

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

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IN THE COURT OF COMMON PLEAS

Address: _____

6 ARAZINE SMITH, executrix of the :
ESTATE of CAROLYN YARBOROUGH, :
7 plaintiff, :
: :
8 vs. : Case No. 326850
: :
9 SAINT LUKE'S HOSPITAL, :
defendant. :

Address **Phone** **E-Mail** **Website** **Notes**

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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.

COPY

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(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

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

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

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

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

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

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

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

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

25 A. I have an opinion, yes.

1 Q. What is your opinion?

2 A. My opinion was that the bowel perforation was
3 likely related to constipation from profound fecal
4 retention as a result of many factors, including
5 immobilization, narcotic use that ultimately
6 eventuated in the perforation that was described
7 originally.

8 Q. Do you have an opinion as to Dr. Bass'
9 standard of care as relates to taking care of
10 Miss Yarborough?

11 A. Yes, I have an opinion.

12 Q. Do you have an opinion as to Dr. Sonpal's
13 standard of care as relates to taking care of
14 Miss Yarborough?

15 A. Yes, I have an opinion.

16 Q. Do you have an opinion as to the mechanism as
17 to Miss Yarborough's proximate cause of death?

18 A. Yes, I have an opinion.

19 Q. Do you have an opinion as to whether or not
20 the Candlewood Nursing Home through its employees
21 complied with reasonable standards of care?

22 A. Yes, I do.

23 Q. Let's start with the last, the nursing home,
24 what is your opinion in that regard as to whether
25 or not the nursing home staff complied with

1 acceptable standards of care?

2 A. I believe there were no deviations from the
3 standard of care on the part of the nursing home.

4 Q. Dr. Chung, am I pronouncing your last name
5 correctly?

6 A. You are, sir.

7 Q. What material has been provided you as
8 relates to this case?

9 A. Medical records relating to the
10 hospitalization at Saint Luke's, medical records as
11 they relate to the confinement at Candlewood.
12 Autopsy report, as well as the depositions of
13 doctors -- the doctors participating at your end of
14 the case as far as expert testimony is concerned.
15 Medical records relating to the preceding admission
16 as well.

17 Q. Have you reviewed the depositions of
18 Drs. Bass and Sonpal?

19 A. I have.

20 Q. Then you indicated you've seen the deposition
21 of Dr. Lerner?

22 A. Correct.

23 Q. You've seen the report of Dr. Donald Frey?

24 A. I have not seen the report of Dr. Donald
25 Frey.

1 Q. Have you seen the report of Dr. Holzman?

2 A. I have not seen the report of Dr. Holzman.

3 Q. Have you now outlined for me the extent of
4 all the material you've reviewed as pertains to
5 this case?

6 A. Yes, I believe that I have. I believe I have
7 run the list.

8 Q. Have you reviewed anything in the medical
9 literature in contemplation of formulating your
10 opinions in this case?

11 A. Yes, I have.

12 Q. What have you reviewed?

13 A. I have reviewed literature as it pertains to
14 the particular infections involved.

15 Q. Doctor, do you have copies of the literature
16 available to you?

17 A. I have copies of literature available to me.

18 Q. Why don't you list for me that which you've
19 read in the medical literature by way of title of
20 the article and author and publication date.

21 A. Chapter from the textbook entitled, "Candida
22 Infections and Candidemia," authored by
23 Dr. Kolomkin, K-o-l-o-m-k-i-n, Dr. Anaissi,
24 A-n-a-i-s-s-i, from a surgical infection textbook
25 edited by Dr. Frey.

1 Q. Anything else?

2 A. That was my major reference.

3 Q. When you say major, were there minor
4 references?

5 A. Minor references refer to my understanding
6 from other medical textbooks about Candida.

7 Q. Did you make reference to the other medical
8 textbooks in contemplation of formulating your
9 opinion in this case?

10 A. The medical textbook known as Mandell's
11 Textbook of Infectious Diseases.

12 Q. Anything else?

13 A. No.

14 Q. Do you consider yourself an expert in the
15 field of infectious disease?

16 A. I do not.

17 Q. Do you consider yourself an expert in the
18 field of general surgery?

19 A. I do not.

20 Q. My understanding from looking at your
21 curriculum vitae is that you are a
22 gastroenterologist; is that true?

23 A. That is true.

24 Q. That you have a subspecialty interest in
25 disease of the liver; is that true?

1 A. Correct.

2 Q. How many times, Dr. Chung, have you
3 personally operated on a patient who experienced a
4 perforation of the bowel?

