#572

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 RAYMOND T. CHUNG, M.D., a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken via videoteleconference before Constance Campbell, a Notary Public within and for the State of Ohio, at Forum Conference Center, 1375 East Ninth Street, Cleveland, Ohio, on FRIDAY, JULY 3RD, 1998, commencing at 10:00 a.m. pursuant to agreement of counsel.

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

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I N D E X

WITNESS: RAYMOND T. CHUNG, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

RAYMOND T. CHUNG, M.D.

of lawful age, a witness herein, called by the Defendant I.M. Sonpal, M.D. 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:

CROSS-EXAMINATION

BY MR. GOLDWASSER:

Q. Your name, please?

A. Raymond T. Chung.

Q. Dr. Chung, it's been represented to me by Donna Taylor Kolis that you are prepared to travel to Cleveland in a week or so to give testimony in the case of the Estate of Yarborough versus Dr. Sonpal and Bass; is that true?

A. That is correct.

Q. Doctor, do you have opinions as relates to the cause for the late Miss Yarborough's neurologic deficits?

A. I do not have a sound medical opinion about the etiology of her neurological deficits.

Q. Do you have an unsound medical opinion?

A. My unsound medical opinion reflects that of

the neurologists who were participating in her care, that is a myelitis of undetermined origin.

Q. Do you have an opinion as to what the ultimate neurologic course would have been for Miss Yarborough had she survived?

A. I do not have an opinion concerning the ultimate outcome.

Q. Do you have an opinion based upon your review of the material provided in this case as to what her mental status was upon admission to the hospital, Saint Luke's Hospital that is?

A. My opinion concerning her mental state at that juncture, the Saint Luke's admission, was that she possessed more or less her baseline capacity. That is, an underlying state reflective of her original neurologic problem, that is the myelitis.

Q. Do you agree that she had a compromised mental status or mental state as a consequence of her central nervous system disorder?

A. Compromised mental status, that is difficult to assess based on the evidence that was presented before me.

Q. Do you have an opinion as to the cause of Miss Yarborough's bowel perforation?

A. I have an opinion, yes.

Q. What is your opinion?
A. My opinion was that the bowel perforation was likely related to constipation from profound fecal retention as a result of many factors, including immobilization, narcotic use that ultimately eventuated in the perforation that was described originally.
Q. Do you have an opinion as to Dr. Bass' standard of care as relates to taking care of Miss Yarborough?
A. Yes, I have an opinion.
Q. Do you have an opinion as to Dr. Sonpal's standard of care as relates to taking care of Miss Yarborough?
A. Yes, I have an opinion.
Q. Do you have an opinion as to the mechanism as to Miss Yarborough's proximate cause of death?
A. Yes, I have an opinion.
Q. Do you have an opinion as to whether or not the Candlewood Nursing Home through its employees complied with reasonable standards of care?
A. Yes, I do.
Q. Let's start with the last, the nursing home, what is your opinion in that regard as to whether or not the nursing home staff complied with

acceptable standards of care?
A. I believe there were no deviations from the standard of care on the part of the nursing home.
Q. Dr. Chung, am I pronouncing your last name correctly?
A. You are, sir.
Q. What material has been provided you as relates to this case?
A. Medical records relating to the hospitalization at Saint Luke's, medical records as they relate to the confinement at Candlewood. Autopsy report, as well as the depositions of doctors -- the doctors participating at your end of the case as far as expert testimony is concerned. Medical records relating to the preceding admission as well.
Q. Have you reviewed the depositions of Drs. Bass and Sonpal?
A. I have.
Q. Then you indicated you've seen the deposition of Dr. Lerner?
A. Correct.
Q. You've seen the report of Dr. Donald Frey?
A. I have not seen the report of Dr. Donald Frey.

Q. Have you seen the report of Dr. Holzman?
A. I have not seen the report of Dr. Holzman.
Q. Have you now outlined for me the extent of all the material you've reviewed as pertains to this case?
A. Yes, I believe that I have. I believe I have run the list.
Q. Have you reviewed anything in the medical literature in contemplation of formulating your opinions in this case?
A. Yes, I have.
Q. What have you reviewed?
A. I have reviewed literature as it pertains to the particular infections involved.
Q. Doctor, do you have copies of the literature available to you?
A. I have copies of literature available to me.
Q. Why don't you list for me that which you've read in the medical literature by way of title of the article and author and publication date.
A. Chapter from the textbook entitled, "Candida Infections and Candidemia," authored by Dr. Kolomkin, K-o-l-o-m-k-i-n, Dr. Anaissi, A-n-a-i-s-s-i, from a surgical infection textbook edited by Dr. Frey.

Q. Anything else?
A. That was my major reference.
Q. When you say major, were there minor references?
A. Minor references refer to my understanding from other medical textbooks about Candida.
Q. Did you make reference to the other medical textbooks in contemplation of formulating your opinion in this case?
A. The medical textbook known as Mandell's Textbook of Infectious Diseases.
Q. Anything else?
A. No.
Q. Do you consider yourself an expert in the field of infectious disease?
A. I do not.
Q. Do you consider yourself an expert in the field of general surgery?
A. I do not.
Q. My understanding from looking at your curriculum vitae is that you are a gastroenterologist; is that true?
A. That is true.
Q. That you have a subspecialty interest in disease of the liver; is that true?

