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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Deadra L. Jefferson, Circuit Court Judge

Appellate Case No. 2024-001698

Patricia P. McGougan and
Edgar McGougan,

.....

Appellants,

v.

Richard F. Frisch, M.D., Timothy
E. West, M.D., The Southeastern
Spine Institute, L.L.C., and
Lowcountry Infectious
Diseases, P.A.

.....

Respondents.

RECORD ON APPEAL (VOL. 2)

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1 antibiotics during your September 2016 hospitalization?

2 A. Yes, ma'am.

3 Q. I think the direction of Dr. West?

4 A. Yes, ma'am.

5 MS. MAPLES: Thank you. I have no further questions.

6 THE COURT: Any redirect?

7 MR. LUGINBILL: Briefly, Your Honor.

8 THE COURT: You may proceed.

9 REDIRECT EXAMINATION

10 BY MR. LUGINBILL:

11 Q. Do you have to be awake for the surgery to come in
12 and administer an IV antibiotics?

13 A. No, sir.

14 Q. Bear with me to kind pluck around and deal with a
15 few issues so that (inaudible).

16 A. Okay.

17 Q. So many I'll try to be quick as I can. I'm going
18 to show you Plaintiff Exhibit 22. Do you see where it says,
19 "Office visit outpatient visit"?

20 A. Yes, sir. Yes.

21 Q. And what date did that office visit occur?

22 A. July 12, 2016.

23 Q. That was after you were already starting to have
24 the -- the back pain, correct?

25 A. Yes.

1 Q. Is that the day that he told you to stop the
2 Enbrel?

3 A. I don't recall.

4 Q. Do you recall whether or not you had to call back
5 in to clarify what he wanted you to do?

6 MR. HOOD: Objection, your Honor.

7 THE COURT: Basis?

8 MR. HOOD: Leading.

9 THE COURT: Sustained, leading.

10 BY MR. LUGINBILL:

11 Q. Do you remember one way or the other?

12 A. Ask me that again, please. I'm sorry.

13 Q. Do you recall whether or not a decision was made
14 at your office visit or whether or not you had to call back
15 in --

16 A. I had to call back in.

17 Q. Okay. Why are you sure?

18 A. Because I was to continue my RA meds until I found
19 out that I was having surgery and I would've called him after
20 I was told that I needed to have surgery.

21 Q. All right. And then while we're on this one,
22 there's a November 28, 2016 visit. Do you recall that one?
23 You see it right above it?

24 A. To Dr. Shanahan? I must have called in.

25 Q. Okay. And -- and Mr. Hood asked you that this is

1 that calling -- what resulted in you restarting your meds?

2 A. When I -- when I called in, he would've told me to
3 restart them.

4 Q. Okay. Do you recall you were asked at some point
5 after the washout you thought things were over, you remember
6 being asked that?

7 A. Yes. Yes.

8 Q. What information would you have had other than how
9 you felt?

10 A. No.

11 Q. About what was going on?

12 A. None. None other than I was discharged home to --
13 to recover from surgery.

14 Q. Had -- at that point in time, had anybody done any
15 blood work?

16 A. No.

17 Q. Had anybody done any serial CRP like you heard the
18 doctor talk about?

19 A. No, not no.

20 Q. From a medical decision-making standpoint, what
21 evidence was there that you were -- that things were over?

22 A. There was none.

23 Q. Now, when you went to Dr. Harkins, and you were
24 starting to have some pain. Why did you think it was all
25 right?

1 A. Because I had had surgery trying to get well. I
2 was hopefully -- you just don't know when you are having the
3 joint pain plus I had the -- I have a complicated illness at
4 this point. It's complicated by an infection that I hadn't
5 -- had in the past.

6 Q. Okay. When you would have flareups in the past,
7 were they ever in your lower back?

8 A. No.

9 Q. Would they ever go down into your groin area?

10 A. No.

11 Q. This is Plaintiff's Exhibit 65. How did you
12 describe it to Dr. Harkins?

13 A. "Left lumbar back discomfort. Radiates from my
14 lumbar back into my left groin."

15 Q. All right. What's the next thing?

16 A. "Discomfort is noted to have developed in the
17 setting of ongoing physical therapy following recent lumbar
18 surgical intervention."

19 Q. Where did he believe the greatest area of
20 discovery was?

21 MR. HOOD: Objection, your Honor.

22 THE COURT: Basis?

23 MR. HOOD: Speculation.

24 THE WITNESS: That's -- yeah.

25 THE COURT: You can't answer the question when --

1 THE WITNESS: Excuse me. Sorry.

2 THE COURT: -- there's objection pending. Is
3 sustained.

4 THE WITNESS: Sorry.

5 THE COURT: It's a subjective opinion. She can't
6 repeat what somebody told her. That -- that foundation for
7 the knowledge from rational perception.

8 BY MR. LUGINBILL:

9 Q. Based on his exam, did Dr. Harkins recommend to
10 you something he could do to help it?

11 A. He did a -- he told me that he was doing a SI, he
12 thought my SI joint maybe inflamed. So he did an injection
13 into my SI joint.

14 Q. Now, you want to draw on your personal knowledge
15 here a little bit. Where is the SI joint?

16 A. I don't know. It's back there and it hurts.

17 Q. Does this refresh your memory from nursing school?

18 A. No, it's -- I know that's my vertebrae and my
19 sacraments, my tailbone.

20 Q. So is this a sacrum?

21 MR. HOOD: Objection, your Honor.

22 THE COURT: Basis?

23 MR. HOOD: Leading.

24 THE COURT: Leading sustained.

25 BY MR. LUGINBILL:

1 Q. I'm going to rub my finger down the spine. You
2 tell me when I get to the sacrum.

3 A. Okay. There.

4 Q. Right here?

5 A. Yes.

6 Q. And the SI joint is the sacral --

7 A. Elite.

8 MR. HOOD: Objection, your Honor.

9 THE COURT: Basis -- basis?

10 MR. HOOD: Leading.

11 THE COURT: Sustained, leading.

12 BY MR. LUGINBILL:

13 Q. What is the SI joint?

14 MR. HOOD: Your Honor, I just --

15 THE COURT: It's --

16 MR. HOOD: It's beyond the scope.

17 THE COURT: It's speculation. You have failed to
18 establish the foundation for a knowledge or rational
19 perception. Do you want to bring questions within ambit of
20 the rules? I'll give you the opportunity to do it. Make
21 sure that your redirect is solely related to
22 cross-examination.

23 BY MR. LUGINBILL:

24 Q. Pat, when you asked about whether or not
25 Dr. Harkins gave you a joint in your SI or gave you an

1 injection in your SI joint?

2 A. Yes.

3 Q. Basing your own personal knowledge as a nurse and
4 using this model to help, can you tell me what -- well, first
5 we'll start with what does SI mean?

6 A. Sacroiliac -- sacroiliac.

7 Q. What does the "I" stand for?

8 A. I don't know. I'm thinking it's iliac, but --

9 Q. All right. What is the bone that connects to the
10 sacrum?

11 A. I -- I can't tell you right now.

12 Q. All right.

13 A. I'm not.

14 Q. Is this where he put the --

15 A. Yes.

16 MR. HOOD: Objection, your Honor.

17 THE COURT: Basis? Basis of the objection?

18 MR. HOOD: Leading.

19 THE COURT: Sustained, leading.

20 MR. HOOD: Can we approach for a minute?

21 THE COURT: Sure.

22 (Bench conference.)

23 THE COURT: You may proceed.

24 BY MR. LUGINBILL:

25 Q. Do you remember how Dr. Harkins performed the SI

1 injection?

2 A. With a long needle.

3 Q. How were you laid out?

4 A. I was over the table. I had to lay over the
5 table. Yes.

6 Q. In what direction do you remember?

7 A. He came --

8 Q. Where he was coming from?

9 A. This -- this left -- this left top of my hip
10 place.

11 Q. Was it closer to the middle of your spine or
12 closer to your hip?

13 A. It was in between my spine and my hip.

14 Q. Based on any soreness you made after that
15 injection, how far away would you say it was from where your
16 surgical site was?

17 A. Oh, it wasn't near the surgical site. He didn't
18 inject my surgical site.

19 Q. Going to the -- the weekend before you were
20 readmitted in December, do you recall whether or not anybody
21 from Southeastern Spine or specifically Dr. Frisch -- let me
22 rephrase that, do you recall whether or not Dr. Frisch called
23 you back and said, get on here to the hospital?

24 A. No, sir.

25 Q. Is there any question in your mind that

1 Southeastern Spine where your pain had gotten worse?

2 MR. HOOD: Objection, your Honor.

3 THE COURT: Basis?

4 MR. HOOD: Speculation.

5 THE COURT: Sustained speculation. Lack of foundation
6 and leading. Rephrase.

7 BY MR. LUGINBILL:

8 Q. Were you aware of the conversations that occurred
9 from you to Southeastern Spine on that Saturday?

10 A. No.

11 Q. Who called?

12 A. Edgar called.

13 Q. Did you ask him to?

14 A. Yes, I did ask him to.

15 Q. To the best of your knowledge, did he do it?

16 A. Yes, he did. And we were told we could wait till
17 Monday is what I was understood him to tell me.

18 Q. What is your understanding who you spoke with?

19 A. It was a PA someone called back. He left a --

20 Q. (Inaudible) work for?

21 A. Southeastern Spine.

22 MR. LUGINBILL: I think that covers it. Thank you,
23 your Honor.

24 THE COURT: Ma'am, you may step down.

25 MS. MCGOUGAN: Thank you.

1 THE COURT: Plaintiff may proceed.

2 MR. LUGINBILL: Your Honor, that would be Plaintiff's
3 last witness.

4 THE COURT: Does Plaintiff rest?

5 MR. LUGINBILL: We rest.

6 THE COURT: Mr. Foreman, ladies and gentlemen, the
7 Plaintiff has rested their case. I have some matters of law
8 I need to take up with Counsel. During this break, please do
9 not discuss the case and please leave your note pads in your
10 seats. We appreciate your patience.

11 (Jury exits courtroom.)

12 THE COURT: Plaintiff is rested. Are there any
13 motions?

14 MS. MAPLES: Yes, your Honor. Oh, I'm sorry. You said
15 Plaintiff.

16 THE COURT: I said the Plaintiff is rested. Are there
17 any motions?

18 Does Plaintiff have any motions?

19 MR. LUGINBILL: We have no motions, Your Honor. I
20 apologize.

21 THE COURT: That's all right. All right. Who wants to
22 go first?

23 MR. LUGINBILL: You go.

24 MS. MAPLES: Okay. Your Honor, at this time on behalf
25 of Dr. West and Lowcountry Infectious Diseases, we would move

1 for directive verdict pursuant to Rule 50(a) in the South
2 Carolina Rules of Civil Procedure.

3 Your Honor, Plaintiff has premised their case on three
4 theories. First being malabsorption, second being choice of
5 antibiotics, and third, length of antibiotics used. However,
6 Plaintiff has not met their evidentiary burden of proving
7 that these Defendants breached their duty of care under any
8 of those three theories.

9 Under South Carolina law, Plaintiffs must produce
10 expert testimony to support whether a standard of care has
11 been violated. And under those three theories, they do not
12 have expert support. In fact, their experts yesterday
13 plainly declined to include malabsorption among their
14 theories for why any of the Defendants allegedly violated the
15 standard of care.

16 Their infectious disease expert. The second witness we
17 heard from yesterday he testified that he disagreed with the
18 choice of antibiotic, but acknowledged that reasonable
19 providers could differ on the choice of antibiotic and he
20 just simply would've chosen a different one. But the one
21 chosen by Dr. West was reasonable because it was sensitive to
22 the type of bacteria that Ms. McGougan was affected with.

23 And then he testified that the length of antibiotics or
24 the time period of antibiotics by Dr. West in both September
25 and December, there's no standard guideline for those. So he

1 did not have an opinion as to that theory as well. So
2 there's not a sufficient evidentiary basis to support that
3 either Dr. West or Lowcountry Infectious Diseases violated
4 the standard of care, let alone that they caused the
5 Plaintiff's claim damages.

6 I would also raise that they failed to produce evidence
7 of Mr. McGougan's loss of consortium claim, specifically that
8 he has incurred any damages. His testimony today
9 demonstrated that it wasn't until today that he had began to
10 experience any kind of emotional damages or any similar
11 damages.

12 And then finally, we've heard zero evidence as to
13 punitive conduct or to support punitive conduct. There's
14 been no evidence of any intentionality, let alone an
15 indifference to Ms. McGougan's care by either Dr. West or
16 Lowcountry Infectious Diseases. So we don't think that would
17 be proper to submit to the jury.

18 And then I know I said finally, but I have one more,
19 and that is there has been zero testimony about Lowcountry
20 Infectious Diseases and its role in this case. They haven't
21 even established that Dr. West is either an agent, let alone
22 an employee of the practice. There's been no testimony
23 whether anyone from Lowcountry Infectious Diseases was
24 negligent. In fact, neither of their experts commented on
25 that entity itself. So we believe they should be dismissed

1 from the case as well. So for those reasons, we would
2 request a directive verdict.

3 THE COURT: Mr. Hood, have any motions?

4 MR. HOOD: Yes, Your Honor. Jamie Hood on behalf of
5 the Defendant, Dr. Frisch and Southeastern Spine, pursuant to
6 Rule 50, the South Carolina Rules of Civil Procedure hereby
7 moves for a directed verdict as all the causes of action
8 asserted by the Plaintiff against the -- these Defendants.
9 The basis for that is the Plaintiff's identified a -- a
10 single orthopedic surgeon expert to offer standard of care
11 opinions with respect to Dr. Frisch.

12 The standard of care opinions were premised on the idea
13 that the patient should have been taken back to surgery on
14 August the 30th. And had that happened, he believes the
15 patient would've a better opportunity to avoid osteomyelitis.
16 The problem with that is that the basis of his opinion was
17 that the patient was immunocompromised. And through a
18 cross-examination, he acknowledged that.

19 And now the -- the Plaintiff has testified and
20 confirmed that she was not taking the medications to
21 immunocompromised then, and their infectious disease expert
22 wasn't able to quantify that she was in fact,
23 immunocompromised in and around that time. Without that
24 fundamental piece of the puzzle or that piece of evidence to
25 support the decision, there is no impetus for proceeding to

1 open a surgical wound at that point in time, given the rest
2 of the clinical picture. I would also move more punitive
3 damages in the absence of any evidence from that point for
4 willful, wanton reckless conduct.

5 With respect to Southeastern Spine Institute itself,
6 the -- the only evidence is that doctor -- Southeastern Spine
7 would be vicariously liable for the claims asserted against
8 Dr. Frisch. There have been no independent claims offered by
9 the expert witnesses. They weren't critical of the PAs.
10 They were critical offer criticism of the physician. So
11 without offering a standard of care that PA Buck or PA Aprill
12 deviated from the standard of care, there's no independent
13 act of negligence.

14 THE COURT: Is your client an employee of Southeastern
15 Spine?

16 MR. HOOD: He is an -- I'm -- I'm not disputing the
17 vicarious liability, and I would like for them to be treated
18 as one because there's a whole host of benefits to my client
19 for that reason. But in terms of whether they're treated as
20 one or their independent acts of negligence asserted, you
21 know, I think that --

22 THE COURT: I think normally we treat them as one.

23 MR. HOOD: Unless they're independent, because what
24 ends up happening is becomes a complicated analysis, Your
25 Honor, because you have two entities on a verdict form and --

1 THE COURT: Well, generally what happens is the parties
2 stipulate that the doctor is an employee and agent of the
3 entity, and then you give instructions regarding the
4 corporate entity being the person in it, on act through the
5 actions of the employee agent or otherwise. I've never had
6 it where they're separated unless there's some evidence to
7 support that. I've always done it as one entity.

8 MR. HOOD: I understand. And -- and --

9 THE COURT: But that doesn't mean it would.

10 MR. HOOD: Well, it typically --

11 THE COURT: I just would see no reason as it has been
12 presented thus far that it would be treated separately.

13 MR. HOOD: Well, this concern that I have is it would
14 give a juror an opportunity to think that they could find
15 that someone at Southeastern Spine other than Dr. Frisch,
16 deviated from the standard of care. And we wouldn't know
17 that.

18 THE COURT: You don't have some evidence of that.

19 MR. HOOD: That's my point. There is none. So I mean,
20 I -- I think we can stipulate that Dr. Frisch is an employee
21 for purposes of this case, at the time care and treatments
22 were rendered at Southeastern Spine and legally therefore,
23 which would matter for the Court, is Southeastern Spine would
24 as the employer be vicariously liable for the care and
25 treatment that he rendered in the scope of his employment.

1 What that would presumably do is put Dr. Frisch on the
2 verdict form, not Southeastern Spine. And because it's
3 stipulated in the event that there's a judgment, the Court
4 deals with --

5 THE COURT: (Inaudible) separate, they'd be listed as
6 one, which you do, you do separate verdict forms for your
7 client, his entity, their client, and their entity. There's
8 no separation because you're -- the corporate entity is
9 vicariously liable for whatever he did because they can only
10 act through him. So it becomes one verdict. If the jury
11 finds that's appropriate, you don't break them into two. It
12 would be -- actually, I've never even done it when nurses
13 have been sued individually. And I've had a case where
14 nurses were sued individually, the doctors were not. And
15 there's a stipulation regarding agency and they weren't
16 separated. I -- I -- I -- I don't mean to look puzzled, I'm
17 just trying to think through if I've ever done it where
18 they've been separated and I haven't.

19 MR. HOOD: I understand. So my -- my concern with --
20 and we can deal with that at the verdict form stage, but
21 there's no per purposes directed verdict. The Plaintiff has
22 failed to produce expert testimony that any individual at
23 Southeastern Spine other than Dr. Frisch, deviated from the
24 standard of care. I don't believe this testimony is
25 sufficient, as I've already argued. But there was no

1 evidence offered that Buck and Ryan Aprill or anyone else
2 there had independent acts of negligence separate and apart
3 from the conduct of Dr. Frisch.

4 THE COURT: I don't think they called any of those.
5 Well, they attempted to call one witness started out, but
6 then the testimony was never finished. And -- and there's
7 been no indication that she's going to be, are you all
8 calling her as a witness?

9 MR. HOOD: We may, but we -- we -- the point is, at
10 this point, the evidence is closed in the Plaintiff's case in
11 chief, and they haven't.

12 THE COURT: I don't think they need evidence from them
13 to establish their burden of proof if they have an expert
14 that's testified there's a deviation from the standard of
15 care and your client clearly under the agency theory, is a
16 act through that corporate entity. I don't know that it -- I
17 don't -- I don't -- I think it's an illogical extension to
18 believe somehow a jury is going to find them responsible for
19 something that hasn't been testified to. They can't, it is
20 not -- that's not illogical.

21 MR. HOOD: So I guess what I'm --

22 THE COURT: You see what I'm saying? It's not -- they
23 can't find them responsible for something when you don't have
24 anybody that's testified that anybody else did it.

25 MR. HOOD: Right. And so if -- if, your Honor, agrees

1 with that that the Plaintiffs failed to provide expert.