5 A. I have never.

6 Q. How many times, Dr. Chung, have you
7 personally been actively engaged in the
8 postoperative care of a patient who experienced
9 perforation of the bowel?

10 A. Over the course of my career, approximately
11 six to 10 times.

12 Q. Was that primarily during your postgraduate
13 training?

14 A. It was primarily during both postgraduate
15 training as well as staffship.

16 Q. Would you agree, Dr. Chung, that
17 postoperative care of abdominal surgical patients
18 is not the focus of your clinical practice?

19 A. I would agree with that statement.

20 Q. How many reports have you prepared in this
21 case?

22 A. I have prepared one report.

23 MR. GOLDWASSER: Donna, my
24 request to you is you favor us with a copy of
25 medical literature that Dr. Chung made reference

1 to, would you do that?

2 MISS KOLIS: I certainly
3 will.

4 MR. GOLDWASSER: Thank you.

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

7 A. You can assume correctly.

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

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

13 Q. Define for me your reasonable sense, please.

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

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

22 A. Undoubtedly.

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

1 judgment decisions how that patient is treated?

2 A. It is absolutely my understanding that this
3 is the case.

4 Q. Do you agree with the statement, Doctor, that
5 medicine is an art as well as a science?

6 A. I wholeheartedly agree with that statement.

7 Q. You've indicated to me you do have opinions
8 as to Dr. Sonpal's standard of care. I would ask,
9 sir, what is your opinion as to whether or not
10 Dr. Sonpal committed medical malpractice?

11 A. It is my opinion based on the question posed
12 to me, that is whether there was a deviation from
13 the standard of care, that the failure to cover
14 particular organisms cultured from the abdominal
15 cavity at the time of the operation for the cecal
16 perforation was a deviation from the standard of
17 care for an immunocompromised patient, i.e. a
18 patient on high dose corticosteroids with diabetes
19 mellitus, and that specific measures should have
20 been taken to address the organisms in question.

21 Q. Hypothetically speaking, if Miss Yarborough
22 had not been immunosuppressed because of
23 corticosteroid medications, would your opinion
24 change?

25 A. My opinion would change.

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

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

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

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

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

18 A. That is correct.

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

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

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

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

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

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

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

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

1 done in order to comply with the standard of care?

2 A. I believe that a strong consideration should
3 have been given to readdressing the issue of
4 administering either continued or adding on
5 antifungal, antimicrobial therapy that addressed
6 the two organisms in question.

7 Q. Have you now completed your answer to my
8 question about Dr. Sonpal's deviation from
9 standards of care?

10 A. I believe I have.

11 Q. So to summarize, there are two deviations.
12 One, he in your opinion failed to cover the
13 organisms cultured during surgery in the presence
14 of an immunosuppressed patient. Number two, he
15 failed to cover with the appropriate antibiotics,
16 antifungal medication in view of a shift in the
17 bands close to the time of discharge?

18 A. Correct.

19 Q. Have I correctly summarized your opinions?

20 A. You have.

21 Q. Doctor, what was the direct precipitating
22 cause of Miss Yarborough's death?

23 A. The direct precipitating cause from my
24 interpretation from the postmortem examination was
25 she succumbed to the consequences of sepsis.

1 Q. What caused the sepsis?

2 A. From a review of the autopsy results, my
3 belief is that her sepsis resulted from persistent
4 and a very large residual, or development of a very
5 large abscess within the intra-abdominal cavity,
6 specifically in the subdiaphragmatic region.

7 Q. The sepsis I assume was a consequence of
8 microorganisms?

9 A. Yes.

10 Q. The abscess was formed as a consequence of
11 microorganisms?

12 A. Yes.

13 Q. Which microorganisms are you alluding to?

14 A. I'm alluding to Candida albicans and
15 Enterococcus fecalis or fecal.

16 Q. What proof do you have that Enterococcus was
17 involved with a residual abscess?

18 A. The suggestive data from the patient at the
19 time of her presentation, her final presentation,
20 presented with Enterococcal bacteremia; therefore,
21 the belief is that the Enterococcus was a
22 contributor to the septic picture.