A. Correct.
Q. How many times, Dr. Chung, have you personally operated on a patient who experienced a perforation of the bowel?
A. I have never.
Q. How many times, Dr. Chung, have you personally been actively engaged in the postoperative care of a patient who experienced perforation of the bowel?
A. Over the course of my career, approximately six to 10 times.
Q. Was that primarily during your postgraduate training?
A. It was primarily during both postgraduate training as well as staffship.
Q. Would you agree, Dr. Chung, that postoperative care of abdominal surgical patients is not the focus of your clinical practice?
A. I would agree with that statement.
Q. How many reports have you prepared in this case?
A. I have prepared one report.
MR. GOLDWASSER: Donna, my request to you is you favor us with a copy of medical literature that Dr. Chung made reference

to, would you do that?

MISS KOLIS: I certainly will.

MR. GOLDWASSER: Thank you.

Q. Doctor, can I assume that you have never had any training in the law?

A. You can assume correctly.

Q. Appreciating that, do you nonetheless have an impression as to what constitutes medical malpractice?

A. I have a reasonable sense of what constitutes medical malpractice.

Q. Define for me your reasonable sense, please.

A. A deviation from the standard of care that results in an altered outcome for a patient either resulting in morbidity or mortality.

Q. Do you agree that different physicians, well trained, conscientious physicians, can see a given patient and have different opinions as to how that patient is treated and none of them necessarily are committing medical malpractice?

A. Undoubtedly.

Q. Do you agree then that in the care and treatment of patients, particularly ones such as Mrs. Yarborough, that the physician must make

judgment decisions how that patient is treated?
A. It is absolutely my understanding that this is the case.
Q. Do you agree with the statement, Doctor, that medicine is an art as well as a science?
A. I wholeheartedly agree with that statement.
Q. You've indicated to me you do have opinions as to Dr. Sonpal's standard of care. I would ask, sir, what is your opinion as to whether or not Dr. Sonpal committed medical malpractice?
A. It is my opinion based on the question posed to me, that is whether there was a deviation from the standard of care, that the failure to cover particular organisms cultured from the abdominal cavity at the time of the operation for the cecal perforation was a deviation from the standard of care for an immunocompromised patient, i.e. a patient on high dose corticosteroids with diabetes mellitus, and that specific measures should have been taken to address the organisms in question.
Q. Hypothetically speaking, if Miss Yarborough had not been immunosuppressed because of corticosteroid medications, would your opinion change?
A. My opinion would change.

Q. What would be your opinion if hypothetically that had been the case, everything else remaining the same?

A. If the patient in question had not been immunosuppressed I think there would have been a wide latitude in terms of decision making responding to the culture reports --

Q. I'm sorry, Doctor, did you finish?

A. -- i.e. it would have been defensible to have pursued any of a number of decisions at that juncture, i.e. to treat according to the culture results or not to treat according to the culture results.

Q. Can I then in summary state that if hypothetically this patient had not been immunosuppressed or compromised, the care rendered in your judgment would have been acceptable?

A. That is correct.

Q. My partner, who is with us in the room today, is representing Dr. Bass. I'm going to allow her to ask you similar questions as relates to him.

Doctor, have you then outlined for me the full extent in which you believe Dr. Sonpal, the primary attending general surgeon, committed medical malpractice?

A. I believe that from the standpoint of those culture results, that another course of action was warranted, i.e. addressing the organism in question. I also believe from the point of view of the discharge of the patient at the time that she was discharged, namely the 25th of that month, I believe that strong consideration should have been given to persistent or unaddressed abnormal objective findings.

Q. I appreciate your answer you've just given, I confess I don't understand it.

What is it about the discharge that you believe Dr. Sonpal should have done?

A. There was a persistent -- in reviewing the laboratory data, there was a persistent presence of what are known as band forms on the differential of the white blood cell count. That persistence to say the least was troubling.

Understanding of course the total white blood cell count had diminished, the persistence of so-called left shift of the white blood cells was both disturbing in view of the fact that certain of the organisms in question had not been fully addressed.

Q. What do you think that Dr. Sonpal should have

done in order to comply with the standard of care?
A. I believe that a strong consideration should have been given to readdressing the issue of administering either continued or adding on antifungal, antimicrobial therapy that addressed the two organisms in question.
Q. Have you now completed your answer to my question about Dr. Sonpal's deviation from standards of care?
A. I believe I have.
Q. So to summarize, there are two deviations. One, he in your opinion failed to cover the organisms cultured during surgery in the presence of an immunosuppressed patient. Number two, he failed to cover with the appropriate antibiotics, antifungal medication in view of a shift in the bands close to the time of discharge?
A. Correct.
Q. Have I correctly summarized your opinions?
A. You have.
Q. Doctor, what was the direct precipitating cause of Miss Yarborough's death?
A. The direct precipitating cause from my interpretation from the postmortem examination was she succumbed to the consequences of sepsis.

Q. What caused the sepsis?
A. From a review of the autopsy results, my belief is that her sepsis resulted from persistent and a very large residual, or development of a very large abscess within the intra-abdominal cavity, specifically in the subdiaphragmatic region.
Q. The sepsis I assume was a consequence of microorganisms?
A. Yes.
Q. The abscess was formed as a consequence of microorganisms?
A. Yes.
Q. Which microorganisms are you alluding to?
A. I'm alluding to Candida albicans and Enterococcus fecalis or fecal.
Q. What proof do you have that Enterococcus was involved with a residual abscess?
A. The suggestive data from the patient at the time of her presentation, her final presentation, presented with Enterococcal bacteremia; therefore, the belief is that the Enterococcus was a contributor to the septic picture.
Q. It was not cultured out of the abscess though was it, during postmortem?
A. May I review again?