2 THE COURT: Oh, no, I don't agree with that.

3 MR. HOOD: But --

4 THE COURT: But I --

5 MR. HOOD: -- but here -- here --

6 THE COURT: I don't want my comment to be
7 misapprehended. What -- what you argued was that somehow
8 they could be held responsible this entity for people whose
9 behavior has never been testified to. And all I'm saying is
10 that that's not, I don't think that's illogical -- illogical
11 assumption because the jury is bound by the evidence and
12 there's no evidence at this point about well, we had some
13 really the testimony from Ms. -- and the PA on Monday, it was
14 so inconsequential. I -- I don't know how the jury could
15 draw anything from that. I don't even think she testified
16 for five minutes.

17 MR. HOOD: I -- I'm in agreement with you about that.
18 I -- my -- my point is, what I don't want to do is get into
19 the rest of the case and have the Plaintiff at some point
20 arguing that the team at Southeastern Spine deviated from the
21 standard of care when there's no evidence. We stand strongly
22 by Dr. Frisch and will defend his care, but without someone
23 saying, hey, nurse, so-and-so, or PA so-and-so, and this day
24 deviating standard of care.

25 THE COURT: I don't think they didn't say that unless

1 they testify. So that's up to you all whether you call them
2 to testify or whether they call him in rebuttal, I don't know
3 that there's no testimony there -- that a verdict can't be
4 premised on something that wasn't testified to. But then you
5 all have let all these records in. So I don't know what
6 those records say.

7 MR. HOOD: My position on that would be under South
8 Carolina Law, this is not common exception. It requires a
9 testimony under oath of an expert witness, as to those
10 individuals, each specific act and each act was a
11 contributing cause and there is no evidence from that.

12 THE COURT: I agree that you all let all those records
13 in, and the jury can read them and they can draw any
14 inference from them if they want to. That's one of the risks
15 you run when you let all that stuff in evidence and you don't
16 believe they going to comb through it because they do.

17 MR. HOOD: I respectfully disagree, your Honor. I
18 think notwithstanding the medical records, South Carolina
19 requires an expert witness.

20 THE COURT: I'm not disagreeing with you. I'm just
21 saying, I'm just using common sense that a whole bunch of
22 medical records and they going to read them. It's been my
23 experience they read.

24 MR. HOOD: I hope they do.

25 THE COURT: Okay.

1 MR. HOOD: So with respect to directed verdict, Your
2 Honor, I -- I mentioned the PAs and -- and -- and so we would
3 move for directed verdict as to any acts other than acts of
4 Dr. Frisch by employees of Southeastern Spine Institute.
5 Have one more that I lost my train of thought on.

6 THE COURT: Take your time.

7 MR. HOOD: Oh, yeah, the loss of chance. So the
8 Plaintiff's expert witness testified that it -- in his
9 opinion, to a reasonable degree of medical certainty, she
10 lost an opportunity out a better outcome, increase the chance
11 that she would have a osteomyelitis or avoided the
12 opportunity to minimize the chance to have osteomyelitis.
13 South Carolina doesn't recognize loss of chance. This case
14 is no different unless they can establish approximate cause.
15 Under the approximate cause standard, which I contend they
16 failed to do. The Defendant's entitled to directed verdict.
17 Thank you.

18 THE COURT: You're welcome.

19 Would you like to respond?

20 MR. LUGINBILL: Yes, ma'am. Your Honor, I'll -- I'll
21 try to be directing as brief as I can. Starting with Dr.
22 West.

23 THE COURT: Excuse me, I'm sorry.

24 MR. LUGINBILL: They're doing it all way with --

25 THE COURT: This is dry air in here. It's

1 recirculated, you know, they turn everything off all weekend.
2 So, you know, everything percolates all weekend, then they
3 turn everything back on which makes no sense to me.

4 MR. LUGINBILL: Until we have one more ground, so I'll
5 wait.

6 THE COURT: Yes, sir.

7 MR. HOOD: So on a specific grounds, one of the claims
8 that the Plaintiff is that it was an act of negligence for
9 the Defendants collectively not to follow the patients with
10 labs and blood work, et cetera. The only expert who offered
11 that testimony was their Dr. Blass, their expert, Dr. Blass.
12 And what he testified to is he didn't know who was
13 responsible, but someone was.

14 And I maintain that's failure to meet the burden of
15 proof as a whose duty it is and who breached that duty. And
16 it would be improper for a jury to find against either
17 Dr. Frisch and Southeastern Spine or Dr. West and Lowcountry
18 Infectious Diseases, when the Plaintiff's expert did not
19 identify whose duty it was and who breached the duty. Thank
20 you.

21 THE COURT: You're welcome.

22 MS. MAPLES: Your Honor.

23 THE COURT: Yeah.

24 MS. MAPLES: I would just assert that on behalf of
25 these Defendants, Dr. West and Lowcountry who joined

1 Mr. Blass, final basis there as well.

2 THE COURT: Noted. Yes, sir.

3 MR. LUGINBILL: I would respectably disagree with
4 Counsel that our theory is there's malabsorption that's just
5 a condition she had that we have asserted needed to be taken
6 into account. The testimony by Dr. Davne -- or sorry by
7 Dr. Blass as to Lowcountry Disease and Dr. West was that the
8 choice in the medication was unreasonable on its face. And
9 so the length of time of the IV antibiotics was -- he
10 essentially gave three options. They could have continued
11 longer IV antibiotics and that would've stayed within the
12 standard of care.

13 They could have used a different form of oral
14 antibiotic afterwards, and that would've been standard of
15 care. But choosing to go seven doses post-surgery and oral
16 minocycline was not within the standard of care and that that
17 caused her damage.

18 Going to the missed chance. I'll just dovetail it onto
19 that. His exact testimony was it reduced the chances below,
20 more likely than not the infection was going to be erratic,
21 and that is the standard we need to meet. And that is what
22 he testified to. Obviously Lowcountry ID, we don't have any
23 separate acts of negligence that strictly respond superior.
24 I -- I don't disagree with -- with any of that.

25 As to the duty to follow, his testimony was quite clear

1 that what would normally happen and what is usual and
2 customary is that the -- the infectious disease doctor will
3 follow the patient afterwards in the office. If however,
4 that was not going to be the case, somebody else had to do
5 it. And it was the infectious disease doctor to coordinate
6 that handoff. He then say, if Dr. Frisch was going to do it,
7 he still had to do the same kind of monitoring that needed to
8 be done. And he talked about the fab four and the labs that
9 needed to be done.

10 So what I would say to that, your Honor, is he -- he
11 basically gave the jury two options of whose responsibility
12 it was. It was either the -- the infectious disease doctor
13 to do it himself or whoever assumed it on behalf of the --
14 the infectious disease doctor when they made that decision at
15 discharge.

16 In this case, there's no evidence in the records,
17 there's no -- my client obviously have no idea what took
18 place out of their presence. So there's no way to establish
19 to this expert if there was an agreement or not. But we do
20 know that Dr. Frisch was following up with the patient and we
21 know he was not coordinating that care with Lowcountry
22 Infectious Disease.

23 And so from that standpoint, the standard being
24 somebody had to do it and nobody did it. So both Dr. West
25 didn't ensure it was done and Dr. Frisch didn't and for sure

1 it was done.

2 And just to be more clear, his testimony as I
3 understood it, and as I read it, was that Dr. Blass had a
4 duty to follow once he assumed care, sorry, Dr. West and
5 Lowcountry Infectious Disease had a duty to follow and that
6 duty was not met. Why it wasn't met or how it wasn't met, or
7 if somebody else intervened, it was negligent as well. Are
8 other questions for the jury. But from a strictly meeting
9 the elements basis, there was a duty, the duty was not met
10 and damage is resolved.

11 And -- and finally, Your Honor, and I think that sucks
12 up the idea. We talked about last opportunity and we have
13 talked about the -- the idea of no direction.

14 THE COURT: But you're not going to argue last
15 opportunity. I didn't understand the testimony to be that.

16 MR. LUGINBILL: I -- I agree. His -- his --

17 THE COURT: But you're not -- let's just go ahead and
18 put that to bed.

19 MR. LUGINBILL: I have not.

20 THE COURT: That -- that is not the theory and you
21 don't plan to argue that.

22 MR. LUGINBILL: I have not.

23 THE COURT: Okay.

24 MR. LUGINBILL: Our -- our argument would be that the
25 -- it fell below a 50 percent threshold, more likely than not

1 that the eradication of the infection was going to occur.

2 And then lastly, I think that covers everything, Your Honor.

3 And lastly we are not CTQ to damage if we withdraw any --

4 THE COURT: You answered my question. Thank you. Are
5 you withdrawing any clinical punitive damage?

6 MR. LUGINBILL: I think I've addressed everything that
7 been raised.

8 THE COURT: In considering a motion for directed
9 verdict, the Court must consider the evidence in the light
10 most favorable to the nonmoving party. Directed verdict is
11 only appropriate when the evidence is susceptible of only one
12 inference. And the Court must look at all reasonable
13 inferences, again in the light most favorable to the
14 nonmoving party.

15 When the evidence yields only one inference, a directed
16 verdict is appropriate. However, when it yields more than
17 one inference, the directed verdict is not appropriate. This
18 Court is not the finder of fact, it is not the Judge with the
19 credibility of believability of witnesses is not the Court's
20 prerogative in ruling on motion for directed verdict to act
21 as the finder of fact.

22 And in the interest of time because time is a premium,
23 I listen very carefully to the motions made by -- on behalf
24 of Dr. West and Lowcountry Infectious Diseases. And the
25 issue of punitive damages is resolved as it was actually, I

1 think I could just really sort of address it all in one fell
2 swoop. Because I -- because the arguments really, quite
3 frankly, in essence are the same.

4 And I will deal with the argument regarding consortium.
5 There's clearly evidence in the record from Mr. McGougan that
6 he met the elements by preponderance of the evidence, at
7 least at this stage of proceedings that are susceptible in
8 more than one inference.

9 He testified that he lost and he didn't use these exact
10 words and I don't think the law requires him to use these
11 exact words. But in essence, he testified that because of
12 this injury, he lost the companionship in society of his
13 spouse that he had -- they have incurred medical bills as a
14 result of her treatment. That he has lost the support and
15 services of his spouse, that he has lost the affection,
16 comfort, solace, and guidance of his spouse. And as a result
17 he has -- because of her illness that he has suffered
18 peripheral damages as a result which he's entitled to recover
19 under the theory of consortium, which is 15-75-20, the code
20 of laws. There is more than -- there is sufficient evidence
21 in the record for him to proceed on a consortium claim. And
22 so that motion is denied. We view evidence in light most
23 favorable to the nonmoving party.

24 As it regards, I think it is an oversimplification to
25 say that the Plaintiff's theory in this case deals with

1 malabsorption. I did not understand the testimony in that
2 way. When I listened to the testimony of Dr. Davne and
3 Dr. Blass. And again, in the interest of time I'm going to
4 keep -- I'm going to try to be brief and not get too much
5 into the weeds, but the Plaintiff must establish several
6 elements in order for to prevail on a cause of action in
7 medical negligence.

8 One, they have to establish a standard of care. They
9 have to establish a breach in that standard of care and they
10 have to establish approximate cause. And in a nutshell, what
11 Dr. Davne and Dr. Blass testified to is that there was a
12 failure to diagnose and to treat Ms. McGougan's infection
13 before it became as exacerbated as it was.

14 And they felt based on a reasonable degree of medical
15 certainty, most probably that a failure to do certain things
16 regarding her treatment led to her injuries. That being the
17 failure to deal with the issues that she was experiencing
18 when her wound began to manifest certain symptoms that they
19 felt they failed to address it quickly. That they failed to
20 take certain cultures that they failed -- in terms of her
21 blood work that they failed to follow-up.

22 And that also attendant to that were the choice of
23 medications. And while it could be argued that there are
24 different courses of treatment and that no doctor's required
25 to adhere to a particular treatment when there are

1 differences, that's the question of fact for the jury to
2 resolve, not for the Court and whether those choices were
3 reasonable or not.

4 And again, there was testimony and they testified to a
5 medical -- to in their medical opinion that it fell below the
6 appropriate standard not to follow-up, not to take blood
7 cultures. The choice of medication. And I recall Dr. Blass
8 saying basically the classification of medication that was
9 used was more appropriate for acne than for -- and is usually
10 used for that type -- those type of maladies. And that
11 would've been a -- a more aggressive course of medication and
12 follow-up was required in order to treat Ms. McGougan.

13 The other thing, and -- and again this is another
14 question of fact. She did in fact have a preexisting ailment
15 that being the rheumatoid arthritis. Again, the extent of
16 her injuries or whether her injuries were exacerbated as a
17 result of that preexisting condition are question of fact.

18 And while there was testimony regarding malabsorption
19 with the doctor and specifically Dr. Blass said was that she
20 was immunocompromised and that is what brought to his -- she
21 brought to the system's attention to the medical
22 professional's attention that she even had this infection
23 that was glooming in her body. Because if she had not been
24 immunocompromised then her symptoms would not have manifested
25 themselves and would not have become apparent such that she

1 needed to be treated for this infection.

2 And there was also a conflicting testimony, well not
3 conflicting testimony, but I'm certain there probably will be
4 at some point. But the testimony and considering the
5 cross-examination of the witnesses is that shelf life, my
6 word's not theirs. They really don't know how long this
7 medication stay in the system before they are no longer -- no
8 longer have an effect on a person's system.

9 So based on what has been presented to the Court, there
10 are questions of fact. Again, this Court is not a finder of
11 fact, it's not for me to determine credibility or
12 believability, but they have two expert witnesses who have
13 established a standard of care breaching standard of care and
14 proximate cause, motion is denied.

15 All right. Mr. Hood, ready to go forward? Who do you
16 have -- Miss -- did you all say you all had a witness ready
17 today?

18 MR. HOOD: We do. We have the -- she's a Zoom witness
19 so we're going to bring a TV in. Open the Zoom link.

20 THE COURT: We can't do it through -- I can't just log
21 into the system?

22 MR. HOOD: We can.

23 THE COURT: But you would need the OWL wouldn't.

24 MR. HOOD: So we got to get the OWL and then we got,
25 the reason we got another TV is because we got to be able to

1 use the exhibits so the jury can see the exhibits and the
2 witness. Or I can set it up and we can start it whatever
3 time you --

4 THE COURT: So you didn't send the exhibits to the
5 witness?

6 MR. HOOD: She does have exhibits.

7 THE COURT: She has them?

8 MR. HOOD: Right. But if -- if she's on the screen --

9 THE COURT: Okay.

10 MR. LUGINBILL: My client needs to go to the bathroom.
11 She (crosstalk) can she go?

12 THE COURT: Yes. Uh-huh. Absolutely.

13 MR. HOOD: So anyhow, we're -- we're ready to pull our
14 stuff in and get set up with your team on the owl or we can
15 do that now.

16 THE COURT: You can do. We have to use the owl in and
17 put it up on screen. You see the problem is everybody has to
18 be able to see, including me and I'm not coming around stand
19 (inaudible). So we got to figure out, we got a lot of
20 technology we need to figure out.

21 MR. LUGINBILL: He doesn't want my help lecture, I'm
22 sure, but if you put the TV there, I've done it similar
23 before.

24 THE COURT: Is it easier than to use Webex? Oh, my
25 secretary (inaudible) do it. I'm not (inaudible).

1 MR. HOOD: I mean if you want me --

2 THE COURT: And I guess I could just hit my courtroom
3 and we could all go in there.

4 MR. HOOD: So she I tell you she's going to take longer
5 than 25 minutes if you want to break at 5:00. I'm not trying
6 to shorten our day, but if --

7 THE COURT: No.

8 MR. HOOD: -- if you want me to work with a team.

9 THE COURT: Well, I'll tell you at 5:00 jury ain't
10 paying attention to you anyway. They think about traffic,
11 picking up their family, doing what they have to do. They
12 had long day.

13 MR. HOOD: So --

14 THE CLERK: (Inaudible).

15 THE COURT: To do the hours take --

16 THE CLERK: I will take a couple minutes.

17 THE COURT: Do what you all do. We'll figure it out.
18 Yeah, because I think at this point there's another courtroom
19 where we use the OWL that makes it easier.

20 THE CLERK: If she -- if she has the HDMI under her
21 computer, they can use OWL.

22 THE COURT: And put --

23 THE CLERK: And put it on.

24 THE COURT: Yeah. That's what I thought.

25 THE CLERK: She won't be able to see you. She'll just

1 be able to see who's up in front of that.

2 THE COURT: That's fine.

3 THE CLERK: I'm fine with that.

4 THE COURT: Shouldn't you see you and you swear?

5 THE CLERK: Yeah, I just (inaudible).

6 MR. HOOD: So if that's what you want to do, that's
7 fine.

8 THE COURT: I just think that's easier.

9 MR. HOOD: I do too. So, but we still need to bring
10 the other TV in and get it set up so we can display the
11 exhibits. Because she's going to be one of these screens.

12 THE COURT: Uh-huh.

13 MR. HOOD: Otherwise there's no way to see where the
14 exhibit -- the jury won't know what we're talking about.

15 THE COURT: Yeah, I don't know. I'm challenged
16 technically.

17 MR. HOOD: All right.

18 THE COURT: Whatever you think. Whatever --

19 MR. HOOD: We're -- we're back.

20 THE COURT: I'm trying my head to work but I -- I'm
21 clearly taxing beyond my capacity. So whatever you all need
22 to do, go ahead and do it.

23 MR. HOOD: I'm so --

24 THE COURT: As long as you all did, I'm good.

25 MR. HOOD: My inclination is for 20 minutes of

1 testimony that we might get 10 minutes up by the time we get
2 to cross.

3 THE COURT: We'll do it in the morning.

4 MR. HOOD: Why don't we set it up now so we can hit the
5 ground running.

6 THE COURT: Okay. That works.

7 MR. HOOD: And then we can let the jury go and --

8 THE COURT: That works.

9 MR. HOOD: We'll get that going.

10 THE COURT: That's fine.

11 MR. HOOD: Okay. That probably good?

12 MR. LUGINBILL: Fine with me.

13 THE COURT: Great.

14 MR. KERN: Your Honor, if I could ask tomorrow morning
15 is Thursday?

16 THE COURT: Uh-huh.

17 MR. KERN: I saw the witness. I know you made a
18 decision at 9:00. You ready?

19 THE COURT: Yeah. Start right now.

20 MR. KERN: Should be ready at 9:00?

21 THE COURT: Uh-huh. Yeah, we got to get it done.

22 MR. HOOD: Do you want to bring him back in and tell
23 them to go home or you can go back there and tell him to go
24 home?

25 THE COURT: No, I mean we don't have any. Oh, what I

1 misunderstood. You tell me what you planning to do then.

2 MR. HOOD: All right. So --

3 THE COURT: I'm sorry, (crosstalk) long day hop out.

4 MR. HOOD: No problem. So we're right at 4:40 or 4:38
5 right now.

6 THE COURT: It's 4:37. Uh-huh.

7 MR. HOOD: And so our -- our witness, her name is Anne
8 Buck, she is in some remote location. She's on standby,
9 ready to click into Zoom.

