VIDEOGRAPHER: Mr. Austin, excuse me. I've got about two minutes.
MR. AUSTIN: Okay. You can go ahead and change it. We'll take a break.
THE VIDEOGRAPHER: We're off the record at 4:15 p.m.
(Break from 4:15 p.m. to 4:24 p.m.)
THE VIDEOGRAPHER: We're back on the record at 4:24 p.m.
Q. (BY MR. AUSTIN) Dr. Correa, we were

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testifying about your hospital privileges a while back. Do you recall that?
A. Yes, sir.
Q. I can't remember if I asked you this. Forgive me if I have. Have you ever -- well, you've said you've never had any privileges suspended or revoked?
A. That's correct.
Q. Have you ever applied for any privileges and not gotten the full privileges that you requested?
A. No, I have not.
Q. And you've never been denied any privileges anywhere?
A. That is correct.
Q. Are you currently licensed by the Texas Board of Medical Examiners?
A. Yes, sir, I am.
Q. Are you licensed in any other states?
A. I am licensed in Mexico.
Q. Are you licensed to practice medicine anywhere else other than Texas and Mexico?
A. No, I am not.
Q. Now, do I understand that -- that the license to practice medicine in Mexico is not

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something that you have to renew once you get it?
A. That is correct.
Q. So without taking any action in Mexico, you're licensed to practice medicine there for life?
A. That's correct.
Q. Whereas in Texas you have to -- you have to have that license renewed from time to time?
A. Yes, sir.
Q. How often do you have to have your license renewed to practice medicine in Texas?
A. It's on a yearly basis.
Q. Have you ever had your licenses in Mexico or Texas suspended for any reason?
A. No, I have not.
Q. Never been revoked?
A. Never.
Q. Ever been investigated by the Texas Board of Medical Examiners?
A. No, sir.
Q. To your knowledge have you ever had a complaint filed against you by the board -- let me strike that.
To your knowledge have you ever had a complaint filed against you with the Texas Board of Medical Examiners?

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A. Not to my knowledge.
Q. When did you receive your board certification in pediatrics?
A. My certification was in November of 1991.
Q. And then you became certified in pediatric infectious diseases at some time after that in '94?
A. That's correct.
Q. Now, you said earlier that you're on the faculty as an assistant professor at Baylor College of Medicine?
A. That's correct.
Q. And in that capacity that requires you to -- or gives you the opportunity to teach to medical students and fellows alike?
A. Medical students, residents and fellows.
Q. Is your title assistant professor or do you have a title like assistant professor of something or other?
A. If I -- probably assistant professor of pediatrics. Or rather, it's assistant professor of the department of pediatrics.
Q. Your title at Baylor College of Medicine is assistant professor of the department of pediatrics?
A. Assistant professor -- no, I'm sorry. I take that back. It's assistant professor of

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pediatrics.
Q. Okay. Just so we can get this clear.
A. Yeah.
Q. Your current title at Baylor College of Medicine is assistant professor of pediatrics?
A. That is correct.
Q. You mentioned earlier that from time to time I think eight to ten times a year you said you lecture as an invited speaker. Is that correct?
A. That is correct.
Q. What groups do you talk to as an invited speaker?
A. It -- typically physicians.
Q. Would that be in the Houston area?
A. Some of the talks have been in the Houston area, some in other parts of the state, the country or sometimes out of the country.
Q. On those occasions do they tell you what they'd like to hear about or is it up to you to come up with the topic?
A. Most of the time they pick the topic.
Q. You said that you belong to the American Society of Microbiology. Is that correct?
A. That's correct.
Q. Does the American Society of microbiology

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have a newsletter?
A. Yes, they do.
Q. Do you take it?
A. I do receive it, yes.
Q. How often does that come?
A. I think ASM news comes on a monthly basis.
Q. How long have you been a member of the American Society of Microbiology?
A. I have been a member since 1993 but took a break from the society probably throughout 1999 and the first part of this year.
Q. Did you quit or just let your -- let your membership lapse or how did that come to pass in 1999?
A. I let my membership lapse.
Q. Why did you do that?
A. Because the budget that we had for membership fees was limited.
Q. Okay.
A. So I couldn't afford to continue to belong to ASM.
Q. In other words, your -- the school, the College of Medicine pays those dues for you?
A. That is correct.
Q. And there wasn't enough money in the budget

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to pay for the American Society of Microbiology membership?
A. I got an amount that I'm able to use for fees or other subscriptions, et cetera, and that particular year I did not have enough funds to pay for ASM membership.
Q. It was lower on your priority list than other memberships you would have liked to maintain?
A. That is correct.
Q. Okay. Now, what happened in late -- what happened in the latter part of 2000 that allowed you to rejoin the American Society of Microbiology?
A. The fees went down and, in addition, the allocation of money changed. Just to give you an example, the DEA license is renewed every three years. It just happened that mine was up for renewal in 1999 and that was an expensive venture, so that particular year I decided to allocate my money to my renewal rather than continuing with ASM.
Q. Okay. How about the Infectious Disease Society of America, when did you first become a member of that?
A. I became a member in training in 1993 and then a formal member according to my C.V. in 1994.
Q. Has your membership in the Infectious

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Disease Society of America ever lapsed?
A. No, it has not.
Q. Do they have a newsletter?
A. Yes, they do.
Q. How often does that come?
A. That comes quarterly.
Q. Do you take it?
A. I do receive it.
Q. Do you read it?
A. Depending on the topic.
Q. What topics would you want to read about from the Infectious Disease Society of America?
A. Well, in particular over the last year one of my colleagues, Dr. Carol Baker, has become the president of that society; so certainly that has raised the interest in that newsletter. In addition, I like to read about upcoming meetings or about emerging infections or current problems.
Q. How long have you been a member of the Pediatric Infectious Disease Society?
A. Probably since 1993.
Q. Have you been a member continuously since '93?
A. Yes, sir.
Q. Does the Pediatric Infectious Disease

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Society have a newsletter?
A. They used to.
Q. Did you take it while they had it?
A. Yes, I did.
Q. When did they stop publishing that?
A. Well, what they did is now they incorporated into a journal. It's a journal that we receive monthly, and that's where the newsletter is included.
Q. Is a journal -- is it a journal of other newsletters?
A. No. It's a journal of pediatric infectious diseases.
Q. How long have you been a member of the Texas Infectious Disease Society?
A. That membership started recently, I believe a year or two ago.
Q. Is that on your C.V.?
A. No, it is not.
Q. Does the Texas Infectious Disease Society have a newsletter?
A. No, they don't.
Q. Do they have meetings that you go to?
A. Yes, they do.
Q. How often do they meet?

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A. They meet annually.
Q. Did they meet this year?
A. Yes, they did.
Q. When?
A. They met in San Antonio over the summer. I unfortunately was not able to attend.
Q. How come you couldn't go?
A. Oh, if I remember correctly it -- it was a weekend that I was on call.
Q. I think when Mr. Martin was asking you questions you referred to your -- to the C.V. that's Exhibit 1 as an updated or current C.V.
A. That's correct.
Q. When was this updated?
A. I printed it this morning.
Q. Did you make any changes to it this morning?
A. No, I did not.
Q. When was the last time that changes were made?
A. When I added the last lecture, shortly after my return from Venezuela.
Q. Well, I guess the one that I have shows lectures going up to No. 35 and this one goes up to 57, does it not?

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A. 57, that's correct.
Q. So this C.V. has been updated since I got mine?
A. That copy, absolutely.
Q. Okay. Your C.V. includes a number of articles that you've written and I guess journal articles and chapters that you've contributed to. Is that fair? Is that a fair summary?
A. That's correct. Yes, sir.
Q. Are there any journal articles or chapters that you've contributed to or articles that you've written that bear on the issues involved in this case?
A. Well, being that this is an infectious disease case and the opinion that I'm giving, I believe that all of them have bearing because they're all infectious disease related. Now, to specifics of this case, no, I do not.
Q. Do any of your writings touch on infections in the postoperative period from bowel bacteria?
A. No, they don't.
Q. Okay. You've also got a number of lectures -- well, strike that.
Do any of your writings touch on bacteria gaining access to the bloodstream through a

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severed ovarian artery?
A. No, they do not.
Q. When I said writings did you understand that to include the book chapters and the abstracts?
A. Yes, I do.
Q. In addition to the journal articles?
A. Yes, sir.
Q. Okay. You've also got a list of invited lectures on your C.V.?
A. Yes, sir.
Q. Do any of these invited lectures touch specifically on the issues involved in this case?
A. Again, as specifically as to infectious disease, which is where I'm giving the opinion, I believe all of them have a bearing on that. However, very specifically as to your second question dealing with access to the bloodstream from a severed ovarian artery, no.
Q. For example, the first invited lecture which you gave in 1992 is neonatal sepsis?
A. That is correct.
Q. And Ms. Bass was not a neonate?
A. That's correct.
Q. So that really wouldn't bear on the issues involved in this case?

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A. That is correct.
Q. Okay. Same with your fourth invited lecture which is diagnosis and treatment of sinusitis?
A. That is correct.
Q. That really wouldn't have anything to do with this case?
A. Yes, sir, that is correct.
Q. So except for the fact that all of these touch on infectious diseases generally, none bear directly on the specific issues in this case. Is that fairly said?
A. That's a fair statement. However, if I may clarify the -- you may see that one of my talks in the Philippines in 1999 had to do with sepsis and the management of sepsis. I guess to a point we can apply that to this particular case.
Q. That's -- is that 44 that talks about immunizations and special circumstances, vaginal discharge in children and childhood meningitis?
A. Yes. What it is, what you're seeing there is four different talks. The title that you mentioned is the other three talks, but I think that the original talk was entitled something like the role of antimicrobials in sepsis.

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Q. Update on sepsis syndrome?
A. Update on sepsis syndrome, that's correct.
Q. Did that talk involve anyone who got sepsis in the postoperative period?
A. Yes, it did.
Q. Did it talk about women who got sepsis following a tubal ligation?
A. No, it did not.
Q. And when you give a talk like this, do you actually discuss patients and their courses and their outcomes?
A. No, I do not.
Q. I don't mean by name, but do you give examples to illustrate points?
A. I do not think so.
Q. And when you say sepsis syndrome, I guess you talked about sepsis to some extent?
A. Yes, that's correct.
Q. What was it that you talked about with regard to sepsis?
A. I talked about the pathogenesis, how it originates, what type of mechanisms occur, and the effects of the different changes that go in the body, as well as the treatment, the management of a patient with sepsis.

