

#594

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, et al., :
 defendants. :

Telephonic deposition of DONALD E. FREY, M.D.,
a witness herein, called by the plaintiff for the
purpose of cross-examination pursuant to the Ohio
Rules of Civil Procedure, taken before Constance
Campbell, a Notary Public within and for the State
of Ohio, at Reminger & Reminger, 113 Saint Clair
Building, Cleveland, Ohio, on THURSDAY, JULY 9TH,
1998, commencing at 12:36 p.m. pursuant to
agreement of counsel.

1 APPEARANCES:

2 ON BEHALF OF THE PLAINTIFF:

3
4 Donna Taylor-Kolis, Esq.
5 Donna Taylor-Kolis Co., LPA
6 330 Standard Building
 Cleveland, Ohio 44113
 (216) 861-4300.

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8
9 ON BEHALF OF THE DEFENDANT I.M. SONPAL, M.D.:

10 Gary H. Goldwasser, Esq.
11 Reminger & Reminger
12 The 113 Saint Clair Building
 Cleveland, Ohio 44114
 (216) 687-1311.

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14
15 ON BEHALF OF THE DEFENDANT STEVEN BASS, M.D.:

16
17 Marilena DiSilvio, Esq.
18 Reminger & Reminger
19 The 113 Saint Clair Building
 Cleveland, Ohio 44114
 (216) 687-1311.

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I N D E XWITNESS:DONALD E. FREY, M.D.PAGE

Cross-examination by Miss Kolis

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(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

1 DONALD E. FREY, M.D.

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

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8 MISS KOLIS: Good afternoon,
9 Dr. Frey, it's Donna Kolis.

10 THE WITNESS: How are you?

11 MISS KOLIS: I'm fine. How
12 about yourself?

13 THE WITNESS: Staying busy.

14 MISS KOLIS: I would
15 imagine. Are you sitting in the rocking chair or
16 the other side of the desk?

17 THE WITNESS: On the other
18 side of the desk.

19 MISS KOLIS': That's good.

20 THE WITNESS: The rocking
21 chair is too far removed from the telephone.

22 MISS KOLIS: I'm probably
23 going to shock you, not ask a tremendously large
24 number of questions today.

25 THE WITNESS: Okay.

1 MISS KOLIS: However, to
2 each and every question that I ask you, if you need
3 clarification as to what information I'm seeking,
4 as always please tell me, okay?

5 THE WITNESS: Okay.

6 -----

7 CROSS-EXAMINATION

8 BY MISS KOLIS:

9 Q. We are not going through your CV because you
10 and I have been through your CV before, correct?

11 A. That's correct.

12 **a.** I have in my possession a report authored by
13 yourself, I would recognize the signature, dated
14 June 10, 1998; do you have a copy of your report
15 available?

16 A. I have it right here before me.

17 Q. I can assume without even asking the question
18 that this is the one and only report you've ever
19 written?

20 A. That is correct,

21 Q. Doctor, can you tell me when Mr. Goldwasser
22 contacted you?

23 A. He contacted me by telephone some time
24 towards the end of February of this year, Gave me
25 some telephone details about the case, asked if I

1 would be willing to review it for him.

2 Q. Fair enough. Have you done any testifying
3 for Mr. Goldwasser before?

4 A. I'm not sure if I have testified for him or
5 against him. I have met him in a previous
6 proceeding. At this point I'm not sure I can
7 remember specifically what role the two of us were
8 playing.

9 MR. GOLDWASSER: As an aside,
10 Eric Kennedy retained you.

11 THE WITNESS: Yes.

12 MR. GOLDWASSER: I had the
13 wonderful task of trying to cross-examine you at
14 trial and I did not succeed.

15 THE WITNESS: I'm sorry to
16 hear that.

17 MR. GOLDWASSER: That's all
18 right.

19 Q. It does happen however. I knew you had
20 appeared as an expert in a case where Gary was
21 defense counsel, I didn't know if you worked with
22 him before.

23 A. I honestly can't remember. I met
24 Mr. Goldwasser previously.

25 Q. Obviously all that is very unimportant.

1 For purposes of the record, anyone
2 who might read it in the future, it's fair to say,
3 Dr. Frey, from time to time you are called upon
4 both by plaintiffs and defendants to render
5 testimony?

6 A. That is correct.

7 Q. It's fair to say that as things in life, your
8 testimony is not always accepted by the jury?

9 A. I'm sure that is true.

10 Q. Now that we have all that out of the way,
11 what we're going to do is talk about this case.

12 The report indicates that you
13 reviewed eight items in contemplation apparently of
14 preparing your report; do you see that?

15 A. That's correct.

16 Q. Since the time you authored this report on
17 June 10th have you received any additional
18 material?

19 A. I have received -- I believe I have received
20 the deposition of Dr. Holzman, I've minimally gone
21 over it to see if it was going to be the same --
22 whether it was going to offer up the opinions he
23 offered in his previous letter. I would not say I
24 have exhaustively reviewed it. I previously
25 reviewed it.

1 Q. In fairness to characterize, if you actually
2 have Dr. Holzman's deposition, you would have
3 gotten it yesterday afternoon; does that seem
4 reasonable to you?

5 A. I received so many depositions I have no
6 idea. Mr. Goldwasser and I reviewed the deposition
7 by telephone here just earlier today.

8 Q. Dr. Frey, have you looked at any other
9 medical records?

10 A. I have only looked at the medical records
11 that were identified in the report of
12 June the 10th.

13 Q. So you haven't looked at the Candlewood
14 Nursing Home records?

15 A. I have not.

16 Q. You don't have any of the documentation
17 showing Mrs. Yarborough's history leading up to her
18 care by Saint Luke's, you haven't seen the
19 Cleveland Clinic chart or Metro General chart from
20 the Fall of 1995?

21 A. The only information about those
22 hospitalizations would have been from entries in
23 the Saint Luke's record that referred back to them,
24 so I have not seen the records themselves.

25 Q. I wondered. During the process of this case

1 we obtained a lot of those, I didn't know if you
2 read them or felt you needed to?

3 A. I have not reviewed those records at all.
4 Those were not provided for me, nor did
5 Mr. Goldwasser fax to me any elements of those.

6 Q. What I'm going to try to do is find out what
7 you really think about this case. That is a good.
8 thing for me to do I suppose.

9 Let me ask the first question:

10 Let's first deal with what you believe, based on
11 your best medical judgment or opinion, is the cause
12 of Mrs. Yarborough's death; can you state that for
13 me with simplicity if it's possible?

14 A. I think she clearly died of fulminant sepsis
15 and septic shock.

16 Q. Let's sort of dissect that out a little bit.

17 When I read your report, in the
18 report you indicated that autopsy demonstrated that
19 the patient died of intra-abdominal sepsis -- I
20 mean abscess. Excuse me.

21 Do you still agree that is what the
22 autopsy most likely demonstrated?

23 A. I would agree with that.

24 Q. Do you have an opinion which you intend to be
25 rendering at trial as to the cause of the

1 intra-abdominal abscess?

2 A. The cause of the intra-abdominal abscess was
3 clearly in my view contamination from the
4 perforation for which she was operated on
5 January 10th.

6 Q. Let me ask you this question: Do you have the
7 autopsy in front of you?

8 A. I do.

9 Q. Somewhere on that table?

10 A. It's right here,

11 Q. The question is, there are two of them I need
12 at least some clarification on: There was a
13 finding on the autopsy of transmural ischemia of
14 the jejunum?

15 A. Yes.

16 Q. Would you agree with me more likely than not
17 the ischemia found in the jejunum would not have
18 been the cause of the abscess found in the abdomen?

19 A. I would agree with that.

20 Q. Thank you very much.

21 In the Huron Road Hospital record
22 there is a positive, I'll call it highly positive
23 urine culture in Carolyn Yarborough.