10 THE COURT: Okay. And how long is her deposition?

11 MR. HOOD: She's got -- she's probably a -- between
12 direct and cross, I would say an hour.

13 THE COURT: Oh, okay.

14 MR. HOOD: That's what --

15 THE COURT: I mean, how many other witnesses do you
16 have?

17 MR. HOOD: Her plus four.

18 THE COURT: And are you going to be able to finish them
19 tomorrow?

20 MR. HOOD: Yeah.

21 THE COURT: Okay. So tell me again what you're asking.
22 I'm sorry. I'm sorry if I traded --

23 MR. HOOD: Yeah, so I -- I mean I think the real
24 decision is -- is cut the jury loose now let us get set up at
25 9:00 we start with a Zoom person, finish her, and then we

1 call start all the live people will be here and then --

2 THE COURT: Okay. I mean is that -- I mean, as long as
3 you all think you can finish a case --

4 MR. HOOD: Yeah, I don't think that 15 minutes tonight
5 is going to make a difference.

6 THE COURT: You all anticipate any the rebuttal
7 testimony?

8 MR. LUGINBILL: Hard to say at the time I don't other
9 than what we have to do in Aprill, but I think we've decided
10 that you're going to call her in your case and I'll just
11 cross her if we fix that.

12 THE COURT: Okay. You can get -- yeah, I -- I -- yeah,
13 it doesn't make sense to make them wait long and I'll just
14 tell them we have some technical stuff we got to work
15 through. We'll starting afresh tomorrow at 9:00.

16 MR. HOOD: And we're just going to get it all set up in
17 a bit.

18 THE COURT: I was going to tell you all I would do it,
19 but my secretary is sick. She had to go home and it's no
20 need for me to pretend I know how to do it because I don't.
21 They just sent me a link and I hit click and I -- and I'm for
22 it just I stay away from this stuff. That's how we get along
23 she tell me don't touch anything and I just obey.

24 (Jury enters courtroom.)

25 THE BAILIFF: All jurors present.

1 THE COURT: Ladies and gentlemen, we appreciate your
2 patience. I'm -- we're going to take advantage of this break
3 in testimony to let you all go home for the evening. We'll
4 resume in the morning at 9:00. During the break, please do
5 not discuss the case among yourselves with anyone else.
6 Please don't do independent research of any type on the
7 internet and refrain from posting on any social networking
8 sites.

9 We have some -- we have another witness that we're --
10 we are going to have to do by remote technology. It's going
11 to take probably 15 to 20 minutes for us to set that up. And
12 so instead of having you all wait while we do that, we're
13 just going to stay and get that all set up so we can just
14 start fresh in the morning at 9:00 and just be able to work
15 straight through. So I hope you all have a great evening.
16 Leave your note pads on your seats. We'll secure them during
17 the break and we'll see you at 9:00 in the morning.

18 (Jury exits courtroom.)

19 THE COURT: All right. Guys, anything else you need to
20 take up before we all go home for the evening?

21 MR. LUGINBILL: Not from the Plaintiff.

22 THE COURT: Plaintiff?

23 MR. LUGINBILL: No, ma'am.

24 THE COURT: From Defense, Mr. Hood?

25 MR. HOOD: No, Your Honor.

1 THE COURT: Defense, Mr. Smyth?

2 MR. SMYTH: No, your Honor.

3 THE COURT: All right. As you all have a good evening,
4 I'll see you at 9:00.

5 (THERE BEING NOTHING FURTHER, THIS HEARING CONCLUDED AT 4:42
6 PM)

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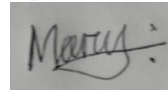
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CERTIFICATE OF TRANSCRIBER

I, MARY RAGSDALE, a court-approved transcriber, do hereby certify that the foregoing is a true, accurate, and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the South Carolina Circuit Court 9 of Charleston County, South Carolina, on the September 11, 2024.

I do further certify that I am neither of kin, Counsel, nor interest to any party hereto.

September 11, 2024

A rectangular box containing a handwritten signature in dark ink. The signature appears to be 'Mary' followed by a stylized flourish or surname.

MARY RAGSDALE

Transcriber

1 CONTINUATION OF PROCEEDINGS - SEPTEMBER 12, 2024

2 THE COURT: You may be seated. Good morning.

3 Plaintiff ready to proceed?

4 MR. LUGINBILL: Yes, ma'am.

5 THE COURT: Defense ready to proceed?

6 MR. HOOD: We are, your Honor.

7 THE COURT: Mr. Smyth?

8 MR. SMYTH: Yes, your Honor.

9 THE COURT: Is all tested? Oh, yeah. Perfect. Read
10 my mind. All right. They should be right now.

11 MR. HOOD: They bring in the jury, then the clerks will
12 walk over here and swear you in. Make sure you have one.

13 THE COURT: Okay.

14 (Jury enters courtroom.)

15 THE BAILIFF: All jurors present, Your Honor.

16 THE COURT: Good morning. I hope everybody had a
17 pleasant and restful evening. We're now going to resume
18 testimony.

19 Mr. Hood, you may proceed.

20 MR. HOOD: Your Honor, at this time the Defense calls
21 Ms. Anne Buck via Zoom.

22 THE COURT: Please swear the witness.

23 THE CLERK: Please raise your right hand.

24 ANNE BUCK,

25 being duly sworn, testified as follows:

1 THE CLERK: Please state your name, spelling your last
2 name.

3 THE WITNESS: My name is Anne Buck, last name B-U-C-K.

4 THE COURT: You may proceed.

5 MR. HOOD: Thank you, Your Honor.

6 THE COURT: You're welcome.

7 DIRECT EXAMINATION

8 BY MR. HOOD:

9 Q. Good morning.

10 A. Good morning.

11 Q. So Ms. Buck where are you today?

12 A. I'm at -- in my office. I work in Norton
13 Louisville, Kentucky.

14 Q. All right. Well, thanks for joining us from
15 Louisville, Kentucky. I've got a few questions today for
16 you. First I just sort of give us a roadmap. I'm going to
17 ask you to share with us a little bit about your background
18 and what you do for a living time to get you to talk
19 specifically about the time you had at Southeastern Spine and
20 then we're going to run through some of your specific medical
21 records related to Ms. McGougan. Okay?

22 A. Okay.

23 Q. All right. So first if you would please describe
24 for the ladies and gentlemen of the jury what you currently
25 doing?

1 A. I currently work for a group called Norton
2 Leatherman Spine Center. I work as a physician assistant on
3 the inpatient side of the practice. I help coordinate
4 preoperative care and discharges.

5 Q. All right. Physician's assistant we've heard a
6 lot about that. Can you tell us what a physician assistant
7 is and -- and how you become one?

8 A. Sure. It's an advanced practice provider. It is
9 a masters in science and physician assistant studies. You
10 become one by obtaining a bachelors degree and completing a
11 pre-req that are required by each program.

12 And then you complete a PA program which is a two-and-a
13 half-year to three-year program continuously including both
14 didactic or classroom study for approximately a year-and-a
15 half, followed by a year of medical rotation where you spend
16 time with individual specialties then you take board, which
17 is nationally certify exam, get licensed and attend practice
18 and then begin practicing.

19 Q. All right. And so that whole process takes what,
20 three years?

21 A. Not including your undergraduate training and then
22 any additional prerequisites that you required. So usually
23 over three years.

24 Q. Got you. All right. So in terms of scope of
25 practice, can you describe for the jury please if you would,

1 what you -- when you were at Southeastern Spine working as a
2 physician's assistant, what you did there?

3 THE COURT: And she's frozen.

4 MR. HOOD: She is frozen.

5 THE COURT: She is frozen. Is she connected to the
6 line? Let me -- let me text her. I sent her a message in
7 the chat. One (inaudible) she is frozen.

8 MR. HOOD: Looks like we got last off.

9 THE COURT: No, we wired, right? So they hardwired
10 there. So I'm wondering if she is on wireless. See if you
11 can reconnect.

12 THE WITNESS: Are you there?

13 MR. HOOD: You there, ma'am?

14 THE WITNESS: Yeah, I dropped out. It froze when you
15 said in terms of the scope of practice.

16 BY MR. HOOD:

17 Q. All right. We are through with that one. All
18 right. So in 2016 were you working at Southeastern Spine?

19 A. Yes.

20 Q. And can you tell -- can you tell the jury what you
21 were doing there as a physician's assistant?

22 A. I -- a clinic-based position and so predominantly
23 seeing patients in clinic setting in collaboration with
24 Dr. Frisch. I also at the time would work with
25 Dr. (inaudible) periodically.

1 Q. All right. Did you have an occasion to -- or do
2 you remember Ms. Patricia McGougan?

3 A. Not beyond my documentation, no.

4 Q. In preparation for today, have you had a chance to
5 review your documentation?

6 A. Yes, sir.

7 Q. All right. So do you have your medical records
8 there in front of you?

9 A. Uh-huh.

10 Q. Is that a yes?

11 A. Yes.

12 Q. All right.

13 A. Thank you.

14 Q. I'm going to jump right in. I'm going to ask you
15 to turn to our exhibit Number . It's been marked as Exhibit
16 Number 6. You see that?

17 A. It's loading.

18 Q. Okay.

19 A. Okay. I have it available.

20 Q. Sorry, trying to zoom it up a little bit. So this
21 would be -- can you tell us what the date of this encounter
22 is?

23 A. July 29, 2016.

24 Q. All right. And tell us about this visit. Is it
25 your visit?

1 A. This is my -- mine and Dr. Frisch's visit when a
2 patient would come into -- a new patient we would see them
3 together.

4 Q. Okay. So tell us what's going on with this
5 patient back in July of 2016?

6 A. She had presented two clinics with a new onset of
7 low back pain that was running into the lower extremity. She
8 had it, looked like -- sorry, reading the portion. Been
9 referred for surgical intervention at that point in time.
10 And had been undergoing chiropractic care without
11 improvement. And from what I can tell, her pain was fairly
12 severe and had failed oral steroids as well.

13 Q. Okay. So we're looking at the history of present
14 illness, is that what you're doing with this information?

15 A. Correct.

16 Q. And so we have it here in front of us on the
17 screen. Where does that information come from?

18 A. The patient directly.

19 Q. Is -- is it you as a PA your -- are you eliciting
20 that information from the patient?

21 A. Correct.

22 Q. All right. So tell us if you would like to --
23 should you go back to the document and I want to specifically
24 go to section about past medical history. Tell us what
25 significant there for you as a physician's assistant seeing a

1 pre-surgery patient?

2 A. Both of them. The hypertension and rheumatoid
3 arthritis.

4 Q. All right. And what's the significance there?

5 A. Their medical comorbidity. They're things that
6 you take into account and factor and ensure evaluating
7 patient and determining that care.

8 Q. All right. Yeah, we're going to talk about
9 rheumatoid arthritis a little bit more. Just beneath that,
10 there's a section called, "Current medications." Do you see
11 that?

12 A. Yes, sir.

13 Q. All right. And are any of those medications
14 pertinent from a rheumatoid arthritis standpoint?

15 A. Yes. The two medications that stand out are the
16 Enbrel and the Leflunomide, as well as her Medrol Dosepak,
17 the steroids that on there.

18 Q. Okay. And tell me what the Medrol Dosepak is?

19 A. It's a steroid used to treat generalized
20 inflammation most typically.

21 Q. And what's the significance of the -- the
22 Leflunomide, however you say that word, and the Enbrel?

23 A. They are both RA medication that can have an
24 impact on your immune function.

25 Q. Okay. All right. The second page of that

1 exhibit, ma'am, has a section titled, "Physical examination."

2 A. Uh-huh.

3 Q. Go there if you could. Tell us what you're doing
4 here?

5 A. Exactly it is a set it says physical exam. So
6 doing a -- typically a modified neuromuscular exam or
7 evaluation.

8 Q. All right. And then at the bottom, you're trying
9 to speed this up because Dr. Frisch was involved in this
10 visit too, right?

11 A. Correct.

12 Q. All right. And so with respect to the decisions
13 about going for surgery or not in that event decision of
14 Dr. Frisch?

15 A. Correct.

16 Q. All right. And so we looked down at the bottom of
17 this document on page two, which give us Exhibit Number 6 and
18 it describes the treatment plan in there. Do you see that?

19 A. Yes, sir.

20 Q. And would you have been in the room at this time?

21 A. I may have.

22 Q. Okay.

23 A. I don't recall the day.

24 Q. All right. Well, let me ask you this way. Was it
25 your understanding the patient go forward with surgery?

1 A. Correct.

2 Q. All right. So in -- in terms of that preoperative
3 visit, we talked about the rheumatoid arthritis. Was that
4 something that was known and recognized to you as the PA who
5 was (inaudible)?

6 A. Yes, sir.

7 Q. And in terms of developing the treatment plan that
8 was part of the data available for the treatment?

9 MS. FLUMIAN: Objection.

10 THE COURT: Basis?

11 MS. FLUMIAN: Leading.

12 THE COURT: Sustained, leading. Rephrase.

13 BY MR. HOOD:

14 Q. What if any consideration was given to her
15 rheumatoid arthritis and treatment as it relates to her
16 surgery?

17 A. So I can't recall, I mean specifically, but it
18 would've been factored into the physicians and discussions
19 based on practice function.

20 Q. Okay. All right. So as I understand your next
21 visit with the patient was not until 2000 -- or excuse me,
22 August 23, 2016. Does that sound familiar to you?

23 A. Yes, sir.

24 Q. All right. So pull that up. Okay. Tell us what
25 was happening on August 23, 2016, if you will, please?

1 A. Is this the Exhibit 21?

2 Q. I'm sorry. Thank you. Yes. Exhibit 21, tell us
3 what's going on -- on August 23rd?

4 A. At this point in time, she was approximately three
5 weeks after the surgery and was working to be seen for an
6 incision check, an incision evaluation that she had reported
7 draining from her incision.

8 Q. I'd like to go if we could please to the section
9 called "History present illness or HPI." Do you have that in
10 front of you?

11 A. Yes, sir.

12 Q. Tell us what the patient's main complaints were?

13 A. So based on this one, she was saying -- sorry
14 (inaudible) I'm talking. She was rating her symptoms as a
15 six out of 10. And it looks like it was predominantly left
16 side of buttock and lateral leg pain or thigh pain.

17 Q. Okay. Now, just above that, six out of 10 it
18 describes that it says, "Significantly improved as compared
19 to prior surgery." What significance if any does that have?

20 A. It -- when the -- when patients get those Number s
21 of their pain scale, they're subjective. They're -- your six
22 might not be my six. And so I'm including that to say she
23 still feels better than where she was before surgery as a --
24 a key to gauging her improvement or severity of symptoms.

25 Q. Got it. Let's move on to the next sentence is

1 history where it says, "Since her last visit she had
2 increased serosanguineous incisional drainage." Do you see
3 that?

4 A. Yes, sir.

5 Q. What significance does that have in your
6 assessment of the patient?

7 A. It -- the reason she came in for a visit and it
8 tell me that she had just that -- that it's increasing or
9 increase in serosanguineous drainage.

10 Q. Okay. Now, just lost my thought. Hang on a sec.
11 What does serosanguineous mean?

12 A. From a medical classification, it generally just
13 means clear to blood change fluid.

14 Q. And what significance, if any, does that have for
15 you, you know, assessing the patient at that point?

16 A. The fluid itself when it's serosanguineous, that
17 can be part of a normal process in the wound healing. It
18 does not indicate any purulence or pus or gross infectious
19 process.

20 Q. Okay. Does it say anything else about the -- her
21 other -- any other symptoms she has at that point in time?

22 A. Let me check. Just that she denied any other
23 constitutional symptoms. So no fevers, no chills, no nausea
24 vomiting, no other generalized physical illness.

25 Q. Okay. And if you could explain to jury what the

1 significance of that is?

2 A. As patients are healing, if there are like a full
3 minute or full-blown infection or issue, you start to feel
4 generally ill from flu like to myalgia to body aches, you
5 just feel ill and she was not experiencing any of that.

6 Q. All right. Let's -- question, let's move to the
7 next section. It's called physical exam. And on August
8 23rd, can you walk us through what you recorded as your
9 observations from the physical exam?

10 A. And so other than the normal parts of it, it looks
11 like she was having still a little bit of diminished strength
12 on the left as compared to the right. And then the drainage
13 on the bandage itself. Some slight redness along the
14 incision, which is documented and then where there's nothing
15 that could be expressed, there wasn't flatuance, no drainage
16 or tenderness.

17 Q. All right. There's a lot of words in there we
18 just got to run through. So you -- you mentioned the
19 slightly diminished strength on the left. I think we
20 understand that. Looking at the bandage it says, "Bandaging
21 shows evidence of serosanguineous drainage." What
22 significance did that have to you of your assessment?

23 A. It just shows that there was drainage on the
24 bandage itself. Again, no sign of purulent or opacity that
25 would point more towards infection. And then I go on to say

1 that I couldn't actually express anything from the incision
2 itself.

3 Q. Okay. We can get to that. So let's get to the
4 word erythema. What erythema mean?

5 A. Redness.

6 Q. And trace of redness along the margin of her
7 incision, what significance if -- if any is that?

8 A. So it -- for significance, but can -- it's tricky
9 because in these cases it can be part of typical scar healing
10 if you have fair skin and can, I think lot of us experience
11 that where it can turn scar is forming.

12 Q. All right. And you notice --

13 A. But to note the margin that it doesn't extend half
14 the boundaries listed.

15 Q. Okay. So what's the significance of not extending
16 beyond one millimeter?

17 A. That it is not a -- a something that is spreading
18 beyond the parameters of that actual scar, the position.

19 Q. All right. And you are -- didn't go into note
20 that there's a small area of granulation tissue, what does
21 that mean?

22 A. Granulation tissue is tissue that forms normally.
23 One of the first stages of the wound healing.

24 Q. All right. So granulation tissue, is that a
25 positive sign?

1 A. It can be, yes. It can indicate normal healing on
2 the position.

3 Q. Okay. No exudates were expressed. Can you tell
4 us what that means?

5 A. That means that an exam, who actively squeezing on
6 the incision trying to push out or replicate any drainage
7 that was seen on the bandage and none came out whatsoever.

8 Q. What does non-fluctulant mean?

9 A. When you press on something if you press against
10 the skin that it does not branch or turn white and then back
11 to red again. So another indicator for any pocketing of
12 fluid or infection or abscess is not continuing. It has no
13 indications of that.

14 Q. All right. And then you got induration, "No
15 induration." What does that mean?

16 A. Induration is a way of describing that when you
17 press on it or palpated that there are no masses or formation
18 or anything solved beneath the surface of the incision. It
19 means that there are no pockets or any concerning physical
20 exam finding or further infection at that point in time.

21 Q. All right. "It did non-tendered to palpation."
22 What does that mean?

23 A. Exactly that, that if you touch it, it is not
24 sensitive. It does not hurt, and there's no pain.

25 Q. All right. So what's your -- well let's keep

1 going through your record. I think we'll - we'll answer that
2 question. Let's go to the next section or the next
3 paragraph. Okay. It starts with, "We will begin."

