482

THE STATE of OHIO,
: SS:
COUNTY of CUYAHOGA.

IN THE COURT OF COMMON PLEAS

ARAZINE SMITH, executrix of the :
ESTATE of CAROLYN YARBOROUGH,
plaintiff,

vs. : Case No. 326850

SAINT LUKE'S HOSPITAL,
defendant.

Deposition of STEVEN BASS, M.D., a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at Saint Luke's Hospital, 11311 Shaker Boulevard, Cleveland, Ohio, on TUESDAY, OCTOBER 28TH, 1997, commencing at 2:10 p.m. pursuant to agreement of counsel.

FLOWERS & VERSAGI
COURT REPORTERS
Computerized Transcription
Computerized Litigation Support
THE 113 SAINT CLAIR BUILDING - SUITE 505
CLEVELAND, OHIO 44114-1273
(216)771-8018
1-800-837-DEPO

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

Donna Taylor-Kolis, Esq.
Ann Garson, Esq.
Donna Taylor-Kolis Co., LPA
330 **Standard Building**
Cleveland, Ohio 44113
(216) 861-4300.

ON BEHALF OF THE DEFENDANT:

Gary H. Goldwasser, Esq.
Susan Seacrist, Esq.
Reminger & Reminger
The 113 **Saint Clair Building**
Cleveland, Ohio 44114
(216) 687-1311.

I N D E X

WITNESS: **STEVEN BASS, M.D.**

(FOR COMPLETE INDEX, SEE **APPENDIX)**

(IF ASCII DISK ORDERED, SEE BACX COVER)

STEVEN BASS, M.D.

of lawful age, a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the **Ohio** Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

MISS XOLIS: For identification purposes on the record we've met, as you know my name is Donna Xolis, I've been retained to represent the Estate of Carolyn Yarborough. My purpose is to gain information that you might be able to provide to me both from your consultation and things that don't appear in the record.

Have you been deposed before?

THE WITNESS: Yes.

MISS XOLIS: That's probably a silly question, I'm never certain.

Knowing Mr. Goldwasser as I do, I'm certain prior to the deposition he would have indicated to you to answer all my questions in a verbal fashion. I would recommit you to that. We don't like to make the court reporter interpret our answers or questions.

Additionally if **I** ask a question

that you don't understand, which is a high likelihood, you can tell me you don't understand what I'm asking. Don't answer a question you are not clear about. As questions and answers appear on the record it's presumed you understood the question.

Additionally if at any point you wish to confir with Mr. Goldwasser or your other counsel who is here today that's acceptable to myself. If for any reason you are paged, patient care of course takes precedence over deposition, we don't mind waiting for you. Have you understood everything I instructed you on?

THE WITNESS: Yes.

CROSS-EXAMINATION

BY MISS ROLIS:

Q. With that said, for the record can you state your name and your business address?

A. Steven Bass, 11311 Shaker Boulevard, Cleveland 44104.

Q. You are identifying **by** address Saint Luke's Hospital; is that accurate?

A. Yes, that is where my office is.

Q. Other than the office in the hospital, do you

have offices outside of the hospital?
A. We share some office space, our group does, I don't physically see patients or have an office elsewhere.
Q. We'll make that very simple. For the record you've indicated your group, you are a member of a group practice; is that accurate?
A. Correct.
Q. What is the name of the group practice?
A. ID Consultants.
Q. How many members are in ID Consultants?
A. Five.
Q. I'm not going to ask you their names at this moment, I don't think it's all that important. So the record is clear, you do not see patients other than here at Saint Luke's Hospital, you don't see them at the other office?
A. Yes, I see patients at other hospitals. I don't see outpatients at any other office.
Q. Where is your office located, the other office?
A. We have at Hillcrest, Hillcrest medical building, we share some space there.
Q. You've indicated that you don't see other hospital outpatients, I'm a little bit confused

about what you told me, maybe I'm not listening too well?

A. Most of the work I do represents seeing patients in the hospital. Our group sees patients at a number of hospitals. There will be an occasion to see a patient as an outpatient in an office setting. I only see patients here. There is another office that we sublet from another physician at Hillcrest and actually out in Geauga County members of our group utilize.

Q. I'm still not clear, it's the questioner, not the answerer.

You see outpatients here in your office at the hospital; is that right?

A. Correct.

Q. You also see patients who are inpatients at Saint Luke's?

A. Correct.

Q. Do you also see patients at Hillcrest Hospital who are in the hospital?

A. Yes.

Q. I think that is pretty clear to me.

Mr. Goldwasser is apparently reviewing your CV.

MR. GOLDWASSER: I'm going to

have a copy made available to you. I'll give it to you. It's the only copy I have, as you saw just brought in.

MISS KOLIS: I won't put any marks on it.

Q. Do you have privileges at an other hospital other than Hillcrest and Saint Luke's?

A. Yes.

Q. What other hospitals?

A. All the Meridia hospitals, Marymount, Bedford, Saint Vincent's, Geauga, that kind of covers it.

Q. I'm probably not going to go through very thoroughly your CV, basically I want to confirm the information that appears on here.

You completed medical school at Cornell University in 1976?

A. Yes.

Q. Thereafter did a one year internship at University Hospitals, correct?

A. Yes.

Q. Residency same place, University Hospitals, '77 through '79?

A. Correct.

Q. Was that an internal medicine residency?

A. Yes.
Q. Thereafter you completed a two year Fellowship in infectious disease, '79 to '81 at University Hospitals?
A. Yes.
Q. Then spent an additional year as the chief resident, was that in internal medicine or infectious disease?
A. Internal medicine.
Q. '81 to '82, right?
A. Correct.
Q. What year did you become Board certified in internal medicine?
A. 1979.
Q. Are you also Boarded in infectious disease?
A. Yes.
Q. What year did you take that Board?
A. I believe 1982.
Q. Have you had to recertify in either of those Boards since that time?
A. No.
Q. In anticipation of the questions that I'm going to ask today, did you review any material?
A. Yes.
Q. What did you review?

A. I reviewed the medical record during the patient's stay at Saint Luke's Hospital. I reviewed the autopsy report, discharge summary from Huron Hospital.

Q. When you say you reviewed the hospitalization, Carolyn was hospitalized here more than once. Did you simply review the January 9, 1996 through January 25th hospitalization, or did you review --

A. Basically that one. I didn't spend a lot of time on the others.

Q. The autopsy report, correct?

A. Correct.

Q. The discharge summary only of the Huron Road records?

A. Correct.

Q. In preparing to discuss Carolyn's care with me, did you have an occasion to do a MEDLINE review of any sort?

A. No.

Q. Doctor, do you have any teaching responsibilities?

A. Yes.

Q. Tell me about those.

A. There are residents on the infectious disease

service here each month, we basically supervise the residents and they have an exposure to the discipline of infectious disease here. We also do that at Meridia Huron. We teach medical students here, Case Western Reserve students. We interact with medical students from Ohio University College of Osteopathic Medicine predominantly at South Pointe Hospital.