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Q. What were the various means of pathogenesis that you talked about?
A. Well, basically I talked about the ways that the causative organism can gain access to the circulation.
Q. Did you -- in that talk when you were talking about means of access to the bloodstream, did you talk about severed blood vessels?
A. Not specifically.
Q. And I assume you did not talk about severed ovarian arteries being a means of access to the bloodstream?
A. I did not.
Q. Have you ever been sued relating to your medical profession?
A. Yes, I have.
Q. How many times?
A. One time.
Q. When was that?
A. That was during my residency.
Q. Can you tell me the -- in a nutshell the circumstances?
A. Sure. It was a case that was filed in Travis County and it involved the death of a child who died as complication of a postop -- or in the

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postop course from cardiac surgery.
Q. Did the patient have an infection of some kind?
A. Not to my recollection.
Q. What was the outcome of that case?
A. The case was -- I guess the proper term is dismissed by summary judgment.
Q. You were actually served and you were a party to that lawsuit?
A. That is correct.
Q. When you were a defendant in that lawsuit, did you feel like you had done anything inappropriate in treating that patient?
A. No, I did not.
Q. Did the fact that you were named in that lawsuit make you feel like you had done anything wrong?
A. No, it did not.
Q. Did you feel like you had acted appropriately in treating that patient?
A. Yes, I did.
Q. Even though allegations were made against you that you had not?
A. That's correct.
Q. When did you first begin reviewing medical

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malpractice cases in the capacity as a potential expert witness?
A. Probably in 1994.
Q. Can you give me an estimate of how many cases that you've reviewed, not testified in or not been retained in, but how many cases have you reviewed either for plaintiff's counsel or defense counsel since you began doing this work in 1994?
A. That I have reviewed, maybe 40 to 45.
Q. Now, your review of medical malpractice cases has increased, has it not?
A. Yes, it has.
Q. In the last two years?
A. Yes, it has.
Q. Would you agree that from the time you began reviewing cases in 1994 up through January 29th of 1999 you had looked somewhere in the neighborhood of 16 to 18 cases?
A. That's a fair statement.
Q. And then from January 29th of '99 to the present -- well, strike that.
Total cases I believe you just testified is that you've reviewed what, 40 to 45?
A. Yes, sir.
Q. Okay. So if my math is right, is it fair

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to say that since January 29th of '99 you've reviewed somewhere between 24 and 27 cases?
A. That is correct.
Q. Earlier when we were describing the percentage of time that you devote to professional activities, were you including the time that you spend reviewing cases and testifying at depositions and so forth?
A. No, I do not.
Q. What sort of percentage would that comprise?
A. I would guess maybe ten percent.
Q. Is that ten percent over the last two years?
A. No. I do believe that over the last two years that number has increased somewhat.
Q. It has increased?
A. Yes.
Q. Let's say January 1st of '99 -- up to January 1st of '99, how much time would you devote to your reviewing litigation matters?
A. And you're asking me a time in a given day or I mean --
Q. No, no. I'm just trying to get a ballpark estimate. Up to that point you would have spent X

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amount of time with direct patient care, X amount of time teaching. How much time would you have spent with litigation matters?
A. Okay. In order to answer that question, I want to clarify that when I was talking about that time I was talking about my professional time as related to Baylor College of Medicine. Then this is really -- it's more on my free time or my time outside of the capacity of the medical school. But prior to that time maybe five, seven percent, and as I mention now it's more ten percent of my time.
Q. And the ten percent has been -- has that been consistent since the beginning of '99?
A. No. I think that particularly 2000 has been busier.
Q. Was it five to seven percent throughout 1999?
A. I guess we can -- no, more like seven to ten percent.
Q. And ten percent as we sit here today?
A. Yes.
Q. Why is it that you're increasing the amount of time that you're devoting to review of litigation matters?
A. I have just been asked more frequently to

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review cases.
Q. Do you recall testifying in January of 1999 that at that time you had about ten open cases?
A. That's a reasonable recollection.
Q. You don't have any reason to dispute that, do you?
A. No, I don't.
Q. How many open cases do you have today?
A. I don't know the exact number.
Q. Could you give me -- well, is it more than ten?
A. Yes.
Q. Is it less than 20?
A. Probably.
Q. Is that as specific as you can get?
A. Yes.
Q. So currently you're reviewing litigation matters at various stages somewhere between 10 and 20 cases?
A. That's a reasonable estimate.
Q. Of those 10 to 20 cases, in how many have you been retained by plaintiff's counsel?
A. About half of them.
Q. The other half defense counsel?
A. That is correct.

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Q. Now, I believe you testified earlier that you have had at least one other litigation matter with -- where you've reviewed a case with Mr. Martin. Is that correct?
A. That's correct.
Q. Not counting this one, how many cases have you reviewed for Mr. Martin?
A. Maybe five or six.
Q. Not counting this one?
A. Not counting this one I would say five.
Q. Now, are those cases that you've reviewed or just cases that you've agreed to testify?
A. No. This is cases that I have reviewed.
Q. And of those five other cases, on how many of those occasions have you been retained as an expert?
A. I believe I've been retained -- I'm sorry. Did I say in addition to this one five?
Q. Correct.
A. Okay. So maybe four.
Q. So total including this case you have reviewed six cases for Mr. Martin?
A. Yeah, six. And again, it's an estimate. I don't know the exact number but I would say yeah, six.

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Q. Is it six to seven, six to eight?
A. Six to eight.
Q. Okay. Including this case you've reviewed approximately six to eight cases for Mr. Martin?
A. That's correct.
Q. And of those you have been retained to testify in how many?
A. That I know for sure four.
Q. What happened in those other two to four cases?
A. Two of them -- let me tell you. One was settled, the other one went to trial, and the other two are pending. One has gone through the deposition stage.
Q. Now I'm actually talking about the cases where you were not retained.
A. Okay. I'm sorry.
Q. By my count there's about two to four cases where you reviewed the case but for one reason or another you were not retained.
A. That's correct.
Q. Is that true?
A. That's correct.
Q. Why were you not retained in those other cases?

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A. Well, in some cases because I did not feel that there was any contribution that I could do either as to standard of care or causation. One other case my understanding this was not pursued any further by Mr. Martin.
Q. Okay. So one of those cases was dropped, just not pursued?
A. I don't know the details. I was just told that the case -- let me take it back. I think the case was dismissed because of the statute of limitations and it's now being appealed.
Q. Okay. Was it dismissed by -- for whatever reason was it dismissed before you had told Mr. Martin that you couldn't help him out?
A. No. It was after.
Q. So you had told him that you, for one reason or another, could not testify for him?
A. No. I -- I had told him I could.
Q. And then it got dismissed?
A. And then it got dismissed.
Q. Okay. And on those other three or four occasions you looked at the case and did not find a breach of the standard of care?
A. Or a causation. In some occasions he had asked me to look as to standard of care and some of

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the cases, as this one, as a causation expert.
Q. Have they all been -- strike that.
How many times have you given a deposition before?
A. How many times have I given a deposition in general?
Q. Correct. Well, related to medical malpractice cases.
A. Maybe 10 to 12 times.
Q. So of the 40 to 45 times you've been retained -- excuse me -- you've reviewed a case -- strike that.
You told me earlier that you've reviewed about 40 to 45 cases?
A. That was my estimation.
Q. Okay. Of those in how many have you been actually retained?
A. I do not know.
Q. Could you give me any estimate?
A. I could not.
Q. Okay. Well, at any rate some of those you were retained and then of those I guess 10 to 12 times you gave depositions?
A. That is correct.
Q. How many times have you given depositions

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for -- on behalf of the defendant, the healthcare providers?
A. About half of the time.
Q. The other half for plaintiffs?
A. That's correct.
Q. How many times have you testified at trial?
A. Two times.
Q. Were those both for plaintiff's counsel?
A. Yes, sir.
Q. Was one for Mr. Martin?
A. Yes, sir.
Q. Were they both for Mr. Martin?
A. No.
Q. What was the outcome in the one case that you testified for Mr. Martin?
A. My understanding is that the case was -- the verdict was in favor of the defendant.
Q. What type of case was that?
A. It was a child who died from a respiratory tract infection.
Q. How old was the child?
A. I don't recall her exact age. She was young. Two or three years.
Q. How about the other time that you testified in trial? What was that case about?

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A. It was a case of tuberculous meningitis.
Q. How old was the patient?
A. At the time that the injuries occurred, about a year old.
Q. What was the outcome of that case?
A. The case was settled with some of the defendants and was found in favor of the defendant for another group of defendants.
Q. So some of the defendants actually went to verdict?
A. That is correct.
Q. And those defendants that went to verdict the jury found in their favor?
A. That is correct.
Q. How many depositions have you given related to your review of medical malpractice cases in the past two years?
A. Again, I would have to estimate maybe five or six.
Q. Half and half, half for plaintiffs, half for defense?
A. Yes.
Q. Can you remember what any of those cases are about?
A. Yes. The majority of them have to do with

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infections, although one of the cases involved surgical complications.
Q. Let's talk -- talk about the first one that you can remember.
A. Okay.
Q. What was that case about?
A. The most recent one involved the -- a case of a child who suffered blindness from retinopathy at prematurity.
Q. Was that an injury that happened at or near birth?
A. It's an injury that happened after birth.
Q. And how old was the child?
A. At this time of this injury, a few months old.
Q. Did you testify for the plaintiff or the defense?
A. I testified for the plaintiff.
Q. Okay. And was your opinion there that a physician had violated the standard of care?
A. No, it was not.
Q. Was it a hospital -- who were you test-- who were the defendants?
A. The defendants were a hospital and a physician.

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Q. What were your opini-- strike that.
What were your opinions relative to the physician defendant?
A. My opinions were not related to standard of care.
Q. What were your opinions related to?
A. Causation.
Q. Did you find that some malpractice had caused an injury?
A. Well, it was not my duty to determine if malpractice had occurred. It was -- what I was asked to do is to determine if the injuries were related to the procedure or the lack of a procedure in this case.
Q. Did you find that the injuries were related to the lack of a procedure?
A. Yes.
Q. What's the next case that you can remember? Can you tell me about it?
A. Yes. It was a case involving a patient with Rocky Mountain Spotted Fever.
Q. Were you retained by the plaintiff or the defense?
A. I was retained by the plaintiff.
Q. What were your opinions in that case?

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A. In that case my opinion was that this child died as a consequence of Rocky Mountain Spotted Fever.
Q. Were you testifying on causation or standard of care or both?
A. I was testifying on causation.
Q. And you found that there was causation?
A. Yes.
Q. What's the third case?
A. The third case involved a child who developed necrosis, destruction of the nose and the palate as a result of a infection due to a bacteria called pseudomonas.
Q. How old was the patient?
A. At the time of the injury, he was several months old.
Q. Did you testify for the plaintiff or the defense?
A. I testified for the defendants.
Q. What was your opinion in that case?
A. It was my opinion that the cause of the infection could not have been prevented and was not the result of negligence on the part of the physicians.
Q. What's the next case you can remember?

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A. It's a case of a neonate suffering injuries at birth from an infection.
Q. Did you testify for the plaintiff or the defense?
A. The defense -- I'm sorry -- the plaintiffs.
Q. And what was your opinion in that case?
A. My opinion was that the injuries that the child had were the result of a infection due to Group B strep bacteria.
Q. Were you testifying only on causation or standard of care?
A. Causation.
Q. And you found that causation did exist?
A. Yes.
Q. What's the next case that you can remember that you gave a deposition in the past two years?
A. It was a case involving a child who died from a -- following surgery for an abdominal -- abdominal stricture.
Q. How was that related to infectious diseases?
A. It was related as to if this complication was expected or could've occurred and as to whether antibiotics would have made a difference or not.
Q. Who did you testify for?