4 A. Yes.

5 Q. And it mentions Bactrim. So can you explain to
6 the jury what Bactrim is and why it was being used here?

7 A. Sure. Bactrim is a broad spectrum antibiotic
8 commonly used in the perioperative setting of (inaudible)
9 post-op. In this case it was used essentially as a
10 prophylaxis just to essentially provide coverage abundant
11 precaution for her incision draining.

12 Q. Why would that -- why did you feel that that was
13 necessary?

14 A. Given her history and knowing her medical
15 comorbidities, knowing that she's got this incisional
16 draining, you just want to be extra cautious and it's a
17 standard of practice across the board.

18 Q. Okay. Let's move on the -- the next sentence. It
19 says, "We discussed wound and scar care instructions of wound
20 today."

21 A. Uh-huh.

22 Q. Is that -- is that a yes?

23 A. Yes. Sorry.

24 Q. No problem.

25 A. Yes, sir.

1 Q. When -- when did you make a note like that, what
2 -- where are your -- what does that reference?

3 A. That means that we extensively went over how to
4 care for her incision, what to keep an eye out for, what to
5 look for, what to expect.

6 Q. All right. Let's look at the next sentence if we
7 could where it says, "That she used to hold off on her
8 rheumatoid arthritis medications for the time being."

9 A. Correct.

10 Q. And that was part of the rheumatoid arthritis
11 thing that we talked about in that first op?

12 A. Correct.

13 Q. The next sentence describes the Neuroton to take
14 at bedtime.

15 A. Uh-huh.

16 Q. To address lower extremity symptoms increase at
17 night. Explain to us what that prescription was for and why?

18 A. Yeah. Neuroton is a neuropathic medication. It's
19 mental health with nerve pain. And if she was experiencing
20 irritation to that -- that nerve or sensitivity at night,
21 Neuroton can be helpful. Looking back at the history
22 (inaudible) portion, it looks like her rheumatologist had had
23 her on a -- a significantly higher dose and she was saying it
24 was maybe her she drastic. So the plan was to reduce the
25 dose and alleviate some of those side effects symptoms, but

1 still provide relief, but when she was symptomatic at night.

2 Q. And that would help her sleep at night?

3 A. Correct. If she were -- yeah. If she were having
4 trouble sleeping from pain and discomfort from neck pain, so
5 yeah.

6 Q. All right. The -- the note goes, "Wanted to say,
7 we discussed that should she fail to note improvement in her
8 left leg symptoms or should this progress worsened in any
9 way, should be a candidate for updated lumbar MRI scan."
10 Read that?

11 A. Correct.

12 Q. Why is that?

13 A. So if a patient does not continue to improve or if
14 there's symptoms worsen then it is one of the first things
15 that we do for screening is to offer and proceed with lumbar
16 MRI, it helps look at those neurologic structures in the
17 physical bed.

18 Q. Okay. And then the -- the next sentence says
19 that, "We offered to obtain this today, however seen a
20 purpose."

21 A. Correct.

22 Q. And it says, "Express understanding." What does
23 that mean?

24 A. It means the patient expressed understanding with
25 everything that we had discussed in the plan.

1 Q. And then she should come back in a week to inspect
2 her incision healing?

3 A. Correct.

4 Q. And then the last sentence there says, "She's
5 aware of red flag symptoms to contact the office
6 immediately." Can you tell us what that means?

7 A. Correct. It means that we -- we discussed reasons
8 and indications to contact the office and that included
9 worsening of any of her symptoms or any concern or issues
10 that she might develop in the interim in that weeks' time.

11 Q. Okay. Now, your next part of this note is the
12 treatment plan, which summarizes the Neuroton that you
13 already testified about; is that right?

14 A. Yes, sir.

15 Q. Follow-up in a week; is that right?

16 A. Yes, sir.

17 Q. And then instructed to call us if pain persist or
18 gets worse?

19 A. Yes, sir.

20 Q. Okay. So prior to this visit, I wanted to ask you
21 would you have the opportunity to review the nurse's notes or
22 -- or the doctor, whatever progress notes there are in the
23 office before you see the patient?

24 A. Yes, sir.

25 Q. And there was one visit, the first postoperative

1 visit, which is Exhibit Number 19.

2 A. Uh-huh.

3 Q. Let me know you have that in front of you.

4 A. It's loading.

5 Q. Got it?

6 A. No, it's still loading, I'm sorry.

7 Q. All right. While it's loading let me -- let me
8 ask you this question and see if you're -- you can answer
9 without it loading. Were you aware the patient had been
10 prescribed a Medrol Dosepak on August the 16th?

11 A. Yes.

12 Q. What significance if any, did that have in terms
13 of your decision making and assessment of the patient one
14 week later on the 23rd?

15 A. At that time it indicates that she was still
16 symptomatic in some regard enough to require steroid for
17 inflammatory pain.

18 Q. All right. Tell us about a Medrol Dosepak in
19 terms of potency, duration, that sort of thing.

20 A. In potency it -- it is all relative, but it is in
21 the class of steroids that is a very mild steroid. And that
22 it is not -- sorry, I'm trying to log back into the -- get
23 the document.

24 Q. We're -- we're almost finished with this. I
25 wouldn't worry about it.

1 A. Okay. But as far as potency in the grand scheme
2 of the medications steroid class of the class for mild
3 steroid.

4 Q. Well, let me just to wrap this up question of this
5 topic up. In terms of your visit on the 23rd, were you aware
6 of the Medrol Dosepak?

7 A. Yes.

8 Q. And did that in any way or was that taken into
9 consideration with your treatment plan?

10 A. Yes.

11 Q. Okay. Can you pull up Exhibit 20?

12 A. Okay. I have it.

13 Q. Okay. And this is an image of the incision from I
14 believe August 19th, which would've been four or five day --
15 four days before you saw the patient. I wanted to ask you
16 the top of this, how would you describe this wound that
17 you're looking at just from the photograph we have?

18 A. Very similarly to how it's described in the
19 progress note, there's some erythema, no obvious active
20 drainage from the picture itself and it appears to be there
21 may be some granulation tissue on that bottom margin that
22 otherwise it appears to be a -- a typical healing incision.

23 Q. Is there anything for -- it just catches your eye
24 and gives you concern, would you see that picture in terms of
25 the patient having some kind of form ongoing infection?

1 A. No.

2 Q. Let's look into your last note, which is Exhibit
3 Number 59, please. Let me know when you have it up.

4 A. I have it.

5 Q. All right. Let me see if I can just walk us
6 through until we get to the court stuff. This encounter date
7 is noted 11/28/16; is that right?

8 A. Correct.

9 Q. Under CC, that's stands for chief complaint?

10 A. Correct.

11 Q. And it's follow-up for low back pain?

12 A. Correct.

13 Q. Okay. Now, let's jump to HPI, History of Present
14 Illness. And just walk us through what -- what you reported
15 here please?

16 A. Yeah, so at this point she's approximately three
17 months from her initial surgery. And I believe two months
18 from her incisional drainage, which she's noted. She had
19 been doing well, but at her last visit starting on physical
20 therapy, after starting physical therapy she had some
21 increased back pain, no nerve component from the
22 documentation. And she had at that point that she thought
23 the pain was related more to her rheumatoid arthritis sent on
24 and documented.

25 Q. All right. And then let's look keep on going. It

1 has a pain scale of what?

2 A. Sorry it's reloaded let me pull it back up.

3 Q. Have it in front of you?

4 A. Now, I do. Thank you. Her pain scale is rated as
5 eight out of 10.

6 Q. Okay.

7 A. And again, she attributes that to her rheumatoid
8 arthritis.

9 Q. Understood. It says then she has been taking
10 NSAIDS in (inaudible) NSAIDS?

11 A. They are Non-Steroidal Anti-Inflammatory drugs.
12 Generally over the counter. And they include medications
13 like ibuprofen, Motrin, Advil and Flexeril.

14 Q. Okay. Is it Advil, Motrin, that sort of thing?

15 A. Correct.

16 Q. All right. Flexeril was that?

17 A. Cyclobenzaprine it a muscle -- a muscle relaxant.

18 Q. Okay. And then it says she was resumed on Kariva,
19 is that -- what's that supposed to do?

20 A. I believe it's supposed to be Arava. We -- the
21 medical transcription and it occasionally produces errors.

22 Q. Okay. And so, by this point when you're seeing
23 she's back on reported being back on that rheumatoid
24 arthritis medication?

25 A. Correct.

1 Q. And did that make sense to you in light of the
2 presentation?

3 A. Yes. And for how far out from -- from perspective
4 (inaudible).

5 Q. I want to look now at the next section or the --
6 sorry. So imaging was done; is that right?

7 A. Correct. X-rays.

8 Q. And tell us what you observed from the imaging?

9 A. That overall they're stable.

10 Q. Was there any -- is that -- what does that
11 indicate to you in terms of following a patient
12 postoperatively?

13 A. Checking to make sure there's no fractures,
14 there's no disc collapse, there's no new development and
15 instability structurally in the skeleton.

16 Q. Good news?

17 A. Yeah.

18 Q. All right. Let's look at the next section's
19 physical exam and tell us what you found here that assume
20 that you've done?

21 A. Specifically that her strength is still improved
22 from her initial visit. She's non-painful range of motion.
23 And that her scar is well healing at this point. Again, no
24 tenders to patient and then no gross infectious process
25 noted, which means she has no symptoms or signs of infection

1 on -- on visual exam.

2 Q. Then the next paragraph starts out "With greater
3 than 15 minutes." Tell us what the significance is here with
4 respect to you follow a patient who has had surgery and has
5 gone back in for an incision drainage.

6 A. It means that there was a lot of time was spent
7 discussing symptoms and evaluating her reviewing records.
8 And this is face-to-face with the patient, not counting time
9 outside of the exact -- exact exam room. And so it said that
10 we, you know, just spent a lot of time with her reviewing and
11 discussing and evaluating this.

12 Q. Okay. The next line there talks about the MRI
13 being recommended. What -- what happened there?

14 A. So from the documentation I had a patient that's
15 post-op and from both from the initial surgery and from an IV
16 coming back from reporting some increased pain. And so my
17 recommendation would be to evaluate that further and to
18 evaluate that with advanced imaging. And so that was my
19 recommendation.

20 Q. And -- and what was ultimately decided there?

21 A. From what it says that says that she declined it,
22 she did not want to proceed with it and instead she was left
23 to observe her symptoms as her pain was improving with the
24 Medrol Dosepak or with the prednisone.

25 Q. Okay. So does that sound like things are

1 improving with the medicine and she wants to see if that
2 works?

3 A. Correct.

4 Q. And then you got here it says "Follow-up in four
5 to six weeks"?

6 A. Correct.

7 Q. Why -- if someone is complaining of pain, why are
8 you going to have them come back in four to six weeks?

9 A. That means to go ahead and get her scheduled for
10 four to six weeks. If she wanted to observe her symptoms
11 that gives her time to watch and see how she feels. And then
12 I follow-up with the patient -- instructed to call us if her
13 pain worsens or continues at all at which point we can get
14 her in sooner.

15 Q. All right. So there you got the red flag signs.
16 Tell us again what those --

17 A. Right.

18 Q. -- it seems like that's a phrase you use?

19 A. Yes. (Crosstalk) it means that we discussed all
20 the things that they would need to keep an eye out for and
21 they are specific to each patient, but generally it all also
22 includes worsening of neurologic function, weakness, pain
23 that doesn't persist and this essentially encompasses all of
24 your warning symptoms to keep an eye out for.

25 Q. Got it. All right. Let's look then if we could

1 at the last section under treatment plan.

2 A. Yes, sir.

3 Q. All right. And that's where we just -- you to
4 summarize for us there.

5 A. I'm sorry, you want me to summarize the treatment
6 plan?

7 Q. Yes, please.

8 A. Yes. It just tells us that we prescribed her
9 Flexeril five milligrams as well as the Motrin which the
10 brand name is ibuprofen 800 milligrams. All the medications
11 risk and side effects were discussed and then for
12 instructions to follow-up and then to contact the office
13 should her symptoms continue or worsen in anyway.

14 Q. All right. Then there's a second page to this. I
15 just want to pull it up so you know what it said that -- this
16 is just would have your signature warrant and exercise
17 regimen recommended?

18 A. Correct.

19 Q. All right. So based on that evaluation that was
20 -- was that the last time you saw Ms. McGougan?

21 A. Correct.

22 Q. And based on that evaluation did you have concerns
23 or did -- let me back up. You've now seen the patient on
24 three occasions pre-op, post-op on August 23rd and again on
25 November 28th, right?

1 A. Correct.

2 Q. Did -- in the first visit, did you any -- did --
3 did you identify anything that gave you concern that she had
4 an infection that require immediate intervention?

5 A. On the very first visit?

6 Q. On the 23rd. Yes, ma'am. That was back when --

7 A. No.

8 Q. Okay. And then for again, on this visit when
9 she's complaining of pain, how did she look constitutionally
10 in terms of poor surgery being performed and that's sort of
11 thing?

12 A. Can you say that again for me, please?

13 Q. Sure. On this second visit that you had, which
14 was November 28th how did she look in terms of where her
15 surgery healing?

16 A. Oh, well healing, yeah, everything careful
17 healing.

18 Q. And as I understand that you didn't have the
19 opportunity to treat Ms. McGougan again, true?

20 A. Yes. True.

21 MR. HOOD: All right. Ms. Buck, and I appreciate you
22 being on Zoom and walking through these records with us. I'm
23 going to turn you over to these other lawyers who can ask
24 some questions, I'm sure.

25 THE WITNESS: Thank you.

1 MR. HOOD: I got a note. Okay. Thank you, Ms. Buck.

2 MS. MAPLES: No questions, your Honor.

3 THE COURT: Any questions from the Plaintiff?

4 CROSS-EXAMINATION

5 BY MS. FLUMIAN:

6 Q. Hi, Ms. Buck.

7 A. Hi, good morning.

8 Q. Hi, my name is Julia Flumian. We met a couple of
9 weeks ago at your deposition. Do you recall?

10 A. Yes, ma'am.

11 Q. Do you remember testifying in your deposition
12 about how Dr. Frisch would provide you with journal articles
13 while you worked at Southeastern Spine?

14 A. Yes, ma'am.

15 Q. Did those include the journals Spine?

16 A. I don't recall the specific.

17 Q. Well, I'm going to ask if my co-Counsel is going
18 to now show you and only you a specific journal article from
19 the journal Spine.

20 MR. HOOD: Your Honor, objection.

21 THE COURT: Mr. Foreman, ladies and gentlemen, I have
22 a brief matter of law to pick up outside of your presence.
23 If you would just stand in the hall for me please and leave
24 your note pads in your seats. Do appreciate your patience.

25 (Jury exits courtroom.)

1 THE COURT: Mr. Hood, basis of the objection?

2 MR. HOOD: It's -- journal article will be hearsay.

3 This -- this is not an expert witness. It's a fact witness.

4 THE COURT: Ms. Flumian?

5 MS. FLUMIAN: Under 803-18, I am showing a medical
6 provider who has already established her education, training,
7 and experience.

8 THE COURT: She's not an expert.

9 MS. FLUMIAN: Ma'am?

10 THE COURT: She's not an expert. You haven't
11 established that you can elicit an opinion from her on Rule
12 701.

13 MS. FLUMIAN: I'm not asking her opinion from her.

14 THE COURT: So what are you asking?

15 MS. FLUMIAN: I'm simply asking her my exact questions
16 are, is she familiar with this journal? Is it fair reviewed
17 that it publishes biweekly and that the Defendant Frisch has
18 actually published it?

19 THE COURT: So how is that relevant and how does that
20 fair on her credibility or believability?

21 MS. FLUMIAN: It is going -- just one second. Your
22 Honor, I apologize. In her deposition, PA Buck explained how
23 extraordinarily helpful Dr. Frisch was that he was constantly
24 concerned with providing updated education. That it was an
25 ongoing process, that he was extremely helpful in this

1 regard. And so it -- she's already laid the foundation in
2 her deposition that this was something that Southeastern
3 Spine focused on. And that is very --

4 THE COURT: You can ask her that question, but you're
5 not going to publish that treat if she's not an expert. She
6 doesn't fall within 702 nor 701, she can only elicit opinions
7 from her under 701 if it's based on her rational perception
8 and it does not require any particularized expertise. The
9 objection is sustained.

10 MS. FLUMIAN: Thank you, your Honor.

11 THE COURT: You're welcome.

12 Please bring in the jury. Now, if you want to ask her
13 the same line of questions that you asked her in your
14 deposition, you're welcome to.

15 Oh, where's the witness? Oh, she's on owl. I'm sorry
16 you all it's been a long -- it's been a long eight months for
17 me. A long eight months. I'm like, I'm just so used to it,
18 I mean.

19 MR. KERN: Have you ever lost a witness before?

20 THE COURT: No, but I'll tell you all when this trial
21 is over something funny that always happens in this
22 courtroom. It's not. I'm not poor (inaudible). I don't
23 think you -- it's good to laugh when it's there. All right.
24 Oh, somebody must have had to go to the bathroom.

25 (Jury enters courtroom.)

1 THE BAILIFF: All jurors present, Your Honor.

2 THE COURT: Thank you. Ladies and gentlemen, we'll now
3 resume the witness's testimony.

4 You may proceed Ms. Flumian.

5 MS. FLUMIAN: Thank you, ma'am.

6 THE COURT: You're welcome.

7 BY MS. FLUMIAN:

8 Q. PA Buck, just to reiterate, I apologize. You
9 recall telling us in your deposition about how you were
10 provided articles by Dr. Frisch while you worked at
11 Southeastern Spine, correct?

12 A. Correct.

13 Q. And he did that because why?

14 A. I would be assuming it had cause.

15 Q. I'm sorry?

16 A. I would be assuming the cause I don't know. I
17 can't speak to why he would do that.

18 Q. Do you recall telling us that he was very involved
19 in helping you further your education and understanding?

20 A. Yes. Yes.

21 Q. And you don't recall if that ever included the
22 journal's spine, correct?

23 A. Not specifically. Correct.

24 Q. Are you familiar with that journal?

25 A. Correct.

1 Q. And do you know if it's peer-reviewed?

2 A. No, I don't.

3 Q. And do you know how frequently it publishes?

4 A. No.

5 Q. And do you know that Dr. Frisch has actually
6 published it?

7 A. No. I don't know which journal article or journal
8 that Dr. Frisch published specifically, no.

9 Q. You don't recall ever receiving any policies or
10 procedures about preoperative workup while you worked at
11 Southeastern Spine, correct?

12 A. Correct.

13 Q. And you don't remember ever ordering any pre-op
14 labs on any patients, right?

15 A. Personally, no, I don't -- I don't recall.

16 Q. And you don't remember ever performing any post-op
17 cultures on any wounds at Chelsea -- Southeastern Spine,
18 right?