23 Q. It was not cultured out of the abscess though
24 was it, during postmortem?

25 A. May I review again?

1 Q. Of course. Are you looking at your personal
2 notes, Doctor?

3 A. I'm looking at the autopsy report.

4 Q. Fair enough.

5 A. That is correct.

6 Q. So I assume there is a positive blood culture
7 for Enterococcus that's the basis of your opinion
8 that contributed to her sepsis?

9 A. It is an opinion that it did contribute to
10 her sepsis.

11 Q. To cut to the quick here, because Candida
12 species were grown or cultured from the
13 subdiaphragmatic abscess, I'm assuming that is the
14 basis of your opinion that Candida played a role in
15 her sepsis; is that true?

16 A. That is correct.

17 Q. Doctor, I've alluded to my next question
18 briefly earlier but I will ask it in a little
19 difference fashion: What has been your experience
20 since your postgraduate training in treating
21 postsurgical polymicrobial or mixed organisms in
22 the abdominal cavity?

23 A. I participate in the care of patients who
24 essentially undergo a perforation in a
25 postoperative fashion. I've also participated in

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

4 Q. GI instrumentation you are a specialist,
5 right?

6 A. Correct.

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

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

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

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

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

22 A. Not directly.

23 Q. Is that publication listed in your curriculum
24 vitae?

25 A. I believe it is.

1 Q. Would you turn to your curriculum vitae, make
2 reference to the page and the number in which that
3 appears.

4 A. Under original reports, item number five.

5 Q. Page 4?

6 A. Page 4.

7 Q. Item number five?

8 A. Correct.

9 Q. Anything else?

10 A. There is a chapter from item number seven,
11 page 5, "Bacterial Parasitic Infection of the
12 Liver" that addresses infection, including fungal
13 infection of the liver.

14 Q. Did this patient, Miss Yarborough, have a
15 fungal infection involving the liver?

16 A. She did not.

17 Q. Doctor, while we're dealing with the subject
18 of your experience of treating polymicrobial
19 infection from bowel perforations, tell me in
20 general what is the nature of your practice?

21 A. The nature of my practice is a
22 gastroenterological practice. I see patients who
23 have general GI problems, I see patients with liver
24 diseases; therefore, the subspecialty of hepatology
25 being prominent within that practice as designated

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

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

8 A. I have.

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

11 A. I do.

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

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

3 Doctor, do you agree with that
4 statement?

5 A. No.

6 Q. Why not?

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

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

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

24 A. I do.

25 Q. What specifically were the corticosteroids

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

3 A. Could you clarify what you mean by
4 specifically?

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

8 A. Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 A. Correct.

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

1 secondary to perforated bowel, correct?

2 A. Correct.

3 Q. These are organisms that are not optimally
4 treated with antibiotic and antifungal medication,
5 correct?

6 A. Not the ones chosen, correct.

7 Q. Here you've got an immunosuppressed patient
8 who for almost three weeks is not demonstrating
9 signs and symptoms of becoming septic from those
10 organisms. I guess my dilemma is if
11 immunosuppression is such a distinguishing feature
12 in this case from your standpoint, how is it that
13 for three weeks this patient can have these
14 residual organisms festering in her body or
15 existing in her body, not show signs of sepsis
16 earlier?

17 A. It's my belief that as I referred to in my
18 previous response, that an immunosuppressed patient
19 can improve on a regimen, there is a phenomenon
20 known as partial treatment, partial response to
21 therapy.

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

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

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

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

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

19 A. I don't understand the question.

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

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

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

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

23 A. That's what I'm saying.

24 Q. Have I correctly cut to the quick?

25 A. You have cut to the quick.

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

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

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

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

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

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

25 A. Theoretically she was at increased risk of

1 super infection, that is correct.

2 Q. I assume from what you are telling me, even
3 though she was a potential candidate to that
4 increased risk, that risk did not overcome the need
5 for empirical antibiotics in this patient?

6 A. Right. The reason I say that is when I say
7 empiric antibiotics, I mean empiric antibiotics to
8 not only cover Enterococcus, more importantly to
9 cover Candida. In the face of antibiotics that
10 promote super infection, you need to cover the
11 super infecting organisms, i.e. the fungus.