Q. I gather from that answer the teaching you do is clinical in nature, you're not teaching in the classroom at Case?

A. There are some presentations that we do give to undergraduate -- not undergraduate, sorry, first and second year medical students.

Q. When you say you have residents that come through on a monthly basis, does Saint Luke's Hospital offer a full residency program in infectious disease medicine?

A. No.

Q. They are rotating through on a monthly basis?

A. Right.

Q. What programs do those residents come from?

A. These are internal medicine residents, they don't come from any program.

Q. Fair enough.

Prior to today I did not have the opportunity to do a Common Pleas index on you, I'm going to ask you these questions by way of background. Other than the instant piece of litigation, have you previously been sued for alleged medical negligence?

MR. GOLDWASSER: Objection, you may answer.

A. Yes.

Q. Without holding you to it specifically, can you recall on how many occasions you were sued?

MR. GOLDWASSER: Objection. You may answer.

A. I believe I've been involved with five, something of that nature.

Q. Were all of those cases filed in Cuyahoga County?

A. Yes, as far as I know.

Q. I assume you've practiced medicine in Cleveland essentially since you --

A. Yes.

Q. Did any of those five matters that were previously filed against you involve a failure to diagnose an infection?

MR. GOLDWASSER: Objection. You

may answer.

A. I can't tell you what the -- I don't recall what the allegations were. In no cases was there a proven allegation. I can't tell you if that was the focus of the claims.

Q. Are you indicating to me by that answer that in the five cases that were filed against you all of them to the best of your knowledge were resolved without a payment on behalf of Dr. Steven Bass?

A. Correct.

Q. Were you represented send by Reminger & Reminger in those actions?

A. Yes.

MR. GOLDWASSER: Not exclusively. I think Jacobson, Maynard had some of those cases.

Q. Fair enough. I'll do my own work, look at the index. I thought I would ask you for what you could remember.

In January of 1996 what was your relationship with Saint Luke's Hospital at the time of Carolyn Yarborough's admission?

A. I first of all was a member of the medical staff, I was a salaried member of the Department of Medicine, teaching capacity in the Division of

Infectious Disease and Department of Medicine.

Q. In terms of any compensation which you might have derived for the consultation which you performed upon Carolyn while she was in January of 1996, who provided payment for those services, if you know?

A. There was no payment for those services as far as I'm aware of.

Q. Was Carolyn Yarborough a clinical patient?

A. I don't know what you mean by that.

Q. If you don't know what I mean, I don't either.

I guess what I'm asking you is a different question, so let's see if we can turn this around. At the time of this incident were you insured for medical negligence?

MR. GOLDWASSER: Was Dr. Bass, did he have professional liability insurance?

Q. Yes, did you have professional --

MR. GOLDWASSER: Objection. You may answer.

A. Yes.

Q. Who was your professional liability carrier?

A. I've been covered by PIE.

Q. In January of 1996 you were working with a

policy of liability coverage provided by PIE; is that right?

A. For the care of patients who were so-called private patients. In one's role as a faculty member here, in the care of staff patients, that liability coverage doesn't apply.

MR. GOLDWASSER: That's why Goldwasser is here instead of John Jackson.

Q. Carolyn Yarborough was not a private patient --

MISS KOLIS: Which is good for me I suppose.

MR. GOLDWASSER: I don't know.

Q. -- she was a staff patient; is that correct?

A. Correct.

Q. Accordingly you are being represented under an indemnification with the hospital for your care of a staff patient?

A. I don't know what you mean by indemnification. My understanding is that any sort of liability coverage is provided by the hospital when these patients are here.

Q. She didn't come through your private practice?

A. No.

Q. Let's try to deal efficiently hopefully with questions that I have for you regarding this case. I reviewed the records, I don't always profess to be able to read everyone's signature. To the best of my ability there is charted only one examination by yourself of this patient, is that accurate, that there was only one examination by you of Carolyn?

A. Correct.

Q. That occurred on January 23, 1996?

A. Correct.

Q. To the best of your recollection, other than the one recorded consultative visit we're going to talk about, did you do any I call them curb side consultations in the management of antibiotics for this patient while she was hospitalized?

A. Not that I can recall.

Q. From your review of the records, Dr. Bass, what was the purpose of the consultation you performed on January 23, 1996?

A. To interpret the results of cultures taken on January 16th of 1996.

Q. Who requested this consultation with yourself?

A. The surgical service.

Q. How does the surgical service request a consultation with you?
A. In this specific case?
Q. Um-hum.
A. I don't recall if I received a phone call from the surgical resident or from the surgical attending.
Q. Have you looked at the orders in the chart?
A. Not comprehensively.
Q. I'm asking you if did you. I went through them, I didn't find an order for an infectious disease consult on any date 16th or 20th or 23rd, that is why I'm asking you whether you have a recollection how you were called in?
A. It's usually through a phone call.
Q. Do you log those phone calls anywhere?
A. Not all of them. If it came through my office it may be in a log. It may have been a message on my beeper that I called right back.
Q. How is it that today you know that the purpose that you were called in for consult was to interpret cultures done on the 16th?
A. I recall that.
Q. When you say you recall it, in reviewing the medical records themselves, you have a specific

recollection that you had received a call to ask you to interpret cultures?

A. I recall the case, I recall having my involvement to interpret those cultures.

Q. When you say that you would have been requested to interpret cultures, what would the process of interpreting cultures entail?

A. If the culture results represented a significant infection that required therapy; or represented colonization, that would require therapy.

Q. Would physically examining the patient be part of what would be required to interpret the cultures?

A. Yes.

Q. What happened on the 16th that caused a culture to be drawn?

A. There was, as I recall in reviewing the chart, there was drainage from the wound.

Q. We're probably going to go through some of the progress notes. That's your recollection, correct?

A. Yes.

Q. What I would like to do first, so we have a place to work from, is I'll have the court reporter

mark this Plaintiff's Exhibit A. I'll represent to you this is a photocopy of an entry from the chart of your one and only consultation in the chart; do agree this is a consultation note?

A. There is usually a note written by the resident, I did not see a consult form, I did not see that in the chart. I don't know where that is.

Q. When you say the consult form, are you talking about standard hospital consultation form?

A. Correct.

Q. From your review of the record did you see a completed consultation form?

A. No.

Q. Nor did I, that's why I'm asking.

A. I didn't see it, I don't know if it was written, that could have been another note referable to infectious disease.

Q. Did you see any note written in the chart by infectious disease residents?

A. No.

Q. I didn't either, I'm trying to confirm that. Customarily then, not trying to beat a dead horse, there is usually a consult form that would be here in the consultation section of the chart?

A. Right.

Q. Your review reveals that there isn't one, correct?

A. Correct.

Q. Generally speaking, on those consult forms, that is where you generally find the information as to who requested the consult and scope of consultation, correct?

A. Correct.

Q. As boring as this might seem, I would like to prevail upon you to read into the record what your actual consultation note says.