19 A. I don't recall if I did them or not.

20 Q. And you all didn't take any photos of Pat's wounds
21 or her medical records, right?

22 A. Not that I recall.

23 Q. So that photo we have is because the patient took
24 it, right?

25 A. I don't recall. I -- I don't recall.

1 Q. Well, have you been shown any photos from your
2 records?

3 A. Say that again?

4 Q. Have you been shown any photos you or anyone else
5 at Southeastern Spine took of Pat's wound?

6 A. I don't know who -- where the -- I don't know
7 where the photo came from.

8 Q. Do you believe that that was something you took?

9 A. I don't recall where the photo came from.

10 Q. And certainly, it's not attached to your note,
11 right?

12 A. From what I can tell, it's not attached to my note
13 right.

14 Q. Now, you know that her wound was actually a deep
15 wound infection, right?

16 A. Say that again, I'm sorry.

17 Q. You know that Pat's wound was a deep wound
18 infection, right?

19 A. Correct.

20 Q. It is not about the incision, right?

21 A. At which point in time it's not about the
22 incision?

23 Q. Meaning, I apologize, this is a bad question. Let
24 me rephrase it. No one's claiming that she had an incisional
25 wound that was infected, right?

1 A. Can you rephrase that again please?

2 Q. Sure. You understand that my client suffered from
3 a deep-seated wound infection, right?

4 A. Correct.

5 Q. And at no point did she have an incisional wound
6 infection, right?

7 A. Not necessarily. So the incision is part of the
8 -- the surgical bed, it's included.

9 Q. And so what day was she diagnosed with an
10 incisional wound infection?

11 A. So I'm not saying she was diagnosed with an
12 incisional infection, I'm saying that transition is part of
13 the evaluation for a post-op patient.

14 Q. And when you're looking at that incision and if
15 it's a deep-seated wound infection, drainage is assigned to
16 that deep-seated wound infection, isn't it?

17 A. Not necessarily.

18 Q. But it can be, correct?

19 A. And it can also be part of a normal healing
20 incision or -- or (inaudible).

21 Q. And that's no matter what time that drainage
22 occurs. Is that your testimony?

23 A. Rephrase that please.

24 Q. You're saying that drainage can be normal and I'm
25 asking you no matter what time that drainage occurs?

1 A. Correct.

2 Q. So months later, that's normal?

3 A. It can be.

4 Q. If you're not the one prescribing the medication,
5 you don't have conversation explicitly about those
6 medications with the patient unless it's documented, right?

7 A. Not necessarily.

8 Q. Okay. Do you remember us discussing that at your
9 deposition?

10 A. No, I don't.

11 Q. You never picked up the phone and spoke to Pat's
12 rheumatologist, right?

13 A. I do not recall picking the phone and speaking
14 with the rheumatologist.

15 Q. But if he had, you would've documented it, right?

16 A. Maybe. I don't know. All I know is that I did
17 not. I -- I do not recall if I talked to a rheumatologist or
18 not.

19 Q. No matter what, you could have, right?

20 A. Could I have spoken with her rheumatologist?

21 Q. Yes.

22 A. Yes.

23 Q. And same for her primary care physician, right?

24 A. Yeah.

25 Q. And you didn't document any phone calls with him

1 either, right?

2 A. Not in the record, no.

3 Q. Anywhere else?

4 A. No, not that I'm aware of.

5 Q. Now, her primary care provider did send you her
6 last visit note and her pre-op and her last labs, right?

7 A. I put in the -- in the record.

8 Q. I'm sorry.

9 A. In the -- the record in the documentation.

10 Q. Bear with me with technology, but I am told that
11 what I need to do is put this in front of myself and I'm
12 going to show you Plaintiff's Exhibit 17, which is also based
13 as Southeastern Spine page 0145. Does this look familiar?

14 A. Not -- I mean not familiar, but I can see it.

15 Q. Okay. And I am showing you the top. Can you see
16 the facts, date and time?

17 A. No, I cannot print is too small.

18 Q. Okay. So it is facts at the top. It says, "July
19 27th at 16:04", which is of course 4:00 in the afternoon. Do
20 you remember during your post-op appointment having these
21 labs in your hands?

22 A. Do I remember from eight years ago?

23 Q. Yes.

24 A. No.

25 Q. And there's nothing in your note this is anything

1 about them, right?

2 A. No.

3 Q. Okay. And do you recall what her sed rate was
4 preoperatively?

5 A. From eight years ago, no.

6 Q. And I apologize, do you have a copy of this file
7 in front of you?

8 A. Yes. Are you bringing up a specific exhibit?

9 Q. Yes, I am.

10 A. Would you like to reference those warning, please?

11 Q. Yes. So this is Plaintiff's Exhibit 17, and it's
12 going to be in -- if you have the full record, it is going to
13 be on page 145.

14 A. From Exhibit 17, is that what you said?

15 Q. Yes. I just want to be sure you understand
16 Plaintiff, so I don't know if you have ours.

17 A. I -- would I take yours?

18 Q. I don't know. You're not my witness.

19 A. And no.

20 Q. Okay. So you don't have a full copy of your
21 records?

22 A. Not that I'm aware of. Are you -- were you in
23 Exhibit 17? I'm not sure what the full copy is.

24 Q. So you only have what Defense sent, right?

25 A. I believe so.

1 Q. Right. Okay. So her sed rate was two out of a
2 range of zero to 40. What does that mean?

3 A. It means that her sed rate was two.

4 Q. Do you remember discussing sed rates at her -- at
5 your deposition?

6 A. Yes.

7 Q. Okay. What's a sed rate?

8 A. It's an -- it is an indicator of inflammation.

9 Q. Okay. And so what does it mean that this patient
10 who is an RA patient who was on TNF block eight medication
11 had a -- a sed rate of two?

12 A. It means that her sed rate is within range, it's
13 two.

14 Q. And it's not only within range, it's actually on
15 the low end of that range, right?

16 A. Between the Number s of zero and I'm sorry, the
17 reference range she said was 40?

18 Q. Yes.

19 A. Then it is two out of 40.

20 Q. And that's on the low end, right?

21 A. Yes.

22 Q. And so she didn't have a lot of inflammation going
23 on preoperatively, right?

24 A. No. It means that her sed rate was two.

25 Q. And that's all it means?

1 A. As an indicator in a whole, yes, that's all. It
2 is not a specific lab for sed rate.

3 Q. And -- and again, you don't -- do you even
4 remember that her primary care physician sent these to you?

5 A. From eight years ago?

6 Q. Yeah.

7 A. No, I cannot -- I cannot speak to what I remember
8 specifically from eight years ago.

9 Q. But you do have your pre-op note, correct?

10 A. Correct.

11 Q. And you made a mention of -- of those records in
12 your note, right?

13 A. Correct.

14 Q. Your -- your involvement with Pat ended on, I
15 believe 11/26; is that correct?

16 A. Yes, ma'am.

17 Q. And so you don't know about the serial lab work
18 that was performed on her by her other doctors, right?

19 A. Not that I recall.

20 Q. So you don't know what her sed rate was later on,
21 right?

22 A. No, not -- not that I have only looked at my
23 involvement.

24 Q. And you're aware that PA Aprill saw Pat three
25 times after you did, right?

1 A. I would need to look at her record.

2 Q. I think you have it in front of you.

3 A. Yeah. Do I have time to look at the record?

4 Q. You sure do.

5 A. Thank you. And the question is if I'm aware that
6 she was seen by Ryan Aprill three times after I did?

7 Q. Yes.

8 A. That appears correct.

9 Q. Okay. And so she saw her on 8/30, correct?

10 A. Can you reference the exhibits for me, please?

11 Q. I can tell you it's Plaintiff's 5, I'm sorry, it
12 can't be more helpful.

13 A. Okay. Let me check. I'm having to download each
14 individual note. And your question -- I'm sorry, your
15 question was that she was seen by Ryan on 8/5?

16 Q. Yes. Or 8/30.

17 A. All right. Trying to access that note, so bear
18 with me. I'm having trouble locating that note. I have an
19 8/16 note.

20 Q. Going to show you what is Plaintiff's Exhibit 5.
21 Can you see this?

22 A. Oh, 8/30.

23 Q. Yes. Thank you.

24 A. I misheard, I heard 8/3.

25 Q. So you have that note?

1 A. I'm trying to pull it up currently. It's
2 reloading.

3 Q. Ms. Buck, I don't want to take up too much of the
4 jury's time with this. So I'm assuming that you still don't
5 have this in front of you?

6 A. It is still trying to load --

7 Q. Okay. I'm going to ask you to look at your
8 screen. Do you see if PA Aprill ever discussed an MRI with
9 my client on that day?

10 A. No. I can't on that screen. I cannot tell.

11 Q. And your prior review of this and your deposition
12 when we talked about this, you don't remember if she
13 discussed an MRI on that day, correct?

14 A. I was not present for that conversation.

15 Q. And you again, you haven't before your deposition
16 or before right now, you haven't looked at these records,
17 right?

18 A. Correct.

19 Q. Okay. And --

20 A. Actually I'm not sure if I -- I'm sorry, can I
21 restate that, please?

22 Q. Sure.

23 A. I'm not sure if I would -- if I saw that in my
24 review.

25 Q. Were you provided it?

1 A. Yes.

2 Q. But you don't know if you bothered to read?

3 A. I have looked through the chart for the portions
4 that I was involved in, but I'm not sure if I read that as
5 part of my review.

6 Q. Okay. So again, this is her 8/30 note. What's
7 the day she signed that note?

8 A. It says 8/30.

9 Q. Okay. And then she saw the patient again on 9/1,
10 right?

11 A. Correct.

12 Q. She signed that on 9/1, right?

13 A. Correct.

14 Q. She saw the patient on 9/8, right?

15 A. I'm sorry.

16 Q. 9/8, right?

17 A. No, the full sentence. She broke up at the
18 beginning.

19 Q. She saw the patient on 9/8, right?

20 A. Yes.

21 Q. And she signed that note on 9/8, right?

22 A. Yes.

23 Q. You saw the patient on 11/28, right?

24 A. Yes.

25 Q. And you didn't sign that note until 12/22, right?

1 A. Yes.

2 Q. And that was after Southeastern Spine knew that my
3 client had a positive blood culture, had been admitted to the
4 hospital, had already received a PICC line, and was receiving
5 IV antibiotics, right?

6 A. Yes.

7 MS. FLUMIAN: No more questions.

8 THE COURT: Any redirect of the witness?

9 MR. HOOD: Very briefly.

10 REDIRECT EXAMINATION

11 BY MR. HOOD:

12 Q. And could you explain to the jury what the
13 electronically-signed signature means and how that works
14 please? So we've got some context to that last line.

15 MS. FLUMIAN: Objection.

16 THE COURT: Could you please repeat the question?

17 MR. HOOD: Sure.

18 BY MR. HOOD:

19 Q. And I'd like for you to explain to the jury how
20 the electronic signature works so you can provide some
21 context about to the last line of questions?

22 THE COURT: Overruled.

23 THE WITNESS: Yes.

24 THE COURT: It's relevant.

25 THE WITNESS: It -- so be me --

1 THE COURT: It's directly responsive to your
2 cross-examine.

3 MS. FLUMIAN: I understand.

4 BY MR. HOOD:

5 Q. Okay. Now, you can go.

6 A. Yes. It simply means that the note has been
7 finalized.

8 Q. And how does that --

9 A. Generally, as far as knowing (inaudible) it's
10 within 30 days of the encounter. And certain practitioners
11 will find right away and others -- some cases are fast.
12 Well, find in a different time.

13 Q. Okay. So then from a note-taking standpoint, can
14 you please describe what your practice was?

15 A. So mine is to dictate and to do the note take
16 exactly of time being encounter. Because you -- me
17 personally, I don't like to rely on memory. And so I like to
18 have it fully entered and then I go through and sign notes as
19 they're in my inbox and finalize them at a later date
20 potentially.

21 MR. HOOD: So -- okay. I think we got a witness here
22 who can provide some -- provide explanation this too. It'll
23 be a little bit easier. Thank you, ma'am.

24 THE WITNESS: (Inaudible). Thank you.

25 THE COURT: Any exception to the witness being excused

1 from the Plaintiff?

2 MS. FLUMIAN: No, your Honor.

3 THE COURT: From the Defense?

4 MS. MAPLES: No, your Honor.

5 THE COURT: From the Defense, Mr. Hood, any exception
6 to your witness being excused?

7 MR. HOOD: No, your Honor.

8 THE COURT: Ma'am, you're excused. Have a good day.

9 MS. BUCK: Thank you. Bye

10 THE COURT: Bye-bye.

11 Call your next witness.

12 MR. KERN: Your Honor, we need to switch the computer
13 and get this off the record. We can call the next witness.

14 THE COURT: You can go ahead and call your next
15 witness. We can do it later. There's no urgency.

16 MR. KERN: All right. The Defense calls Ryan Aprill.

17 THE COURT: Mr. Hood, we can do all that later. You
18 can leave it. Yeah, you can just put it --

19 MR. HOOD: Yeah, trying to do that.

20 THE COURT: Don't worry about it. Yeah, we can -- we
21 can do that --

22 Ma'am, you stand and raise your right hand so that the
23 clerk can swear you.

24 THE CLERK: Please raise your right hand and put your
25 left hand on the Bible.

1 GERMAINE RYAN APRILL,

2 being duly sworn, testified as follows:

3 THE CLERK: Please be seated. Please state your full
4 name spell your last name directly in the microphone.

5 THE WITNESS: Germaine Ryan Aprill, G-E-R-M-A-I-N-E.
6 Is the first name. R-Y-A-N middle name, last name,
7 A-P-R-I-L-L.

8 THE COURT: Thank you.

9 You may proceed.

10 DIRECT EXAMINATION

11 BY MR. KERN:

12 Q. Good morning Ms. Aprill.

13 A. Good morning.

14 Q. How are you?

15 A. Okay.

16 Q. All right. Make the technology work for me this
17 morning without (inaudible).

18 All right. How are you doing this morning?

19 A. I'm all right.

20 Q. Okay. Could you please tell the jury a little bit
21 about your back -- your professional background as it relates
22 to this case?

23 THE COURT: Mr. Kern, I don't mean to interrupt you,
24 but I would prefer that you use the podium, you have
25 documents over there. It's not a good setup. Thank you.

1 Appreciate it. You can proceed once you get situated.

2 MR. KERN: Sure. I'm good.

3 THE COURT: You dropped something.

4 MR. KERN: Thank you very much.

5 THE COURT: You're welcome.

6 THE WITNESS: Oh, my background, yes. I'm originally
7 from Louisiana moved to Chicago when I was in junior high. I
8 don't know how far back you want me to go.

9 BY MR. KERN:

10 Q. (Inaudible) a good snapshot of your education, you
11 professional background.

12 A. Sure. I attended Indiana University in
13 Bloomington. I received a four year bachelor degree there,
14 majored in biology. After college I attended Tulane
15 University in New Orleans. I received my masters of science
16 in human genetics. Following that, I moved back to Chicago.
17 I worked for a few years in pharmaceutical advertising in
18 their clinical research department. And a few years into
19 that I realized that I wanted to practice medicine. I'd
20 always wanted to practice medicine and that corporate America
21 was not for me.

22 So I took the MCAT again, I took the GRE again, I
23 applied to PA schools and was accepted to Marquette
24 University attended Marquette for I think their program is 32
25 months. After that, I passed my board exam. I moved to

1 Charleston, which is about 12 years ago and started working
2 at Southeastern Spine in 2012.

3 Q. Okay. So was Southeastern Spine your first job
4 after your -- did your PA program?

5 A. Yes, it was.

6 Q. And what do you do for a living now?

7 A. I am currently at Roper Hospital. I work with the
8 hand surgery team. I'm a hand surgical PA upper extremity.

9 Q. And is that still a surgical practice?

10 A. Yes, it is.

11 Q. You still see surgical patients a regular basis?

12 A. Every day.

13 Q. Now, we've heard some about what a physician
14 assistant does, but can you expound on generally what is a
15 physician assistant doing in surgical practice?

16 A. Can probably give you an answer as to what we did
17 at Southeastern Spine. What I do now, I don't know what
18 every surgical PA does. In general, we are part of a medical
19 team. We work with each other, we work with surgeons, we
20 work with nurses. And we care for pre-op and post-operative
21 patients from start to finish in collaboration with the
22 supervising physician.

23 Q. All right. So you just described the team in
24 collaboration. How closely are you working with your
25 supervised physician?

1 A. Very closely. Usually shoulder to shoulder.

2 Q. Is that a daily occurrence or a weekly occurrence?

3 A. Every day. I mean, currently now I do run some
4 solo clinics for postoperative patients and new patients, but
5 for the main part we work together side by side.

6 Q. Does that include your clinical practice and your
7 operating room practice?

8 A. Yes, although I was more clinical based when I was
9 at Southeastern Spine.

10 Q. All right. What does that do?

11 A. I -- I did not go to the operating room.

12 Q. Okay. So what would you do in the clinic in
13 Southeastern Spine?

14 A. I would see follow-up patients and postoperative
15 patients, evaluate them. That's pretty much it.

16 Q. Okay.

17 A. I -- I would enter, you know, orders for hospitals
18 if there were admissions.

19 Q. And that includes the collaboration process that
20 you just talked about?

21 A. Yes.

22 Q. All right. Now, are you allowed to evaluate
23 patients as a PA?

24 A. I am.

25 Q. Are you allowed to make a diagnosis?

1 A. Yes.

2 Q. Are you allowed to prescribe treatments if
3 necessary?

4 A. Yes.

5 Q. Are you allowed to prescribe medications if
6 necessary?

7 A. Yes.

8 Q. Is -- that's -- those are things that you
9 regularly do. Are those things you would regularly do at
10 Southeastern Spine?

11 A. Yes, I'm board-certified to do that.

12 Q. Well, do you recall when you worked at
13 Southeastern Spine or post discectomy patients, the type of
14 patients that you might see?

15 A. Yes, in general.

16 Q. So what is a -- you can recall postoperative plan
17 for a lumbar discectomy patients?

18 A. I believe that patients usually came back in
19 around two weeks post-op, for their first initial
20 post-operative visit. Assuming that everything was going
21 well, we may or may not prescribe physical therapy at that
22 visit. It's very patient-specific. Second postoperative
23 visits were usually around the six week postoperative date.
24 And then kind of longer and longer between visits at that
25 time.

1 Q. So what would you do to prepare for a patient who
2 was coming in for her first postoperative lumbar discectomy
3 visit?

4 A. I would definitely review the operative note
5 because I was not in surgery. So that gives me some details
6 as to how the case went. Any notes from the hospital that
7 would have included her inpatient care and any prior notes
8 that I may need to review to jog my memory on who the patient
9 was if I didn't have on, you know, memory on my own of
10 somebody that I had seen over and over and over again.

11 Q. Prior to from (inaudible)?

12 A. Either the physician or PA who had seen them prior
13 to me. Sometimes that might include notes from other
14 providers if they were available.

15 Q. And what type of information are you learning or
16 trying to learn as you assess that information -- that those
17 documents before you see a picture?

18 A. It paints a picture of -- of the patient
19 themselves what their past medical history is, what
20 medications they're on, what happened in surgery, what
21 happened in the hospital.