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A. On behalf of the defendants.
Q. How old is the child who passed away in that case?
A. Maybe four or five years old.
Q. Are there any other cases that you can remember giving depositions in in the past two years?
A. I think there's one more.
Q. Tell me about that one.
A. That I can remember. It was a -- I can't remember the details and it again involved a child who was not treated in a timely manner, diagnosed and treated in a timely manner.
Q. What was the illness?
A. Meningitis.
Q. How old was the child?
A. If I remember correctly less than a year of age.
Q. Were you retained by the plaintiff or the defendant?
A. I was retained by the plaintiff.
Q. Can you remember giving any other depositions in the past two years?
A. I probably have, but I don't remember on behalf of who.
Q. To the best of your recollection, you've

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testified two times at trial as an expert witness. Is that true?
A. That is correct.
Q. And both times were for -- on behalf of the plaintiff?
A. That is correct.
Q. And in the past two years you've given by my count six depositions. Is that -- by your recollection is that true?
A. I think that's the number I said, yes.
Q. And of those is it true that four of those were on behalf of the plaintiffs?
A. That's correct. Of the ones that we counted, yes.
Q. Well, the ones we counted were the ones that you could remember. Correct?
A. That's correct.
Q. And of the ones you could remember, four of the six were on behalf of the plaintiffs?
A. That's correct.
THE WITNESS: Would it be possible to take a quick time-out?
MR. AUSTIN: Sure, sure.
THE WITNESS: Thank you.
THE VIDEOGRAPHER: We're off the

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record at 5:06 p.m.
(Off the record from 5:06 p.m. to 5:15 p.m.)
THE VIDEOGRAPHER: We're back on the record at 5:15 p.m.
Q. (BY MR. AUSTIN) Dr. Correa, just to recap what we've been talking about, is it true that in the past -- well, is it true that you've testified two times at trial as a medical/legal consultant?
A. That is correct.
Q. Both times have been for plaintiffs' counsel?
A. That is correct.
Q. And both of those cases have involved children, one being a one year old and one being a two to three year old?
A. That is correct.
Q. And in the past two years you've given six depositions that you can remember?
A. Yes, that's correct.
Q. Four of those were for plaintiff's counsel and two for defense counsel?
A. That is correct.
Q. And all of those six cases involved children, did they not?

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A. Yes, sir.
Q. Excuse me.
Do you belong to any expert witness referral services?
A. No, I do not.
Q. Do you do any advertising for your medical/legal consulting services?
A. No, I do not.
Q. So is it fair to say that whether you're retained by plaintiff or defense counsel they hear of you through word of mouth?
A. That is very correct.
Q. And I guess like Mr. Martin, you have some repeat customers?
A. Yes, I do.
Q. Earlier we talked about the differences between treating infectious diseases in pediatric patients versus adult patients. Do you remember that?
A. Yes, sir.
Q. And I think you told me there were differences in the antimicrobial drugs that have been approved for adults that might not be approved in children?
A. That is correct.

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Q. And the way children metabolize these antimicrobials might be different?
A. That is correct.
Q. And some diseases are more common in children than adults?
A. That's correct.
Q. Or vice versa?
A. Or vice versa.
Q. Isn't it true that there are also differences in the patients themselves, besides the obvious like pediatrics are kids and adults are adults?
A. No, I don't think so.
Q. For example, a child's resting heart rate is not typically different than an adult's?
A. Yes, it is.
Q. And typically a child will have less urine output than an adult per pound?
A. I don't know that to be true. It depends on the age of the adult and the age of the child, but there may be differences in urinary output. That's one of the things I was trying to point our on how antibiotics may behavior differently in an adult than a pediatric patient.
Q. Besides possible urine output and resting

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heart rate, what other differences are there in the bodily function of children versus adults?
A. Well, there's certainly the -- I guess limit of normal for vital signs are different. That includes blood pressure, respiration, heart rate, et cetera.
Q. How would respirations differ in -- the normal range of respirations differ from children versus adults?
A. Well, in general the younger you are the more breaths per minute that you take.
Q. So in a normal adult would the normal range of respirations be around 20?
A. Even less than that sometimes.
Q. 18 to 22?
A. Anywhere from 14 to 22.
Q. And in children what would that same range be for normal respirations per minute?
A. It depends on the age. It can be as high as 50 times in a newborn to a teenager that has a more similar rate to that of the adult.
Q. The older you get the slower your respirations get?
A. In general, yes.
Q. You mentioned there were some differences

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between children and adults with regard to blood pressure, as well?
A. That is correct.
Q. How do the blood pressures differ?
A. Again, the younger you are the lower your blood pressure in general is, and as you go into adulthood those numbers tend to increase. So what may be high blood pressure for an adult may -- or I'm sorry -- what may be high blood pressure for a child may be completely normal for an adult.
Q. So we've talked about differences in -- when we talk about children versus adults, we've got different resting heart rate. Correct?
A. All of the vital signs may be different.
Q. So different resting heart rate, different respirations, different blood pressures?
A. That's correct.
Q. And you've said that there may be possibly different urinary output?
A. Sure.
Q. Are there other differences in -- when we talk about bodily functions between children and adults?
A. Yes. There -- there -- you know, if we -- we could actually go organ by organ. Obviously the

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digestive system, maybe the transit time, the time that it takes for food to go from the mouth to the stomach and then to the bowel is different in children than in adults.
Q. Is it faster or slower in adults?
A. It depends on the age.
Q. Generally speaking, are pediatric -- you said there was a difference between children and adults, did you not?
A. That is correct.
Q. And what does that mean? Is the transit time faster or slower in kids versus adults?
A. The transit time is typically faster in children than in adults.
Q. What other organs operate differently in children versus adults?
A. Well, virtually all of them do. The vision may be different in an adult than in a pediatric patient, the GI tract, the heart, the lungs, even the kidneys.
Q. Is it fair to say as you just have that virtually all of the organs function differently in children versus adults?
A. Yes. There may be differences in virtually every organ between pediatric and adult patients.

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Q. And we've already discussed the various vital signs that are typically different in children than adults, have we not?
A. That is correct.
Q. Doctor, let me ask you about Deposition Exhibit 3 which is your affidavit. Do you see that?
A. Yes, sir.
Q. And we've referred to that from time to time today, have we not?
A. Yes, yes, we have.
Q. Are all of your opinions that you have relative to this case contained within this affidavit?
A. Allow me to review it again.
Q. Certainly.
A. Yes. All of my opinions are included in -- in this affidavit with the exception of some of the -- the specific questions that Mr. Martin asked.
Q. Generally speaking, though, this affidavit encompasses your opinions in this case?
A. Yes, sir, it does.
Q. And there are opinions that you have relative to this case, generally speaking, that are not in here?
A. That is correct.

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Q. Did you testify earlier that in your opinion the infection that Gloria Bass got in her abdomen was bacterial?
A. Yes.
Q. Now, we can't be sure of that, can we?
A. I am very confident that this was bacterial in nature.
Q. Can we be certain that it was bacterial in nature?
A. I can.
Q. How can you be certain that it was bacterial without blood cultures -- excuse me -- without cultures of what was in her abdomen?
A. Because the other possibility which there is viral or fungal or parasitic are not typically producers of pus, and in this case there was a large amount of pus present. So we can say with the high degree of medical certainty that this was bacterial. In addition, neither of those three would have caused a picture of septic shock and toxic lung.
Q. If you get a viral infection in the peritoneum, that won't cause -- that can't lead to shock lung?
A. No, it cannot -- I don't think that that was my answer. A viral infection of the peritoneum

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does not cause the amount of pus that was found in this case.
Q. Can a viral infection in the peritoneum cause pus at all?
A. Not that I'm aware of.
Q. How about a fungal infection?
A. Yes, it can produce some pus.
Q. How about a parasitic infection, can that cause pus in the abdomen if it gets in the peritoneum?
A. Not the parasites that are found in this country.
Q. Now, let's talk about the actual bacteria. You've surmised -- or you've expressed the opinion that the bacteria that was in Ms. Bass' abdomen originated in the bowel. Is that true?
A. Yeah, that's correct.
Q. And I think you expressed an opinion as to what family of bacteria that might have been in?
A. Yes, sir.
Q. What family is that?
A. Well, the most likely is what we call the enteric gram-negative bacteria.
Q. Is that enterococcus?
A. No. Actually enterococcus is not a

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gram-negative bacteria, but an enterococcus is included among the enteric bacteria. This term enteric means they live within the bowel.
Q. Okay. And are there -- there's a family of enteric bacteria?
A. I guess we don't call them a family. We call them a group.
Q. So there's a group of enteric bacteria?
A. That is correct.
Q. You're not able to tell us, are you, the specific identity of the bacteria that caused that infection, are you?
A. No, I am not.
Q. And the only way to do that would be to have -- would be to take a culture from the pus that was in her abdomen. Is that fair?
A. That is fair.
Q. And that was not done in this case?
A. That is correct.
Q. I think you said earlier that it was your understanding that Dr. Peacock didn't do -- didn't culture the pus because she didn't feel it would be -- the results would be reliable. Is that your understanding?
A. No, because she said that the yield would

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not be reliable.
Q. What does that mean?
A. It means that in order to process a culture appropriately you have to get the swab that you get the pus with and plate it and then put that plate under the appropriate conditions. In this case she would have had to hold onto those plates for a number of days before getting it to the appropriate facility where the appropriate conditions would have occurred. So the word that she used is the yield would not have been sufficient or worth of this test.
Q. In your practice if you want to find out what bacteria is growing in a person's body, what do you do?
A. Well, ideally, if I can obtain a culture that would be the way to do it. However, that's not always possible. Depending on what bacteria I'm looking for, sometimes there are blood tests that can be done, serologic tests that can be done, or you can do some of the newer techniques; one of them is called PCR.
Q. Were any blood tests done on Gloria Bass to determine whether she had bacteria in her bloodstream?
A. Not to my knowledge.

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Q. Did you say earlier that fecal material in the bowel contains bacteria?
A. That is correct.
Q. I think you listed -- you said that was the enteric bacteria?
A. That is correct.
Q. Does that include in that group E coli?
A. Yes, it does.
Q. Did Dr. Peacock's autopsy report reflect any findings of fecal material in Ms. Bass' abdomen?
A. In my opinion, the finding of pus indicates that there was fecal material, but she did not specifically describe it as such.
MR. AUSTIN: Objection; nonresponsive.
Q. (BY MR. AUSTIN) Did Dr. Peacock's autopsy report reflect that she found any fecal material in Gloria Bass' abdomen?
A. No, it did not.
Q. In your opinion, how small a defect in the bowel would it take to release the bacteria to give the result that we had with Gloria Bass?
A. I don't know that I can give you a specific size, but certainly it would have had to be at least a few millimeters in size.