12 Q. When were antibiotics discontinued in this
13 patient, what date?

14 A. They were stopped at day 10.

15 Q. How many days thereafter was it before
16 Miss Yarborough demonstrated signs and symptoms of
17 sepsis?

18 A. She came in on the 30th, antibiotics were
19 stopped at day 10, that would be about 10 days.

20 Q. Let me make sure I understand. I realize
21 some of this is overlapping testimony, please be
22 patient with me.

23 I thought I heard you say that one
24 of the reasons why a patient such as
25 Miss Yarborough might have resistant organisms

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

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

10 Q. Here she is totally off antibiotics for
11 10 days before she is septic, what is stalling it
12 during those 10 days?

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

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

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

4 Q. Do you state that with reasonable medical
5 certainty?

6 A. I state that as an opinion.

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

10 A. It is strong speculation.

11 Q. So less than reasonable medical certainty,
12 correct?

13 A. It is less than reasonable medical
14 certainty.

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

18 A. Yes.

19 Q. Do you agree?

20 A. That would be my interpretation.

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

23 A. It was reassuring.

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

1 10 days postop?

2 A. Yes.

3 Q. Do you agree that during the patient's
4 postoperative course, that except for one day, the
5 white blood cell count was stable and then was
6 dropping to within the normal range by the time of
7 discharge?

8 A. I agree with the fact that the trend of the
9 absolute white blood cell count had decreased;
10 however, as I believe I stated earlier, the object
11 of residual concern was that of the band forms.

12 Q. Do you agree that or do you have any reason
13 to disagree with the physicians who were there
14 looking at the patient, that the wound, the
15 surgical wound was looking good?

16 A. I was not there at that time, I would have to
17 defer to their direct exam opinion.

18 Q. Do you agree from your review of the medical
19 record that considering the very serious surgical
20 emergency that was confronting this patient, a
21 patient who clearly was at risk for death merely
22 because of bowel perforation, in fact
23 postoperatively this was a patient who generally
24 was looking well?

25 A. This was a patient who had made an impressive

1 short term recovery.

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

7 A. Yes.

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

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

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

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

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

6 A. That's a fair statement.

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

9 A. But it's a fair encapsulation.

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

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

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

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

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

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

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

14 A. That is a correct statement.

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

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

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

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

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

6 A. Yes, they can.

7 Q. Did they in this case?

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

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

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

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

25 Q. What medications do you order for the

1 treatment of Candida albicans?

2 A. There are two predominant agents, the first
3 is Amphotericin B intravenously. The second is
4 Fluconazole or other related derivatives.

5 Q. You've read Dr. Lerner's deposition, you've
6 read his discussion of those two drugs?

7 A. I have.

8 Q. Is that correct?

9 A. Yeah, I have.

10 Q. Do you agree with Dr. Lerner that
11 Amphotericin B puts the patient at risk for
12 developing kidney malfunction?

13 A. Yes, Amphotericin B has a number of
14 toxicities. The most prominent of which is renal
15 toxicity; however, if given for a reasonable course
16 of time, most patients can endure that therapy
17 without significant complication or sequelae.

18 Q. So it's your opinion that the risk of renal
19 toxicity from the administration of Amphotericin B
20 should not outweigh the consideration of giving
21 that medication in a setting such as Miss
22 Yarborough; is that what you are saying?

23 A. I believe that is correct.

24 Q. Nonetheless do conscientious physicians take
25 into consideration the toxicity of medication

1 before they order it?

2 A. There is no question.

3 Q. Doctor, I want to change the focus for a
4 moment to your medical/legal experience.

5 To your knowledge how is it that
6 you came to meet Donna Taylor Kolis?

7 A. Excuse me?

8 Q. How did you meet Miss Kolis?

9 A. Miss Kolis called me upon referral from
10 another local physician in town in Boston, another
11 physician who has worked with her before.