Q. Of course. Are you looking at your personal notes, Doctor?
A. I'm looking at the autopsy report.
Q. Fair enough.
A. That is correct.
Q. So I assume there is a positive blood culture for Enterococcus that's the basis of your opinion that contributed to her sepsis?
A. It is an opinion that it did contribute to her sepsis.
Q. To cut to the quick here, because Candida species were grown or cultured from the subdiaphragmatic abscess, I'm assuming that is the basis of your opinion that Candida played a role in her sepsis; is that true?
A. That is correct.
Q. Doctor, I've alluded to my next question briefly earlier but I will ask it in a little difference fashion: What has been your experience since your postgraduate training in treating postsurgical polymicrobial or mixed organisms in the abdominal cavity?
A. I participate in the care of patients who essentially undergo a perforation in a postoperative fashion. I've also participated in

the care of patients who have undergone perforations through GI instrumentation, of which I'm a specialist.

Q. GI instrumentation you are a specialist, right?

A. Correct.

Q. These patients you participated in, were you the physician who was responsible for ordering the antibiotics?

A. I was not the physician responsible for ordering the antibiotics, I was the physician responsible for consulting and helping to advise on antibiotics.

Q. Have you published anything in the medical literature dealing with this subject?

A. I have published on the subject of Candidas in a solid organ, especially the GI tract, on specifically the formulation of Candidas as relates to the pancreas.

Q. Does that have relevancy to this case, the case of Miss Yarborough?

A. Not directly.

Q. Is that publication listed in your curriculum vitae?

A. I believe it is.

Q. Would you turn to your curriculum vitae, make reference to the page and the number in which that appears.
A. Under original reports, item number five.
Q. Page 4?
A. Page 4.
Q. Item number five?
A. Correct.
Q. Anything else?
A. There is a chapter from item number seven, page 5, "Bacterial Parasitic Infection of the Liver" that addresses infection, including fungal infection of the liver.
Q. Did this patient, Miss Yarborough, have a fungal infection involving the liver?
A. She did not.
Q. Doctor, while we're dealing with the subject of your experience of treating polymicrobial infection from bowel perforations, tell me in general what is the nature of your practice?
A. The nature of my practice is a gastroenterological practice. I see patients who have general GI problems, I see patients with liver diseases; therefore, the subspecialty of hepatology being prominent within that practice as designated

in the curriculum vitae. I perform instrumentation, i.e. colonoscopy and endoscopies on patients as well as liver biopsies. I help to prepare patients for the transplantation of the liver.

Q. Doctor, you have reviewed Dr. Sonpal's deposition, have you not?

A. I have.

Q. Turn to page 24, line 13 of his deposition, please. You have it there?

A. I do.

Q. Doctor, I'm going to read this into the record so that the question and answers make sense for your deposition, bear with me, you can follow along if you like. Question beginning on line 13, page 24, "Between January 10th and January 22nd you didn't need clarification on those two organisms by infectious disease? Answer: No. Question: Why not? Answer: The reason for that was those two organisms were growing out of the abdominal cavity, where we had cultured the stool in the abdomen, in addition to multiple other organisms that grew at the same time. She had been treated with multiple antibiotics at the time. In a situation like that it is more of a response of the patient to the

treatment that is important rather than treating the actual cultures." End quote.

Doctor, do you agree with that statement?

A. No.

Q. Why not?

A. I believe that there are a set of extraordinary circumstances which I outlined earlier that characterize this particular patient.

That is, she was immunosuppressed. I believe as I have stated in my own formal opinion earlier that immunosuppression changes the equation insofar as it throws out her ability to reliably follow signs and symptoms on the part of the patient, i.e. a patient can appear by signs and symptoms to be doing reasonably well, indeed experiencing failure to improve or indeed continued proliferation of the organisms, potentially these organisms in question; therefore, that is the basis for my disagreement with that statement.

Q. So you believe that Miss Yarborough's postoperative clinical state was in part influenced by the fact she was receiving corticosteroids?

A. I do.

Q. What specifically were the corticosteroids

influencing during the postoperative course while she was at Saint Luke's Hospital?

A. Could you clarify what you mean by specifically?

Q. You say her clinical course was being in part influenced by the fact she was on corticosteroids, correct?

A. Right.

Q. I want to know specifically what it was that was being influenced by the corticosteroids?

A. Specifically corticosteroids in high doses as she was receiving have an immunosuppressive effect. I think there is general agreement on that fact, that in the face of immunosuppression by corticosteroids and secondarily by her state of diabetes which it could have been aggravated by corticosteroid use, she was in an immunosuppressed condition.

Q. But what specifically is it impacting? Is it impacting upon the white blood count, impacting upon the formation of abscess, those are the kinds of things I mean by my question, not intending to answer it for you; do you see what I mean?

A. I do. As a matter of fact, I believe that corticosteroids had an impact on white blood cell

function specifically. They also impact white blood cell count, making it difficult to interpret the nature or trend of her counts. They also impact as you actually have pointed out the development or ability to form abscesses.

From all of those standpoints, I believe at that level they always result in impaired post defense of other infections of a bacterial or fungal nature.

Q. Doctor, were the offending organisms that led to her death ever covered by antibiotics during her postoperative -- postsurgical course?

A. I believe infectious disease consultants would speak to this with more expertise than I.

It's my belief that Candida was clearly not covered. Secondly, Enterococcus was suboptimally covered by the antibiotic regimen chosen.

Q. How do you explain, sir, that by virtue of what you just stated, that this patient clinically appeared well for a postsurgical candidate up until the day she was transferred septic to Huron Road Hospital?