A. ID patient seen, has myelitis, on steroids, cecal perforation, treated and has improved. Currently off systemic antibiotics. Surface cultures with enterococcus, yeast. Foley out times one day, afebrile. Blood count down to 13,000. Urinalysis, January 20th, negative. Assessment: No signs of significant infection, positive culture represents surface and mucosal colonization and patient at high risk for superinfection. Keep off all antibiotics. Recheck urine since Foley is out. May treat with Fluconazole.

Q. I'll come back and ask questions about that. I wanted that as my baseline.

In assessing the patient for the

purpose of the cultures that were drawn on the 16th, did you take it upon yourself to review the charting up to the point that you saw her at that time?

A. Yes.

Q. Were you aware of the operative cultures in this patient at the time that you saw her?

A. Yes.

Q. Had a yeast organism been identified and isolated from the abdominal fluid?

A. Yes.

Q. Had an enterococcus organism been identified and isolated?

A. Yes.

Q. At the time that you consulted with her on January 23rd, were you aware of what systemic antibiotic therapy she had been on?

A. Yes.

Q. What therapy do you recall, or you can look at the record, her having been on up to the point you saw her?

A. My recollection is that she was on Cefotetan and Flagyl. Can I check that for sure?

Q. If I suggest that the chart also reflects Gentamycin does that the refresh what you reviewed?

A. Yes, that would make sense. I'll take your word for it.
Q. You don't ever have to take my word for it.
A. That was my recollection.
Q. At that time would you agree with me that the three antibiotics that we just listed don't include coverage either for the Candida or enterococcus found?
A. Yes.
Q. From your review of the chart, up until the time you saw the patient, did you consider that Carolyn had carried a postoperative fever?
A. She had fever postoperatively, yes.
Q. What is your definition of postoperative fever, what ranges?
A. I would say temperature over 38.
Q. 38 in Fahrenheit is what, if you can do the math for me, if you can't, tell me?
A. I would say a temperature of 100. Pretty close to that.
Q. Using your definition, you would agree with me she had postoperative fevers through the course of her hospitalization up until the time of discharge; do you agree or disagree with that?
A. It is my recollection her temperature came

down during the course of her hospitalization.

Q. Is it your recollection it came down and stayed down or fluctuated in the postop 100 degree range?

A. It's my understanding from looking at the record that her temperature dipped below 37 on numerous occasions, was in the high 37's for most of the time in the hospital. Later on she had a temperature of 38.9, 38.3, temperature had come down.

MISS KOLIS: I'm going to hand you this because we may want to refer to it, I'll state for the record that this is a graph. This graph doesn't appear in the hospital chart, for purpose of questioning I'm going to mark it Plaintiff's B.

MR. GOLDWASSER: Who prepared the graph or created it?

MISS KOLIS: We created it based on the temperature. It's subject to dispute or anything at a later time. This is a graph prepared showing dates and plotting out dates and temperature by nursing staff.

MR. GOLDWASSER: Centigrade or Fahrenheit?

MISS XOLIS: Converted Fahrenheit.

Q. Hang onto that in case we need to use it.

Looking at a person, when I say a person, talking about Carolyn Yarborough, what is the importance of calculating in the postoperative fevers in trying to assess whether or not there is an intra-abdominal infection?

A. Repeat the question.

Q. Looking at Carolyn Yarborough's situation, a person who had a perforated secum and peritonitis, in attempting to assess in her particular circumstances whether there is postoperatively an intra-abdominal infection, what importance do you place upon postoperative fever?

A. The persistence of fever would raise the concern about there being an infection.

Q. So that we don't have a problem with semantics, when you say persistence of fever, can you explain to me in layman's terms how you quantify or define the persistence of fever?

A. Temperature that stays elevated above the defined range during the course of her stay. That would be a fever.

Q. Having just given that definition, when you

say sustained, do you mean a fever that spikes and then stays the same through a number of days, or is there within that temperature a spike, drops, spikes again; is it variable or does it have to be constant?

A. Fevers can vary. I don't think that a fever pattern defines what is going on. Usually in a setting of a postoperative fever there is high grade temperature.

Q. In terms of your perspective as a Board certified infectious disease physician, what clinical single diagnostic finding is most highly suggestive of intra-abdominal infection?

MISS KOLIS: Connie, can you read that back?

(Question read.)

A. Persistent fever, persistent leukocytosis.

Q. Leukocytosis meaning white blood count?

A. Yes.

Q. Elevated white blood count?

A. Yes.

Q. We're going to get into this specifically a little further in my questioning, I'm trying to set

the stage in this way: In Carolyn Yarborough was there a diagnostic complication in terms of leukocytosis because of the fact Carolyn Yarborough was taking steroids?

A. I think the steroids probably played a role in her leukocytosis.

Q. That's something you as an infectious disease doctor are aware of, correct?

A. Correct.

Q. Can you give me, pretend I'm the medical student, your definition or explanation as to why the administration of steroids affects the leukocytosis?

A. It causes leukocytosis by demarginating white cells in the periphery and measured white count is elevated.

Q. The person who is on steroids could have no infection, but have a demonstrated higher white blood count, correct?

A. Correct.

Q. How do you as an infectious disease doctor discern what it is that is elevating the white blood count in a situation like that?

A. Well, we use other parameters. Those would include clinical findings, presence of sense of

well-being, the examination of the patient, the abdomen, the wound, the presence or absence of fever.

Q. At the time that you examined Carolyn, were you aware of a CAT scan result from January 20th?

A. Yes.

Q. When I say were you aware of them, did you read the actual finding or did you look at the CAT scan?

A. I don't recall. I usually do review the CAT scan but I do remember the report.

Q. I think that it was suggested in your answer, I always like a clear question and answer for the record to the extent possible, when you say you usually review, are you indicating for the record **you** usually look at the film itself?

A. Yes. I don't recall if I looked at the film in this particular situation.

Q. This situation you don't have a specific recollection **of** which you did, although it would be your custom to look at the CAT scan?

A. Correct.

Q. I gather from the answer that you feel a certain degree of competence to review a CAT scan film, to detect the presence and/or absence of an

infective process in the abdominal cavity?
A. I usually review with a radiologist.
Q. In this case you just don't remember, the note doesn't say you reviewed the film?
A. Correct.
Q. That does or doesn't mean one way or the other that you did, correct?
A. Correct.
Q. Have you had an opportunity to, subsequent to the time I filed this lawsuit, to look at the film, we won't say rereview?
A. No.
Q. Have you reviewed the findings as interpreted by the radiologist of the CAT scan?
A. Yes.
Q. Do you agree or disagree that the findings on that CAT scan as reported by the radiologist are not unequivocal for no infection?
MR. GOLDWASSER: I don't know, that is a double negative.
Q. We're going back to English.
Do you agree or disagree with me the findings on the film don't conclusively establish there was no infection in the abdomen as of January 20th?

A. No single test can ever definitively conclude that there is no infection, if that is answering your question.

Q. I think I understand the answer. Let me try to ask a better question.

Would you agree with me the finding of ascites obtained in the abdominal cavity could be suggestive of abdominal infection?