24 Would you agree UTI that seemed to
25 demonstrate was not the cause of her death?

1 A. Are you specifically refering to the Candida
2 urine culture?

3 Q. No, I think I just made myself not specific.

4 A. I do not consider urinary tract infection to
5 be the cause of this patient's death.

6 Q. You just made this very easy for me. That
7 eliminates a majority of the questions I would have
8 needed to ask on that issue.

9 I don't know that you and I are
10 going to go through every hospital note, let's see
11 what we can do with this.

12 Your contention of course is these
13 physicians, and those physicians being Drs. Sonpal
14 and Bass, did not deviate from what you consider to
15 be the standard of care; am I stating that
16 accurately?

17 A. That is correct.

18 Q. We will get into the specifics later. You
19 conclude, I'll read it for the record, "This
20 unfortunate patient died of severe
21 immunosuppression from her underlying illness and
22 steroid therapy;" did I read that statement
23 accurately?

24 A. That is correct.

25 Q. Try to explain to me what you meant when you

1 wrote that statement.

2 A. That when patients die of sepsis, they can
3 die of sepsis, if you will, for two reasons.

4 Number one, they can die because
5 the volume and the virulence of the microorganisms
6 with which they were infected overwhelms their host
7 defenses; or they die from quantities of bacteria
8 that might have otherwise been adequately managed
9 by a competent host, but because of the
10 individual's immunosuppression status the
11 microorganisms were able to cause a systemic septic
12 response and death.

13 Q. Mrs. Yarborough's case, which of those two
14 possibilities or not possibilities, which of those
15 two events was the cause of her sepsis?

16 A. It would be my opinion that her
17 immunosuppressed state materially contributed to
18 her inability to eradicate the residual
19 microorganisms that were not killed or handled by
20 the antibiotic therapy.

21 Q. You're distinguishing that from a person who
22 has a volume and virulence overwhelming the host?

23 A. Correct. If we take the analogy of an
24 otherwise very healthy 20 year old that would have
25 a very large perforation, if you will, of an

1 appendix, that was then not managed, there was
2 continuous and sustained stool contamination of the
3 abdominal cavity, you would then have a
4 circumstance where the volume of the microbes and
5 the invasive infectious capability of those
6 microbes would overwhelm the capabilities of what
7 would have otherwise been a normal host.

8 Q. Thank you very much for that answer.

9 Based upon the autopsy result
10 and/or Huron Road records, whichever you need to
11 answer the question, the intra-abdominal abscess,
12 abscesses as best you can determine from the
13 autopsy, were caused by what? Let me rephrase
14 that, that was a poorly asked question.

15 We already established you believe
16 the abscesses developed as a result of the original
17 contamination which occurred at the time of the
18 perforation. Tell me based upon your review of the
19 medical records what the components if you will of
20 the abscess were?

21 A. The abscess as identified on the face sheet
22 identifies the pathogen as being principally that
23 of Candida. That is to say if we look at the very
24 final diagnosis, it's identified as anteroposterior
25 subdiaphragmatic abscess containing organisms

1 consistent with Candida species.

2 Q. I think in your report you indicated the
3 abscess also had a component of Enterococcus?

4 A. The abscess, the original culture of the
5 peritoneum had Enterococcus and Enterococcus was
6 identified from --

7 Q. The blood stream?

8 A. -- the blood cultures that were done at the
9 time of the postmortem, so one would have to
10 conclude that the Enterococcus was likely a
11 participant in some capacity in this patient's
12 terminal event.

13 Q. You're inferring that based on the reason
14 you've given that was an organism identified by
15 culture at the time of the original contamination
16 and it actually had gone into the blood stream by
17 the time of death, correct?

18 A. She had the organism cultured in her blood
19 stream at the time of her death, we have to
20 conclude that it was a participant in her terminal
21 process.

22 Q. That's fair enough. I just want to know how
23 you respond to that.

24 A. I understand. I want to make it clear that
25 it may or may not have been the same strain of

1 microorganism that was cultured from the original
2 culture at the time of the original operation.

3 Q. When you say it may or may not have been the
4 same strain, are you referring to the Enterococcus?

5 A. That's correct.

6 Q. Have you compared the sensitivity to the
7 blood culture at Huron Road Hospital to the
8 sensitivity of the Enterococcus cultured at the
9 time of the surgery?

10 A. I have not.

11 Q. Let's do it this way: You could do that?

12 Let me ask you generally speaking
13 Doctor, do you agree with me we can pretty much
14 tell if something is the same strain by looking at
15 its sensitivities, its resistance and its
16 synergistic abilities?

17 A. That would imply similarity or
18 dissimilarity. It might not stand up in a court of
19 law.

20 Let me amplify that way, very
21 different strains of Enterococcus could have the
22 same sensitivity pattern and genetic analysis would
23 show that they are clearly different.

24 Similarly an organism that was
25 similarly isolated at the time of the peritoneal

1 culture which may have mutated or developed
2 resistance during the course of the patient's
3 treatment, could actually potentially demonstrate a
4 different sensitivity and resistance pattern some
5 15, 16 days later, in fact still be the same
6 strain.

7 In general I would agree with what
8 you are implying. Please understand that there
9 would be a perfectly logical argument that would
10 say that it may not be certainly a 100 percent
11 accurate statement to make that linear correlation.

12 Q. Is it more likely than not it's the same?

13 A. Probably.

14 Q. That's what I need to know.

15 Doctor, let me ask you this
16 question: Given that you just now testified that
17 in fact it's the intra-abdominal abscesses that
18 precipitated in I assume you believe the events
19 that led to this woman's death, can you explain to
20 us why the hospital didn't find Candida in the
21 blood stream?

22 A. First of all if one reads the literature on
23 Candida you will find that recovering the Candida
24 from the blood stream can be difficult in that
25 Candida is sometimes an episodic organism in the

1 blood. In some respects there are random chances
2 involved in identifying the organisms in the blood
3 or not.

4 Secondly, because one dies of
5 sepsis from an organism does not necessarily mean
6 that the organism had to be in the blood.

7 That is to say there is a fairly
8 wealthy volume of literature that would clearly
9 identify that what we call clinical sepsis relates
10 to the various mediators of inflammation and that
11 one can have sepsis independent of really having
12 the organism in the blood or not. So I think there
13 is a couple of very plausible explanations why one
14 could potentially die from a severe Candida
15 infection and in fact not have the microorganism in
16 the blood.

17 Q. What you describe, if I can characterize, is
18 a differentiation I think which causes confusion to
19 lay people, particularly lawyers, the difference
20 between sepsis and septicemia, the organism
21 actually being in the blood. Sepsis describes a
22 physical state of being.

23 A. Actually you know you are getting into the
24 issue of terminology which is very confusing for
25 physicians and I would guess it's equally confusing

1 for lawyers. Sepsis and septicemia are sort of
2 used as interchangeable terms. We are referring to
3 a clinical state that is due to infection but
4 neither sepsis nor septicemia in fact have to have
5 the organism documented or present in the blood to
6 establish that as a clinical diagnosis.

7 Q. Fair enough.

8 A. Sepsis is a clinical state, bacteremia or
9 fungicemia is the process of recovering the
10 organism from blood and the two are commonly
11 associated but they don't have to be.

12 Q. Thanks for clarifying that issue for us.

13 Dr. Frey, you are aware that on
14 January 14th, 1996, that the results of the
15 intra-abdominal wound cultures came back; does that
16 seem accurate to you?

17 A. That is correct.

18 Q. It indicated in that culture result that
19 there were Enterococcus and Candida, right?

20 A. On the surface culture of the open wound,
21 that's correct.

22 Q. Let me ask you this question: Based upon your
23 training and background in managing surgical
24 patients who have perforated, would there have been
25 a contraindication at that time to initiating

1 antifungal therapy?