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Q. When you say a few, does that mean three, three to five, two to three?
A. Five to ten.
Q. Which one are you talking about?
A. I mean, you gave me several numbers and my answer was five to ten.
Q. Okay. In order for the bacteria to be released from a defect in the bowel and have the result that we saw with Gloria Bass, you would expect that puncture of the bowel to be 5 to 10 millimeters large?
A. Well, I mean, like I said, there's not a easy estimate to make but I would say yes, somewhere in the neighborhood of, you know, three to five to ten millimeters.
Q. Well, you said five to ten earlier and now you're saying three to five to ten.
MR. MARTIN: Objection; form.
A. I'm correcting my answer. I would say somewhere in the neighborhood of three to ten millimeters.
Q. (BY MR. AUSTIN) Okay. So in order for a defect in the bowel to cause the result that we saw with Gloria Bass, is it your testimony that you would expect that defect to be -- to measure three to ten

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millimeters?
A. I would say that that would be the minimum I would expect it to be.
Q. It could be larger?
A. Sure.
Q. I believe earlier you testified that one possible mechanism of allowing bacteria to get into the peritoneum would be something called translocation?
A. That is correct.
Q. And that means that -- does it not, that bacteria can get into the abdomen simply by means of handling the bowel?
A. That is correct.
Q. Is that because the bowel -- the lining of the bowel is porous to some extent?
A. I would use the word elastic maybe or there's a potential for some gapping of the union of the cells, yes.
Q. It's not unusual, is it, for -- for this translocation to allow bacteria to get into the peritoneum, is it, during surgery?
A. I honestly don't know how frequent it is. I don't think it's a common finding. Otherwise, we would have a large number of infections. I'm sure it

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does occur, but I certainly do not know what that number would be.
Q. My question really was whether it's uncommon. Is it something that is uncommon? I assume if it was uncommon it wouldn't be in your list of possibilities, would it?
A. That is correct.
Q. So it's not uncommon for translocation to cause bacteria to get into someone's peritoneum during surgery. Is that fair?
A. That is correct.
Q. Now, you also mention that translocation can occur from what you called excessive handling of the bowel. Do you recall saying that?
A. I think I did.
Q. Okay. Now, the translocation can occur even in the absence of excessive handling, can it not?
A. It can.
Q. Simply manipulating the bowel, for example, moving the bowel around during surgery, that can cause translocation of bacteria, can it not?
A. Yes, it can.
Q. And then the third possibility that you mentioned as far as bacteria getting into Ms. Bass'

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abdomen would have been contaminated instruments?
A. I think I used contamination in general, but yes, that includes an instrument.
Q. That includes instruments. It also includes bacteria getting into the abdomen by other means, even though the surgeon and the surgical team used aseptic technique?
A. That is correct.
Q. And no matter how hard a surgeon or a surgical team tries to keep a field sterile and to keep the surgery germ free, it does happen, does it not, that sometimes germs still get in the body?
A. Yes, it does.
Q. And people can get infections from that?
A. That is correct.
(Brief interruption.)
Q. (BY MR. AUSTIN) Is it true that you believe that the perforation of the bowel is a more likely cause than these other possibilities?
A. Yes, it is.
Q. Are they all likely and perforation is just more likely?
MR. MARTIN: Objection; form.
A. No. I think that if I was going to use a percentage I think that it's 95 plus likely that it

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was from perforation, and it's unlikely that it was from translocation or contamination.
Q. (BY MR. AUSTIN) Why is it that you've chosen perforation of the bowel as the most likely culprit in this case?
A. Based on how rapidly this disease progressed and the amount of pus that was encountered. If -- if this had been translocation as you pointed out something that does occur but it means that one or two bacteria have gotten access to the abdominal cavity, it would take several days for the bacteria to replicate and cause the damage that it caused in Ms. Bass. A similar thing would happen with a contaminated wound. In a contaminated wound -- or sorry. From contamination you would expect to see maybe a local infection at the wound site but certainly not the degree of peritonitis and sepsis that this patient had within a matter of 48 hours or less.
Q. Was it your testimony that infection from surgery is a known risk of any surgery?
A. Yes, it is.
Q. And that can happen even in the best of care?
A. Absolutely.

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Q. Just because an infection happens from a surgery does not mean that the surgeon was negligent. Is that fair?
A. That is correct.
Q. Likewise, it is your understanding that during surgery instruments can and sometimes do puncture a patient's bowel?
A. That is correct.
Q. And that is, again, something that just happens even in the greatest of care?
A. That is correct.
Q. Simply because if an instrument does puncture the bowel, that does not in and of itself mean that the surgeon was negligent, does it?
A. That is correct.
Q. Do you find any fault with Dr. Peacock's autopsy?
A. No, I do not.
Q. Do you think that she performed it properly from what you can glean by reviewing the report?
A. From my knowledge as a physician I believe that her autopsy was appropriate, and I do not see any fault in her procedure.
Q. Or her findings?
A. Or her findings.

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Q. And you know -- you're aware that she did not find any defect in the bowel. Correct?
A. I'm aware that she did not specify that there was a defect in the bowel. That's correct.
Q. If she had found a defect in the bowel, would you -- wouldn't you expect it to be in her report?
A. Yes, I would.
Q. And that's not in there, is it?
A. That is correct.
Q. When Mr. Martin was asking you questions I think you said that in order to generate the amount of pus that was found in Ms. Bass' abdomen you'd need, and these are your words, a large amount of bacteria. Do you remember saying that?
A. Yes, sir.
Q. And I believe you described that as a visible amount of bacteria.
A. What I meant was a visible amount of bowel content, not -- the bacteria itself is not visible, that's by definition, but I meant the amount of bowel content that came through that defect.
Q. In other words, to produce the result that we saw with Gloria Bass you would expect actual fecal material -- a visible amount of actual fecal material

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to be in the peritoneum?
A. Not necessarily fecal material. It's bowel content. Depending on what part of the bowel is perforated, the consistency can be different. I think when I talk about fecal material or when we use the term fecal material, that has to do with the large intestine, the large bowel. The smaller bowel depends on what state you are. The upper part of the small bowel contains basically still unprocessed food or partially digested food, so the concept of fecal material has to be carefully used here. I think that bowel content would have been a better choice -- a better word.
Q. To get the result that we saw in Gloria Bass' abdomen, you would expect to see a visible amount of bowel content in the abdomen. Is that true?
A. That would be my expectation, yes.
Q. Did you note anywhere in Dr. Peacock's report where she says anything about bowel content?
A. I would not have expected to see it in Dr. Peacock's report but on Dr. Grayson's operative report. That's where I would expect that it would have been visible.
Q. Did you see anything in Dr. Peacock's

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report about her noting seeing any -- any visible bowel content in the abdomen?
A. No, she couldn't. The bowel was covered with pus.
MR. AUSTIN: Objection; nonresponsive.
Q. (BY MR. AUSTIN) Does Dr. Peacock's report say anything about her having seen visible bowel content during her -- during her autopsy?
A. No.
Q. Now, Dr. Grayson was the surgeon who was actually there performing the surgery. Correct?
A. That is my understanding.
Q. Now, by convention -- I realize you're not a surgeon, but by convention if something happens like a -- if a surgeon knows that there's been a puncture to the bowel, that's typically noted in the operative report, isn't it?
A. That's correct.
Q. And have you read -- you've read Dr. Grayson's deposition?
A. Yes, I have.
Q. Have you seen where he says nothing about knowing anything about a puncture of the bowel during this procedure?
A. Yes, I have.

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Q. And you've certainly seen in his operative report where he mentions nothing about having punctured the bowel?
A. That is correct.
Q. You're not suggesting, are you, that he knew that he punctured the bowel but didn't put it in his report, are you?
A. No, I'm not suggesting that.
Q. And if Dr. Grayson had seen a visible amount of bowel contents during his procedure, wouldn't you expect him to have put that in his operative report?
A. Yes, I would.
Q. I believe you testified earlier that the severed artery created, these are your words, the perfect place to grow. Can you explain what you mean by that?
A. Yes, I can. The severed artery now meant that anything distal to that artery was not getting appropriate blood supply. So now --
Q. Let me cut you off there. When you say distal do you mean downstream?
A. Downstream, that's a better way to say it. Anything downstream from that artery was not getting appropriate blood supply. So now you have tissue

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that is dying or is dead that becomes the perfect grow media for any bacteria. You have a place where there's still nutrients, there's still food for the bacteria to grow, and at the same time it's an area that goes unchecked by the immune system. So that is the perfect place for the bacteria to proliferate and grow.
Q. In order for the bacteria to proliferate and grow, feeding on you're talking about the necrotic ovary?
A. That is correct.
Q. Okay. In order for the bacteria to propagate and grow because of this ovary, would they not have to be in -- the bacteria would have to be in contact with that ovary, would they not?
A. That is correct.
Q. Do we know -- you've speculated or -- strike that.
You've expressed the opinion that you believe there was a puncture to the bowel. Correct?
A. Yes, sir.
Q. Do you know where that puncture to the bowel occurred?
A. No, I do not.
Q. If the puncture to the bowel occurred on

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the other side from the necrotic ovary, would that have any effect on your opinions?
A. No, it would not.
Q. How would the bacteria from the other side of the body, the other side of the abdomen get to the side where the necrotic ovary was?
A. Well, even though I'm saying that the ovary was the perfect grow place, the bacteria had also been growing in the other side, if that was indeed the case. The peritoneum extends throughout all the abdominal cavity. So the bacteria because as I have said, I opine that it is -- was in large amount, it prob-- very, very rapidly spread from one side to the other of the abdomen and then found the ovary as the perfect place to grow further and to invade the bloodstream.
Q. You believe that the infection that she had in her abdomen grew quickly and spread to that necrotic ovary?
A. Yes.
Q. So even if that necrotic ovary were not present, the bacteria in Ms. Bass' abdomen would still have spread quickly?
A. I think it would have spread. I don't know that it -- I do not think it would have spread as

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quickly.
Q. But you said it spread quickly to the ovary, did you not?
A. Well, yes, but not to the extent where you would see a liter of pus.
Q. How much pus do you think would have been in Ms. Bass' abdomen under the same circumstances if we take away the necrotic ovary?
A. I don't know that I can give you a guess. I would say certainly less than what was found.
Q. How much less?
A. I cannot give you a number.
Q. Even without the necrotic ovary you would still have a infection that was spreading and creating pus. Correct?
A. Yes, sir.
Q. And by your testimony it would even spread quickly, would it not?
A. That's correct.
Q. It would just spread more quickly -- it began to spread more quickly once it got to the necrotic ovary?
A. I think that it was the case.
Q. Now, I'm not a physician. So as a layperson can you explain to me how it is that

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bacteria -- I think you've told us that you think the bacteria that were proliferating in Mrs. Bass' abdomen gained access to her bloodstream via the ovarian artery. Is that true?
A. The severed ovarian artery, uh-huh.
Q. Can bacteria -- well, as I understand it from my high school biology, the blood is flowing away from the heart through the arteries. Is that in a nutshell correct?
A. That is correct.
Q. And then it flows back to the heart through the veins?
A. That is correct.
Q. If -- so the blood is running -- in the ovarian artery is it running away from the heart?
A. It's running away from the heart.
Q. Can the bacteria go -- for lack of a better term, can the bacteria swim upstream?
A. Yes, it can, but a more likely mechanism is if you interrupt the flow on the side, the blood doesn't just stop there. It will go back and find another pathway. And that's the most likely mechanism by which it found other places or it went into the bloodstream in other sites. In addition, the artery itself, the walls of the artery have blood

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vessels, have veins that will eventually go back to the heart, carry blood that goes back to the heart. And then finally the distal part, the part that was downstream that has been severed also will continue to have blood being taken away from it. Even though it has very limited blood coming into it, the veins are much more than the arteries. There's usually just one artery and there's many veins coming out of the same place. So the bacteria can also gain access from that downstream place.
Q. There's no blood flowing through the distal portion of the severed artery, is there?
A. There's very little blood flowing.
Q. If it's connected from the -- if it's disconnected from the upstream portion of the artery, how can blood still be getting pumped through that ovarian artery?
A. Because there's always a small amount of collateral circulation. There's always the possibility I guess of collateral circulation. But again, I don't think that's the most likely scenario here. I was just trying to present to you the different scenarios where this -- how this could have happened.
Q. What is the most likely scenario?