A. The presence of ascites could be -- postoperative, could be related to edema, could be related to infection, it is not a sign of infection, not diagnostic of infection, not inconsistent with infection.

Q. That is probably the question I should have asked you, using the word inconsistent.

The picture that was presented on the CAT scan did not exclude the possibility that there was an intra-abdominal infection and could in fact have been consistent with the presence of one as of January 20th; do you agree with that?

A. I think that the interpretation of the CAT scan as I recall was more weighted on the side of no infection than infection, as I recall.

Q. By the radiologist?

A. Correct.

Q. You yourself as an infectious disease doctor get an opportunity to look at those films, decide the film in combination with the clinical setting could be more suggestive of infection than the radiologist would be able to determine; would you agree with that?

A. We use that test as any other test.

Q. What are corticosteroids, Doctor?

A. Medications that are anti-inflammatory.

Q. How do they affect the inflammatory process?

A. They blunt the inflammatory process.

Q. Can you explain simply how they do that?

A. They affect T cell function, halt the or affect the ability of white cells to work.

Q. In general, within your subspecialty, what is your understanding of the general affect of corticosteroids on the healing of an intestinal anastomosis or surgical wound?

A. In general it impedes the healing.

Q. That is something obviously you would have been aware of at the time you examined Carolyn?

A. Yes.

Q. Changing directions just for a second, we will get back to that issue.

Had you work with Dr. Sonpal --

perhaps the use of my word worked with might make you uncomfortable -- in the past had you been involved in cases where Dr. Sonpal chose to initiate and maintain the antibiotic regimen before you came as the ID consult?

A. I can't recall that as being either an individual circumstance or a pattern.

Q. Based upon your review of this chart, do you believe that an infectious disease consultation should have been requested prior to January 23, 1996?

MR. GOLDWASSER: Objection. You may answer.

A. My surgical colleagues treat surgical infection all the time without infectious disease consultation. I wasn't there at the time, my review of the record it appears the patient seemingly improved and antibiotics were stopped. There was an issue of having her discharged. To answer your question, it seemed to the physician taking care of her she was improving.

Q. All right, I'll accept that answer.

Prior to me interjecting that thought that crossed my mind we were talking about corticosteroids. In addition to impeding the

healing of a surgical wound or surgical anastomosis, intestinal anastomosis, what affect do the corticosteroids have on other signs and symptoms of infection?

A. Corticosteroids may blunt signs of infection.

Q. Blunt fever?

A. Can.

Q. Do you presume when you are seeing a patient who is on corticosteroids who has a fever, that fever may in actuality be a little bit higher if the steroids are withdrawn?

A. I don't think I would presume that at all. I think if we want to refer to this specific case.

Q. Okay.

A. The patient had no difficulty in generating a rather significant fever while on a fair amount of corticosteroids so I don't think that in this specific case that would be relevant.

Q. Following what you just said, she was able to generate a rather significant fever on steroids, I'm asking you if you have the understanding based on your training and experience in infectious disease medicine whether the temperature would have recorded higher but for the administration of

steroids?

A. No, I believe she had an infection, the fever was high, she was treated surgically and medically and her fever came down, I think that is clear.

Q. What is peritonitis?

A. Inflammation of the peritoneum.

Q. Just a general explanation so we can ask a question, how does peritonitis arise following the perforation of the secum?

A. The peritoneal cavity is soiled with intestinal content, which includes bacteria, inflammation occurs.

Q. Going back, I just had forgotten to ask a question in terms of the affect of the corticosteroids on signs and symptoms of the infection.

You indicated the answer it does blunt fever, does/can, does it also affect your classical clinical symptoms of abdominal rigidity or stomach pain?

A. It can.

Q. That ties with my next question. The corticosteroids themselves, can they specifically affect the signs and symptoms of peritonitis?

A. In this particular case she had no difficulty

mounting signs and symptoms of peritonitis, her belly became soft while on corticosteroids. Related to the case I believe the corticosteroids did not blunt the signs and symptoms of the peritonitis.

Q. At the conclusion of your infectious disease consult, as you read into the record, it seemed my recollection is you said, the last sentence, may treat with Fluconazole. Tell me what is Fluconazole?

A. It's an antifungal agent.

Q. Why were you recommending treating with Fluconazole at that point?

MR. GOLDWASSER: He said may treat with.

MISS KOLIS: Excuse me.

MR. GOLDWASSER: You said recommend. I thought he said may treat with.

Q. To clarify Mr. Goldwasser's appropriate interjection into this, so the record is clear you say may treat with Fluconazole, you were telling them what they could put on it if they wanted to?

A. I was expressing I may treat with Fluconazole.

Q. You may treat. In that context at that point

you had not made a decision to treat with Fluconazole?

A. No, she had urine that grew yeast, I wanted to recheck the urine after the Foley was removed. See, often times yeast will colonize surfaces, doesn't represent a significant infection, particularly if there is a catheter in place like a Foley catheter.

The Foley was removed for one day, a repeat urine culture was ordered and checked. If that was growing, that was still positive with the Foley being removed, given her situation, Fluconazole may have been used.

Q. You never did end up using Fluconazole on the wound then?

A. The wound was clean, it was beefy, granulating, there were no signs of infection in the wound at the time I saw the patient. At that time I felt that the wound was not infected, at that time.

The organism isolated represented surface colonization. My concern with Fluconazole was she had yeast in her urine, I wanted to see what her urine grew, if anything, after the Foley was removed, the urine was sterile.

Q. You are indicating to me that at the time that you checked -- can you point me back to the note where you describe the wound?
A. I don't have that written on this note.
Q. So the note doesn't have a description of the wound, does it?
A. No.
Q. So you just related a description of the wound, are you doing that from your memory?
A. There are numerous notes by the surgeons about the wound before, during the time I saw the patient and after the time I saw the patient, which I don't have a specific recollection of the wound as we speak now.

My note indicated that there were no significant signs of infection, that the wound was granulating and beefy, which was supportive of that.

Q. What is mucosal contamination?
A. Mucosal is being the urinary tract, bladder mucosa.
Q. These cultures that you were asked to consult on, you are saying they were cultures taken on the 16th?
A. Correct.

Q. Cultures from where?
A. From the wound.
Q. You weren't consulted because of a concern of urinary tract infection, were you, or culture growing from the urinary tract?
A. No, but the time I saw the patient, during the time I saw the patient that was positive, one wanted to be sure that yeast had disappeared. Patients who, particularly a patient who has a neurological condition, once the Foley is removed, the organism can grow if it actually is still there. That was the reason for checking the urine after the Foley was removed. She eliminated that organism from the urinary tract as the catheter was removed.
Q. That was the same organism that was found in the abdominal cavity at the time of surgery, correct?
A. It was a Candida species, I don't know that was the same species, it was a Candida.
Q. Why had Carolyn been removed from antibiotics prior to you seeing her?
MR. GOLDWASSER: You only know what the chart will tell you, you can't guess what an other doctor's thought process was.