A. It is I think not mutually exclusive. It is not exercising mutually exclusive statements to say

that one could clinically improve initially on antibiotic regimen that covered most of the microbes present in fecal soilage, i.e. anaerobes and gram negative organisms, but leave behind residual organisms that were less well covered, therefore had a chance in a sense to catch up over the course of time in terms of their development of larger and larger in this case abscess formation, but to be left behind to residually replicate and become more problematic over the course of time. I do not believe it is inconsistent that the idea that there be a transient movement, improved, followed by an abrupt decline.

Q. Doctor, I hear your answer, I'm certainly not qualified to debate the subject with you. I'm a little confused. I ask for your help here.

The basis of your opinion as I understand it is really coming down to the fact that an immunosuppressed patient secondary to taking corticosteroids is the distinguishing feature in this case; you made that clear, correct?

A. Correct.

Q. So here you've got a patient whose got soilage of the abdominal cavity, including the gut organisms of Enterococcus and Candida, correct,

secondary to perforated bowel, correct?
A. Correct.
Q. These are organisms that are not optimally treated with antibiotic and antifungal medication, correct?
A. Not the ones chosen, correct.
Q. Here you've got an immunosuppressed patient who for almost three weeks is not demonstrating signs and symptoms of becoming septic from those organisms. I guess my dilemma is if immunosuppression is such a distinguishing feature in this case from your standpoint, how is it that for three weeks this patient can have these residual organisms festering in her body or existing in her body, not show signs of sepsis earlier?
A. It's my belief that as I referred to in my previous response, that an immunosuppressed patient can improve on a regimen, there is a phenomenon known as partial treatment, partial response to therapy.

It is difficult to assess completeness of response in someone who is immunosuppressed; however, in view of the fact as I referred to earlier signs and symptoms are not to

be trusted, therefore in abandoning your reliance on signs and symptoms we may have to resort to more empiric approaches, reflexive approaches if you will to addressing the generally immunocompromised host, even as there appears to be a transient improvement in the short term.

Q. So the CT scan that was ordered by Dr. Sonpal, taken on January 20th, would you agree from your interpretation of the radiologist's review of that scan that it was reassuring at least as to that aspect of her progress?

A. From an objective standpoint it suggested an improved trend, yes. It could not exclude the diagnosis of infection, i.e. residual infection.

Q. I understand you are telling me then that the reason you have a CT scan 10 days postop that is reflective of an encouraging trend is because she was on corticosteroids?

A. I don't understand the question.

Q. Here is Dr. Sonpal trying to do the right thing for this patient, he says he knows that he's got gut organisms from soilage when the bowel perforated, he orders blood cultures which are negative, he orders a CT scan, the purpose of which is to see whether or not there is a development of

abscess or abscesses in the gut to give him a reason to be concerned about her postoperative course, he's reassured from the negative blood cultures, he's got a CAT scan that is reassuring, do I understand from you these reassuring tests were in fact negative, at least negative from the standpoint of giving the doctor reason to be concerned about a development of abdominal abscess because she was on corticosteroids, is that what you are saying?

A. I believe that as reassuring as the data were, that it does not change the initial impression that those microorganisms should have been covered based on the original data.

Q. So to really cut to the quick, what you are saying is in the presence of the abdominal cultures that we see in this case, in the presence of a patient who is immunosuppressed because she is on corticosteroids, it is the absolute duty and responsibility of the attending physician to empirically cover this patient with an appropriate antibiotic and antifungal medication?

A. That's what I'm saying.

Q. Have I correctly cut to the quick?

A. You have cut to the quick.

MR. GOLDWASSER: That is my M.O., right, Connie?

Q. Doctor, between the two organisms, the Enterococcus and Candida, was more than the other the trigger leading to the patient's sepsis and death?

A. I believe that the development, as I referred to earlier as the development of the abscess was the major contributor to the proximate cause of her death; therefore, I believe it was the persistence of Candida that was more preeminent a factor or a stronger factor than the presence of Enterococcus.

Q. Was this patient at risk for developing a super infection if antibiotics had been administered to cover the Enterococcus?

A. She was at risk for super infection whether Enterococcus was covered or not. I suppose if you look at this quantitatively, the broader the spectrum of antibiotics added on, yes, the greater the risk of super infection. I believe she was at risk of super infection irrespective.

Q. Wasn't she at increased risk of super infection if additional antibiotic coverage had been given?

A. Theoretically she was at increased risk of

super infection, that is correct.
Q. I assume from what you are telling me, even though she was a potential candidate to that increased risk, that risk did not overcome the need for empirical antibiotics in this patient?
A. Right. The reason I say that is when I say empiric antibiotics, I mean empiric antibiotics to not only cover Enterococcus, more importantly to cover Candida. In the face of antibiotics that promote super infection, you need to cover the super infecting organisms, i.e. the fungus.
Q. When were antibiotics discontinued in this patient, what date?
A. They were stopped at day 10.
Q. How many days thereafter was it before Miss Yarborough demonstrated signs and symptoms of sepsis?
A. She came in on the 30th, antibiotics were stopped at day 10, that would be about 10 days.
Q. Let me make sure I understand. I realize some of this is overlapping testimony, please be patient with me.
I thought I heard you say that one of the reasons why a patient such as Miss Yarborough might have resistant organisms

which have not fulminated is because she is receiving other antibiotic therapy or collateral antibiotic therapy. Those are my words, trying to paraphrase what you said. Did you say something to that effect?

A. I said that the administration of a broad spectrum antibiotic initially given may have, may have stalled the development of a more fulminant picture.