2 Ae It would have been outside of the standard of
3 care to have initiated antifungal therapy at that
4 time.

5 Q. Why do you say that?

6 A. Because you are talking about colonization
7 with no clinical evidence the patient in fact had
8 Candida as a participating microorganism. So even
9 the most liberal person in using antifungal therapy
10 would not institute antifungal therapy based on the
11 surface culture of an otherwise clinically
12 uninfected wound.

13 Q. That's your position in this case that is why
14 there is no deviation as to the standard of care,
15 at least as to that issue?

16 Ae There is no question in my mind that is the
17 standard of care and that if one uses surface
18 cultures of open wounds as a justification for
19 antibiotics, every patient with an open wound would
20 be on antibiotics. So one has to make the clinical
21 differentiation of what is surface colonization
22 versus what represents a clinically relevant
23 pathogen.

24 Q. Clear this up for me so I understand what you
25 are thinking.

1 A. You are calling the return of the cultures
2 surface cultures; is that accurate?

3 A. On the wound, cultures of the 14th.

4 Q. Not the results that came back on the 14th?

5 A. The results that came back on the 14th, of
6 course those are from the peritoneal cultures,
7 different than the wound.

8 Q. It could have, as everything else in this
9 case, been the problem with the person that asked
10 the question.

11 I was referring to the cultures
12 that came back from the peritoneum itself,

13 A. Okay.

14 Q. Those grew Candida and Enterococcus, correct?

15 A. That is correct.

16 Q. Having said that, we're asking a different
17 question: Would there have been a contraindication
18 based upon the cultures that grew from the
19 peritoneal area to instituting antifungal therapy
20 in this patient?

21 A. Contraindication, that is a pretty strong
22 term. I would say it's clearly not the standard of
23 care to implement antifungal antibiotics for a
24 patient who had Candida identified in the initial
25 peritoneal swab four days later without there being

1 some additional evidence of Candida's involvement
2 in the patient's infectious state.

3 Q. So you are saying it's not the standard of
4 care to initiate antifungal?

5 A. That is correct.

6 Q. Would you answer the question any
7 differently, Doctor, if I added to that that the
8 person was known to be immunosuppressed from taking
9 corticosteroids?

10 A. It would still be the same answer.

11 Q. I'm going to deviate from what I thought I
12 was going to ask you and ask you a couple other
13 questions looking at textbooks do you have a copy
14 of your textbook?

15 A. There are one or two of them here.

16 Q. I would guess there would be.

17 If I heard you correctly, your
18 answer was that it was clearly not the standard of
19 care to initiate antifungal therapy for Candida
20 which grows out of peritoneal cultures in the
21 absence of some sign that there was an infection; I
22 did hear you right when you said that, let me
23 clarify.

24 A. I would refer you to our article in the
25 Annals of Surgery in 1991, that has as a first

1 author Dr. Mosdell, M-o-s-d-e-l-l. In that article
2 you will find if you review those 480 patients with
3 acute peritonitis that a number of them, in fact if
4 my memory serves me correct, somewhere around 5 or
5 6 percent of the patients had Candida identified on
6 the initial culture of the peritoneal cavity.

7 If one looks at the outcome in
8 those patients, you will find first of all none of
9 them received antifungal therapy. That secondly
10 their survival as a group was no different than the
11 population as a whole.

12 So it would be my very considered
13 opinion that there is no justification for adding
14 antifungal therapy in the initial treatment of a
15 patient with acute bacterial peritonitis.

16 Q. Let me back up. The Mosdell study of 480
17 patients, that didn't specifically address itself
18 to immunosuppressed patients, do you agree with
19 that?

20 A. I would agree with that.

21 Q. So the 5 to 6 percent population group we
22 were looking at, that had no adverse Candidal
23 illness I'll call it, I don't think that's a real
24 phrase, were not immunosuppressed patients?

25 A. For the most part that would be true.

1 Q. Let's move this a little bit.

2 A. There is still not a shred of evidence that
3 shows in immunosuppressed patients that empirical
4 antifungal therapy would make any difference in the
5 patient's outcome. I would continue to hold
6 steadfastly to the position there is no
7 justification for the addition of antifungal
8 therapy in a patient with an acute intestine
9 perforation, even though that person is on
10 immunosuppressive treatment.

11 Q. We're going to look at a couple pieces of
12 literature, see if you can tell me what they mean I
13 suppose. Let me go back to what you said.

14 You said there is empiric evidence
15 that the initiation of antifungal therapy will
16 change the outcome, I was trying to listen to you,
17 I don't think I was clear about what you said, that
18 it's effective?

19 A. That's not what I said.

20 Q. Tell me what you said, I really did miss it.

21 A. Antifungal therapy for patients that have
22 positive blood cultures for Candida would generally
23 be considered a standard of care.

24 If you had patients that were
25 reoperated after acute bacterial peritonitis, those

1 patients at the time of reoperation were identified
2 as having Candida peritonitis at that time, then
3 there would be certainly a body of evidence to
4 support the implementation of anti-Candida
5 therapy,

6 There is no evidence to support the
7 initiation of antifungal therapy in the initial
8 management of patients with perforations and acute
9 peritonitis.

10 Q. Let me ask you the following questions, I
11 know for sure we're going to look at your
12 literature, that which you edited: Do you believe
13 or agree with me medically that steroids have an
14 effect on potential growth of Candida in the GI
15 tract?

16 A. I would not agree with that.

17 Q. You don't think there is anything published
18 that says that?

19 A, I would say what is published indicates that
20 steroids promote Candidemia, it's antibiotics that
21 change the micro flora.

22 I do not believe that steroids in
23 and of themselves in a patient without antecedent
24 antibiotic therapy results in Candida overgrowth in
25 the gut.

1 So they are commonly linked
2 together. I would certainly agree that
3 corticosteroid therapy is associated with
4 Candidemia. If you look at the various articles
5 that have been written on it, the patients
6 invariably have had antecedent antibiotics which
7 eliminated the bacterial component in the gut.

8 Q. You answered the question I was going to make
9 a two step question, which you just explained,
10 which is my understanding if a person is on
11 steroids, received a course of antibiotics, that
12 they will -- I'm paraphrasing -- create an
13 environment for overgrowth of Candida which can
14 lead to infection with a Candida organism, that's
15 the simple way of stating it?

16 A. That's pretty close. I think the antibiotics
17 create the potential Candida overgrowth. The
18 steroids inhibit the host's ability to contain the
19 Candida organisms.

20 Q. Do you agree with me as a simple matter, I
21 understand there is no such thing as a simple
22 matter in this kind of treatment, that what happens
23 is the traditional antibiotic regimen such as
24 Cefotetan, Gentamycin and Flagyl inhibits the
25 bacteria that usually take precedence over Candida

1 in the gut; do you agree with that?

2 A. Run that one by me again, please.

3 Q. I'm making up the questions based on
4 everything I read in two weeks. I think we're
5 saying the same thing, I want to make sure I'm
6 understanding the mechanism what allows the Candida
7 to grow in an immunosuppressed person taking
8 steroids is the antibiotic regimen more or less
9 kills the normal bacteria that Candida compete
10 with; does that make sense the way I'm saying it?

11 A. I think that is very accurate. I think
12 predominance of the Candida microorganisms in the
13 gut is more a consequence of eliminating the
14 bacteria which competitively suppress Candida under
15 normal circumstances, so I would agree with you
16 completely that the growth of Candida is the
17 consequence of bacterial suppression. That the
18 Candida then assumes some greater significance in
19 potentially immunosuppressed patients because of
20 their immunosuppression.

21 Q. Right, because as a general principle I don't
22 know if you agree or disagree with this, a person
23 who had a perforation such as Mrs. Yarborough did,
24 who was not immunosuppressed, they received the
25 Gentamycin, Flagyl and Cefotetan, we would not be

1 very concerned about them having a Candida
2 overgrowth?