A. My recollection of the case, the surgeons felt the patient was improving, had decided to stop antibiotics. That was their sense. I assume that is why they stopped the antibiotics, because the patient was improving.

Q. There is your reference to infectious disease point of view, I'm not asking you to guess what anyone was thinking, is there another reason you are aware of in a general principle of infectious disease medicine you remove a person from antibiotics other than the sense they are getting better?

A. Yes, if a patient has persistent fever, that could be a drug fever, you want to stop antibiotics.

It starts at the top 1-19-96, that looks like shorthand afebrile, VSS, that is the

note I'm referring to. Towards the middle portion of the page, Dr. Sonpal -- I'm assuming this is Dr. Sonpal's note and signature, we haven't deposed him, let's assume that is who it is -- says hyperglycemia secondary to steroid. Impression -- does that say the word impression to you or is that something else, if you are familiar with Dr. Sonpal's handwriting?

A. Hyperglycemia secondary to steroids then what?

Q. Can you make out the word between steroids and sepsis?

A. No. Usually impression is at the beginning of a line, that isn't.

Q. I would agree, that is why I'm asking.

A. That is doubt.

Q. You think that is doubt?

A. Yes.

Q. Fine.

A. He's saying hyperglycemia secondary to steroid, doubt sepsis. Makes sense.

Q. Had you read that note prior to your examination of Carolyn?

A. Yes.

Q. If you would turn to 1-20-96, top of the

page, did you read that note before you examined Carolyn; do you know?

A. I can't tell you at this point if I read the note. I read through the chart when I saw Carolyn, I read the notes. I read all the notes before when I saw Carolyn Yarborough.

Q. This note pretty clearly indicates the white blood count is still up at that point?

A. Right.

Q. He's recommending a CT and pelvis, is that the way you read that?

A. Which note, the 19th?

MR. GOLDWASSER: Turn the page.

Q. 20th, top of the page?

A. Yes.

Q. At the point would you suspect that Dr. Sonpal -- when I say suspect I know you don't know what he thinks -- does this note indicate to you that there is a test being ordered to determine whether or not there is infection?

A. Yes, he's concerned about it.

Q. He's not worried about that white blood count going up because of the wound infection, the external wound infection; would you agree with that?

A. Correct.
Q. That's why he's ordering a CT.
By the way, what is his description of the wound at that point in time?
A. Wound is healing well except for slight infection in central portion.
Q. By the 23rd you are saying you didn't see any sign of infection in the wound?
A. The next day granulating nicely, incision clean and granulating on the 22nd. Incision clean, unchanged on the 23rd. On the 24th wound clean, pink and boggy. Correction, clean, pink and beefy. On the 25th incision granulating nicely. These are all indications of a wound that is not infected.
Q. We're talking the surface wound though?
A. Correct.
Q. The condition of the surface wound does not necessarily tell us what the condition is intra-abdominally; would you agree with that?
A. Correct.
Q. Let's switch gears again, try to be organized with my questions.
You indicated initially that you were called in on this consultation to interpret

cultures that were drawn on the 16th?
A. Yes.
Q. So you came in, did this physical exam, made some recommendations, you also testified that you did read all of the records. Of course by reading those records you would have been aware that there had been some increasing white blood counts, correct?
A. Yes.
Q. CT was done to look for intra-abdominal infection, right?
A. Correct.
Q. Did you, Doctor, on the 23rd, make a determination that there was no possibility of intra-abdominal infection in this person?
A. Can you repeat the wording?
Q. The ending part was did you make a determination on January 23rd that there was not the possibility of intra-abdominal infection in Carolyn Yarborough?
A. I can't answer the question in those terms. There is never a situation there is no possibility. I didn't find any signs of significant infection. I felt the cultures that were done on the 16th represented surface and

mucosal colonization. Dr. Sonpal on his note of the 22nd noted urine Candida, wound Candida and enterococcus, consult ID. His request was, Dr. Bass, what do you make *of* the cultures.

I felt the clinical picture of the patient at that time did not indicate signs *of* infection. As far as no possibility, that is not possible.

Q. Once again, the asker asked a poor question, doesn't have anything to do with you. Let me rephrase this.

Did you perceive or was it indicated to you that part of your assessment *of* this patient was to determine the existence or nonexistence of an infective process intra-abdominally, not the wound, I'm talking about the intra-abdominal infection?

A. No, my recollection of this case was the CAT scan was done, there wasn't evidence of infection, according to the radiologist. The wound cultures were obtained essentially six days, seven days earlier, a week before **I** saw the patient, they just wanted to know what I thought about those cultures.

They felt the patient was

improving. The elevated white count was considered part and parcel of her steroid therapy. The white count had come down, her temperature had come down.

The answer to your question is the surgeons felt as though the patient had improved, they wanted an interpretation of these cultures that were obtained, that is what Dr. Sonpal writes in his note. That note is January 22nd in the middle of the page.

Q. I'm asking you based on your review what the purpose of the consult was.

A. Obviously it's important to me to know that, it's right there on January 22nd.

You asked me before, by the way, if they were asking me about the urinary Candida, the answer is yes.

Q. Understand there is no order in the chart that let's me know the purpose for the consult. I need to know if you knew what the purpose was?

A. Let me share with you the protocol here at Saint Luke's.

Q. That would be fine.

A. Consults are not placed in the order. Consults require a doctor-to-doctor discussion. A

phone call. So that is why it probably was not in the orders.

Q. So you clarified that's how they occur at Saint Luke's, someone will call you?

A. Right.

Q. Say, Dr. Bass, I hope you are not too busy to come down see my patient, tell you what they need?

A. My recollection of this case, the surgeons did not feel the patient had ongoing intra-abdominal sepsis, that there was some surface cultures they wanted some interpretation of.

Q. Do you agree with me that it is medically prudent to change a person's antibiotic regimen, if you will, from empiric to specific once you identified certain organisms?

A. Referring to this specific case?

Q. We can do that in a second. Generally speaking, can you give me generally speaking?

A. It depends on the organism. If for example an organism is isolated from the sputum, a patient is clinically improving, we often times ignore it.

If an organism is isolated from the wound, or even isolated from the peritoneal cavity, doesn't necessarily mean the antibiotics need to be changed.

Q. In this instance do you agree with me after the intra-abdominal contents were cultured out there was no change in the antibiotic regimen to cover the Candida or enterococcus?
A. That's what the record says.
Q. I believe that is what it says.
A. I wasn't there at that time, I saw the patient on January 23rd.
MR. GOLDWASSER: You are asking after January 23rd?
Q. No, I'm asking you first of all obviously you know this case deals with an infection I claim should have been treated that wasn't treated. Did you understand that from reading the complaint and looking at the record?
A. (Indicating affirmatively.)
MR. GOLDWASSER: He's never seen the complaint. We agreed I would accept service for him, that is all right.
Q. Generally let me tell you what I allege.
MR. GOLDWASSER: He knows that.
Q. Infection should have been treated that wasn't, that ultimately led to this woman's death. Let me ask the question in this context.
In this instance I think that

probably 30, 40 minutes ago we established that there was treatment with antibiotics empirically, Flagyl, Gentamycin?