22 Q. And I mean, why is that important to you as a
23 physician assistant?

24 A. Well, you have to know who you're treating in
25 order to form a plan of care.

1 Q. All right. Do you remember Ms. McGougan?

2 A. Somewhat.

3 Q. Okay. Do you remember that she was treated by you
4 and Southeastern Spine following discectomy in 2016?

5 A. Yes.

6 Q. Do you remember reviewing some records in her
7 chart progression for trial this week?

8 A. I did.

9 Q. All right. So this is what?

10 A. This looks to be her first postoperative visit
11 note.

12 Q. What day is that?

13 A. 8/16/2016.

14 Q. All right. Do you recognize this as your note?

15 A. Yes.

16 Q. Is that information that you would've been
17 documenting in real time as you accept patients?

18 A. Yes.

19 Q. In other words, is any of this a template or the
20 words are not, are already there before you see the patient?

21 A. I don't use templates in my notes.

22 Q. Okay. All right. So how many days postoperative
23 was this note for you?

24 A. Fourteen days. My math is correct.

25 Q. All right. So walk me through for HPI what you

1 have pulled up there. What are you looking at?

2 A. I make note of the surgery that she had done the
3 date that it was done. I documented her pain, her pain level
4 which was a one out of 10. Made note of any medications that
5 she was taking for pain control and any constitutional
6 symptoms that may, you know, give me any indication that
7 anything else was going on.

8 Q. Okay. So let's --

9 THE COURT: Please make sure you're referring to all
10 exhibit Number s and (inaudible) in testimony.

11 MR. KERN: This is Defense Exhibit 19.

12 THE COURT: Thank you.

13 BY MR. KERN:

14 Q. So the second sentence talks about overall she's
15 doing well and is reporting significant improvements from her
16 preoperative surgery. Why is that important?

17 A. It tells me that in a postoperative patient that
18 she's doing well, that nothing seems to be going in the
19 opposite direction. She's had some relief of her
20 preoperative symptoms, which would've been her back and leg
21 pain.

22 Q. Correct. And what is a one out of 10 pain?

23 A. It's a one out of 10 on a scale of zero to 10.

24 Q. All right. And what -- there's some notes in here
25 in the last sentence about her medication she's taking. What

1 does that mean?

2 A. She's taking tramadol, which is a low dose pain
3 medication on the scale of narcotics. And then oxycodone is
4 a stronger pain medication that she was requiring at night.

5 Q. So does -- does she at this point look like a
6 patient who has received some relief from the surgery?

7 A. Yes, it does.

8 Q. Is it unexpected that she might still have pain
9 after the discectomy?

10 A. No, it's not unexpected.

11 Q. All right.

12 A. Some patients well you have postoperative pain,
13 incisional pain, back and leg pain. Nerves only heal a
14 millimeter a day. So to expect that a patient comes in and,
15 you know, have zero pain, I -- I would not expect a
16 postoperative patient to come in with zero out of 10 pain.
17 Does it happen? Yes, but usually not. And again, this is
18 self-reported from the patient, which is subjective.

19 Q. From your opinion, when you say that nerves only
20 regrow or heal one millimeter a day, what -- what happens in
21 a discectomy?

22 A. I'm not a surgeon, but my understanding of a
23 discectomy is that the portion of the disc in between the
24 vertebrae that has been herniated is removed thus taking
25 pressure off of the nerve, allowing it the time to heal.

1 Q. So the nerve had been directly impacted?

2 A. By?

3 Q. The herniation.

4 A. Yes.

5 Q. All right. All right. So the last sentence of
6 HPI begins with, "She denies." Run -- run through that with
7 me.

8 A. This is she denies any fevers, any chills, night
9 sweats, chest pain, drainage from her incision or weakness or
10 loss of bowel bladder function.

11 Q. Why? Why would you document those notes?

12 A. Specifically fevers, chills, night sweats or
13 drainage would answer any questions about whether or not she
14 was having any signs of an infection. Sometimes after
15 patients go undergo anesthesia heart attack and strokes can
16 happen. So I ask about chest pain. She does have a history
17 of hypertension. Weakness and we knew she had some weakness
18 before that was because of the disc herniation. And then
19 loss of bowel bladder function would indicate that there was
20 some kind of spinal cord compression which would be a
21 surgical emergency.

22 Q. Okay. So a complete picture of the patient is
23 something that you're trying to create at that moment in
24 time, right?

25 A. Yes.

1 Q. And to evaluate whether any adverse event either
2 occurred during the surgery or resulted in the surgery at
3 least at that point in time?

4 A. Correct.

5 Q. That includes something like infection; is that
6 right?

7 A. Always.

8 Q. All right. So next is an imaging note that I see.
9 What is that?

10 A. We typically did X-rays on the first post-op
11 visit. And that we're just looking to make sure that the
12 spine is still stable, that there aren't any structural
13 changes that have occurred.

14 Q. Take me through the process of how imaging occur
15 or X-ray imaging for in-office clinic visits how did it
16 occur?

17 A. What do you mean how did it occur?

18 Q. So like what was the process for getting her image
19 and then reviewing images?

20 A. Oh, typically, I mean the patient would be brought
21 to the room. We would evaluate them, recommend getting the
22 X-rays. They would be taken down the hall to the X-ray room
23 come back in and we can pull them up on the screens in the
24 exam rooms and review them with the patient usually.

25 Q. Is that what this note indicates after on this

1 leave?

2 A. Yes, it does.

3 Q. All right. Can you see -- can you tell from your
4 note how the X-ray looked?

5 A. It looked normal. There was no instability noted.
6 And the disc space was still maintained. You can't see the
7 disc on an X-ray. All you can see is bone and hard
8 structure.

9 Q. Okay. All right. Moving down to physical
10 examination. Take a look at that.

11 A. Okay.

12 Q. What does that mean?

13 A. This is a visual evaluation of the patient. She's
14 well developed, she's well nourished. Alert oriented means
15 she is aware of where she is, what date it is and what time
16 it is. She was wearing her brace, which was given to her
17 post-op instructed visually inspecting her incision. The
18 bandages she had on were clean, meaning no evidence of any
19 drainage. And the incision was itself intact.

20 Q. All right. So is that something where you're
21 physically removing a bandage and evaluating what's going on
22 with the patient?

23 A. Yes.

24 Q. So your hands are on the patient and are you --
25 and you're evaluating your cots?

1 A. Yes.

2 Q. At the same time you're having a conversation with
3 her about what she's experiencing?

4 A. Exactly.

5 Q. You say no signs of infection, what does that tell
6 you? Why is that important to you?

7 A. It says exactly what it says. There are no signs
8 of infection.

9 Q. Okay. And her strength is five out of five. What
10 does that mean?

11 A. When you're evaluating a post-op patient or any
12 patient doing a physical exam strength five out of five means
13 she had full strength. If you have weakness, you know, you
14 have different levels of weakness. And that's what that
15 scale means.

16 Q. Okay. Is that a good thing after a lumbar? Is
17 that mean to have five out of five strength?

18 A. Yes. That's a good thing.

19 Q. All right. Beyond a treatment plan, walk through
20 that.

21 A. Reviewing generalized precautions after any type
22 of spine surgery, typically recommend patients not bend or
23 lift anything heavy or do any twisting. You can reherniate
24 with activities such as that. To wear their brace, walking
25 to their tolerance. I discussed medication so I gave her a

1 refill of the pain medication. She was having some pain at
2 night, which was causing her to lose sleep, which is why the
3 Medrol Dosepak was recommended. She has a prescription from
4 her -- another provider I believe for the Neuroton. So I
5 discussed taking that at bedtime to help her sleep. And if
6 she was having any worsening symptoms to contact the office
7 and otherwise we would see her back in four weeks.

8 Q. All right. So what -- what is the Medrol Dosepak
9 going to do?

10 A. It decreases inflammation.

11 Q. And is inflammation something is abnormal in a
12 patient two weeks out from a discectomy?

13 A. No.

14 Q. Okay. All right. Hang on. Let's go to Exhibit
15 22, please. This is Defendant's Exhibit Number 22. Can you
16 see it in front of you?

17 A. I can.

18 Q. All right. What's this?

19 A. This is an encounter on 8/30/2016 for a follow-up
20 for an incision check.

21 Q. And do you remember this visit?

22 A. From the review of my notes, yes.

23 Q. All right. So describe for me, since you had just
24 previously told her to come back in four to six weeks unless
25 something changed, why is she being seen on August 30th?

1 A. If my memory is correct, she had called the office
2 with some complaints and concerns and so we said please come
3 in, we'll take a look at things.

4 Q. Okay. All right. Let's look at the HPI. What
5 would you have reviewed in terms of her medical history to
6 prepare for this particular visit?

7 A. Since I had just seen her recently, I'm -- I don't
8 know that I reviewed anything prior to this visit. I can't
9 answer that, but I -- I usually review the note from the
10 prior visit at least.

11 Q. Okay. So it would've been your custom of practice
12 to review the prior -- prior visit this (inaudible)?

13 A. Yes.

14 Q. All right. So take me through her history of this
15 hole what you're seeing?

16 A. Again, I mentioned what surgery she had and the
17 date that she had it on. I asked her her pain and she rated
18 her pain as zero out of 10. It says that she had some
19 complaints of drainage from her incision. She was started on
20 Bactrim at that prior visit. She --

21 Q. I got to stop you there.

22 A. Sure.

23 Q. Do you know why she would've started on Bactrim?

24 A. I'd have to review the prior note.

25 Q. Do you -- would you have done that and know why

1 she stopped -- started on Bactrim?

2 A. Yes.

3 Q. Okay. So what is Bactrim?

4 A. Bactrim is an antibiotic.

5 Q. Okay. Why would a previous provider prescribe
6 Bactrim in this particular case?

7 A. Again, I'd have to look at the note. If you
8 prescribe Bactrim prophylactically you could also prescribe
9 Bactrim if there's any other signs of infection.

10 Q. Okay. And what is prophylactic?

11 A. In anticipation of something, you know, oftentimes
12 and I'm not a immunologist, but infections can start very
13 slow and there may not be any signs of them. And so
14 prophylactically putting a patient on an antibiotic is a
15 conservative thing to do.

16 Q. Tell me following sentence after she started on
17 dosepak or the Bactrim what happened after she started it?

18 A. She reported that she had some severe itching and
19 she discontinued the medication four days after taking it.

20 Q. Okay. And then again, she's denying what here?

21 A. She's denying any of those signs of infection
22 fevers, chills, night sweats, leg pain would be a recurrence
23 of a disc herniation or increased pain or weakness.

24 Q. Is it fair to say that on this visit you were
25 evaluating her potential signs of an infection?

1 A. I was, yes.

2 Q. Describe your physical examination, walk me
3 through that.

4 A. Again, her general state of appearance, her age
5 measured her strength and it was intact, meaning that there
6 were no changes from prior. I looked at her incision site.
7 There was a minimal amount of drainage and when I palpated
8 that I could get a minimal amount of drainage from that
9 incision, maybe a drop. There was no erythema at that time.
10 Redness, there was no fluctuance indicative of any pocket of
11 pus. And there was no swelling.

12 Q. All right. Why would it -- why is it significant
13 if there's no indication for pocket of pus?

14 A. That would lead me to think that she had an
15 infection.

16 Q. Okay. So at the absence of that, what was your
17 conclusion?

18 A. That this patient is doing well. She has a
19 minimum amount of drainage, which is commonly seen in
20 postoperative wounds, and she denied any fevers, chills, or
21 night sweats and was doing well.

22 Q. Okay. So let's go down to your treatment plan.
23 You again reiterate she's not exhibiting symptoms of fever or
24 infection and why?

25 A. Signs of an infection always -- I can't say

1 always, but nine times out of 10 I guess would indicate you
2 would have fever and you have increased pain. In the absence
3 of those, the idea that someone has an infection is very low
4 or suspicion that someone has an infection is extremely low.

5 Q. All right. Now, what was your -- what -- what did
6 you do in response to what you were seeing on physical exam
7 in terms of addressing bandaging had taken your -- what was
8 it -- what was your treatment of that?

9 A. My treatment pain for her incision?

10 Q. For her -- her bandaging and how -- and how
11 evaluating her incision.

12 A. Can you rephrase that?

13 Q. Yeah. She says I redress the area for the today.

14 A. Oh.

15 Q. And then you started it on your treatment plan.
16 What did you do?

17 A. Oh, I put a Band-Aid on it or gauze and tape,
18 usually probably a Band-Aid at that point. And she had
19 reported that she had itching on the Bactrim. So again,
20 prophylactically in the event that something was going on
21 changed her to doxycycline, which is another broad spectrum
22 antibiotic.

23 Q. And how long do you want her to reveal that
24 doxycycline?

25 A. I don't see it noted here.

1 Q. Well, when did you want to call up with her next?

2 A. One week.

3 Q. Would that have been time to give the doxycycline?

4 A. Yes.

5 Q. The chance to work?

6 A. Typical. Yes.

7 Q. All right. So why would you want see her back in
8 a week after putting her on antibiotic?

9 A. I want to make sure that she's improving.

10 Q. What else?

11 A. Or that she's not improving.

12 Q. Right. In other words, just in case medicine is
13 not working?

14 A. Correct.

15 MR. LUGINBILL: Objection leading, your Honor.

16 THE COURT: Sustained leading. Rephrase.

17 BY MR. KERN:

18 Q. Did you want to give the medication a chance to
19 work?

20 A. Yes.

21 Q. And what else was she instructed to do? It says
22 we will follow-up with her one week or sooner. What would --
23 why did you write that on?

24 A. If she was having any worsening symptoms sooner
25 than one week, then we wanted to see her back.

1 Q. Okay. And so this is August 30, 2016, correct?

2 A. Uh-huh.

3 Q. Talked earlier about the collaborative process at
4 Southeastern Spine. Do you remember that?

5 A. Yes.

6 Q. Walk me through, if you're seeing this patient now
7 who's been working for an incision check.

8 A. Uh-huh.

9 Q. How are you collaborating with your team about
10 what you're seeing?

11 A. Oh, sure. We have conversations.

12 Q. With who?

13 A. I would have conversations with Anne who had seen
14 her previously. I would definitely let Dr. Frisch know what
15 was going on. He was always available whether or not he was
16 in the OR, or whether he was standing right next to me.

17 Q. Side by side?

18 A. Side by side.

19 Q. And so when you let him know, why did you do that?

20 A. In case he would want to change the treatment
21 plan.

22 Q. Okay. So my understanding is that you let him
23 know what your treatment plan was, wait for any feedback, and
24 then implement the treatment plan that everybody agreed on?

25 A. Yes.

1 Q. And that's what -- is that real time?

2 A. Yes.

3 Q. What's happening?

4 A. Oh, well, it could be. I mean, if he was in the
5 operating room at the time when I saw this patient, you know,
6 I would've relayed the information and what was going on and
7 if he wanted to make any changes, I would've made changes.

8 Q. And if he was in the clinic when this happened?

9 A. That would've been in real time.

10 Q. Real time same process?

11 A. Yes.

12 Q. Either way, was he always immediately available
13 and -- and you have consulted with him on all these patients?

14 A. Yes.

15 Q. Including Ms. McGougan?

16 A. Yes.

17 Q. Is that especially true in -- in a case where
18 she's being worked in for an incision check?

19 A. Absolutely.

20 Q. All right. Let's move on to exhibits, Defense's
21 Exhibit 23, please. Can you see that?

22 A. I can.

23 Q. All right. What is that?

24 A. It is a note on September 1, 2016, for an incision
25 check.

1 Q. All right. Is this the -- the one week follow-up
2 that you had prescribed or asked her to come back for?

3 A. No, this was just a couple days later.

4 Q. So why is she back a couple of days later?

5 A. I'd have to read the note.

6 Q. What already she got?

7 A. So she was seen on the 30th and she was having
8 some drainage at that visit. At that visit I started her on
9 the doxycycline and she said she's still having some
10 drainage. She still denies any fevers, any weakness, or
11 significant pain.

12 Q. Okay. So how does she look compared to how she
13 looked two days prior?

14 A. Exactly the same.

15 Q. Was this sufficient time to give the doxycycline a
16 chance to work?

17 A. No.

18 Q. All right. Let's go to the physical examination.
19 All right. Take a look at that.

20 A. Okay.

21 Q. So is it true that even though you had just seen
22 her two days prior, you still conducted a full physical
23 examination?

24 A. I did.

25 Q. Why?

1 A. To -- I mean, I wanted to evaluate to make sure
2 that nothing had changed. I looked at her incision, it still
3 looked the same as it did. There was no erythema, there was
4 no swelling, no fluctuance.

5 Q. Okay. Let me stop you right there.

6 A. Uh-huh.

7 Q. How -- how did you evaluate whether there's
8 erythema, fluctuance those sort of things?

9 A. You physically look at the incision site you
10 palpate it.

11 Q. Palpate meaning?

12 A. Press touch.

13 Q. Okay. So two -- two days following August 30,
14 you're doing the exact same. Are you in the exact same
15 physical examination?

16 A. Yes.

17 Q. All right. Well, before we get there on physical
18 examination, did you check her bandage?

19 A. Yes.

20 Q. How did it look?

21 A. There was a minimal amount on the bandage.
22 Minimal.

23 Q. All right.

24 A. Not saturated, just very minimal.

25 Q. All right. And in your words, what does minimal

1 mean? What is (inaudible)?

2 A. A drop or two.

3 Q. Okay. All right. Let's move up on the treatment
4 form. All right. First thing, it says "She's not exhibiting
5 constitutional signs of -- symptoms or signs of an
6 infection." Why did you chart that?

7 A. Well, we have a post-op patient who's on
8 antibiotics now. She has some drainage from her incision,
9 but documenting that she's not exhibiting any signs of the
10 deeper infection, meaning fever, chills, night sweats, or
11 increased pain.

12 Q. Is this the kind of patient that you would have
13 expected to go to surgery on that day to evaluate?

14 A. On this day?

15 Q. Yes.

16 A. No.

17 Q. Then you say, "We will keep a close eye on this."
18 What does that mean?

19 A. I wanted to reassure her that we were going to
20 follow her and that she would have appropriate care.

21 Q. But why a close eye? What does that mean?

22 A. Okay. Just to be cautious to make sure that we're
23 not ignoring anything.

24 Q. Okay. You encouraged her to continue on the doxy?

25 A. I did.

1 Q. Why?

2 A. It needs time to work. If she had any superficial
3 infection then my anticipation was that the doxycycline would
4 help.

5 Q. All right. And then the last sentence and it
6 says, "We are" -- I'm sorry, before that, let me back up.
7 "We are scheduled to see her early next week for a follow-up
8 visit." Was that the visit that was already scheduled from
9 an 8/30 interaction?

10 A. I believe it was, yes.

11 Q. Okay. And then we discussed that should she
12 continue to have drainage or the drainage increase or develop
13 fevers, increased pain or weakness to contact you
14 immediately, right?

15 A. Yes.

16 Q. Why -- why did you write that?

17 A. If she was worsening in any way, I wanted her to
18 contact us and let us know so that we could handle it.

19 Q. Did she -- let's move on to Defense's Exhibit 24,
20 please. Okay. Is that the 9/8 visit?

21 A. Yes, it is.

22 Q. All right. Let's take a look at your history
23 visit. So this was her one week follow-up from your prior
24 visit with her, correct?