3 A. I don't think that is correct at all.

4 Q. Okay, tell me what you think then.

5 A. I think if you have 10 days of those
6 antibiotics, you have a real chance of having
7 Candida overgrowth. It probably happens in the
8 majority of patients that would receive that. Just
9 because the patient has steroids, they
10 realistically have a greater risk of Candida being
11 clinically significant than with somebody who has
12 an intact immune response.

13 Q. We were saying the same thing, you say it
14 more articulately. The person who is not
15 immunosuppressed is not likely to have a clinically
16 significant event occur because of Candida growing,
17 not as likely I suppose is a better way to put it?

18 A. I think that's fair to say.

19 Q. Do you agree or disagree with Dr. Bass'
20 testimony that through the course of
21 Mrs. Yarborough's hospitalization, that she
22 demonstrated postoperative fever?

23 A. She did demonstrate postoperative fever.

24 Q. Would you say that it was a low grade postop
25 fever?

1 A. It was low grade much of the time. I guess
2 low grade depends on your perspective of it. Some
3 of it was if I remember above 38 degrees
4 Centigrade, which some would consider a higher
5 grade than others. She clearly had a waxing and
6 waning fever pattern postoperatively.

7 MR. GOLDWASSER: Doctor, let me
8 correct you, I think only one day following her
9 initial insult was it 38.

10 A. I do remember that it was above 38 at one
11 time.

12 Just for purposes of clarification
13 in this deposition, in case we argue about what low
14 grade means, I did want to indicate there was an
15 over 38 degree event. That the temperature for the
16 most part sort of waxed and waned in the 37 plus
17 range.

18 Q. I don't want to have an argument at trial if
19 that is where this goes on this issue, What I'm
20 trying to indicate, we will make it simple, if I
21 can do such a thing ever, is that she did not have
22 a stable, normalized temperature during her
23 confinement from January 9th through January 24th;
24 would you agree with that?

25 A. Well I guess it depends what you call

1 normal. I would say it was pretty normal fever
2 curve for a convalescing patient from peritonitis.
3 To say she was stone cold 37 degrees, she was not.

4 Q. No, She did have a persistent fever,
5 although it fluctuated, she did persist with
6 fevers?

7 A. She had low grade fever.

8 Q. Fair enough.

9 In general, one of the participants
10 in this case whose been identified on the side of
11 the defense has indicated that in his medical
12 opinion steroids are the most powerful antipyretic
13 that exists; do you agree with that statement?

14 A. Maybe not most. I would be reluctant to say
15 most powerful. I would agree.

16 Q. He might not have used the word most,

17 A. Corticosteroids are known to suppress the
18 fever response.

19 Q. They are he said a powerful antipyretic.

20 A. I would generally agree with that.

21 Q. Doctor, do you infer, I'm just asking what
22 you infer as a doctor, if you were looking at these
23 fevers, since Mrs. Yarborough was on
24 corticosteroids, was able to mount fevers, without
25 them the fevers could have been higher?

1 A. That is a potential conclusion.

2 Q. Is there some other conclusion?

3 A. I think that whether a patient is on steroids
4 or not, the fever needs to be evaluated in the
5 overall light of how the patient is doing.

6 So I think it is not unreasonable
7 to conclude that the temperatures may have been
8 higher had she not been on steroids.

9 Q. Because the steroids would -- I use the word
10 repress a lot because I don't understand steroids
11 quite as well as I probably should. I guess the
12 import of what I'm saying is if the body is trying
13 to mount an afebrile response to an initiator in
14 the body, whether it's trauma or infection, the
15 steroids repress to some degree that inflammatory
16 response; do you agree with that?

17 A. In many patients they do, in some others they
18 don't. In general we recognize steroids as
19 suppressing the fever response.

20 Q. In this patient, we've already established
21 you believe she was immunosuppressed?

22 A. I think from the magnitude of the steroids
23 that she was receiving, I think it would be fair to
24 say she was immunosuppressed.

25 Q. A couple other points about the effect of

1 steroids.

2 Do you agree that steroids in the
3 quantity, however declining it was that
4 Mrs. Yarborough received, would also inhibit the
5 body's ability to respond to your classic abdominal
6 finding of rigid abdomen, things of that nature
7 that might be indicative of a brewing infection?

8 A. It would potentially modify the response
9 because steroids modify the inflammatory response,
10 it would clearly be a potential modifier of the
11 physical findings that one might customarily see.

12 Q. Doctor, I'm going to ask if you don't mind to
13 pull out your textbook for a second.

14 A. Just a second.

15 Q. This textbook has got your name on the front,
16 that means it's your textbook, you are the editor,
17 correct?

18 A. That is correct,

19 Q. Every article that has found its way into
20 this textbook had to be approved by yourself?

21 A. It would mean that I would have edited and
22 reviewed it.

23 Q. If someone put blatantly wrong information in
24 an article, can I suspect you would have removed it
25 from the article or chosen not to put it in your

1 book?

2 A. Blatantly wrong I would have edited it out.

3 Q. I'm being facetious. I assume that is the
4 process, I know it took years to put this book
5 together.

6 I would like to turn to page 69,
7 the chapter by R. Lawrence Reed, II.

8 A. Okay.

9 Q. Nice general discussion for surgeons about
10 the activity of antibiotics. I would like you to
11 look in the section on antifungal agents.

12 A. All right.

13 Q. Second column at the bottom, actually I'm
14 going to read the whole section, you can discuss
15 it, tell me how I'm misinterpreting this.

16 It says that fungal infections are
17 being observed more frequently in the surgical
18 patients one to two weeks after having prolonged
19 parenteral hyperalimentation who received broad
20 spectrum antibiotic coverage, that had some
21 violation of alimentary tract integrity, correct?

22 A. That's correct.

23 Q. That's what you and I just discussed, broad
24 spectrum antibiotics causing shall we say the
25 existence of more fungal infections.

1 Says the diagnosis is sometimes
2 difficult to make because luxuriant Candida growth
3 may represent merely colonization, not invasive
4 infection?

5 A. I think we've been saying that too.

6 Q. It goes on to talk about further
7 complications. The problem is the potential
8 toxicity seen with Amphotericin B traditionally
9 used for severe fungal infections -- you are
10 reading along with me, right?

11 A. Yes.

12 Q. Because of this, therapy for fungal infection
13 is generally withheld until the diagnosis is
14 confirmed with tissue biopsy or positive blood
15 culture, You refer to in a situation such as a
16 positive blood culture it's a must do; however,
17 there are frequently patients that fail to receive
18 appropriate therapy because the diagnosis was not
19 made until the autopsy was performed.

20 That harkens back to what you and I
21 already discussed, Candida doesn't, for some reason
22 unknown to us, just doesn't always present in the
23 blood, correct, it intermittently can?

24 A. Correct.

25 Q. We're still together on this.

1 It says it is generally advocated
2 therefore an aggressive attitude be taken; do you
3 agree with the statement in this article?

4 A. Generally I would.

5 Q. Skipping to where it talks about what dosage
6 of Amphotericin B, then says thus granulocytopenic
7 patients, this was not one, or other severely
8 immunocompromised hosts with persistent fever,
9 after one week of antibiotic therapy, should
10 receive Amphotericin B therapy, despite the absence
11 of microbiologic confirmation; do you agree with
12 that statement as written by Dr. Reed?

13 A. I think it is a controversial statement, not
14 blatantly wrong. The introduction to this series
15 of questions would I edit something out that was
16 blatantly wrong, I would say there would be a
17 substantial split in vote. Most of us appreciate
18 the fact that the diagnosis of Candida to be
19 extraordinarily difficult, but he does say
20 granulocytopenic patients, which this patient was
21 not.

22 Q. Correct.

23 A. Persistent fever gets into the debate about
24 what defines a persistent fever. While we may say
25 there was a smoldering fever in this patient, who I

1 might add had an open abdominal wound which would
2 cause fever, I would generally agree with the
3 flavor of Dr. Reed's comment, would obviously make
4 the proviso that there are no absolutes. That
5 clinical judgment is in order. That I would not
6 for a second have advocated antifungal therapy for
7 this patient.