A. Cefotetan.

Q. I believe you agreed with me those didn't specifically cover Candida or enterococcus; did I understand that testimony?

A. Yes.

Q. In this instance, because those were intra-abdominal organisms which grew from a situation where the woman had peritonitis, don't you agree that medication should nave been added or the regimen changed to specifically cover for those organisms?

MR. GOLDWASSER: When should it have been changed? I'll let you answer.

Q. You couldn't change them until you knew what the cultures were. Once the culture results were reported out on the 14th of January, that's when my question is don't you believe they should have been changed to cover for those?

A. I can't speak to the thinking of surgeons who were taking care of the case. I will say this: The isolation of enterococcus, isolation of yeast does not necessarily mean that there are

significant pathogens. There is no consensus on whether or not a Candida isolated from the peritoneal cavity even needs to be treated. I'm not saying shouldn't be, I'm saying there is no consensus it should be. Same for the enterococcus. The original animal model showed that antibiotic therapy was not effective against enterococcus. Many people feel that enterococcus is a second rate pathogen, doesn't necessarily need to be treated. The belief at one point has been that polymicrobial anaerobes, aerobes, yeast, the treatment of gram negative anaerobes is crucial.

Whether or not all the organisms need to be treated absolutely specifically, I don't believe there is a uniform consensus about that.

Q. Do you believe they need to be treated?

A. In general?

Q. Yes.

A. I'm having difficulty answering the question. In this particular case they weren't treated.

They weren't treated because the patient seemingly improved, she did. She improved to the point she was discharged from the hospital, never receiving an antibiotic directed against

enterococcus or Candida. She came on steroids with hyperglycemia and survived. To all observers was in good enough shape to leave the hospital. She was in the hospital for well over two weeks.

To answer your question did she need to have these organisms treated, I can't really answer given the course that took place. When I saw her on January 23rd, she had no clinical signs of infection that I was clear about.

Q. No clinical signs you were clear about, is that what your testimony is?

A. There were no signs of significant infection, that is what I wrote in my note, that's what I felt at the time. Her temperature had come down, white count down, CAT scan showed no evidence of abscess, all the findings on CAT scan were consistent with postoperative change, the patient improved, wound became beefy, she was awake, nursing notes confirmed that, she went out of the hospital.

Q. Were you asked to give an opinion as to whether she was an appropriate candidate for discharge on the 23rd?

A. On the 23rd?

Q. Let me rephrase that question. If my English teacher was here, she could write the questions for

me.

As part of your assessment of the 23rd of January had anyone asked you for an opinion as to whether or not Carolyn should be discharged or not?

A. No.

Q. Going back to the question I asked you, I asked if you believe, not general community consensus, how you practice medicine as an infectious disease physician, would you have treated the enterococcus and Candida with a specific antibiotic?

MR. GOLDWASSER: I'm going to have a little trouble with this, Donna, Now you are making him an expert witness pertaining to matters in which he's not involved.

Q. Let me withdraw the question.

You are talking consensus. When I sat down today I noticed that you happen to own Mandell's on infectious disease; is that right?

A. Yes.

Q. You or the hospital. Do you consider Mandell's authoritative on the therapeutic regimen for intra-abdominal antibiotics?

A. I think there are many authoritative

sources. I don't believe Mandell's represents the single authoritative source. There are a number of places one can go, there are a number of things in textbooks, other textbooks, that represent opinions offered by the authors.

Q. Do I gather then you do consider it to be one of the authoritative texts on that subject matter?

A. One of the sources I refer to.

Q. Do you agree with me enterococcus is one of the most virulent of abdominal organisms?

A. Absolutely not.

Q. You don't think it is?

A. No.

Q. Just asking if you agree or disagree.

From your review of the autopsy and discharge summary in this particular matter, what is your understanding of Carolyn's cause of death?

A. She left the hospital and returned I understand five days later in extremis, hypotensive, acidotic, she was in desperate shape. The feeling was she was in desperate shape and subsequently died.

I was surprised to learn from the autopsy that she had transmural bowel ischemia, which to me represents a significant finding.

You only saw the discharge summary, not the complete Huron Road records, correct?

A. Correct.
Q. If I indicate to you that what was cultured in Carolyn at Huron Road was enterococcus, same variety we found intra-abdominally at the time of surgery at Saint Luke's, Candida, those were found to be the two organisms at work in her sepsis, do you have an opinion if changing her antibiotic regimen while she was at Saint Luke's to something that covered for those would have changed the outcome?
MR. GOLDWASSER: Objection. You may answer.
A. If one concludes that the bowel ischemia was a major contributor to her septic shock, if one also concludes that the patient was colonized with enterococcus which would include the gastrointestinal tract, then the septic shock which was reflected by the positive blood culture for enterococcus could easily have been attributed to bowel ischemia. That would not have been affected at all by changing antibiotics.
Q. Have you spoken with Dr. Rabin --
A. No.
Q. -- who prosected this?
A. No.

Q. If Dr. Rabin opined that the bowel ischemia, the process is the result of the bowel becoming ischemic because of the abscess, the abscess that was found -- you read the autopsy, found where the abscess was?
A. Yes.
Q. That was at the approximate location of the surgery, correct?
A. I can't speak to those details.
Q. Might be out of your range. I don't mean that disrespectfully. Don't take it that way.

I gather you don't have an opinion on the question I asked whether or not treatment at Saint Luke's for enterococcus and Candida would have changed the outcome?
A. I do have an opinion. The case speaks for itself to some extent. Remember now she came in with a serious infection on the 9th of January, left 16 days later without being treated for enterococcus and Candida. Then comes in five days later in extremis, why wasn't -- she wasn't in extremis before.

What had changed, despite the fact abscesses were found at surgery, there was also bowel ischemia. It may have well been the bowel

ischemia was an intercurrent, unrelated event. I'm having difficulty why she didn't die at Saint Luke's Hospital or why did she improve at Saint Luke's Hospital if these organisms were ultimately contributory to her death. I'm asking you the question.

Q. When the case is over maybe we will have lunch and debate it. I'm asking you.

A. I don't think either -- I think that raises a serious question as to what ultimately happened on the 30th of January that caused this lady to have an exacerbation that abruptly brought her to Huron Hospital.

MR. GOLDWASSER: Do you have to get that?

THE WITNESS: Let me get this.

(Interruption in proceedings.)