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A. The most likely scenario was that by severing the artery, the bacteria that was in the abdominal cavity found an open door in which to get access to the bloodstream.
Q. Is the open door you're talking about the upstream portion of the severed artery?
A. It would be the upstream portion of the severed artery.
Q. Now, if you have a severed artery, would you expect to find bleeding?
A. Not necessarily. It depends on which way it was severed.
Q. Well, in this case if an artery was severed you said there was still some collateral circulation that would be going through the vessel. Is that right?
A. I said it's a possibility. I don't know in this particular case.
Q. So you don't know if the blood would still be running through the artery?
A. Again, very specifically, you're asking me collateral circulation, means an organ, and then you ask me to the artery. If you're asking me will blood still be running through the artery, yes, to the part that is upstream of where the severance occurred.

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Q. Right. To the point where it was cut?
A. That's correct.
Q. And if it's severed wouldn't you expect blood to spill out of that artery into the abdominal cavity?
A. It would depend on how -- which way it was severed. If it was a clean cut severance with a knife, yes, you would expect to see blood coming out of there. However, if the severance occurred by a laser or an electric mechanism, something that will cauterize, that will close that opening, then you may not see any bleeding.
Q. Did you see any reference in Dr. Grayson's operative report that he was using any lasers during this procedure?
A. No.
Q. Was he using any electrocautery devices?
A. I believe so.
Q. During -- in the procedure in the abdomen?
A. I -- I cannot recall specifically.
Q. Okay. So -- so let's assume that he was not taking -- using electro-- if we assume that he was not using a laser or an electrocautery device, is there any other way that the -- you can sever an artery and not have blood spilling out of the

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upstream portion of the artery?
A. Yes. If the artery was confused or taken with the ovar-- with the fallopian tube, it is very possible. In fact, I think that that was a high possibility that he put a clip or a device to prevent blood flow thinking that he was clipping just the ovarian tube, and then when he cut on the ovarian tube then he cut on the artery; but you had interrupted the flow already upstream.
Q. Via the clip?
A. I don't know what he used in his specific procedure. It could be a clip, it could be a rubber band. There's different techniques.
Q. Well, you don't know at all if he clipped the ovarian artery or --
A. I do not know at all.
Q. And you don't know if he put a rubber band on it?
A. I do not know.
Q. Or a clip or anything?
A. I do not know.
Q. If he did clip the ovarian artery or put a band on it, would that not close off the upstream portion?
A. No, it would not.

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Q. It wouldn't prevent blood from coming out of the artery?
A. The blood will continue to flow into that area, except that once it found a dead end it will return and go back upstream.
Q. And how did the bacteria get into that dead end?
A. How did the bacteria get into the dead end? Well, it's -- he had just opened the door for it by severing the artery.
Q. Well, if it's clipped off so that the blood can't get out, how did the bacteria get in?
A. Well, the clip is far from being perfect, you know. It is not a complete clipping to a microscopic. I mean, you have now tissue that is -- the clipping is enough to prevent a very -- a clear flow of blood, but it certainly will allow the bacteria to go back in. And again, it's not necessarily that it went directly to the artery but it could have gone in one of the blood vessels that take blood or take blood away from the wall of the artery.
Q. In this case, since no electrocautery device was used and since no laser was used, would you expect to see bleeding in the abdomen?

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A. Umm...
Q. If the ovarian artery was severed?
A. If the ovarian artery was severed and there was no mechanism to cauterize or to close that opening, yes, I would have expected to see so.
Q. Did you see any mention in Dr. Townsend -- excuse me -- in Dr. Peacock's report about bleeding in the abdomen?
A. I would not have expected to see it in her report but in Dr. Grayson's report.
MR. AUSTIN: Objection; nonresponsive.
Q. (BY MR. AUSTIN) Did you see anything in Dr. Peacock's report about blood, free blood in the abdomen?
A. No, I did not.
Q. Did you see anything in Dr. Peacock's report about any clotting relative to the ovarian artery?
A. No, I did not.
Q. Doctor, did you say earlier that your treatment area involves treating patients who are known or suspected to have infectious diseases?
A. I think I said that was one of my areas. I also treat and diagnose patients with noninfectious

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problems.
Q. Part of your practice area, then, is involved in treating patients who are known or suspected to have infectious diseases?
A. That's correct.
Q. And you can't treat an infectious disease until you know it's there, can you?
A. Well, I disagree. We very often treat empirically for infections that we suspect or consider as possibilities.
Q. What are some of the things that you look at to tell you -- that raise your suspicion or tell you that there's a possibility that there's an infection?
A. It depends on what organ or what site you're thinking of.
Q. Well, in this case with Gloria Bass, what symptoms would you have expected to see in her indicating that she had an infection going on in her abdomen?
A. I would certainly have expected to see abdominal pain. I -- you could have seen fever, an elevated white count and --
Q. Poor appetite?
A. That's a possibility, sure.

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Q. What else would you expect to see in a patient that had an abdominal infection going on like Ms. Bass?
A. Well, in her case at the terminal stages you could expect to see alteration in consciousness and profusion in blood pressure related to the septic shock that she was on. But earlier I would have expected to see, again, abdominal pain which I believe she did have. You may have expected to see discomfort when using the restroom or having a bowel movement. Certainly you may have seen discomfort in certain positions such as when bending over or getting up from laying flat on your back. And again, the ones that I had mentioned, a fever or if you did a blood count, maybe an elevated blood count.
Q. Aren't there maybe other factors that you can look at to see -- that would tip you off that there's an infection going on in the bowel --
A. Well --
Q. -- excuse me -- in the abdomen?
A. In terms of examinations, definitely. I mean, the tenderness when you palpate the abdomen, when you push on the abdomen. You could, again, look at changes in heart rate or blood pressure or temperature as I had mentioned earlier. Sometimes

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you can see changes in the skin or you may be able to find an infection that's likely to be occurring by doing a blood culture or doing an abdominal ultrasound or a CAT scan. Unfortunately in this case none of those tests were done.
Q. Is there anything else you would expect to see in a patient such as Gloria Bass if she had an abdominal infection going on, things that would tip you off to let you know that an infection was in her abdomen?
A. Other than the ones I mentioned, you know, certainly you can see all kinds of things but those are the ones that I would expect to see.
Q. Did she have -- was her temperature outside normal limits for a patient in the postsurgical arena?
A. Her temperature outside of where?
Q. Let me rephrase that. Prior to her discharge from the hospital, did Gloria Bass have a temperature that was higher than you would expect to see from a patient in the postoperative period?
A. Not that I recall.
Q. Did she have an elevated white count?
A. I -- if you'll allow me to look at the records very quickly. I do not recall seeing a white

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count done in the postop period.
Q. What would a normal white count be in the postoperative period in a patient such as Gloria Bass?
A. Somewhere between 5,000 and 15,000.
Q. If Gloria Bass' white count the morning after surgery was 8500, is that normal?
A. That is normal.
Q. Did you see any indication in the records that Ms. Bass' heart rate was above or below normal limits after the surgery?
A. No, I did not see any such indication.
Q. Did you see any indication that Ms. Bass' respirations were above or below normal limits in the postoperative period?
A. No, I did not.
MR. AUSTIN: Read the last question back
(Requested portion was read)
Q. (BY MR. AUSTIN) Dr. Correa, did you see any indication that Ms. Bass' blood pressure was above or below normal limits in the postoperative period?
A. Not that I recall.
Q. You did see -- I believe you mentioned that

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you think Ms. Bass had some abdominal pain in the postoperative period?
A. Yes, I did.
Q. Would you expect a patient who had had a laparotomy and had their abdomen opened up to have pain in the postoperative period?
A. Yes, I would.
Q. Did you see any indication that Ms. Bass had pain in your opinion above and beyond what you'd expect from a patient who had just undergone a laparotomy?
A. I do not have an opinion.
Q. Okay. So you do not have an opinion as to whether she had pain above and beyond what a normal patient would have. Is that correct?
A. That's correct.
Q. And you saw no indication of fever?
A. That is correct.
Q. If the white count was 8500, you see no indication that the white count is elevated?
A. That is correct.
Q. You saw no indication that her heart rate was above or below normal limits?
A. That is correct.
Q. No indication that her blood pressure was

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above or below normal limits?
A. That is correct.
Q. No indication that her respirations were above or below normal limits prior to discharge?
A. That is correct.
Q. Are you critical -- strike that.
Are you aware that the morning after the surgery that Saturday -- strike that.
Are you aware that the Saturday after the surgery Dr. Grayson was actually off?
A. I remember reading it from his deposition.
Q. And that he was -- are you aware that Dr. Konop was actually covering for him?
A. Yes, I do.
Q. Are you critical of Dr. Grayson or Dr. Konop -- well, strike that.
Do you believe that Dr. Grayson or Dr. Konop failed to see signs or symptoms of infection in Gloria Bass?
A. No, I have not formulated an opinion as to whether they did see or not any symptoms of infection.
Q. So you're not of the opinion that there were symptoms there that went undiagnosed whether by Dr. Grayson or Konop. Is that true?

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MR. MARTIN: Objection; form.
A. What I answer is I don't have an opinion one way or the other.
Q. (BY MR. AUSTIN) Okay. You have no opinion one way or the other as to whether Dr. Konop or Dr. Grayson failed to appreciate or evaluate signs of infection in the postoperative period?
A. That is correct.
Q. Do I understand your opinion correctly that if we take away the severed bowel -- excuse me. Strike that.
If we take away your belief that the bowel was punctured and if we take away your belief that there was a severed artery there would be no need for antibiotics in the postoperative period. Is that true?
A. If we take away those two factors, that is correct.
Q. So in a patient who has a -- strike that.
In a patient such as Gloria Bass who undergoes an attempted tubal ligation by laparoscopy that's later converted to a laparotomy, you do not believe that if that surgery goes according to plan and if there's no indication of complications that that patient need antibiotics in the postoperative

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period?
MR. MARTIN: Objection; form.
Q. (BY MR. AUSTIN) That was a terrible question. Let me rephrase that.
Do you believe that all patients who have tubal ligations that start by laparoscopy and end by laparotomy need to have antibiotics in the postoperative period?
A. No, I do not.
Q. But patients here where you feel like there was a punctured bowel and a severed ovarian artery require antibiotics in the postoperative period?
A. I think that if the -- there is a possibility that a punctured bowel occur or that a severance of the ovarian artery occur, that antibiotics are indicated, postop antibiotics are indicated.
Q. Isn't it always a possibility that a bowel has been punctured or that other complications have occurred during a surgery?
A. I think that it depends on the surgeon. There's certainly many qualified surgeons that do not consider that perforation has occurred.
MR. AUSTIN: Objection; nonresponsive.
Q. (BY MR. AUSTIN) Didn't you tell me earlier

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that a puncture to the bowel is a known risk of a surgical procedure?
A. Yes, it is.
Q. And if it's a known risk, then doesn't that mean that there's always a possibility that the bowel will be punctured during a surgery?
A. Yes.
Q. And it is true, isn't it, that sometimes when surgeons do surgery in the abdomen and then close up the abdomen, sometimes it happens that that -- that a puncture to the bowel isn't known at that time?
A. Absolutely.
Q. And we don't know until maybe hours or days later that there's actually been a defect in the bowel. Is that true?
A. That is correct.
Q. I want to make sure I understand your testimony. Is it the possibility of a punctured bowel in combination with the possibility of a severed ovarian artery that leads you to think that Ms. Bass should have had antibiotics in the postoperative period?
A. No. It is one or the other or both. I think that it comes down many times to a judgment

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call. The physician knows that his surgery, his planned surgery is not going according to plan. He knows that the patient is obese, that there is the possibility that at the time of the introduction of the laparoscope a bowel puncture could have occurred, then a consideration for postop antibiotics needs to be made on a case by case.