8 I would also point out to you he's
9 talking about after one week of antibiotic therapy,
10 the cultures that you are referring to are in fact
11 the cultures that were obtained at the time of the
12 operation, before the patient had received any drug
13 therapy.

14 Knowing Dr. Reed very well, I would
15 be confident that he would have not advocated
16 antifungal therapy for this patient. You might
17 even choose to call him and ask him.

18 Q. I don't know if I have time to recruit him as
19 an expert. I might call him some day and ask him
20 at your request.

21 A. You might call him, he's a terrific person.

22 Q. Isn't the issue in this case that a culture
23 was grown from the peritoneal cavity that contained
24 two organisms, Candida and Enterococcus, that in a
25 person who was not immunosuppressed you might not

1 ever change the therapy to address those cultures;
2 you agree with that?

3 A. That is correct.

4 Q. I think that you appreciate obviously based
5 on reading the reports, you haven't had an
6 opportunity to talk to me about it, my contention
7 is in a person such as Mrs. Yarborough it's
8 absolutely foreseeable she is at risk to develop
9 ill effects of Candida that you already indicated
10 may not show up in the blood until after the fact;
11 do you agree with that, she was at risk to develop
12 an infection from Candida?

13 A. She was at risk,

14 Q. That is a foreseeable series of events?

15 A. That was a possible outcome, not
16 foreseeable.

17 Q. When I use the word foreseeable I was not
18 using it in the legal sense of the word. If you
19 are a doctor, someone says to you here is an
20 immunosuppressed patient, she has had massive fecal
21 contamination due to perforation, there is what we
22 grew out of the culture, you know what the
23 antibiotics are. Isn't it a fair medical
24 conclusion to draw at that point that you will have
25 a concern that the person may become infected from

1 the Candida because of their circumstances?

2 A. I think that it is a fair medical concern
3 that Candida would be an issue for this patient.

4 Q. Skipping to the chart itself, this may be the
5 only chart question I ask you today.

6 Have you had an opportunity to
7 review the progress notes that are included in the
8 chart from the day that the positive cultures came
9 back? We can turn to it if you would like to.

10 A. Why don't you tell me which ones you are
11 referring to so I don't have to guess.

12 Q. I wouldn't want you to guess. We will flip
13 to it.

14 MISS KOLIS: Gary, I don't
15 know, did you send him a Bates stamped copy?

16 MR. GOLDWASSER: I did not.

17 MISS KOLIS: We're going to
18 have just a little trouble. Not much.

19 MR. GOLDWASSER: Doctor, I
20 should have sent you a chart which has tabs in it,

21 THE WITNESS: It has tabs. I
22 have the progress notes before me.

23 Q. If you would flip to the 14th, the 14th of
24 January.

25 MR. GOLDWASSER: There are two

1 entries for that day.

2 Q. The first entry I would like to look at is on
3 the bottom half of the page, the notes of the 13th,
4 POD 3 starts at the top.

5 A. I got it.

6 Q. That is the date obviously when we see these
7 recorded in the chart, correct?

8 A. That's correct.

9 Q. I want to ask you this question: Based upon
10 progress notes alone, no other extraneous material,
11 from the 14th to the date after this lady's
12 discharge do you see any concern or discussion in
13 the medical chart itself about this woman
14 potentially being infected with Candida?

15 A. On the 14th they identify the culture
16 results, I try not to memorize these, so I'm having
17 to read through it all again.

18 Q. I'd be more than happy to pay you for the
19 time it takes you to read them today, that is
20 fine.

21 A. Yeah, there was the concern about having a
22 positive urine culture which was on the 22nd. That
23 a culture of the wound as it was indicated here
24 grew a Candida and Enterococcus, and that led to
25 the infectious disease consult.

1 Q. Let me ask you this question a different way:
2 First of all, I know I'm going to know the answer,
3 I would like to ask it. You aren't advocating the
4 elimination of the subspecialty of infectious
5 disease? I'm not talking about this case, in
6 general?

7 A. Certainly not.

8 Q. Certainly not. You've written the book
9 Surgical Infections to better educate surgeons what
10 exists out there; would you agree with that?

11 A. Yes. I would hope that it would have some
12 value to infectious disease specialists as well
13 since many of them have a more limited exposure to
14 surgical based infections than they might
15 otherwise. Since they get consulted, that I hope
16 this book might serve as some value to clinicians
17 who were infectious disease specialists as well as
18 surgeons.

19 Q. My question is this: Do you or do you not
20 call in infectious disease doctors when you receive
21 cultures with these organisms in them from the
22 peritoneal cavity?

23 A. I would myself almost never call in an
24 infectious disease person for this kind of
25 situation.

1 Q I would expect that would be true.

2 There is no standard of practice
3 that you are aware of that requires a surgeon to
4 bring in an infectious disease person to help
5 interpret treatment for cultures, is there?

6 A. In this situation, I would not consider it as
7 standard of care to have an infectious disease
8 consultant.

9 Q. You would expect that the general surgeon who
10 was caring for this patient would have enough
11 medical knowledge to understand and interpret the
12 event and issues surrounding an immunosuppressed
13 patient?

14 A. I would generally expect that he would but I
15 wouldn't fault him if he wanted his impressions and
16 feelings confirmed by someone else.

17 Q. You've read the depositions of Dr. Bass and
18 Dr. Sonpal?

19 A. Yes.

20 Q. What do you interpret the testimony of
21 Dr. Bass to be as to what his understanding was for
22 the purpose of his consult on the 23rd?

23 A. You know you are asking me now how much can I
24 remember, so I would have to refer specifically to
25 the deposition itself.

1 Q. I'm going to withdraw that question.

2 Let me ask you this: Is part of
3 the way you reasoned this case based on the fact
4 that Dr. Bass, if he testified to this, testified
5 that he was called in for the limited purpose of
6 looking at the results of the wound cultures that
7 occurred later in the hospital course.

8 MR. GOLDWASSER: Donna, excuse
9 me, he did testify to that. He also testified that
10 he reviewed the patient's entire course before
11 writing his progress note.

12 Q. Mr. Goldwasser will be able to ask you that.

13 I'm asking if he testified that it
14 was his understanding his purpose was to evaluate
15 solely the culture that subsequently grew out of
16 the wound, is that how you worked out whether or
17 not someone deviated from the standard of care?

18 A. Independent from the deviation of the
19 standard of care issue it would be my understanding
20 as I'm looking through Dr. Bass' deposition and
21 with your comments he does suggest that he was
22 consulted for the reason of evaluating the wound
23 cultures. I would expect generally that an
24 infectious disease person, in a patient like this,
25 should be at liberty to make whatever

1 recommendation he or she thought was appropriate in
2 the patient's overall care relative to infection.

3 Q. Fair enough answer.

4 Doctor, have you seen the CTs?

5 A. I have not.

6 Q. Let me ask you a question about CTs and your
7 ability to look at them. I gather that you read --
8 skip what you read.

9 Do you in your surgical practice
10 look at the CTs when you have ordered them for the
11 purpose of looking for an abscess?

12 A. I almost always do.

13 Q. Let me ask the question this way, I don't
14 know if there is a good or easy way to ask the
15 question: Don't you look at them because through
16 the years you've developed an eye for ferreting out
17 what may be a sign of infection on a film?

18 A. I've looked at lots of them so I like to look
19 at suspicious things. Potentially if there is
20 something that I see that is troublesome that may
21 not have been addressed by the radiologist in his
22 or her formal report, we would have an opportunity
23 to discuss it.

24 Q. Just as a general matter to establish this
25 line of thinking I suppose, it's not that you are

1 being disrespectful to the radiologist, it's that
2 you acknowledge that radiologists read lots of
3 different kinds of films; would you agree with
4 that?