12 Q. What is the name of that physician?

13 A. Dr. Mark Peppercorn.

14 Q. Do you know Dr. Peppercorn?

15 A. I do know Dr. Peppercorn.

16 Q. What is his specialty?

17 A. Gastroenterology.

18 Q. Do you know why Dr. Peppercorn didn't review
19 this case for Donna?

20 MISS KOLIS: Do you want me
21 to testify? Are you asking him?

22 MR. GOLDWASSER: I want to know
23 if he knows.

24 Q. Do you know?

25 A. I don't.

1 Q. Did you ever speak to Dr. Peppercorn in any
2 fashion whatsoever about reviewing this matter?

3 A. Not at all.

4 Q. How many medical/legal cases have you
5 reviewed in your professional career?

6 A. This is the initial.

7 Q. What motivated you to review this one?

8 A. Donna came to me seeking my opinion
9 concerning the events that surrounded the initial
10 perforation event, asked for my opinion whether I
11 would be willing to review the records concerning
12 those events. I told her I would be willing to
13 review those events.

14 Q. So initial reason why she came for your
15 opinion has been now transcended; is that true?

16 A. It has evolved, that is correct.

17 Q. I assume that is because you concluded that
18 the care other than that which you've criticized,
19 was perfectly acceptable and appropriate?

20 A. It is because there was -- it was deemed
21 there was not significant deviation from the
22 standard of care surrounding those events.

23 Q. By the way, Doctor, when you prepared your
24 report of January 25, 1998, I assume that you had
25 essentially the same documents available to you

1 then as you do now?

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

7 Q. Is that true, Doctor?

8 A. Yes.

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

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

14 THE WITNESS: Should I
15 answer?

16 MISS KOLIS: Of course.

17 A. \$200 an hour, sir.

18 Q. Is that what you are charging Donna?

19 A. Correct.

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

22 A. Yes.

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

1 unacceptable or substandard care of Dr. Sonpal?

2 A. Yes.

3 Q. Other than Dr. Bass, which my partner will
4 ask you about in a few moments, do you have
5 criticisms of any other physicians at Saint Luke's
6 Hospital?

7 A. No because the responsible physician, the
8 attending physician of record was Dr. Sonpal.

9 Q. Have we thoroughly discussed your opinions as
10 to what we lawyer's refer to as proximate cause of
11 death?

12 A. Yes.

13 Q. Have you been asked to render any opinions at
14 trial on a subject we have not discussed?

15 MISS KOLIS: Life expectancy
16 question.

17 A. Yes, the life expectancy question.

18 MR. GOLDWASSER: Donna, is there
19 anything else?

20 MISS KOLIS: I believe that
21 is it other than --

22 Q. What is your opinion?

23 MR. GOLDWASSER: Go ahead.

24 MISS KOLIS: Other than a
25 question I would undoubtedly ask him, although it

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

5 Q. What is your opinion as to that?

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

9 Q. Was the patient at risk for such?

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

12 Q. What is your opinion as to life expectancy?

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

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

1 that not true?

2 A. It's probable.

3 Q. Are you able to guess for us how many years
4 were reduced from her statistical life expectancy?

5 A. I could not state with reasonable certainty
6 an exact number of years. Only I could attest to
7 the fact her expectancy would be shortened.

8 Q. Here you have an individual who is not only
9 immunosuppressed because of her corticosteroid
10 regimen, but a patient who has got diabetes, a
11 patient who is in fact debilitated, essentially
12 nonambulatory; isn't that true?

13 A. At that point in time that is true.

14 Q. She was nonambulatory over and beyond the
15 development of the bowel perforation, correct?

16 A. Yes.

17 Q. Doesn't that added factor, that is the fact
18 of being nonambulatory, increase the likelihood
19 that there would be a reduction in life expectancy?

20 A. Yes.

21 Q. Doctor, we have now then I take it covered
22 all of your opinions that you currently hold in
23 this case; is that true?

24 A. Yes.

25 Q. Because you understand since this is your

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

9 A. That is true.

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

15 A. I will.

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

23 -----

24 (Recess had.)

25 -----

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

4 -----

5 CROSS-EXAMINATION

6 BY MISS DISILVIO:

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

10 A. That is correct.

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

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

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

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

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

13 A. Sure.

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

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

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

22 A. January 23rd.

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

25 Q. On what date, Doctor, were antibiotics

1 discontinued?

2 A. January 20th.

3 Q. It's your opinion from your review of the
4 records then that Dr. Bass was called in to endorse
5 the antibiotic selection which had been
6 discontinued three days prior to his seeing the
7 patient?