Q. Does that mean that every time an obstetrician or gynecologist encounters difficulty with a laparoscopy, that he then needs to give the patient antibiotics in the postoperative course?

A. No, it does not.

Q. Okay. So your belief that this patient should have had antibiotics in the postoperative period turn on, one, the possibility of a punctured bowel, and two, the possibility of a severed artery, or either of those independent of each other?

A. That is correct.

Q. So if we take away the severed artery, she still -- you think she still should have had antibiotics?

A. I think that if he considered that a puncture could have occurred, yes.

Q. If Dr. Grayson thought that he had possibly punctured the bowel, then he should have given her

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antibiotics?

A. Yes, sir.

Q. And if Dr. Grayson didn't think that he had punctured the bowel, is it appropriate in your opinion that he did not order antibiotics?

A. That is correct.

Q. Same with the severed artery. If it's Dr. Grayson's belief that he had possibly severed the artery, then he should have given her antibiotics?

A. Yes, in addition to -- and I don't know the details, but fixing or consulting somebody about how to repair that.

Q. And if Dr. Grayson did not see or believe that there was a severed artery, you don't fault him for not ordering antibiotics, do you?

MR. MARTIN: Objection; form.

MR. AUSTIN: What's the objection.

MR. MARTIN: He's not qualified to testify as to the standard of care of an OB/GYN and all your question --

MR. AUSTIN: He's been doing it all day.

MR. MARTIN: No. He's talking about causation and he's talking about when antibiotic therapy is appropriate from an infectious disease

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standpoint. If you want to take it another way, you're welcome to.

Q. (BY MR. AUSTIN) Let me rephrase that. If Dr. Grayson did not see a severed artery or believe that he had severed the ovarian artery, do you fault him for not ordering antibiotics in the postoperative course?

MR. MARTIN: Objection; form.

A. I believe that that question has to do with standard of care, and I am not qualified to give you an opinion.

Q. (BY MR. AUSTIN) So you don't feel qualified to say whether Dr. Grayson should have ordered antibiotics in the postoperative period in the presence of the possibility of a severed artery?

MR. MARTIN: Objection; form.

A. Would you please repeat the question?

Q. (BY MR. AUSTIN) I'll rephrase that. I'm trying to get a handle on what you don't feel qualified to answer. Is it that -- let me back up. I think you said earlier that if there's a possibility of a punctured bowel, you think antibiotics should have been ordered. Is that true?

A. Yes.

Q. And you're expressing an opinion based on

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something that Dr. Grayson -- that you think Dr. Grayson should have done. True?

A. No. I'm basing it on any case where there is the possibility that the bowel was punctured, antibiotics are indicated.

Q. In Gloria Bass' case do you believe that Dr. Grayson should have ordered antibiotics in the postoperative period if he believed that there was the possibility of a punctured bowel?

A. In that case as you're asking me as to standard of care, I do not have an opinion.

Q. Okay. And same question with regard to the severed artery. If Dr. Grayson believed that there was a possibility of a severed artery, should he have ordered antibiotics in the postoperative course?

A. Again, specifically as to Dr. Grayson in this particular case, I do not have an opinion.

Q. Do I understand you correctly that you have no opinion as to whether Dr. Grayson should or should not have ordered antibiotics in the postoperative care of this patient?

A. That is correct.

Q. Let's say hypothetically you had been consulted on this case.

A. Yes.

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Q. While the patient was still in the hospital.
A. Okay.
Q. What antibiotics would you have ordered?
A. If I had been consulted and told what the difficulties of the surgery had been, I could have chosen maybe 20 to 25 different combinations. My personal preference would have been ampicillin, gentamicin and clindamycin.
Q. Okay. Let's say you've been consulted on this case before anyone knows that there's actually an infection in Mrs. -- in Ms. Bass' abdomen. Okay?
A. Okay.
Q. So let's say in the postoperative period if someone just thought there was a possibility that Ms. Bass had a punctured bowel and a possibility that she had a severed ovarian artery, would you as the consulting infectious disease physician put her on antibiotics?
A. Yes, I would.
Q. Would you put her on oral or intravenous?
A. Intravenous.
Q. And would she have stayed in the hospital?
A. Yes, she would.
Q. For how long?

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A. Until you determine whether an infection has occurred or not.
Q. How can the infection occur if she's on antibiotics?
A. That still can happen. It has to do with the number of bacteria, whether the bacteria are susceptible or not, and whether the bacteria are hiding in a place where antibiotics are not reaching it.
Q. Where do -- where would antibiotics -- excuse me -- where would bacteria hide where they can't be reached by antibiotics?
A. Most commonly in dead tissue, necrotic tissue.
Q. Like the ovary in this case?
A. It's possible.
Q. Can antibiotics get to the -- let's say you've got an infection causing pus in the peritoneum like Ms. Bass had.
A. Yes.
Q. Can -- are there antibiotics that can get to that area and fight that infection?
A. Yes, there are.
Q. Don't antibiotics work in the bloodstream?
A. No. They actually work on the tissue.

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Q. In the perito-- if the bacteria are propagating in the peritoneum, that's not actually in the tissue? Not all of it is in the tissue, is it?
A. That's correct.
Q. Now the part of the bacteria that's getting into the tissue, now that's treatable with antibiotics because the bloodstream can reach it. Is that fair?
A. Yes.
Q. But the bloodstream doesn't reach the bacteria that are free-floating in the peritoneum, do they?
A. No, that's incorrect. There is also an amount of antibiotic that will go into the free-flowing fluid. It is only the one that is able to find dead necrotic tissue that can on occasion hide from the antibiotics.
Q. So if there's a infection flourishing in necrotic tissue, that can't be reached by an antibiotic?
A. It may not.
Q. In this case if you've got a bacteria that is propagating and growing in the abdomen including with a necrotic ovary because there are portions of that infection that will not be able -- may not being

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able to be reached by antibiotics. Is that true?
A. That is true, but by the same times the antibiotics would have been able to reach the bacteria that was propagating on her bloodstream, thus preventing her demise.
Q. And if the antibiotics can't reach the necrotic tissue, would that bacteria continue to grow?
A. It is possible.
Q. And that would continue to propagate in her abdomen?
A. Sure.
Q. And that would cause symptoms like we talked about earlier?
A. Yes, sir.
Q. Okay. Did I understand you correctly that you're not expressing opinions relative to the standard of care for Dr. Grayson as a obste-- obstetrician and gynecological surgeon?
A. That is correct.
Q. You're not qualified to do that, are you?
A. That is correct.
Q. You haven't had any residency training in obstetrics or gynecology?
A. That is correct.

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Q. Have you had any residency training in surgery?
A. No, I have not.
Q. You're not board certified in surgery, are you?
A. I am not.
Q. And you're not board certified in obstetrics or gynecology?
A. I am not.
Q. Have you ever performed a laparoscopic tubal ligation?
A. No, I have not.
Q. Have you ever performed a tubal ligation by laparotomy?
A. I have assisted in some of them.
Q. Was that during your early medical training?
A. That is correct.
Q. You haven't done that since 1990, have you?
A. Since 1986.
Q. Paragraph 4 of your affidavit says, "From an infectious disease standpoint, the standard of care in antibiotic therapy was to provide Ms. Bass with antibiotics after the surgery, because of the nature of the surgery, the increased risk of bowel

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perforation and the severed ovarian artery." Do you agree with that?
A. Yes, I do.
Q. You would not hold Dr. Grayson to that standard, would you?
MR. MARTIN: Objection; form.
A. I don't understand what you mean by that.
Q. (BY MR. AUSTIN) You understand that Dr. Grayson is not an infectious disease specialist?
A. I do understand that.
Q. And you're testifying as to what you would expect an infectious disease doctor to do?
A. That is correct.
Q. You're not testifying as to what you would expect Dr. Grayson to have done under these circumstances?
A. No, that's not correct. I'm -- I'm testifying as to from an infectious disease standpoint, not from an infectious disease expert but from infectious disease -- disease standpoint. The administration of antibiotics was indicated in light of the factors that you have mentioned.
Q. But you've already said that you're not going to testify on the standard of care for Dr. Grayson. True?

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A. That's correct.
Q. So you're not faulting him for not ordering antibiotics, are you?
MR. MARTIN: Objection; form.
Q. (BY MR. AUSTIN) You're not expressing any opinion one way or the other on whether Dr. Grayson should have ordered antibiotics. Is that true?
A. That's correct.
Q. On the other hand, had there been an infectious disease physician consulted on this case, that's what you would expect that physician to do?
A. That is correct.
Q. Would you agree with me -- strike that.
We went through the various symptoms that you would expect to see in a patient such as Gloria Bass if she had an intraabdominal infection. Do you recall that?
A. Yes.
Q. And I think you said you had no opinion as to whether her pain was greater or lesser than you would expect a normal patient in the postoperative period?
A. That's correct.
Q. To your knowledge, did she have any symptoms prior to discharge that would have indicated

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that she had an intraabdominal infection?
A. I have not given my opinion as to whether she had any symptoms or not.
Q. Do you not -- do you have an opinion?
A. No, I do not.
Q. Do you have an opinion as to when Ms. Bass would have begun to exhibit symptoms of an intraabdominal infection after her discharge?
A. No, I do not.
Q. Well, this is a woman who had a thousand -- roughly a thousand cc's of pus in her abdomen?
A. That is correct.
Q. That's a pretty severe infection? By your own testimony that's a pretty severe infection?
A. Yes, sir.
Q. Would you not expect to see a patient with an infection like that to have very high fever?
A. Not necessarily.
Q. In all medical probability, though, a patient with that sort of infection would have high fever, wouldn't they not?
A. At least at some point, yes.
Q. Fever in excess of a hundred degrees?
A. Sometimes, yes.
Q. Would that patient have -- would you expect

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to see that patient have severe abdominal pain, too?
A. Yes, I would.
Q. Decreased appetite?
A. Possibly.
Q. Decreased urine output?
A. Not necessarily.
Q. Would you expect a patient with an infection like Ms. Bass had to have -- to just overall feel -- have general malaise and feel bad?
A. Yes, I would.
Q. When would you expect the onset of those symptoms to occur? For example, in this case Ms. Bass went to the hospital, returned to the emergency room I believe shortly after 10:00 a.m. on Sunday morning, June 8th, and she had collapsed prior to that. Do you have any opinion as to how long before she collapsed you would expect to see those symptoms?
A. No, I do not.
Q. None whatsoever?
A. None whatsoever.
Q. Do you think she'd have a fever even five hours before she collapsed?
A. It is possible.
Q. Isn't it likely?