5 A. I would generally agree with that.

6 Q. Because this is something you deal with, you
7 may have a better grasp what something looks like
8 on a CT film, right, as a general principle?

9 A. I think that relative to abdominal abscess
10 that I can give a radiologist a pretty good run for
11 his money on identifying whether a patient has an
12 abscess or not. Since I have seen probably as many
13 abdominal abscesses on CT as any living person, I
14 don't think the radiologist would be offended if I
15 chose to ask about a specific.

16 Then of course the only thing that
17 is always a problem, that when we order CTs we
18 probably don't give the radiologist enough of a
19 history about what may have transpired in the
20 patient's care leading up to the CT. So sometimes
21 I think it's very useful for the surgeon and the
22 radiologist to go over the CT together.

23 Q. Along those lines, when you say you don't
24 give them enough history, I guess what you -- not
25 that you said you don't give them enough history,

1 sometimes they don't have enough history?

2 A. Sometimes in the hassle of life we don't
3 write down on the consult the pertinent things that
4 would necessarily help the radiologist, so it's
5 certainly been my observation that a patient like
6 this may well have written on the consult rule out
7 abdominal abscess without necessarily identifying
8 for the benefit of the radiologist that the patient
9 had a perforated viscus 10 days previously so on
10 and so forth, giving them a little more help.
11 Sometimes after the scan is completed it's I think
12 beneficial for the surgeon and a radiologist to go
13 over the films together.

14 Q. Doctor, do you have an opinion based upon the
15 course of events that occurred in this patient as
16 to whether or not on the day she was CAT scanned,
17 I'm stating that it's January 20th.

18 MISS KOLIS: Am I right,
19 Mr. Goldwasser?

20 MR. GOLDWASSER: That's right.

21 Doctor, as an aside before trial
22 you'll have a chance to look at the film itself but
23 go ahead.

24 Q. Do you have an opinion as to whether or not
25 the abscess was present on January 20th?

1 A My suspicion is that it is unlikely that the
2 abscess formed completely from scratch if you will
3 between the 20th and the time that the patient
4 died. So I would say there was clearly at the
5 least incipient abscess that was present on the
6 20th, but was just outside of the resolution of the
7 CAT scan to identify.

8 Q Right. I was wondering if that would be your
9 answer. To put it in layman's terms so you and I
10 can talk about it at trial, you do have an opinion
11 it had to at least as you state be in its incipient
12 form on the 20th?

13 A. That is correct. I think despite all of our
14 perception of CAT scan technology, there is still a
15 definable false negative or false positive rate for
16 the abscess when one scans the abdomen.

17 Q. Or sometimes the radiologist taking as many
18 cuts as he thinks he should, lines it up on the
19 Scout film, we're doing 16 levels, sometimes you
20 need a little closer level?

21 A. Perhaps I think in fairness to everybody when
22 there is an anatomic distortion from inflammation,
23 peritonitis, operation and so forth, one doesn't
24 always -- the anatomic resolution just isn't as
25 good as we might like. So arguing that maybe too

1 few or that not enough cuts were taken is a
2 possibility.

3 Q. Except that when I am discussing this, it's
4 just to establish a principle, I'm not criticizing
5 the radiologist.

6 A. I'm not interpreting what you are going in
7 that direction.

8 I'm also just saying that
9 understanding the natural history of abscess
10 formation, with surrounding inflammation and loops
11 of intestine being in and around the process, that
12 it is perfectly understandable to me that one may
13 have -- I believe I've written this down, a
14 10 percent or so risk of a false negative abdominal
15 CT scan.

16 Q. That is what you wrote down, I agree with
17 that.

18 Would you expect that a surgeon who
19 does abdominal surgery would understand that a CAT
20 scan is not a 100 percent fail safe in the
21 detection of an abscess, I should use that phrase?

22 A. I think that most surgeons would appreciate
23 it is not a totally foolproof enterprise. I would
24 generally think that most surgeons would recognize
25 that.

1 Q. I'm going to read you a sentence, I'll tell
2 you it's out of your lovely chapter on peritonitis,
3 page 229. If you want to turn there, you know I
4 wouldn't misread it on purpose, I'll read it into
5 the record. "While the physical examination is of
6 enormous value in establishing a diagnosis of acute
7 peritonitis, it's often of limited value in a
8 postoperative patient in whom abdominal abscess is
9 suspected;" do you see where you wrote that?

10 A. That sure sounds like me.

11 Q. It does sound like you. To clarify for me so
12 I understand that assertion correctly, are you
13 stating in pretty simple English in the postop
14 patient if we were worried about something lurking
15 that is going to cause an abscess, correct, we're
16 not going to have a real easy time palpating or
17 finding in the regular person, finding that abscess
18 in the face of abdominal wall incision; do you
19 agree with that in general?

20 A. Doing a physical exam, a manual physical exam
21 in someone who has a recent abdominal incision will
22 show all of those patients having equal degrees of
23 pain and discomfort, so there is no discriminating
24 value in my opinion to the physical exam in a
25 patient that's had a recent abdominal operation for

1 peritonitis or anything else.

2 Q. I agree with you. Let me talk to you about
3 something else you've written in your article in
4 your book,

5 Almost all the peritonitis patients
6 you will see a leukocytosis shift on differential
7 examination to more immature neutrophil forms; you
8 agree that is probably something you wrote?

9 A. Yes.

10 Q. Same page.

11 Have you seen leukopenia with a
12 shift being indicative of infection in any
13 situation?

14 A. I think you can. I think you can see
15 patients that have profound fulminant sepsis end up
16 having for whatever reason -- I could actually
17 explain it, this may not be the time or the place
18 they develop a leukopenia, a low white count.

19 The white cells that are mature are
20 all gravitating to the site of the infection. So
21 when one samples the blood, you find an overall low
22 white count, but because the mature forms have gone
23 to the site where they are supposed to be, you will
24 see a relative increase in the number of immature
25 forms.

1 Q. Have you been -- I'm going to try to ask a
2 question here: Would you agree that a band of 10
3 is indicative of a left shift or could be?

4 A. A band count of 10 is probably a modest left
5 shift shall we say.

6 Q. Let me ask you the question a different way.

7 If you have a trend toward a shift
8 let's say January 20th it's 1; January 21st, 2;
9 January 23rd it's 5; January 24th it's 7; January
10 25th it's 10; do you see that as a trend toward a
11 left shift indicative of the body's need to respond
12 to inflammation or injury?

13 A. It may or may not. It depends on whether the
14 overall white blood count was declining or rising
15 because one of the things you have is if the
16 overall white count is declining, what you are
17 seeing is a preponderance of immature forms simply
18 because the mature forms are leaving the
19 circulation for whatever reason. I would not argue
20 that a band count of 5 to 10 would reflect some
21 influence of potentially ongoing mild
22 inflammation,

23 Q. Let me ask you this, Doctor: Since you and I
24 already established that in your honest medical
25 opinion in looking at the totality of the

1 circumstances that at least on January 20th or at
2 least by that time when the CAT scan was taken
3 there were the probably incipient beginnings of
4 abscess in Carolyn, are you aware that there was a
5 trend in the left shift, have you been made aware
6 of that?

7 A, Yes, I'm aware of that.

8 Q. Would you say that trend in the left shift,
9 now that we both can agree obviously this abscess
10 had to be forming at that time, was in response to
11 the response to the abscess being formed in the
12 abdomen?

13 A. It may or may not have been. I would just
14 emphasize that patients that have open wounds have
15 reasons to have some element of a left shift by
16 itself, so I think in retrospect one could make the
17 conclusion that you're making, I think it's a
18 pretty big reach to say that every patient that has
19 a modest left shift has an incipient Candida
20 abscess in the abdomen,

21 Q. We're not talking about any patient. I'm
22 asking if this clinical data doesn't make sense to
23 you in light of what we already know about this
24 patient?