Q. Here she is totally off antibiotics for 10 days before she is septic, what is stalling it during those 10 days?

A. I believe that what you've just alluded to in constructing a scenario could very well be the fact that having removed the impetus for super infection, i.e. the administration of broad spectrum antibiotics, the Candida in a sense was left behind to reproduce under the selective pressure of immunosuppression alone.

In a sense you could plausibly state the Candida had a chance to grow at a lesser rate than it would have on broad spectrum antibiotics, that would have promoted its growth further. In a sense the rate of growth of Candida post discontinuation of antibiotics may have been

slowed by the removal of that stimulus to its growth. This is a hypothetical explanation of the event as you know.

Q. Do you state that with reasonable medical certainty?

A. I state that as an opinion.

Q. I understand. Is your opinion stated with reasonable medical certainty, or is it mere speculation?

A. It is strong speculation.

Q. So less than reasonable medical certainty, correct?

A. It is less than reasonable medical certainty.

Q. From your review of the medical record, do you agree that the patient postoperatively had no rebound phenomenon, abdominal rebound phenomenon?

A. Yes.

Q. Do you agree?

A. That would be my interpretation.

Q. We've already discussed that postoperatively the January 20th CT scan was reassuring, correct?

A. It was reassuring.

Q. Do you agree from reviewing the medical record that the patient had negative blood cultures

10 days postop?
A. Yes.
Q. Do you agree that during the patient's postoperative course, that except for one day, the white blood cell count was stable and then was dropping to within the normal range by the time of discharge?
A. I agree with the fact that the trend of the absolute white blood cell count had decreased; however, as I believe I stated earlier, the object of residual concern was that of the band forms.
Q. Do you agree that or do you have any reason to disagree with the physicians who were there looking at the patient, that the wound, the surgical wound was looking good?
A. I was not there at that time, I would have to defer to their direct exam opinion.
Q. Do you agree from your review of the medical record that considering the very serious surgical emergency that was confronting this patient, a patient who clearly was at risk for death merely because of bowel perforation, in fact postoperatively this was a patient who generally was looking well?
A. This was a patient who had made an impressive

short term recovery.

Q. Would you agree from your review of the record, that the urine culture ordered by Dr. Bass or recommended by Dr. Bass, interpreted and finally read on January 24th I believe it was, was negative?

A. Yes.

Q. How do you explain the fact that she has a negative urine culture on January 24th, a positive urine culture for Enterococcus on January 30th?

A. One of my concerns there is that with the development of the septic picture that eventuated in her demise, that the extent of her bacteremia was so high grade that she developed not only positive blood cultures, but a positive urine culture.

Again, as perhaps my infectious disease colleagues may opine more definitively than I on this subject, when we see positive blood and urine cultures, especially in the absence of a positive urine culture from five or six days previous, we need to be concerned about the fact this has been high grade bacteremia, leading to the seeding of multiple sites, including the urine.

Q. So what in essence we're having, if I

understand right, if I could use lay terminology, you had persistent organisms that were festering in this patient, because of her immunosuppressed state, she literally broke loose after she was out of Saint Luke's Hospital; is that fair?

A. That's a fair statement.

Q. I know that's not a scientific statement, as a layman?

A. But it's a fair encapsulation.

Q. Doctor, you've indicated that you've published as relates to the subject of Candida.

Does Candida require treatment when it is part of a mixed infection generally speaking?

A. Generally speaking it is a debateable point. It depends on the context under which it is cultured. The fact is, is that in the setting of polymicrobial sepsis in the immunocompromised host the Candida must be addressed.

Q. This may be moot because of your opinion about the distinguishing role that immunosuppression played in this case; Dr. Lerner testified on page 36 of his deposition, I'm not going to read the whole thing, you can glance at it if you want, my impression, to summarize what he

said on page 36, is that many surgeons do not treat every patient with antibiotics based upon what is grown from stool. Obviously we're talking about in a setting like Mrs. Yarborough, that's a perforated bowel; do you agree with that?

A. Once again I agree with that statement generally speaking in an immunocompetent host. As I've said before, in an immunocompromised host, all bets are off.

Q. Do you agree that even if antibiotics and antifungal medication are given to patients such as Miss Yarborough, that it might not eliminate all organisms?

A. That is a correct statement.

Q. Do you have an opinion as to whether or not she would have succumbed to sepsis even if she had been treated with antibiotics sensitive to Enterococcus and antifungal medication?

A. I'm not a seer, it's my belief that more likely than not she would have made it through this period if those agents had been administered empirically.

Q. The autopsy report describes the jejunum, I'm sure that Donna, being the wonderful lawyer that she is, has pointed that out to you. Just for the

record, we note from the postmortem exam that there is a five centimeter area of transmural ischemia.

Doctor, can gut organisms escape from the jejunum in the presence of a transmural ischemia?

A. Yes, they can.

Q. Did they in this case?

A. It cannot be stated either with certainty -- excuse me, it cannot be stated with certainty that they did or did not in this case.

Q. Can it not be a reasonable scenario in this case, that in fact this patient died because of the escape of organisms from the transmural ischemia of the jejunum?

A. Given all the evidence from the microscopic and macroscopic description of the autopsy, I believe that is an unlikely scenario.

I believe the more rational scenario is that the area of ischemia in question, the focal ischemia was the result of a hypotension or low flow state created by an overwhelming sepsis that brought her to the hospital during her terminal admission, therefore effect rather than cause.