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A. Not necessarily. Sometimes these infections go the other way. They may cause low temperature depending on how overwhelming the infection is.
Q. Do you know one way or the other whether Ms. Bass had fever on the morning before she went to the hospital on June 8th?
A. No, I do not know.
Q. Do you have any knowledge as to whether she had abdominal pain before she went to the hospital on June 8th?
A. My recollection is that she did have abdominal pain.
Q. Where -- where did you get that information?
A. If I remember correctly it's from the deposition of Dr. Grayson.
Q. If Ms. Bass was going to have a fever that went along with this infection that she had, when would you have expected her to have it?
A. Anytime before her death.
Q. Did you see where Dr. Peacock said that Ms. Bass would likely be exhibiting symptoms of her infection 12 to 24 hours before her death?
A. I don't recall that specifically, but I

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wouldn't be surprised if she said so.
Q. Do you disagree with that?
A. Yes, I do.
Q. Tell me why or tell me with what part of that opinion do you disagree.
A. I disagree because I don't think anybody could give a time frame of when she would have the symptoms. This was a overwhelming, rapid-progressing infection that may have exhibited symptoms five minutes before she collapsed or 12 hours before she collapsed. There's just no way of knowing especially since we don't have a monitoring that occurred during that time period and there was not somebody taking her temperature or heart rate or respiratory rate during that time. It's pure speculation as to when she could have shown the symptoms.
Q. It's not medically likely, is it, that she exhibited symptoms five minutes before she collapsed, is it?
A. I don't think so.
Q. Isn't it more likely that she exhibited symptoms of her infection hours before she died?
A. It is.
THE VIDEOGRAPHER: Mr. Austin, excuse me. We've got about two minutes left on this tape.

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MR. AUSTIN: Okay. Yeah. Go ahead and change it.
THE VIDEOGRAPHER: We're off the record at 6:30 p.m.
(Off the record from 6:30 p.m. to 6:36 p.m.)
THE VIDEOGRAPHER: We're back on the record at 6:36 p.m.
Q. (BY MR. AUSTIN) Dr. Correa, is it your understanding or your belief that the patient died from, what is it called, is it acute respiratory distress syndrome?
A. Adult respiratory distress syndrome.
Q. Do you think she died of adult respiratory distress syndrome?
A. I think she had adult respiratory distress syndrome based on the autopsy report. I think she died from sepsis and peritonitis.
Q. Can you have -- is it possible to have adult respiratory distress syndrome without having bacteria in the bloodstream?
A. Yes.
Q. That's not unusual, is it?
A. It is unusual but it's possible.
Q. It's unusual to have ARDS without a

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septicemia?
A. You can have ARDS from other causes.
Q. All right. My question is: Is it unusual to have ARDS without a septicemia?
A. It is unusual.
Q. But that's something that can happen?
A. It can happen.
Q. Would the only way to know whether there was bacteria in Ms. Bass' blood be from a blood culture?
A. Yes.
Q. You're not aware of any blood cultures that were done?
A. No, I am not.
Q. Is the -- you're not testifying on the standard of care for Dr. Grayson. We've covered that at length, have we not?
A. We have.
Q. And you agree with that?
A. Yes, sir.
Q. But you are here to testify about causation meaning that the bacteria, however it got into Ms. Bass' abdomen, got into her blood via the severed artery?
A. That is correct.

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Q. Is that a fair summary?
A. Yes, it is.
Q. And the severed artery, then, is important to your opinion, is it not?
A. Yes, it is.
Q. What's the difference between severed and ligated from a surgical standpoint?
A. Well, being that I'm not a surgeon, I can give you what my interpretation is. Ligation just means there's something interrupting the flow. There's -- ligas is actually Latin or the root ligas means rubber, like rubber band. And so it's something just interrupting the flow, and it could be string like suture string or suture material. It could be, again, a rubber band or a piece of plastic or a clip. Severance means that there's actually interruption, that there is a cut.
Q. Now, before you started giving me that explanation, you qualified that to some extent by saying that you're not a surgeon. Correct?
A. That is correct.
Q. Why did you do that?
A. Because the terms that you're asking me to define are terms that a surgeon will be more qualified to discuss, and that's why I qualified that

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this was my opinion as a general physician.
Q. Would you expect a surgeon such as Dr. Grayson to know the difference between ligation and severance?
MR. MARTIN: Objection; form.
A. I would expect so.
Q. (BY MR. AUSTIN) Would you expect Dr. Peacock to know the difference between ligation and severance?
A. Yes, I would.
Q. And it is your understanding that ligation, if I understand correctly, means something that has interrupted the flow?
MR. MARTIN: Objection; form.
Q. Yeah. I kind of believe that. What did you say?
MR. MARTIN: Objection; form.
A. In a blood vessel, yes, after they have interrupted the flow or the lumen if it's something else. Now, you can have ligation and severance. In fact, that's the most common situation. You first ligate and then you do the severance or cut or interruption, whatever term you want to use.
Q. (BY MR. AUSTIN) At any rate when we're talking about a blood vessel ligation means something

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that is interrupting it, something tied off, like string or clipping it like a clip?
A. That's correct.
Q. Whereas severance means dividing it into two parts?
A. Sure.
Q. Or more parts if you have more than one severance?
A. Sure.
Q. There's a clear difference, is there not?
MR. MARTIN: Objection; form.
A. In my opinion, yes.
Q. (BY MR. AUSTIN) Are you familiar with Dorland's Medical Dictionary?
A. I've heard the name.
Q. Is that something that you use in your practice?
A. I don't think I've ever used it.
Q. You're familiar with it as a text, as a medical dictionary?
A. Sure.
Q. Would you believe it -- would you believe the definitions that are in here?
A. I -- since I've never used it, I don't know if I would believe them or not.

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Q. Okay. Let me read you a definition and see if you agree. Dorland's defines to ligate as "to tie or bind with a ligature." Do you agree with that?
A. I think that's what I said in other words.
Q. Do you agree with that?
A. Yes.
Q. And then ligature is defined, tell me if you agree with this, "Any substance such as catgut, cotton, silk or wire used to tie a vessel or strangulate a part." Do you agree with that definition?
A. Yes, I do.
MR. MARTIN: Can I see that?
Q. (BY MR. AUSTIN) Do you have Dr. Peacock's records in front of you?
A. The records or the --
Q. The -- well, the report.
A. Yes, I do.
Q. That should do it. That should do it.
A. Okay.
Q. Wait. It doesn't have the --
A. Okay.
Q. It doesn't have the conclusions.
A. That is the one that is incomplete. Here.
Q. Dr. Correa, we've talked a lot about the

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possibilities in your opinion as to how the infection got into Ms. Bass' bloodstream. Correct?
A. That is correct.
Q. And we've talked a lot about the possibilities as to how that infection got there in the first place, have we not?
A. Yes, we have.
Q. And we've also talked about your statement that you're only here to talk about causation. Correct?
A. Yes, we have.
Q. Are you -- the causation aspect of your testimony would only involve how that bacteria got into the bloodstream. Is that fair?
MR. MARTIN: Objection; form.
A. No.
Q. (BY MR. AUSTIN) You're assuming an infection, correct, from whatever source?
MR. MARTIN: Objection; form.
A. I have no doubt that an infection occurred.
Q. (BY MR. AUSTIN) Right, and I wasn't asking you that. You -- you believe that there was an infection?
A. Yes.
Q. And you're not here to -- you're not here

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to testify, are you, as to how that infection got into the abdomen, are you, as opposed to how the infection got into the bloodstream?
A. No, that's not correct. I have testified that I believe the infection got to the abdomen by a perforation of the gut.
Q. Which is not a causation opinion, is it?
MR. MARTIN: Objection; form.
A. I honestly don't know. That's a legal term that I have no idea what it means.
Q. (BY MR. AUSTIN) Okay. On the Page 4 which is the findings section of Dr. Peacock's autopsy report, will you read to me what it says under Roman Numeral II?
A. "Interruption with ligation of the right ovarian artery with necrosis of the right ovary."
Q. It doesn't say severance of the ovarian artery, does it?
A. Not in this sentence.
Q. It says ligation, does it not?
A. That's correct.
Q. And ligation means to -- as you said earlier, to -- to tie off rather than cut. Correct?
A. The word ligation, yes. Now, there could be cutting in addition to ligation. I don't know if

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that occurred in this case or not.
Q. Dr. Peacock didn't note any cutting in her report, did she?
A. Not in her report but in her deposition.
Q. Okay. The severance, which is important to your opinions, is not mentioned anywhere in the autopsy report. Is that true?
A. There is mention of the severance of the fallopian tubes but not specifically to the ovarian artery.
Q. The severance of the ovarian artery, which you've said is important to your conclusions, is not mentioned in Dr. Peacock's report, is it?
A. That is correct.
MR. AUSTIN: I'll pass the witness.
FURTHER EXAMINATION
QUESTIONS BY MR. MARTIN:
Q. Dr. Correa, let's just talk about that point right away. We already read to the jury Dr. Peacock's deposition testimony. Is that right?
A. We sure have.
Q. And she uses the term severance interchangeably with interruption. Is that right?
A. That is correct.
Q. Is that a reasonable construction to make

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of those words?
A. Yes, it is.
Q. Do you have an opinion whether there was -- whether interruptions as used in Dr. Peacock's report means severance?
MR. AUSTIN: Objection; form.
A. Yes, I do.
Q. (BY MR. MARTIN) And what is that opinion?
MR. AUSTIN: Objection; form.
A. My opinion is that it's used as similar terms, exactly the same.
Q. (BY MR. MARTIN) Is it your opinion -- do you have an opinion whether that ovarian artery was severed?
A. Yes, I do.
Q. And what is that opinion?
MR. AUSTIN: Objection; form.
A. My opinion is that it was.
Q. And Dr. Peacock is the one -- the only one that looked inside to see whether that ovarian artery was severed?
A. That is correct.
Q. She looked in at her autopsy?
A. She did.
Q. She gave a deposition?

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A. She sure did.
Q. And that deposition was noticed by the defendants?
A. That is correct.
Q. All right. A couple other follow-ups about Dr. Peacock's report. Why did Dr. Peacock fail to see blood in the abdominal cavity when she did the autopsy?
MR. AUSTIN: Objection; form.
A. Because the abdominal organs were covered with a purulent material. Actually I think she uses the word shaggy fibro-- fibrinopurulent exudate. So that is in my opinion the likely reason she was not able to see any bowel content or blood.
Q. All right. Just to clarify his objection. Do you have an opinion as to why Dr. Peacock did not see blood in the abdominal cavity?
MR. AUSTIN: Objection; form.
A. Yes. In my opinion it was because the peritoneal surfaces were covered with a shaggy, yellow-green, purulent material.
Q. (BY MR. MARTIN) Do you have an opinion as to why Dr. Peacock failed to see bowel content during the autopsy?
MR. AUSTIN: Objection; form.