25 A. In retrospect that you can make that

1 statement that may have been a piece of evidence
2 that may have supported the ultimate diagnosis.

3 Q. I hate asking you these silly lawyer
4 questions but I have to do it, you know that: Do
5 you agree with me -- let's talk about the fact that
6 the peritoneum was -- peritoneal cavity was
7 cultured.

8 Someone, I think Dr. Lerner in his
9 report, I suspect I may hear it on video, said it's
10 not the standard of care to culture abdominal
11 wounds; do you agree with that?

12 A. I agree with that.

13 Q. Do you agree with me however if you do
14 culture those, you learn the results, that your
15 knowledge now places you in a position of
16 responsibility?

17 MR. GOLDWASSER: Responsibility
18 for what?

19 Q. In other words it isn't a defense to fail to
20 act on a culture -- I'm not leading you to try to
21 get you to say anybody was responsible. You are
22 not going to say that. You can't sit there and say
23 we didn't have to do it anyway, the fact we knew
24 what was on the culture doesn't make any
25 difference; does that make sense to you?

1 MR. GOLDWASSER: Do you
2 understand the question?

3 A. No, I really don't. I don't know if you are
4 talking about the wound culture or peritoneal
5 culture.

6 Q. Talking strictly the peritoneal culture?

7 A" I think that if you have some information
8 before you, it's always good to know what the
9 information is. I think if the surgeon chooses to
10 do the culture, whether the culture is a standard
11 of care or not, if you do the culture you should
12 probably know what the results are.

13 Q. That is all I was trying to establish.

14 Doctor, further in your chapter on
15 peritonitis you say you and your colleagues, I'm
16 not sure who they were at that time, page 233 to
17 234, where you summarized essentially it looks like
18 to me an investigation that you and your colleagues
19 did from major hospitals in urban communities,
20 talking about standard of practice employed in
21 clinical circumstances, I want to ask you a couple
22 of questions in case you bring this up at trial.

23 You concluded that not everybody
24 does cultures and they don't necessarily have to do
25 them is a nice easy way to state what you said?

1 1. That is probably a soft expression of what I
2 said in the article, I think I say that there is
3 no value to culturing the peritoneal cavity in a
4 patient with acute peritonitis.

5 Q. In the study you did, let me indicate that
6 unless I'm misreading this you did conclude that
7 24 percent of people who were sampled in the study
8 that you did had a subsequent change in antibiotic
9 therapy from the empiric selection chosen?

10 A. That's correct.

11 Q. So some people do culture and do change based
12 upon what is in the culture?

13 Am That is correct,

14 Q. Let me ask you if you've had an opportunity
15 to review Dr. Solomkin's chapter 62 in your book?

16 A. I haven't read it recently, of course I have
17 read it.

18 Q. Since it was in your book, when I learned you
19 were going to be an expert I copied it, provided it
20 to everyone so they could review it. I would like
21 to look at page 583.

22 A, Okay.

23 Q. Suffice it to say Dr. Solomkin pretty
24 exhaustively covers Candida infection in this
25 chapter, doesn't just talk about intra-abdominal,

1 agreed?

2 A. That's correct,

3 Q. While this is not meant to probably be
4 exhaustive, he does include in the section
5 intra-abdominal abscess and peritonitis, I want to
6 talk about what I interpret to me to be an
7 assertion a person who is receiving
8 immunosuppressive therapy should receive systemic
9 antifungal therapy, do you see that he writes that
10 in the second paragraph?

11 A. I understand where he writes that, that's
12 correct.

13 Q. I hope that I didn't misread this. I know
14 you are going to tell me to call Dr. Solomkin, I
15 don't know if he'll return my calls.

16 Once again this is obviously your
17 textbook, he says, Candida organisms are frequently
18 cultured, doesn't say anything about out of the
19 blood or any place else, from intra-abdominal
20 infections but should be considered a serious
21 threat only in high risk patients. He goes on to
22 define a high risk patient as a person with an
23 antecedent episode of sepsis,

24 Do you know if Carolyn Yarborough
25 had any antecedent sepsis?

1 A. She had just the peritonitis identified in
2 this particular case.

3 Q. Or those who have received immunosuppressive
4 therapy.

5 He then states in pretty plain
6 English such patients should receive systemic
7 antifungal therapy.

8 A. That's his opinion.

9 Q. I gather you disagree with that opinion?

10 A. I think that is an opinion that I would
11 tailor to the individual patient. That if I
12 received the information on the fourth
13 postoperative day in a patient who has
14 substantially improved, I would not do that.

15 Again, this is not an egregious or
16 outrageous statement. This a statement of his
17 opinion. All I can say is that all of this has to
18 be framed in the interpretation of the specific
19 patient's situation.

20 Q. Doctor, you are probably aware, I take it
21 you've gone through the chart sufficiently enough
22 to have looked at the total white blood cell counts
23 for this patient?

24 A. Yes.

25 Q. The seventh or eighth day postoperatively she

1 had a surge in her white blood count; does that
2 comport with your recollection?

3 A. She had an increase in her white count at
4 that time. I'm trying to filter through the record
5 to identify specifically what you are referring
6 to.

7 Q. I can probably find it for you. I'm going to
8 represent to you the count was 26,2 I think.

9 MR. GOLDWASSER: Doctor, if you
10 look at the lab reports, at the bottom the lab
11 sheets are numbered. Page 29 of the lab sheets
12 you'll find where they start on January 12th.

13 THE WITNESS: All right.

14 MR. GOLDWASSER: If you have
15 that.

16 THE WITNESS: Yes, I see.

17 MR. GOLDWASSER: She is going to
18 show you the 16th where it's up you see from the
19 12th, so forth.

20 MISS KOLIS: I believe it's
21 the 16th.

22 MR. GOLDWASSER: Yes, it's the
23 16th on page 30, up to 26.

24 Q. You see it's up to 26. Let me ask you this
25 question: Here is a woman whose been in the

1 hospital on these antibiotics for seven days, she
2 has got I'm calling it a persistent fever, it is
3 frequently above 98.6, correct?

4 A. That's correct.

5 Q. We know that her culture grew out Candida.
6 As a physician would you not have had a concern
7 that she had an increase in her white blood count?

8 A. I would be concerned.

9 Q. What would you possibly think was going on
10 that would cause it to surge that way?

11 A. There could be any of a number of things that
12 could cause a patient on the seventh postoperative
13 day to have a white count go up. It simply
14 requires a systematic assessment trying to define
15 what is the source of the patient's infection.

16 Q. Did you see a systematic assessment?

17 A. They clearly noted in the record that they
18 are examining her and following her and so forth,
19 that cultures, additional cultures were taken to
20 try to identify potential pathogens and so forth.

21 Q. Didn't they take those cultures on the 20th
22 in response to --

23 A. There is a culture identified if you look at
24 the progress notes on the 16th of January, that is
25 when the cultures were sent.

1 Q. You know you are right, I'm wrong.

2 A. All I can say is that I think that reasonable
3 vigilance was being exercised. I'm not sure what
4 one is supposed to do in addition.

5 Clearly if the patient had an
6 abscess as we know that she subsequently had, that
7 adding antifungal therapy on the 16th to 17th was
8 not going to impact the course of the abscess, it
9 would have to be operated on and drained. So I
10 don't believe, in my review of the records, that
11 event of the 16th constitutes any breach in the
12 standard of care.

13 Q. I'm sitting here thinking for a minute. I'm
14 looking for something.

15 What corticosteroid was
16 Nrs. Yarborough on while she was at Saint Luke's?

17 A. I believe it's Prednisone.

18 Q. Are you aware she was on anything other than
19 Prednisone?

20 MR. GOLDWASSER: Was she,
21 Donna?

22 A. In terms of --

23 MR. GOLDWASSER: Tell us if she
24 was.

25 Q. Hydrocortisone?

1 A. That is part and parcel of the same -- again
2 that is a five fold difference in strength, in
3 glucocorticoid effect. If you multiply
4 Hydrocortisone by five, you come up with
5 Prednisone. You are talking a variation of the
6 same product if you will.