Q. What medications do you order for the

treatment of Candida albicans?
A. There are two predominant agents, the first is Amphotericin B intravenously. The second is Fluconazole or other related derivitives.
Q. You've read Dr. Lerner's deposition, you've read his discussion of those two drugs?
A. I have.
Q. Is that correct?
A. Yeah, I have.
Q. Do you agree with Dr. Lerner that Amphotericin B puts the patient at risk for developing kidney malfunction?
A. Yes, Amphotericin B has a number of toxicities. The most prominent of which is renal toxicity; however, if given for a reasonable course of time, most patients can endure that therapy without significant complication or sequelae.
Q. So it's your opinion that the risk of renal toxicity from the administration of Amphotericin B should not out weigh the consideration of giving that medication in a setting such as Miss Yarborough; is that what you are saying?
A. I believe that is correct.
Q. Nonetheless do conscientious physicians take into consideration the toxicity of medication

before they order it?
A. There is no question.
Q. Doctor, I want to change the focus for a moment to your medical/legal experience.
To your knowledge how is it that you came to meet Donna Taylor Kolis?
A. Excuse me?
Q. How did you meet Miss Kolis?
A. Miss Kolis called me upon referral from another local physician in town in Boston, another physician who has worked with her before.
Q. What is the name of that physician?
A. Dr. Mark Peppercorn.
Q. Do you know Dr. Peppercorn?
A. I do know Dr. Peppercorn.
Q. What is his specialty?
A. Gastroenterology.
Q. Do you know why Dr. Peppercorn didn't review this case for Donna?
MISS KOLIS: Do you want me to testify? Are you asking him?
MR. GOLDWASSER: I want to know if he knows.
Q. Do you know?
A. I don't.

Q. Did you ever speak to Dr. Peppercorn in any fashion whatsoever about reviewing this matter?
A. Not at all.
Q. How many medical/legal cases have you reviewed in your professional career?
A. This is the initial.
Q. What motivated you to review this one?
A. Donna came to me seeking my opinion concerning the events that surrounded the initial perforation event, asked for my opinion whether I would be willing to review the records concerning those events. I told her I would be willing to review those events.
Q. So initial reason why she came for your opinion has been now transcended; is that true?
A. It has evolved, that is correct.
Q. I assume that is because you concluded that the care other than that which you've criticized, was perfectly acceptable and appropriate?
A. It is because there was -- it was deemed there was not significant deviation from the standard of care surrounding those events.
Q. By the way, Doctor, when you prepared your report of January 25, 1998, I assume that you had essentially the same documents available to you

then as you do now?

MISS KOLIS: I'm going to testify. I believe the only thing he didn't have was the most recent submission of all her preceding hospital records. I think by that time he had everything.

Q. Is that true, Doctor?

A. Yes.

Q. Since this is your first experience at a medical/legal matter, what are you going to charge, what is your fee?

MISS KOLIS: He wants to know what your hourly charge is for reviewing.

THE WITNESS: Should I answer?

MISS KOLIS: Of course.

A. $200 an hour, sir.

Q. Is that what you are charging Donna?

A. Correct.

Q. Is that what you are charging me for this deposition?

A. Yes.

Q. Doctor, have we now thoroughly discussed with you in the last hour all of your opinions as relates to what you believe constitutes

unacceptable or substandard care of Dr. Sonpal?
A. Yes.
Q. Other than Dr. Bass, which my partner will ask you about in a few moments, do you have criticisms of any other physicians at Saint Luke's Hospital?
A. No because the responsible physician, the attending physician of record was Dr. Sonpal.
Q. Have we thoroughly discussed your opinions as to what we lawyer's refer to as proximate cause of death?
A. Yes.
Q. Have you been asked to render any opinions at trial on a subject we have not discussed?
MISS KOLIS: Life expectancy question.
A. Yes, the life expectancy question.
MR. GOLDWASSER: Donna, is there anything else?
MISS KOLIS: I believe that is it other than --
Q. What is your opinion?
MR. GOLDWASSER: Go ahead.
MISS KOLIS: Other than a question I would undoubtedly ask him, although it

is not a major issue in the case, as a gastroenterologist what were the chances of a successful reversal of the ileostomy if she had lived.

Q. What is your opinion as to that?

A. My opinion was that the reversal of the ileostomy had the intra-abdominal infection cleared was definitely feasible.

Q. Was the patient at risk for such?

A. It depends on the state of immunosuppression at that time that would be entertained.

Q. What is your opinion as to life expectancy?

A. Again, not having a real feel for her underlying neurological condition, I believe that her life expectancy was limited by the fact that she was being treated with immunosuppressives that not only increased her risk for complication of immunosuppression, also the diabetes it may have also contributed to. So the surrounding, perhaps not the underlying condition, but the surrounding aspect of that condition may have shortened the expectancy.

Q. It is true, is it not, Doctor, that it is probable Miss Yarborough would not have survived a statistical life expectancy for a black female; is

that not true?
A. It's probable.
Q. Are you able to guess for us how many years were reduced from her statistical life expectancy?
A. I could not state with reasonable certainty an exact number of years. Only I could attest to the fact her expectancy would be shortened.
Q. Here you have an individual who is not only immunosuppressed because of her corticosteroid regimen, but a patient who has got diabetes, a patient who is in fact debilitated, essentially nonambulatory; isn't that true?
A. At that point in time that is true.
Q. She was nonambulatory over and beyond the development of the bowel perforation, correct?
A. Yes.
Q. Doesn't that added factor, that is the fact of being nonambulatory, increase the likelihood that there would be a reduction in life expectancy?
A. Yes.
Q. Doctor, we have now then I take it covered all of your opinions that you currently hold in this case; is that true?
A. Yes.
Q. Because you understand since this is your

first experience with this, let me explain if you don't understand, the reason we're going through this exercise is that I as attorney for the Defendant Dr. Sonpal, Saint Luke's, can discover from you all the opinions that you hold in this case in preparation for trial. So I want you to make sure that you share with me all your opinions you indicated now that you have; is that true?