25 A. From the 8/30 visit. Yes.

1 Q. That was scheduled at 8/30?

2 A. Uh-huh.

3 Q. All right. Tell me what the history visit shows
4 on this day?

5 A. Again, I mentioned the surgery that she had and
6 the date that she had it and that she was complaining of
7 drainage at that prior visit. She did complete her
8 postoperative antibiotics. She is denying any constitutional
9 symptoms of infection to be fevers, chills, night sweats, or
10 any increased pain. She rated her pain as zero out of 10
11 that day, meaning no pain at all. She had been walking and
12 she was no longer requiring any form of narcotic pain
13 medications, but was just taking over the counter pain
14 relievers.

15 Q. So -- so before I ask you a series of questions
16 about that, as you're looking at this HPI, what is that
17 telling you about her as a patient one week after you
18 prescribed that medication?

19 A. It tells me that she's doing much better.

20 Q. How so?

21 A. She has no pain. There don't seem to be any signs
22 of any infection at that time. And she's walking, she's down
23 to over-the-counter pain relievers and that she's doing very
24 well.

25 Q. Is that -- is this something that you would have

1 consulted with and informed Dr. Frisch about?

2 A. I would've let him know that she was doing better.

3 Q. Okay. So is it fair to say that she showed no
4 constitutional symptoms of an infection on this day?

5 A. Not at all.

6 Q. About your physical examination, and does this
7 tell you that doxycycline was working?

8 A. Yes. Her incision was closing up. There was no
9 drainage that I could express on the by examining her. And
10 still just a minimal amount on the Band-Aid.

11 Q. Okay. So what is order oriented times three and
12 no acute distress?

13 A. That she's -- she knows where she is, what time it
14 is, what date it is, that's the orientation. And then no
15 acute distress meaning or no labored breathing. She's acting
16 very normal.

17 Q. Okay. So I mean this is not a one data point
18 reference for whether she has or does not have signs of an
19 infection; is that right?

20 A. I'm not sure what you mean by that.

21 Q. Well, I mean, you're looking at -- are you looking
22 at whole patient?

23 A. Oh yes, absolutely.

24 Q. Are you looking at individual signs and symptoms
25 that could indicate an on ongoing infection?

1 A. Yes.

2 Q. Does that include how she's communicating with
3 you?

4 A. Yes.

5 Q. And how she looks physically?

6 A. Yes.

7 Q. That does that also include how the incision looks
8 and how it heals?

9 A. Yes.

10 MR. LUGINBILL: Your Honor, I object to the --

11 THE COURT: Basis?

12 MR. LUGINBILL: I want --

13 THE COURT: Sustained.

14 MR. LUGINBILL: -- to go to, but --

15 THE COURT: No speaking objections. Objection is
16 sustained. Leading.

17 MR. KERN: I'll move on.

18 BY MR. KERN:

19 Q. All right. Back up down to the treatment plan.
20 What does this tell you?

21 A. That from my visit with her today she was doing
22 very well. The incision was healing up fine. If she noticed
23 any changes that I wanted her to contact us that we would see
24 her back in one to two weeks which would've been her
25 originally scheduled second post-op visit at her six week

1 post-op.

2 Q. All right. So did you tell her some specific
3 things to look for as far in terms of changes?

4 A. Yes. If she developed any increasing drainage,
5 redness at her incision site, swelling, any increased pain,
6 any fevers, chills, or night sweats.

7 Q. Why is it important to give the patient that kind
8 of specific instruction?

9 A. Well, not all patients know those signs and
10 symptoms of an infection. So it's important to educate
11 someone on what those warning signs would be.

12 Q. All right. Let's -- let's move to Defense's
13 Exhibit Number 57, before we get there, did she ever call you
14 back or see you in clinic after September 8th, over the next
15 two weeks of report of fever?

16 A. Not that I'm aware of.

17 Q. Did she report to you any increased drainage or
18 differences in her drainage?

19 A. Not that I'm aware of.

20 Q. What -- this is the October 11, 2016 note; is that
21 correct?

22 A. Yes, it is.

23 Q. All right. Let's move to physical exam, tell me
24 what we're seeing?

25 THE COURT: Let's make sure you reference to exhibit

1 (inaudible).

2 MR. KERN: That's the Defense Exhibit 24 there.

3 THE COURT: Actually that says 57.

4 MR. KERN: I'm sorry, yeah. Exhibit 57.

5 THE COURT: Uh-huh.

6 THE WITNESS: This is a post-op visit note.

7 BY MR. KERN:

8 Q. So why is she here on this day?

9 A. This -- I -- I believe this is a two-week post-op
10 visit from the incision and drainage that she underwent on
11 9/22.

12 Q. Okay. So why would you have been seeing her on
13 this day?

14 A. As a regular post-op visit from her recent
15 surgery.

16 Q. Okay.

17 A. Yes.

18 Q. So what does -- what does that -- what else are
19 you looking from the history of those two from that day?

20 A. Today again she denies any drainage from the
21 incision, any fever, any chills, night sweats, chest pain,
22 shortness of breath, loss of bowel or bladder function. She
23 had a yeast infection from the antibiotics that she had been
24 on and that her current pain was 3.5 out of 10.

25 Q. So why was she -- why had she had an incisional

1 drainage this (inaudible)?

2 A. She developed a deep infection.

3 Q. Where?

4 A. Where?

5 Q. Yeah.

6 A. In her lower back.

7 Q. Okay.

8 A. Uh-huh.

9 Q. And so would that be something you were aware of
10 when you saw her on the 11th?

11 A. Yes.

12 Q. Okay. Is that -- so is that an explanation for
13 why you would be describing the incision within the -- of the
14 constitutional system -- symptoms she has?

15 A. Yes.

16 Q. Okay. All right. Let's move to the physical
17 examination, and what did you do here?

18 A. Again, looking at the patient, testing her
19 strength and her lower extremity it was five out of five,
20 which is normal. I looked at her incision site. There were
21 no signs of infection, there was no erythema, there was --
22 which is redness, no drainage, no signs of infection at all.
23 She had sutures in, I removed those. And she -- yeah.

24 Q. Okay. So any -- any concerns with her recovery at
25 this point?

1 A. No, she seems to be doing fine.

2 Q. Okay. What did you want to do from there when you
3 completed the plan?

4 A. She was doing well, so I recommended we start
5 physical therapy. She developed a yeast infection, so I gave
6 her a prescription for Diflucan, which treats yeast
7 infections. If that were to get any worse or if that didn't
8 take care of it, I wanted her to follow-up with her primary
9 care physician for further treatment of a yeast infection and
10 that we would follow-up with her in six to eight weeks which
11 would be typical or sooner should she need us. And the
12 necessity excuse form, I believe that -- that was probably a
13 -- a form to keep her out of work.

14 Q. So I mean, at this point were you all still always
15 available for a phone call if something were to go to change?

16 A. Always.

17 Q. Was that consistent with what was happening before
18 or?

19 A. Yes.

20 Q. Okay. I'll jump ahead to Defense's Exhibit 87,
21 please. I read that this is in March 15, 2017 note; is that
22 accurate?

23 A. Yes.

24 Q. So this is some time later than the -- the October
25 visit for the post-op (inaudible)?

1 A. Yes.

2 Q. What's going on here on HPI?

3 A. She had undergone her discectomy on 8/2. Said
4 that "She had developed dicitis", which is an -- an IND on
5 9/22/16. She was following with infectious disease and she
6 was currently on IV antibiotics. I made note of the changes.
7 She was switched to daptomycin, which is a different type of
8 antibiotic and that she was scheduled to be on that until
9 April of that year.

10 Her pain level was three out of 10, still minimal. And
11 that she localized most of the pain to her hands due to her
12 rheumatoid arthritis. She was unable to restart her
13 medications. I -- because of the IV antibiotics, but respect
14 to her surgery back in September that she was doing well, she
15 was having some issues with performing her job function due
16 to stiffness, pain in her hands and her lower back.

17 Q. All right. So at this point she -- do you recall
18 had she been in the hospital for a treatment?

19 A. Yes, she did.

20 Q. What -- what was your understanding of what
21 happened that December?

22 A. In December? I would have to read the note if you
23 have that.

24 Q. Well, I'm just asking from this note.

25 A. Uh-huh.

1 Q. Can you discern how she did progress, this
2 specific?

3 A. Yeah, she was following with infectious disease
4 since that prior surgery and she was on IV antibiotics she
5 was having some pain attributed to her rheumatoid arthritis.

6 Q. Okay. Let me stop you there. Why -- why is it
7 important to chart that the pain that you're seeing is
8 attributed to the rheumatoid arthritis?

9 A. People can have pain from all sources. And, you
10 know -- you know is it postoperative pain. It could be, you
11 know, is it pain coming from a chronic disease state, which
12 it seemed to be and this is in her words.

13 Q. So she's -- does this mean -- does that mean that
14 she's telling you where her pain is?

15 A. Yes.

16 Q. All right. And then you -- you identify her hands
17 or -- what areas of her body you identify her pain if any
18 (inaudible)?

19 A. Specifically her hands and joints. I -- I don't
20 know exactly what joints were bothering her.

21 Q. Where was that information from?

22 A. The patient.

23 Q. Go to your treatment plan. You start off that you
24 spent 15 minutes with her. Why did you write that?

25 A. It's documentation that I spent a lot of time with

1 the patient in the room discussing her treatment and her plan
2 of care, reviewing past medical history, which would've
3 included her prior hospital visit and general precautions.

4 Q. So in terms of her presentation, were you
5 satisfied that she was okay to keep healing and come see you
6 at her one-year post-op visit?

7 A. Yes. At that time, yes.

8 Q. And then you -- you recommended a stretching
9 regimen. What is that?

10 A. Just general, like physical -- physical therapy
11 exercises.

12 Q. Okay. Let's jump into Exhibit 91 please. And
13 here you are again, you're now seeing her again. Do you --
14 is that right?

15 A. Yes.

16 Q. What is the significance of a one year post-op
17 visit?

18 A. Typically, in orthopedics you follow a patient for
19 approximately a year longer if need be. Just wanting to
20 assess how's she doing, are things going well. Are there any
21 new concerns, any new problems. Yeah, that's pretty much it.

22 Q. Did you order any imaging?

23 A. I ordered X-rays.

24 Q. Why would you have done that? Well --

25 A. Typically we did X-rays on all of our post-op

1 patients. So standard of care

2 Q. One year post-op or?

3 A. Yes.

4 Q. Okay.

5 A. Uh-huh.

6 Q. And why -- what are you looking for?

7 A. You are looking for any instability or any changes
8 from prior films.

9 Q. Okay. And let me back up for a second. What --
10 what was she rating her pain at on that day, (inaudible)?

11 A. Zero out of 10.

12 Q. Why is that significant?

13 A. It's her one year post-op visit. So it tells me
14 that she's doing well, and that she's not having any pain.

15 Q. All right. So in terms of the imaging then, what
16 would you be communicating patient about on about in terms of
17 what you're seeing in X-ray?

18 A. I typically go over the X-rays with patients and
19 show them her surgery was at the L4-5 level, which is in the
20 lower part of the spine. And just walking through that to,
21 you know, let a patient know that everything looked fine.

22 Q. Okay. I mean, is that part and parcel to
23 understanding her medical history at this one point of post-
24 op?

25 MR. LUGINBILL: Objection. Leading.

1 THE COURT: Sustained, leading. Rephrase.

2 BY MR. KERN:

3 Q. Would you have talked to her about her previous
4 year of treatment at this visit?

5 A. I -- I don't know if I talked about -- talked to
6 her about everything.

7 Q. Did you talk to her about her medical history?
8 Does that include --

9 MR. LUGINBILL: Objection leading.

10 THE COURT: Sustained, leading. Rephrase.

11 BY MR. KERN:

12 Q. Can you tell from your note what you all talked
13 about?

14 A. Yes, we talked --

15 Q. What did you talk about?

16 A. -- we talked about her antibiotic therapy. She
17 had told me that she had completed the IV antibiotics and she
18 was still doing physical therapy and she was still following
19 up with her rheumatologist.

20 Q. Okay. And I mean, did you ever have a chance to
21 see her again after this visit?

22 A. I'd have to look at the notes, but I don't think
23 so.

24 Q. Was she always welcome to come back if she had an
25 issue?

1 A. Yes.

2 MR. KERN: That's all I have for you. For now please
3 answer any questions Defense Counsel may have.

4 THE COURT: Mr. Foreman, ladies and gentlemen, we're
5 going to take advantage of this break in testimony to take a
6 brief comfort break. During the break, please do not discuss
7 the case and please leave your note pads in your seats.

8 (Jury exits courtroom.)

9 THE COURT: We will be at ease for 10 minutes. They've
10 been sitting since 9:10 (inaudible).

11 Ma'am, you can walk around if you'd like, just please
12 don't discuss your testimony with anyone.

13 (Off the record.)

14 MR. LUGINBILL: Your Honor, we have housekeeping
15 (inaudible).

16 THE COURT: I'm sorry, go ahead. I'm listening.

17 MR. LUGINBILL: We have agreed upon updated (inaudible)
18 that's for you (inaudible).

19 THE COURT: Does it just add exhibits?

20 MR. LUGINBILL: Yeah.

21 THE COURT: Oh.

22 MR. KERN: What's the Number again?

23 MS. FLUMIAN: They will be Number s --

24 MR. LUGINBILL: One hundred and forty five through --

25 MS. FLUMIAN: I think actually 144.

1 MR. LUGINBILL: Yes, 144 through --

2 MS. FLUMIAN: I do not have them scanned.

3 MR. LUGINBILL: -- with objects.

4 THE COURT: Is there any exception to these
5 submissions?

6 MR. HOOD: Not from Defendant Frisch, your Honor.

7 MR. SMYTH: No, your Honor.

8 THE COURT: So that's 145 to 156?

9 MR. LUGINBILL: Yes, ma'am.

10 THE COURT: Is that correct? It should be right time.
11 I'm sorry. Yes, sir.

12 (Jury enters courtroom.)

13 THE BAILIFF: All jurors present, your Honor.

14 THE COURT: Thank you. Ladies and gentlemen, I hope
15 you enjoyed your break. We'll now resume testimony.

16 Any cross-examination?

17 MS. MAPLES: No, your Honor.

18 THE COURT: Any redirect?

19 MR. LUGINBILL: Your Honor, Plaintiff would like to
20 cross.

21 THE COURT: I'm sorry. I apologize. I told you all
22 I've been having a all moment I apologize.

23 You may proceed.

24 MR. LUGINBILL: Thank you, Judge.

25 CROSS-EXAMINATION

1 BY MR. LUGINBILL:

2 Q. Ms. Aprill, part of your function at Southeastern
3 Spine is to provide an exam prior to the surgery seeing
4 patient at times, correct?

5 A. At times, yes.

6 Q. Did you understand it to be your duty to do a
7 complete and thorough exam so that you get the best
8 information you can give that patient in an individualized
9 manner?

10 A. Yes.

11 Q. There was a discussion when we first started
12 talking a while ago. Did Dr. Frisch as a routine practice
13 provide PAs with certain journal articles that you found
14 useful or informative helpful?

15 A. I -- I don't remember.

16 Q. Is there a library at the -- at Southeastern Spine
17 that have various journals and things of that nature?
18 Anything you could go consult?

19 A. Not that I remember.

20 Q. Okay. Did you have any online access to things
21 like up-to-date or things of that nature?

22 A. I don't know that that was provided for us at
23 Southeastern Spine.

24 Q. So what did you do then if you came across
25 something that you weren't really familiar with while seeing

1 a patient?

2 A. Well, I have resources of my own.

3 Q. What would that be?

4 A. Well, you -- I have books. I have my academic
5 knowledge. There are websites that I can go onto on my own
6 if I had an account.

7 Q. My -- my question is, while you were working in
8 Southeastern Spine, you had a patient in front of you, you
9 came across a set of findings that -- that didn't feel
10 comfortable with or you needed some -- to do a little
11 research on it. How would you do that?

12 A. Well, I also had several of their spine surgeons
13 that were working near us that I could always ask.

14 Q. So was it your -- your typical approach then is
15 that you saw something you didn't like or weren't comfortable
16 making a decision on it, you would go grab one of these
17 surgeons?

18 A. Yes.

19 Q. They were your reference?

20 A. At times.

21 Q. Okay. Based on your education training and
22 generalized knowledge of patients in a spine surgery center.
23 Would you agree that RA patients are at a higher risk of
24 developing post-surgical infection?

25 A. Anyone that's immunocompromised is at a elevated

1 risk.

2 Q. So that's a yes?

3 A. Yes.

4 Q. Do you agree that the -- the disease itself puts
5 them at risk of increase -- or an increased risk of
6 post-surgical infection?

7 A. I'm not a rheumatologist.

8 Q. Did you -- you treat patients who were -- when you
9 were at Southeastern Spine, you treated patients who were
10 both post-surgical and RA status, correct?

11 A. I'm sure, yes.

12 Q. So did you know that all your RA patients were
13 potentially immunocompromised?

14 A. Anybody with rheumatoid arthritis is
15 immunocompromised. Yes.

16 Q. Okay. And then they take medications to treat
17 that -- that further immunocompromised, correct?

18 A. Yes.

19 Q. And that includes corticosteroids, right?

20 A. Yes.

21 Q. That can include anything -- a lot of different
22 ways that they treat it. Would that include drugs like
23 Enbrel and Arava, correct?

24 A. Yes.

25 Q. Now, when you first saw Pat Ms. McGougan after her

1 initial discectomy, how long had she been off of her RA meds
2 to your knowledge?

3 A. I believe that she was instructed to be off of
4 them for two weeks.

5 Q. In your experience, is two weeks long enough for
6 those meds to have completely been out of the system?

7 A. It depends on the half life of the medication.

8 Q. Do you know how long the half life of Enbrel is?

9 A. No, I'm not a rheumatologist.

10 Q. Do you know how long the half life of Arava is?

11 A. No.

12 Q. Did you consult anyone when you met with Pat that
13 day?

14 A. No.

15 Q. Did you grab any of the surgeons out in the hall
16 would you say with your practice?

17 A. No.

18 Q. So you prescribed her a dose of steroids, which
19 you just told me is immunosuppressive, you did that not
20 knowing status of her previously-administered RA medications,
21 correct?

22 A. Yes. But she was instructed to stop those
23 medications preoperatively.

24 Q. She just told me you didn't know if they were
25 still in her blood stream?

1 A. No, I don't have any record of that.

2 Q. I mean even if you stopped them, you agreed they
3 they're still there for some period of time, correct?

4 A. I cannot say that yes or no.

5 Q. You just told me they have a half life.

6 A. They do, but I don't know what that half life is.

7 Q. Well, that's my point. On that day when you saw
8 her for her first post-op visit, you had no idea whether
9 those medications were active or not active?

10 A. No, I did not.

11 Q. And yet you gave her another immunosuppressant by
12 giving her Medrol Dosepak, correct?

13 A. It's a very low dose to treat inflammation. Yes

14 Q. It is or is not an immunosuppressant?

15 A. Medrol Dosepak is not an immunosuppressant.

16 Q. It is your testimony today that a Medrol Dosepak,
17 prednisone is not an immunosuppressant?

18 A. It is not an immunosuppressant drug, but it does
19 have immunosuppressive effects.

20 Q. Based on your training, would you agree with me
21 that patients with deep surgical site infections, is that
22 differently in patients with subsurface or surface surgical
23 site infections?