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A. Yes.
Q. (BY MR. MARTIN) And what is your opinion?
MR. AUSTIN: Objection; form.
A. My opinion is that the -- Dr. Peacock was unable to see bowel content because of the shaggy, yellowish-green, purulent material that was covering the organs.
Q. (BY MR. MARTIN) Let's talk a minute about the medical education of a pediatric infectious disease medical doctor such as yourself versus an adult infectious disease doctor such as yourself. First of all, are there differences in the medical education you receive?
A. No, there are not.
Q. All right. In terms of the test to become board certified, what -- are there differences in the information that a pediatric infectious disease doctor would need to know that are on the board certification test for adult infectious disease? Are there differences?
A. Not for the pediatric person.
Q. All right. What about for the adult -- for the adult infectious disease person?
A. Yes, there are.
Q. And what are those differences?

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A. The difference is that the adult doctor does not have the knowledge or is not required to have the knowledge and understanding about how certain antibiotics interact in children, how they are metabolized by children, how they are processed by children.
Q. So to be board certified in pediatric infectious disease are there more or less requirements than to be board certified in adult infectious disease?
MR. AUSTIN: Objection; form.
A. There are more because a pediatrician -- a pediatric infectious disease specialist needs to know how these antibiotics behave in the newborn period as compared to an older child, as to an adolescent, as to an adult. As we have been mentioning throughout this deposition, there are differences in the way those medications are metabolized or processed by the body. So a pediatric infectious disease person has a knowledge of how those antibiotics act both in the very young and the older.
Q. Let's me talk about tubal ligations, laparoscopies converted to minilaparotomies. You've never performed one of those operations?
A. No, I have not.

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Q. You have to -- you're not qualified to know the intricate risks and the increased risks associated with those operations?
A. That's correct.
Q. Let me ask you this: Assume for a second that in an OB's patient there is an increased risk of bowel perforation when performing a laparoscomy -- a laparoscopy. From an infectious disease standpoint, do you have an opinion as to what proper -- whether there would be proper antibiotic therapy for such procedures after completion?
A. Yes, I do have an opinion.
Q. And what is that opinion?
A. My opinion is that antibiotics should be administered because of that increased risk.
Q. Is there any reason in the world that you can think of why antibiotic therapy would not be appropriate given an increased risk of bowel perforation?
A. Not a single one that I can think of.
Q. Is there any quest-- problem you'd have with someone gaining, what do you call it, gaining an immunity from an antibiotic because of such therapy after a tubal ligation?
A. Such thing does not happen in a short-term

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situation like that.
Q. Let's talk about Gloria Bass' conduct. Based upon what you've reviewed -- by the way, you've reviewed the Hillcrest medical records?
A. Okay.
Q. Have you done that?
A. Yes, I have.
Q. And that's pertaining to her visita-- her stay in the hospital after the surgery. Is that right?
A. That is correct.
Q. And at least in terms of the ambulance records, you've reviewed the ambulance records. Right?
A. Yes, I have.
Q. Is there anything at all that you've seen in any of those records that make you critical that Gloria Bass may have caused her own death?
A. No, not at all.
Q. Are you critical in any way of Gloria Bass for her death?
A. No, no, certainly not.
Q. Do you have an opinion as to whether she caused that bacteria to get in her abdomen in the first place?

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A. Yes. My opinion is that she had no bearing in that.
Q. Did she have anything to do with the bacteria getting into her blood?
A. No, certainly not.
Q. Last series of questions, Doctor. Do you review cases for both lawyers who represent plaintiffs and lawyers who represent doctors who are being sued?
A. Yes, I do.
Q. Do you review cases for large defense firms --
A. Yes, I do.
Q. -- who defend doctors?
A. Yes, I do.
Q. Are those in different states -- I'm sorry -- in different counties throughout Texas?
A. Yes, they are.
Q. Do you turn down a case simply because a plaintiff lawyer asks you to review it?
A. No.
Q. Do you review cases equally for both sides?
A. Yes, I do.
Q. Are you willing to review a case sent to you by any defense lawyer in this state and any

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plaintiff's lawyer in this state?
A. Yes, I am.
Q. Are you -- do you have any opinion whether some doctors are hesitant to testify in lawsuits against other doctors?
MR. AUSTIN: Objection; form.
A. Yes, I do have an opinion.
Q. (BY MR. MARTIN) And upon what is that opinion based?
A. Well, that opinion is based on my experience with colleagues and friends in the medical field.
Q. And what is that opinion?
MR. AUSTIN: Objection; form.
A. Unfortunately, many of them refuse to testify just because a case is coming from a plaintiff's lawyer.
Q. (BY MR. MARTIN) What about do -- in your experience do some of these doctors have problems testifying against other doctors?
A. Yes, they do.
Q. Do you feel that is fair?
A. No, I do not.
Q. Why are you willing to express your opinions even if they are against a doctor in a

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lawsuit?
A. Because I believe firmly that I have an ethical obligation to do so. I believe that even large organizations like the American Medical Association have said that physicians do have a role in these medical/legal cases and that that role should be unbiased whether it's -- they're testifying for the defense or the plaintiffs. I think that my ethical obligation is to present the facts as I understand them, as I -- as to what my professional conclusion is. I know that sometimes the physician involved or the -- sometimes the plaintiff's lawyer involved may not like what I have to say but it is -- I feel it's my obligation to say so.
Q. You have reviewed other cases for me?
A. Yes, I have.
Q. Do you tell me when you review some cases that they have no merit?
A. I certainly have.
Q. Do you call them like you see it?
A. I call them like I see it.
Q. For both sides, defense lawyers and plaintiff's lawyers?
A. I certainly do.
Q. Is it fair that you're compensated for your

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time when you review these cases?
A. Yes, it is.
Q. Doctor, certainly if -- well, let me ask you this: If you were told that Gloria Bass had a perforated bowel, what would your treatment have been?
A. I would have recommended starting antibiotics immediately.
Q. Do you have an opinion whether that would have saved her life?
A. Yes, I do.
Q. And what is that opinion?
A. That it would have certainly served -- saved her life.
MR. MARTIN: No further questions.
FURTHER EXAMINATION
QUESTIONS BY MR. AUSTIN:
Q. Dr. Correa, is it true that you're not expressing an opinion one way or the other as to whether Dr. Grayson or Dr. Konop should have ordered antibiotics in the postoperative period?
A. As to specifically Dr. Grayson, no, I'm not.
Q. You're expressing no opinion either way, are you?

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A. I'm expressing the opinion that in a situation like the one Dr. Grayson had encountered antibiotics were indicated.
Q. From an infectious disease standpoint?
A. That is correct.
Q. Okay. Dr. Grayson is not an infectious disease specialist, is he?
A. No, he is not, but as a physician he does have the knowledge of general infectious diseases.
Q. So now you are testifying that Dr. Grayson -- as to the standard of care regarding Dr. Grayson?
A. No, I'm not. I'm testifying as to from an infectious disease standpoint.
Q. So you're not testifying one way or the other whether Dr. Grayson as an OB/GYN should or should not have prescribed antibiotics. Is that --
A. That is correct.
Q. Would it change -- does it change your opinions at all -- strike that.
Would it change your opinions at all in this case if the ovarian artery were ligated rather than severed?
A. I don't think so.
Q. Why not?

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A. Because you still have a situation where tissue is dying. The tissue that is dying would have continued to foster the infection and could have been the entry site for the infection to reach the bloodstream. Irrespectively of whether there was a cut of the artery or not, you had tissue that is dying to where there's still some amount of blood flow and to which still can act as an entry site for an infection.
Q. Would it have entered the blood as quickly had the artery been ligated rather than severed?
A. More likely no.
Q. It would have taken a while to enter the bloodstream, longer than it would have had the artery been severed?
A. That's correct.
Q. Okay.
MR. AUSTIN: I'll pass the witness.
MR. MARTIN: Thank you, Doctor.
THE WITNESS: Thank you.
THE VIDEOGRAPHER: Off the record at 7:02 p.m.
(Exhibit No. 4 was marked)
(Proceedings concluded/recessed at 7:02 p.m.)

CHANGES AND SIGNATURE

PAGE	LINE	CHANGE	REASON

I, ARMANDO G. CORREA, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

ARMANDO G. CORREA, M.D.

THE STATE OF)
COUNTY OF)

Before me, , on this day personally appeared ARMANDO G. CORREA, M.D., known to me (or proved to me under oath or through) (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this day of , .

NOTARY PUBLIC IN AND FOR
THE STATE OF

NO. 99-2625-3

SEVERA DeLEON) IN THE DISTRICT COURT
)
Plaintiff(s),)
VS.) McLENNAN COUNTY, TEXAS
)
ROBERT W. GRAYSON, M.D.)
)
Defendant(s).) 74TH JUDICIAL DISTRICT

REPORTER'S CERTIFICATION
DEPOSITION OF ARMANDO G. CORREA, M.D
DECEMBER 20, 2000

I, Velma C. LaChausse, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, ARMANDO G. CORREA, M.D., was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the deposition transcript was submitted on , 2000, to the witness or to the attorney for the witness for examination, signature and return to me by , 2000;

That the amount of time used by each party at the deposition is as follows:

Mr. Robert E. Austin, IV - 3:30
Mr. James F. Martin - 00:52

That pursuant to information given to the

deposition officer at the time said testimony was taken, the following includes counsel for all parties of record:

Mr. James F. Martin, Attorney for Plaintiff(s)

Mr. Robert E. Austin, IV, Attorney for Defendant(s)

I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Further certification requirements pursuant to Rule 203 of TRCP will be certified to after they have occurred.

Certified to by me this 22nd day of December, 2000.

Velma C. LaChausse, Texas CSR 5782
Expiration Date: 12-31-2000
Esquire Deposition Services, Inc.
3401 Louisiana, Suite 300
Houston, Texas 77002-9547
(713) 524-4600

NO. 99-2525-2

SEVERA DeLEON) IN THE DISTRICT COURT

Plaintiff(s),)

VS) McLENNAN COUNTY, TEXAS

ROBERT W. GRAYSON, M.D.)

Defendant(s).) 74TH JUDICIAL DISTRICT

FURTHER CERTIFICATION UNDER RULE 203 TRCP

The original deposition was/was not returned to the deposition officer on

If returned, the attached Changes and Signature page contains any changes and the reasons therefor;

If returned, the original deposition was delivered to Mr. James F. Martin, Custodial Attorney;

That $ is the deposition officer's charges to the Plaintiff for preparing the original deposition transcript and any copies of exhibits;

That the deposition was delivered in accordance with Rule 203.1, and that a copy of this certificate was served on all parties shown herein on and filed with the Clerk.

Certified to by me this day of .2000

Verna C. LaChausse, Texas CSR 5782
Expiration Date: 12-31-2000
Esquire Deposition Services, Inc
1431 Louisiana, Suite 200
Houston, Texas 77002-9147
(713) 524-4600