7 Q. Based on your experience you don't find those
8 two have any different affect on white blood
9 counts, asking if you know?

10 A. I do not consider them personally to have any
11 different affects upon white blood counts. They
12 have different potencies if you will.

13 Q. Okay.

14 A. In terms of the glucocorticoid affect, I
15 would say Prednisone is five times more potent than
16 Hydrocortisone.

17 Q. I know I have a couple more questions, not
18 many.

19 Are you going to be asked to render
20 any opinion at trial as to Mrs. Yarborough's life
21 expectancy had this event not occurred?

22 MR. GOLDWASSER: Wait a minute.
23 In fairness, Doctor, I haven't discussed with you
24 what I'm going to ask you at trial, so you're not a
25 mind reader. Is the question hypothetically if he

1 is asked that if he has an opinion?

2 Q. Obviously my purpose today is to find out
3 what you are going to say at trial. Let me put it
4 this way: Hypothetically if Mr. Goldwasser chooses
5 to elicit that testimony from you, do you have an
6 opinion as to what the probable life expectancy of
7 this patient would have been barring this
8 catastrophic abscess incident?

9 A. I could not make a rational assessment of
10 what the life expectancy would be of a cervical
11 myelopathy patient so at this point I would have no
12 intention of testifying to her life expectancy.

13 Q. I want to be real clear about this: Going
14 back to where we began, the final sentence of your
15 report, you said Nrs. Yarborough died of severe
16 immunosuppression.

17 How will you be explaining that to
18 the jury? I can take a shot at it, you could tell
19 me better, because of her immunosuppression it
20 wasn't possible to defend the process going on in
21 her abdomen?

22 A. No, I would explain it this way: That if one
23 would have used an antibiotic therapy to cover
24 Enterococcus, and if one had used antifungal
25 therapy to cover Candida in this immunosuppressed

1 patient, she would have died but it would have been
2 with an organism that was resistant to the drug
3 therapy she was being given. That in an
4 immunosuppressed patient, they do not have the
5 capacity to deal with even the most residual
6 organisms, so the fundamental premise of your
7 experts is certainly flawed.

8 That is to say that if we gave all
9 antibiotics of all kinds to all patients, there
10 would be no infection, that is simply not true.

11 Q. I don't know they are saying that. Let me
12 see if I understand what you are saying. I think
13 I've added something so I'm glad I reasked the
14 question.

15 I asked you obviously a long time
16 ago if there was some contraindication to adding
17 antifungal therapy, you told me that was a strong
18 word, it wasn't a deviation from the standard of
19 care not to. I forgot to follow through.

20 She didn't get additional therapy
21 so she didn't die from the addition of medications,
22 correct?

23 A. Yes. I'm not saying the medication would
24 would be responsible for the patient's death.

25 Q. Let's ferret this out. Are you saying she

1 died of her severe immunosuppression?

2 A. Let me explain it for you so you understand
3 it.

4 Q. Okay.

5 A. The concept of trying to cover every
6 conceivable microorganism is simply not going to
7 work in the treatment of an immunosuppressed
8 patient. It simply comes down to the fact mother
9 nature abhors a biological vacuum. As we add more
10 drugs, we simply precipitate out more resistant
11 organisms. What happens is as you add more drugs,
12 the residual organisms that remain behind are in
13 essence resistant to the drug therapy that you've
14 used.

15 So that the same clinical
16 circumstances that set the stage for this patient
17 having Candida overgrowth, then Candida sepsis
18 would simply be operational. If you suppress the
19 Candida, there would be something else that would
20 be the overgrowth organism. You simply change the
21 microbe that causes the patient's demise when the
22 patient host's responsiveness cannot address a
23 remaining colonization that exists after a course
24 of drug therapy.

25 So immunosuppression is really the

1 disease in this patient, not so much the specific
2 organism that led to her demise,

3 Q. Should Dr. Sonpal have sat down with the
4 family and told them she was destined to die from
5 immunosuppression?

6 A. No, because he actually discontinued the
7 antibiotics on the 19th, proceeded with parenteral
8 nutritional strategy which would be an effort to
9 try to resort to a normal nutrition, normal
10 colonization.

11 It would be my observation, as it
12 was his at the time of her discharge, it fully
13 appeared she had successfully recovered from the
14 catastrophic illness. It would not have been
15 appropriate for him to have counseled the family.

16 He actually eliminated the
17 antimicrobial pressure, tried to refeed and
18 re-establish normal colonization in the patient,
19 In that sense he was fully compliant with the
20 standard of care in managing this patient.

21 Q. Have you asked to see the nursing home
22 records?

23 A, I have not.

24 Q. You are not curious what her course was in
25 the nursing home?

1 A. I am curious. I guess I'm curious as to what
2 was her course in the nursing home, why the nursing
3 home may have not perhaps been a defendant in this
4 case, but I was not asked by Mr. Goldwasser to
5 review the nursing home records, so accordingly
6 I've not requested them.

7 MR. GOLDWASSER: Doctor, as an
8 aside, if it's relevant for your opinion she did
9 well in the nursing home up until the day before
10 she crashed, it was a sudden, relatively sudden
11 acute event.

12 THE WITNESS: Thank you. I
13 don't think you and I ever discussed the matter.

14 MR. GOLDWASSER: We have not.

15 A. I would say in fairness to answering the
16 question, I was curious as to what her course would
17 have been, whether there was any earlier evidence
18 that she was deteriorating, rather than the moments
19 immediately before her demise.

20 Q. If you had been the surgeon making the
21 decision to discharge this patient to a nursing
22 home, what instruction would you have given that
23 nursing home regarding this immunosuppression?

24 A. I would have pointed out that she was a
25 patient who was postop from a major abdominal

1 operation, that she was on immunosuppressive
2 treatment, that infection would be emerging at a
3 point remote from the original operation was a
4 realistic concern. That delayed infection of the
5 abdomen might be an issue.

6 Probably more importantly things
7 like pneumonia and so forth would have tended to
8 have been more of my focus than a patient who has
9 had a negative CT scan and resumed parenteral
10 feeding having a very late occurring abscess.

11 I guess more than anything else I
12 would encourage them to give me a prompt call if
13 there was any deterioration in her course so that
14 an appropriate assessment could be made.

15 MISS KOLIS: Doctor, I don't
16 have any further questions for you,

17 MR. GOLDWASSER: Dr. Frey, we
18 thank you very much,

19

20

21 -----

22 (Deposition concluded; signature not waived.)

23 -----

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ERRATA SHEET

NOTATION

PAGES/LINES

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

DONALD E. FREY, M.D.

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, DONALD E. FREY, M.D. was
6 by me first duly sworn to testify the truth in the
7 cause aforesaid; that the testimony then given was
8 reduced by me to stenotypy in the presence of said
9 witness, subsequently transcribed onto a computer
10 under my direction, and that the foregoing is a
11 true and correct transcript of the testimony so
12 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 10th 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: **1,330**
 TOTAL OCCURRENCES: **3,660**
 NOISE WORDS: **385**
 TOTAL WORDS IN FILE: **11,492**

SINGLE FILE CONCORDANCE

CASE SENSITIVE

PHRASE WORD LIST(S):

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

COVER PAGES = **4**

INCLUDES ONLY TEXT OF:

QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES **ON**

INCLUDES PURE NUMBERS

POSSESSIVE FORMS **ON**

MAXIMUM TRACKED OCCURRENCE
 THRESHOLD: **50**
 --

NUMBER OF WORDS SURPASSING
 OCCURRENCE THRESHOLD: **2**

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