A. That is true.

Q. Doctor, between now and trial if for any reason you should change your opinion, modify your opinion or add to your opinion, would you assure me, please, that you will so inform Donna Taylor Kolis who in turn will have the duty to inform me?

A. I will.

MR. GOLDWASSER: Doctor, I thank you. My partner is now going to inquire of you. Before she does I want to take a one minute break to go to the men's room. I don't know if you are comfortable, you can do the same if you want, then we will continue with Marilena's inquiry of you. I'll be back in one minute.

(Recess had.)

MISS DISILVIO: Dr. Chung, my name is Marilena DiSilvio, I represent Dr. Bass in this lawsuit.

CROSS-EXAMINATION

BY MISS DISILVIO:

Q. I understand from your testimony to Mr. Goldwasser that you have some opinions about Dr. Bass' care of Miss Yarborough?

A. That is correct.

Q. Doctor, could you please tell me your opinions?

A. My opinion is that Dr. Bass was called in to render an opinion on the judiciousness of antibiotic or antimicrobial selection well into the admission of Miss Yarborough. It is my opinion that from the standpoint of rendering opinion on a strict question, rather than on a global picture, that a less than optimal opinion was therefore delivered.

It is not my place to determine the quality in terms of the delivery of a suboptimal opinion or substandard opinion from the standpoint of addressing the original question, i.e. whether that problem lay in the hands of the asker of the

consultation or the consultant himself, i.e. whether he was put in a position -- a compromised position by being asked a very specific question long after the series of events had taken place. Was it the fault of the original asker of the question is again beyond by ability to render judgment on; however, my net opinion is that a more complete opinion, based upon the entire facts of the case, should have been rendered.

Q. Doctor, forgive me, I heard your answer but I didn't understand it. So I want to break it down if we can.

A. Sure.

Q. What is your understanding, based on your review of the records, as to why Dr. Bass saw this patient?

A. He was being asked to in a sense endorse the antibiotic selection in the case of that patient several days after the cultures had returned from her intraoperative cultures.

Q. On what date did Dr. Bass see the patient?

A. January 23rd.

MISS KOLIS: Look in your records if you want to.

Q. On what date, Doctor, were antibiotics

discontinued?
A. January 20th.
Q. It's your opinion from your review of the records then that Dr. Bass was called in to endorse the antibiotic selection which had been discontinued three days prior to his seeing the patient?
A. Correct. To endorse not just the selection but the choice to discontinue.
Q. Is that your understanding of the sole purpose of why he was called to see this patient?
MISS KOLIS: You can look at the note.
A. May I look at the note?
Q. Certainly.
MISS KOLIS: It's in the progress notes, he didn't write a consultation.
A. Could you once again remind me of the question.
MISS DISILVIO: Connie, read it please.

(Question read.)

A. It's difficult to determine from the medical

records because the reason for the consultation was not stated.

Q. Doctor, you reviewed Dr. Bass' deposition testimony?

A. I have.

Q. From your review of his deposition testimony, what is your understanding why he was called to see this patient?

A. It is my understanding that he was asked to interpret the results of the cultures from the intra-abdominal cavity at the time of the operation.

Q. Was he asked to inspect the wound?

A. He was asked to render an opinion as to the appropriateness of therapy. He indeed did examine the patient. Whether he was asked explicitly to examine the wound is inference.

Q. Other than January 23rd, did Dr. Bass ever have another opportunity or any other opportunity to examine this patient?

A. No, there is no other record.

Q. So returning then to my original question, Dr. Chung, what are your opinions and/or criticisms of Dr. Bass' conduct on January 23rd?

A. Given the circumscribed nature of the

question, given the fact that this patient at that point had been off of systemic antibiotics for several days, I do not believe that his opinion was a deviation from the standard of care in view of the fact that there had been the interval of improvement.

I should note that other recommendations were reasonable from the point of view of rechecking the urine culture with the Foley catheter out, a recommendation was made as to may treat with Fluconazole for the Candida. These were reasonable recommendations given the position he was placed.

Q. So then, Doctor, am I correct you have no opinions that are critical of Dr. Bass' conduct?

A. They are critical I think in the realm of infectious disease. I would defer to the infectious disease opinion of other expert witnesses or expert opinions concerning his conduct from an infectious disease standpoint.

From my general interpretation though of events is that given the position he was put in, that there was not significant deviation from standard of care.

Q. Again, Doctor, because this is the only time,

the only opportunity I will have to speak with you before trial, am I correct in understanding your testimony that at the time of trial you will not be verbalizing any opinions that are critical of Dr. Bass?

A. From a medical/legal standpoint that is correct.

Q. From any other standpoint will you be verbalizing any criticism of Dr. Bass?

A. It is I believe unfortunate that he was placed in that position because I think it was difficult to render an opinion that could have been extremely helpful when consulted at that point in time.

Q. Doctor, let's see if we can distill this to one simple proposition we can both agree on. You are not going to give an opinion to a reasonable degree of medical certainty that Dr. Bass deviated in any way from accepted standards of care, correct?