Q. Doctor, have you discussed Carolyn's case with any of the other doctors since I filed the lawsuit?

A. I mentioned it in passing to one of my partners.

Q. You haven't discussed this case with, sat down with Dr. Sonpal?
A. I'm sorry, one of the members?
Q. Yes, not anyone in the group.
A. Absolutely not, no.
Q. Anyone else involved?
A. No.
Q. In your note you indicated under your assessment that patient is at high risk for superinfection. I know what that says in English. Can you tell me what you are trying to convey to medical personnel, I assume that is who reads the note, what you are trying to convey in terms of writing that?
A. Something that is resistant to all antibiotics, Vancomycin. We're being inundated with Vancomycin resistent enterococcus. We need to be careful with the use of Vancomycin and this would be the agent needed in the situation. We have a high risk of VRE, Vancomycin resistent enterococcus. That is the point I'm trying to convey.
Q. So I'm clear about it, when you say Vancomycin would have been effective for the enterococcus --

A. That is not what I said.
Q. Give it to me again.
A. Vancomycin wouldn't have been the antibiotic one would choose except in a clinically significant infection due to this organism.
Q. In writing this, that the patient is at high risk for superinfection, you were trying to convey not to use Vancomycin?
A. If for example treating with Vancomycin for this patient, who did not have signs of significant infection, it would be very likely that she would be colonized or become colonized with Vancomycin resistent enterococcus and if she became colonized with Vancomycin resistent enterococcus, does develop an infection down the road, this could be an infection that couldn't be treated at all.
That's thinking now that antibiotic therapy is specifically against efecium, sensitive only to the Vancomycin, what we want to do is try to prevent superinfection. The other concern of course is other superinfections that may arise with the use of antibiotics.
Q. I'm trying to find out what you were trying to communicate where it seems to me you, correct me where I'm wrong, taking at face value what you

testified to, you were not concerned with surface enterococcus, right?

A. The point I'm making is if one treats for surface colonization for enterococcus, the patient doesn't have a significant infection, the next thing you know the next surface culture is going to grow YRE or intestinal culture grows VRE, the patient will need isolation, may not be able to go back to the nursing home. May ultimately develop an infection that can't be treated at that point.

Q. It's been pointed out to me by my associate, she had a chance to cruise through your CV, you've done research in clinical epidemiology of YRE, that's what that note means; is that right?

A. Well my partner and I published a paper regarding the VRE acquisition. It's a case report. I wouldn't call myself an expert on VRE or its epidemiology.

Q. I didn't know, I haven't read your CV, is that a publication on your CV?

A. It should be.

Q. You have also published on "Combination Antibiotic Therapy," correct?

A. That is a long, long time ago. Pediatric Clinics of North America where I was a pediatric

person, when I was a child.

Q. You know I'm going to run out, read this, Mr. Goldwasser will tell you I read everything people publish, do you remember what you reported on in that article "Combination Antibiotic Therapy" you published in 1983, were you for it or against it?

A. It was a review article describing the role of combination of antibiotics, pros and cons for various agents in various clinical situations.

Q. Any of the agents that are at issue in this case contained in that article?

A. I can't recall.

Q. No problem, I'll read it.

A. I can tell you Fluconazole is not.

Q. Fair enough.

A. Cefotetan is not. I expect Gentamycin is.

Q. Because that has been around for a while.

Let me ask you another question: Postoperatively in a patient like this, if someone was thinking that there is an infection intra-abdominally that had not been treated or resolved, how difficult **is** it to draw a fluid sample from the area indicated on the **CT** scan and culture it?

A. If there was a localized collection it could be done rather easily. With a small amount of ascites it may be difficult.

Q. That's something as an infectious disease doctor you order if you feel a necessity for?

A. Something I would discuss with a surgeon, discuss the practically with a radiologist.

Q. Along those issues of localization, do you agree with me that corticosteroids can also prevent the formation of a localized site of fluid?

A. It can. It had no difference in this since at autopsy she has an abscess which is pretty well localized, which she did not have on January 20th I might add.

Q. I agree with that, we didn't see that, did we?

A. No.

MISS KOLIS: Doctor, I don't have any other questions. I will have today's deposition transcribed, your counselor I'm certain will instruct you as to whether you should read your deposition or waive your right to read it.

MR. GOLDWASSER: Connie, send me a copy and I'll get you signature.

MISS KOLIS: I'll waive the

seven day reading requirement since we don't need to read it in seven.

Thank you a very much, Doctor.

(Plaintiff's Exhibits A and B marked for identification.)

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.

_____

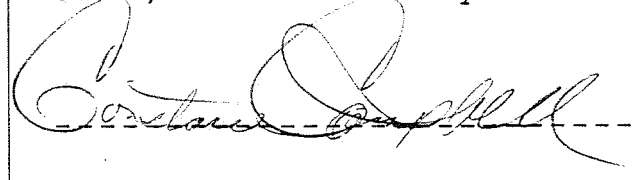
STEVEN BASS, M.D.

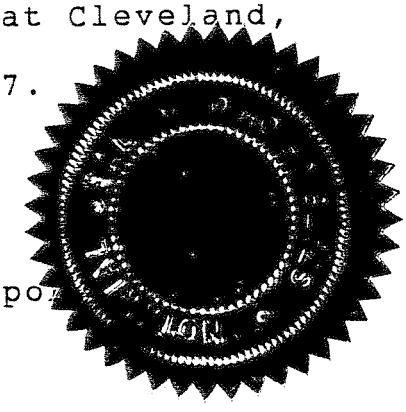
The State of Ohio,
County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, STEVEN BASS, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 31st day of October, 1997.





Constance Campbell, Stenographic Repo
Notary Public/State of Ohio.
Commission expiration: January 14, 1998.

Look-See Concordance Report

- - -

UNIQUE WORDS: 1,155
TOTAL OCCURRENCES: 3,291
NOISE WORDS: 385
TOTAL WORDS IN FILE: 9,850

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

PHRASE WORD LIST(S):

- - -

NOISE WORD LIST(S): **NOISE.NOI**

- - -

COVER **PAGES** = 4

- - -

INCLUDES ONLY TEXT OF:
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

- - -

DATES **ON**

- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE FORMS **ON**

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: 1

- - -

LIST **OF** THRESHOLD WORDS:

- - -

infection [53]

* * DATES * *

1-19-96 [1]
38:24
1-20-96 [1]
39:25
January [4]
47:19; 50:3; 54:18; 55:11
January 9,1996 [1]
10:7
January 16th [1]
16:22
January 19th [1]
38:21
January 20th [5]
20:17; 27:5; 28:25; 29:20; 60:13
January 22nd [2]
44:9, 14
January 23,1996 [3]
16:10, 20; 31:10
January 23rd [5]
21:16; 42:18; 46:8, 10; 49:8
January 25th [1]
10:8
January of 1996 **[3]**
13:20; 14:4, 25
May [2]
20:22; 58:9

* * 1 * *

1-19-96 [1]
38:24
1-20-96 [1]
39:25
100 [2]
22:19; 23:3
11311 [1]
5:20
13,000 [1]
20:16
14th [1]
47:19
16 [1]
54:19
16th [8]
16:22; 17:12, 22; 18:16; 21:2; 36:24; 42:1, 25
1976 [1]
8:17
1979 [1]
9:14
1982 [1]
9:18
1983 [1]
59:6
1996 [8]
10:8; 13:20; 14:5, 25; 16:10, 20, 22; 31:11
19th [2]
38:21; 40:12