8 A. Correct. To endorse not just the selection
9 but the choice to discontinue.

10 Q. Is that your understanding of the sole
11 purpose of why he was called to see this patient?

12 MISS KOLIS: You can look at
13 the note.

14 A. May I look at the note?

15 Q. Certainly.

16 MISS KOLIS: It's in the
17 progress notes, he didn't write a consultation.

18 A. Could you once again remind me of the
19 question.

20 MISS DISILVIO: Connie, read it
21 please.

22 -----

23 (Question read.)

24 -----

25 A. It's difficult to determine from the medical

1 records because the reason for the consultation was
2 not stated.

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

5 A. I have.

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

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

13 Q. Was he asked to inspect the wound?

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

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

21 A. No, there is no other record.

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

25 A. Given the circumscribed nature of the

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

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

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

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

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

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

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

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

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

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

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

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

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

1 A. Correct.

2 Q. Doctor, is there any circumstance in which an
3 immunosuppressed patient with a polymicrobial
4 infection, including Candida, does not require
5 empiric coverage?

6 A. I can think of none.

7 Q. So it is your opinion that an
8 immunosuppressed patient should always be managed
9 by treating the culture?

10 A. That is my belief.

11 Q. You have indicated to Mr. Goldwasser in an
12 immunosuppressed patient a white blood cell value
13 is not clinically reliable; is that correct?

14 A. In and of itself as a solitary determination
15 that is correct.

16 Q. Help me to understand. It was my impression
17 from your testimony that in an immunosuppressed
18 patient you do not find clinically reliable
19 indicators such as white blood cell count, blood
20 culture, absence of abscess, absence of rebound, et
21 cetera; is that correct?

22 A. That is more or less correct. The only
23 contention I would have with that is if you had a
24 clear-cut trend in an ominous direction, so in
25 other words if you had any of those objective signs

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

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

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

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

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

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

21 A. Correct.

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

1 Amphotericin B or Fluconazole; is that correct?

2 A. Correct.

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

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

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

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

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

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

5 Q. In addition to --

6 A. You go with what you have.

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

11 A. Of course.

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

16 A. That is correct.

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

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

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

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

7 Q. Forgive me for poorly phrasing it.

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

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

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

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

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

1 not have any specialty training in infectious
2 disease?

3 A. You are correct.

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

6 A. Correct.

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

10 A. Fairly frequently, not excessively common.

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

14 A. Yes.

15 MISS DISILVIO: Thank you very
16 much, Doctor.

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

20 THE WITNESS: Thank you.

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

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

1 MISS KOLIS: We will waive
2 signature.

3 MR. GOLDWASSER: Doesn't matter.

4 MISS KOLIS: We will waive
5 signature.

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10 (Deposition concluded; signature waived.)

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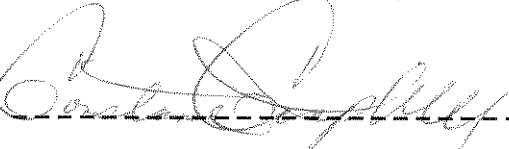
1 The State of Ohio, :

2 County of Cuyahoga. : CERTIFICATE:

3 I, Constance Campbell, Notary Public within
4 and for the State of Ohio, do hereby certify that
5 the within named witness, RAYMOND T. CHUNG, M.D.
6 was by me first duly sworn to testify the truth in
7 the cause aforesaid; that the testimony then given
8 was reduced by me to stenotypy in the presence of
9 said witness, subsequently transcribed onto a
10 computer under my direction, and that the foregoing
11 is a true and correct transcript of the testimony
12 so given as aforesaid.

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

18 IN WITNESS WHEREOF, I have hereunto set my
19 hand and affixed my seal of office at Cleveland,
20 Ohio, this 6th day of July, 1998.

21 
22 -----

23 Constance Campbell, Stenographic Reporter,
24 Notary Public/State of Ohio.

25 Commission expiration: January 14, 2003.

Look-See Concordance Report

 UNIQUE WORDS: 1,126
 TOTAL OCCURRENCES: 3,335
 NOISE WORDS: 385
 TOTAL WORDS IN FILE: 9,260

 SINGLE FILE CONCORDANCE

 CASE SENSITIVE

 PHRASE WORD LIST(S):

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 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: 3

 LIST OF THRESHOLD WORDS:

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