A. I will defer to an infectious disease consultant who could speak to those things better than I could.

Q. Based on the fact you defer, we can agree you will not have any such opinions?

A. Correct.
Q. Doctor, is there any circumstance in which an immunosuppressed patient with a polymicrobial infection, including Candida, does not require empiric coverage?
A. I can think of none.
Q. So it is your opinion that an immunosuppressed patient should always be managed by treating the culture?
A. That is my belief.
Q. You have indicated to Mr. Goldwasser in an immunosuppressed patient a white blood cell value is not clinically reliable; is that correct?
A. In and of itself as a solitary determination that is correct.
Q. Help me to understand. It was my impression from your testimony that in an immunosuppressed patient you do not find clinically reliable indicators such as white blood cell count, blood culture, absence of abscess, absence of rebound, et cetera; is that correct?
A. That is more or less correct. The only contention I would have with that is if you had a clear-cut trend in an ominous direction, so in other words if you had any of those objective signs

or symptoms speaking to something in a positive sense, i.e. for a finding of a complication, then of course you need to follow those.

On the negative side, i.e. in the absence of such data suggested by any of the criteria you just described, that is correct, you cannot trust negative data. You can trust positive data; does that make sense?

Q. I believe that makes sense. Let me pose another question so we can rest comfortable I understand what you are saying.

Where the clinical indicators of white blood count, wound healing, blood cultures tend to show improvement, you would not rely or trust those factors in monitoring the treatment of an immunocompromised patient?

A. That's right. They cannot be relied upon incontrovertibly.

Q. In the treatment of infection in such a patient, correct?

A. Correct.

Q. It's further my understanding that you would treat an immunosuppressed patient with a polymicrobial infection, including Candida, such as Miss Yarborough, with an antifungal such as

Amphotericin B or Fluconazole; is that correct?

A. Correct.

Q. Doctor, could you tell me then what clinical findings or indicators you would look to to monitor the patient's treatment once these antifungals are started?

A. This is obviously empiric therapies must rely on empiric end points, so I would defer to an infectious disease consultant concerning duration of therapy. One would have to set duration limits in view of the fact those signs and symptoms are hard to rely upon.

The short answer to that question is we do not have clear landmarks and I would defer to the infectious disease consultant from the point of view of establishing duration of such treatment.

Q. Are there any parameters you would look at in the day-to-day treatment of this patient while he or she is receiving an antifungal, to determine how effective the treatment was?

A. Yes, insofar as all of these criteria and parameters have been described as being imperfect, they are what we have. We do follow those criteria, irrespective of -- in terms of guessing a

gestalt if you will of how a patient might be doing. We can't use them an absolute basis for determining either persistence or recovery of microorganism in question.

Q. In addition to --

A. You go with what you have.

Q. In addition to white blood cell count, wound healing, negative diagnostic studies, we also have the physician's hands-on evaluation of the patient, correct?

A. Of course.

Q. These parameters all taken together are parameters you would monitor in the treatment of a patient who is on antifungals for polymicrobial infection?

A. That is correct.

Q. Doctor, what if any significance did Mrs. Yarborough's wound culture have, not her abdominal wound from surgery, the subsequent superficial wound culture?

A. Again I would defer to the opinion of your infectious disease consultant concerning the significance of that culture. It's a general sense that they are less informative than the intra-abdominal cultures from the operation.

Q. When a patient is being treated with antibiotics, are you able to tell me what organisms we expect then to see during that time period that the patient is receiving antibiotics subsequent to the discharge of those antibiotics?

A. I'm not sure I understand the question.

Q. Forgive me for poorly phrasing it.

If a patient is on antibiotics, such as the antibiotics Miss Yarborough was on postoperatively, are there any organisms in the body that we expect to see?

A. From the point of view of super infection the presence of Candida in the original culture certainly would raise concern about the overgrowth of Candida in the face of broad spectrum antibiotics, so the answer to your question I guess is yes.

Q. Indeed is it fair to say that because Candida is a fungus, and the antibiotics were antibacterials, we would expect to see the fungus?

A. It is a very fair statement to say that the growth of the fungal organisms would have been promoted by the use of antibiotics, yes.

Q. Doctor, am I to understand from your curriculum vitae and your testimony today you do

not have any specialty training in infectious disease?

A. You are correct.

Q. You do not hold yourself out as a physician who practices infectious diseases?

A. Correct.

Q. Indeed in your practice I would suspect that you often call upon infectious disease to consult on your patients?

A. Fairly frequently, not excessively common.

Q. Doctor, have we discussed all of your comments, as you will not be giving opinions, as they relate to Dr. Bass?

A. Yes.

MISS DISILVIO: Thank you very much, Doctor.

MR. GOLDWASSER: Doctor, Donna, we've now finished. We thank you both very much. Doctor, thanks for cooperating with us.

THE WITNESS: Thank you.

MISS KOLIS: Will you agree to waive signature on this deposition, or you want him to read it?

MR. GOLDWASSER: That's up to Connie. I don't care if he reads it or doesn't.

MISS KOLIS: We will waive signature.

MR. GOLDWASSER: Doesn't matter.

MISS KOLIS: We will waive signature.

(Deposition concluded; signature waived.)

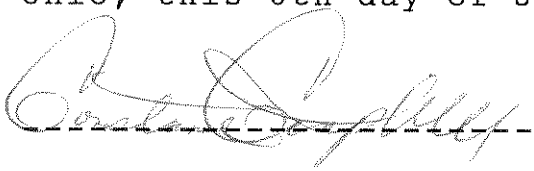
The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, RAYMOND T. CHUNG, 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 6th day of July, 1998.



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

Look-See Concordance Report

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TOTAL OCCURRENCES: **3,335**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **9,260**

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SINGLE FILE CONCORDANCE

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PHRASE WORD LIST(S):

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

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COVER PAGES = 4

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INCLUDES ONLY TEXT OF:
QUESTIONS
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POSSESSIVE FORMS **ON**

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MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

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NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **3**

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