* * 2 * *

20th [illegible]
17:12; 20:17; 27:5; 28:25; 29:20; 40:14; 60:13
22nd [4]
41:10; 43:2; 44:9, 14
23 [3]
16:10, 20; 31:10
23rd [12]
17:12; 21:16; 41:7, 11; 42:13, 18; 46:8, 10; 49:8, 22, 23; 50:3
24th [1]
41:11
25th [2]
10:8; 41:13

* * 3 * *

30 [1]
47:1
30th [1]
55:11
37 [1]
23:6
37's [1]
23:7
38 [2]
22:16, 17
38.3 [1]
23:9
38.9 [1]
23:9

* * 4 * *

40 [1]
47:1
44104 [1]
5:21

* * 7 * *

77 [1]
8:23
79 [2]
8:23; 9:3

* * 8 * *

81 [2]
9:3, 10
82 [1]
9:10

* * 9 * *

9 [1]
10:7
9th [1]
54:18

* * A * *

abdomen [2]
27:2; 28:24
abdorninai [7]
21:10; 28:1; 29:7, 8; 33:19; 37:17; 51:10
ability [2]
16:5; 30:14
able [5]
16:4; 30:5; 32:20; 52:23; 58:8
abruptly [1]
55:12
abscess [6]
49:15; 52:17; 54:3, 5; 60:12
abscesses [1]
54:24
absence [2]
27:2, 25
Absolutely [2]
51:11; 56:5
absolutely [1]
48:14
accept [2]
31:22; 46:18
acceptable [1]
5:9
according [1]
43:20
accurate [3]
5:23; 6:7; 16:7
acidosis [1]
52:2
acidotic [1]
51:20
acquisition [1]
58:16
actions [1]
13:12
actual [2]
20:11; 27:8
actuaiity [1]
32:11
add [2]
52:21; 60:14
added [1]
47:12
addition [1]
31:25
additional [1]
9:6
Additionally [1]

* * D * *

* * J * *

* * K * *

* * L * *

* * M * *

* * G * *

* * H * *

* * I * *

* * E * *

* * F * *

* * N * *

* * O * *

* * P * *

* * Q * *

* * R * *

* * S * *

* * * * T * *

* * Y * *

PLAINTIFF'S EXHIBIT
A 10-28-97
DR. BASS

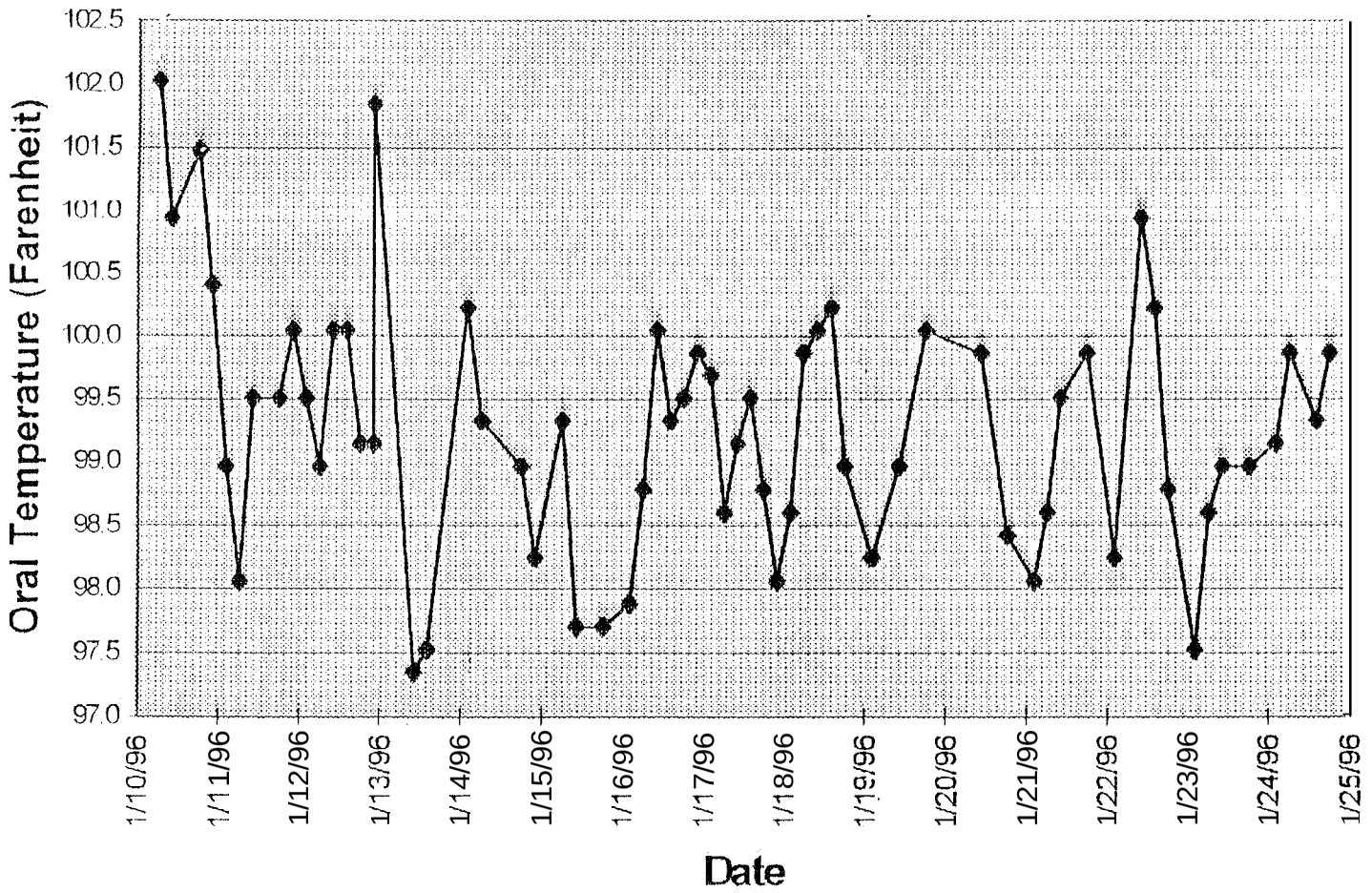
Date	
1/23/96	I.P Pt seen Hx myelitis on steroids → ocular prob → Rx'd and has improved. currently If systemic alx. Surface cultures + Entamoeba, Yeast Flagyl out x 7 days Lasix down to 12K U/A 1/hpf → 0 (A) No signs / symptoms infection Re ⊖ cultures repeat surface and mucosal Continue tx PT is @ high risk Steroid taper
	Impression (1) keep pt all antibiotics (2) Re-culture stool Flagyl out (3) May Rx c Halcinonide
1/23/96	Medicine - Attending Asked to see for c/s consult Fatty Consult in chart + recommendations

000288

A

05-606

Carolyn Yarborough



PLAINTIFF'S EXHIBIT
B 10-28-97
DR. BASS