24 A. Yes, they can. Yes.

25 Q. Specifically some of the things that are different

1 with deep surgical wound patients includes that they may have
2 pain out of the portion, correct?

3 A. Yes.

4 Q. And that pain generally sits in the -- sets in in
5 the one to three week postoperative time, correct?

6 A. Patients can have infections up to 30 days if
7 there's implants even longer.

8 Q. My question is very specific, the patients, when
9 you study patient with postsurgical infection, we always have
10 to do it looking backwards, correct? And find out the
11 patient has one. And then there's a study of when there's
12 three blood that happen in between, that's how you study what
13 happens in the life of a postsurgical infection; is that
14 fair?

15 A. I don't study postoperative infections.

16 Q. And so when a surgical site infection, if it's a
17 deep surgical site infection, most commonly percentage wise
18 they show up in the one to three week period post-surgery, is
19 that?

20 A. I don't know the exact timeframe.

21 Q. I am sure you also know that fevers are not a
22 predictable indicator for deep site surgical infections,
23 correct?

24 A. Fevers are one of those symptoms.

25 Q. Fevers are a symptom more commonly associated with

1 surface versus sub; is that correct?

2 A. No. You can have fevers in both.

3 Q. We can, but what -- you agree with me that the
4 amount of patients who have deep site infections only report
5 fever in about 30 to 50 percent of the time?

6 MR. KERN: Objection, Your Honor.

7 THE COURT: Basis?

8 MR. KERN: She's not an expert witness. He's asking
9 for opinions.

10 MR. LUGINBILL: I know you don't want, I would like to
11 state the last (inaudible) I will wait.

12 THE COURT: Mr. Foreman, ladies and gentlemen, I have a
13 brief matter of law to take up with Counsel. During the
14 break, please do not discuss the case. If you would just
15 stand up in the hallway for me. I appreciate it.

16 (Jury exits courtroom.)

17 THE COURT: All right. Please repeat the question.

18 BY MR. LUGINBILL:

19 Q. (Inaudible) each surgical site infections they
20 only present with fever 30 to 50 percent of the time?

21 THE COURT: You'd have to lay the foundation for her
22 rational knowledge and perception to answer that question.
23 And you have -- so do you think you can rephrase?

24 (Crosstalk) or establish the foundation? She's not an expert
25 witness. Any questions you ask her that are a list of

1 opinions have to come within Rule 701 and you have not done
2 that.

3 MR. LUGINBILL: Excuse me, ma'am? I'll go -- come back
4 to you. Well, I want to qualify her an expert.

5 THE COURT: She wouldn't be an expert.

6 MR. LUGINBILL: Correct. So all I'm going to ask her
7 --

8 THE COURT: You can only ask her. She's a fact
9 witness. You cannot ask her hypothetical. And I would
10 suggest if you want that information, you get it or try to
11 elicit it from the witnesses qualified to answer it.

12 MR. LUGINBILL: Your Honor, I guess I -- I want to make
13 sure I know the rules, but don't you (inaudible). She sees
14 patients with surgical site infections and so my questions
15 are going to be, you know how to tell the difference and how
16 --

17 THE COURT: Then why don't you just ask it that way?

18 MR. LUGINBILL: Okay.

19 THE COURT: Instead of putting it in the form of a
20 hypothetical where you're asking her and trying to elicit an
21 expert opinion from her. Because that's what you did. You
22 asked her about percentages and otherwise, and she's not
23 qualified to answer that question. She's qualified to answer
24 questions based on her rational perception to come within the
25 scope of her employment. So if you want to ask her that

1 question, you need to ask it the way you just said it.
2 Because then that's based on her rational perception and it's
3 not eliciting an opinion, it's based on what she does for a
4 living.

5 MR. LUGINBILL: And can I ask her, as -- as a result as
6 what you do for a living, are you required to know how often
7 these symptoms occur so that you can treat her?

8 THE COURT: I don't think I have -- you all have
9 problem with that question? I need all of them.

10 MR. KERN: No, your Honor.

11 THE COURT: All right.

12 MR. LUGINBILL: We'll do it that way. That be fine.

13 THE COURT: I think that's the appropriate way to do
14 it. You can get the jury for me please.

15 (Jury enters courtroom.)

16 THE BAILIFF: All jurors present, your Honor.

17 THE COURT: We appreciate your patience ladies and
18 gentlemen.

19 You may proceed.

20 BY MR. LUGINBILL:

21 Q. Excuse me. Would you agree to that in your job as
22 the PA at Southeastern Spine you have to know how often a
23 specific symptom shows up so that you can properly interpret
24 it, correct?

25 A. No.

1 Q. If you see a symptom and you don't know how common
2 that symptom is, how do you then evaluate the importance of
3 that symptom?

4 A. It's not up to statistics. You're treating a
5 human being and there are certain signs and symptoms of
6 infections and when a patient has those, you treat them for
7 it.

8 Q. And so do you know or is it your understanding
9 that fevers do not occur in most deep site surgical wound
10 infections?

11 MR. KERN: Objection, your Honor.

12 THE COURT: Basis?

13 MR. KERN: 701.

14 THE COURT: You have not established foundation for
15 that question. You need to ask the question within the ambit
16 of law we've already discussed.

17 BY MR. LUGINBILL:

18 Q. In order to interpret what a fever is telling you,
19 do you have to know how often it occurs in deep site surgical
20 wound infections and in surface wound infections?

21 MR. KERN: Objection, your Honor.

22 THE COURT: Overruled. The scope of which does for a
23 living.

24 Ma'am, you may answer the question to the best of your
25 knowledge.

1 THE WITNESS: Can you repeat the question?

2 BY MR. LUGINBILL:

3 Q. In order to interpret the significance of a
4 patient having or not having a fever, don't you have to know
5 how often it appears in a post-surgical patient who has a
6 deep site wound infection?

7 A. No.

8 Q. If you are looking for fevers to tell you that a
9 patient is not infected, wouldn't you need to know whether
10 people who have infections don't usually run fevers?

11 A. There are multiple signs to infections. Fever is
12 not the only one. Increased pain is one. Chills and night
13 sweats are also part of that puzzle that you try to put
14 together.

15 Q. But just because the patient doesn't have those
16 doesn't mean they don't have infection, correct?

17 A. Like I said, there are other signs and symptoms of
18 that. It's not just fever.

19 Q. So my question is just, because they don't have a
20 fever, it doesn't mean they don't have an infection, correct?

21 A. It probably, I mean I don't know.

22 Q. In your experience when you're evaluating the
23 wound by the picture you were shown earlier, can that wound
24 tell you anything about what's happening with the deep wound
25 infection?

1 A. No. That's a surface picture that I see.

2 Q. You can only tell you as far as your eyes can see,
3 fair?

4 A. Fair.

5 Q. And a person can have that post-surgical wound and
6 they can have a deep site surgical infection at the same
7 time; isn't that true?

8 A. I don't know. Sure.

9 Q. And because of that, there are laboratory studies
10 that we can do to give us more information than the eye
11 can't; is that fair?

12 A. The first step would be to obtain an MRI in that
13 case.

14 Q. Fair. Can you also do blood work?

15 A. You could do blood work.

16 Q. In fact, you've ordered blood work on patients
17 when there has been suspected infection, correct?

18 A. I'm sure I have. Yes.

19 Q. You ordered blood work for Pat when she went back
20 into the hospital in September. Specifically you ordered the
21 ESR and sed rate, correct?

22 A. Yes.

23 Q. ESR is sed rate.

24 A. Uh-huh.

25 Q. And then you also ordered CRP, correct?

1 A. I believe that was part of our workup. Yes.

2 Q. And that -- and you do that because that tells you
3 there's an inflammatory response going on, correct?

4 A. An inflammatory response. Yes.

5 Q. And you can also do those after an IND to see how
6 the patient's doing in terms of the infection being
7 eradicated, correct?

8 A. Yes.

9 Q. And sed rate is very sensitive and it will stay
10 elevated for a while, correct?

11 MR. KERN: Objection, Your Honor.

12 THE COURT: I didn't hear the whole question and I was
13 distracted by the phone that was ringing. Anybody has their
14 phone on needs to be turned off.

15 Now, please repeat the question. Do you remember?

16 BY MR. LUGINBILL:

17 Q. Do you agree with me that a sed rate is a
18 sensitive test for (inaudible)?

19 THE COURT: Zero objection.

20 MR. KERN: That wasn't the same question. Not to that
21 question.

22 THE COURT: Response. Ma'am, you may answer the
23 question to the best of your knowledge.

24 THE WITNESS: Yes.

25 BY MR. LUGINBILL:

1 Q. And it could be elevated immediately after
2 surgery, correct?

3 A. Sed rate probably would not be elevated if -- to
4 my understanding that is a longer term marker of
5 inflammation. CRP would probably be more immediate.

6 Q. And how quickly does the CRP return to baseline
7 follows of your general?

8 A. I don't know that.

9 Q. And would you agree that if those are being
10 monitored in a serial fashion, you can make sure that those
11 trends are going back down after the initial infection that
12 brought you to the IND procedure in the first place?

13 MR. KERN: Objection, Your Honor.

14 THE COURT: Basis?

15 MR. KERN: 701.

16 THE COURT: Sustained. Lack of foundation.

17 BY MR. LUGINBILL:

18 Q. As a PA, are you aware that serial monitoring of
19 those lab values gives you information as to whether or not
20 the infection has been or is being eradicated?

21 A. Yes, I would be able to interpret that
22 information.

23 Q. And would you also agree with me that in this case
24 no one from Southeastern Spine ran any of those tests who Pat
25 initially began draining fluid?

1 A. No, they were not indicated.

2 Q. When you were determining that they're not
3 indicated, you were relying on fever, correct?

4 A. Fever, chills, night sweats, increased pain and
5 drainage.

6 Q. And when you first saw her on her postoperative
7 week three, she did have an increase in pain, correct?

8 A. I'd have to review that note again.

9 Q. What -- I mean as well, when you first saw her,
10 she had low back pain, Ms. Buck saw her pain increase. I
11 apologize for that. If you have a draining wound, that is an
12 indication of potential infection, correct? It has to be,
13 but it can.

14 A. No. Normal postoperative wounds will drain and it
15 does not mean that they're infected. It's a normal part of
16 the body's healing process.

17 Q. I noticed in your responses you keep saying it
18 doesn't mean it is. My question was, isn't it true that when
19 you have a wound especially in a wound that was closed first
20 and then open, that drainage can be there because fluid was
21 building up under that closed incision and then pushed its
22 way through, correct?

23 MR. KERN: Objection, Your Honor.

24 THE COURT: Basis?

25 MR. KERN: 701.

1 THE COURT: Sustained. Establish the appropriate
2 foundation based within the rational perception and the scope
3 of what she does for an occupation, for her to be able to
4 answer that question.

5 BY MR. LUGINBILL:

6 Q. As a PA, you see post certifications of all
7 patients, correct?

8 A. I do.

9 Q. Every day?

10 A. Every day.

11 Q. And is it true that post-surgical patient can have
12 a closed wound that is starting an infection underneath it,
13 which then causes fluid to build up and then that wound goes.

14 A. I'm not aware of the mechanism of how that occurs.

15 Q. So how then do you interpret a new onset of
16 drainage as being not related to infection, which is what you
17 have testified to?

18 A. You look at it.

19 Q. It is your testimony that you can look at the
20 fluid and rule out that there's an infection?

21 A. No, I'm not saying that. I'm saying that there
22 are different types of drainage. There is serosanguineous
23 drainage and there is purulent drainage and serosanguineous
24 drainage is normal postoperative drainage.

25 Q. So is it your testimony then that if you have

1 serosanguineous drainage you can rule out a deep surgical
2 wound infection?

3 A. No, I'm not saying that.

4 Q. Okay. And so in this patient who had a three-week
5 post surgical infection, they had new onset drainage. If you
6 can't rule out that you have deep surgical site infection,
7 correct?

8 A. You would need an MRI to rule that out.

9 Q. You need either an MRI.

10 A. Uh-huh.

11 Q. Or you would be -- inflammatory markers like the
12 CRP or a sed rate, correct?

13 A. Those markers are markers of inflammation, not
14 infection.

15 Q. Correct. But if they were elevated and if they
16 were elevated specifically over her baseline, that would give
17 you another piece of information, fair?

18 A. Fair.

19 Q. And you could do those at Southeastern Spine you
20 all had the ability to run those, I assume?

21 A. We did not have a lab at Southeastern Spine.

22 Q. You could draw blood and send it to the lab?

23 A. No.

24 Q. You could send the patient to Labcorp, which is
25 blocks away from your office, correct?

1 A. Yes.

2 Q. You could send them to East Cooper and have it
3 done, correct?

4 A. Sure.

5 Q. And you can send those labs out. You can also ask
6 for blood cultures, correct?

7 A. I think that's typically done as an inpatient in
8 the hospital.

9 Q. You testified earlier that you had a low index of
10 suspicion for Ms. McGougan, correct?

11 A. Correct. But based on her presentation.

12 Q. Is it the standard of care for PAs, you have a
13 high index of suspicion for infection when you are treating
14 immunocompromised patients?

15 MR. KERN: Objection, Your Honor.

16 THE COURT: Basis?

17 MR. KERN: 701.

18 THE COURT: Sustained. Rephrase.

19 BY MR. LUGINBILL:

20 Q. You are a PA, correct?

21 A. Yes, I am.

22 Q. You do know what the standard of care is for your
23 -- for treating incisions, correct?

24 MR. KERN: Objection, Your Honor.

25 THE COURT: Basis?

1 MR. KERN: 701.

2 THE COURT: Mr. Foreman, ladies and gentlemen, I have
3 matter with law to take up with Counsel. During the break,
4 please do not discuss the case and please leave your note pad
5 on your seats. We appreciate your patience.

6 (Jury exits courtroom.)

7 THE COURT: Okay. I guess I'm trying to -- you -- you
8 continue to posit questions as if she's an expert. She's
9 not. She's been called as a fact witness. And your -- your
10 questions need to be confined to that. I know there's a
11 temptation to try to elicit testimony from witnesses in a
12 certain manner, but you really should in the interest of
13 time, direct those questions to people who are qualified to
14 answer them.

15 So I need you to ask this witness questions within her
16 capacity as a physician's assistant. She's a fact witness as
17 to her care of Ms. McGougan. And so the question should be
18 posited in that way. Does that help give guidance? She's
19 not an expert witness. Just because she's a PA doesn't mean
20 she gets to render opinions. She doesn't. Rule 701 is not
21 that flexible.

22 MR. LUGINBILL: I guess my -- the -- I'm trying not to
23 be difficult. I promise I'm not.

24 THE COURT: No, you don't have to apologize. It's your
25 job to be an advocate. I'm -- I just call balls and stripes.

1 If you all -- if you all don't object, I'm going to object
2 myself. But once I -- once an objection is made, I have to
3 rule on it.

4 MR. LUGINBILL: I have not -- I -- I have not tried to
5 make her an expert. And then my question does not. I asked
6 her as a PA does she know what the standard of care is for
7 herself? I don't know how I can say, well, how I have to be
8 able to say if you don't know --

9 THE COURT: You can ask it.

10 MR. LUGINBILL: -- what the rules are.

11 THE COURT: You -- you have to ask it in a different
12 way as a fact witness and then you can argue based on what
13 your experts have said, that she has failed to -- to adhere
14 to the standard of care.

15 MR. LUGINBILL: And I have not engaged her --

16 THE COURT: But you have to ask the question in a
17 different way. She's not an expert. You need to ask the
18 question a different way and there is a way to ask it. And
19 what you do is you frame the questions within the standard of
20 care. You ask them as you asked the questions. Based on her
21 ration and perception.

22 MR. LUGINBILL: I'm fine. I -- I'll just save that for
23 you, your Honor.

24 THE COURT: All right. Thank you. All right. Bring
25 the jury.

1 (Jury enters courtroom.)

2 THE BAILIFF: All jurors present, your Honor.

3 THE COURT: Thank you. We appreciate your patience.

4 You may proceed.

5 BY MR. LUGINBILL:

6 Q. Ms. Aprill, when you are looking at patients with
7 surgical wounds, are you keeping a high end index of
8 suspicion when they are an immunocompromised patient? I mean
9 and a high end index of suspicion for infections?

10 A. I keep a high end of suspicion for every patient.

11 Q. You told me -- previous attorney said that she had
12 low index of suspicion to this patient?

13 A. In this specific case.

14 Q. And yet immunocompromised patients, you need to
15 always keep a high index, meaning you have to be looking for
16 signs and symptoms of infection including deep infection all
17 the time. Because if you don't catch it quick, it's going to
18 be really a bad problem for this patient, correct?

19 A. Correct. And I believe that we did that.

20 Q. But you did no blood work to check for
21 inflammatory markers, correct?

22 A. That was not indicated based on her appearance and
23 based on exam findings.

24 Q. And you did not consult a rheumatologist prior to
25 giving her a steroid, correct?

1 A. I did not.

2 Q. And it is -- is it your belief that fever is a
3 reliable or unreliable indication for deep wound surgical
4 infection?

5 A. It is one indicator of a deep wound infection.

6 Q. Is it a reliable one or unreliable?

7 A. I would say it's reliable, not definitive, but
8 reliable.

9 Q. Is it more or less reliable than other methods to
10 test for deep wound surgical infection?

11 A. I'm not sure I understand your question.

12 Q. Is a fever, you said it is in quantitative.

13 A. Uh-huh.

14 Q. Is it better or worse at detecting the presence of
15 a deep wound surgical site infection than another indicator?

16 A. It's not a detection, it's a symptom. You would
17 need an MRI to see any evidence of a deep wound infection?

18 Q. I agree to the symptom. And you have to take that
19 symptom along with other evidence of keeping data to
20 determine what's going on with any patient at any time, fair?

21 A. Yes.

22 Q. Okay. In the earlier question, and I may have
23 missed Ms. Aprill I do need to make sure that I hear what you
24 said. Did I understand you to say that you believed when you
25 saw Ms. McGougan that she was getting -- and this is after

1 the ID that she was following with -- with infectious disease
2 doctor?

3 A. If my memory is correct, I believe that was in the
4 -- her last visit note, her one year post-op, but I don't
5 remember.

6 Q. Okay. So you were -- you do not believe that in
7 between September IND and December admission that she was
8 following with a infectious disease practice?

9 A. After her initial IND, I did believe she was being
10 followed by infectious disease.

11 Q. Which practice?

12 A. I don't remember the name.

13 Q. If she saw Dr. West and Lowcountry Infectious
14 Diseases while she was in the patient, if they were managing
15 her while she was inpatient?

16 A. Uh-huh.

17 Q. Is that who you would expect based on your
18 experience that she would've followed up with?

19 A. Yes. And I believe that that was documented in
20 her hospital course.

21 Q. Do you believe it was documented that she would be
22 following up on a post-op post discharge --

23 A. From -- from the --

24 Q. -- basis?

25 A. It -- which -- which admission are you talking

1 about?

2 Q. The 9/29.

3 A. I'd have to look at those notes.

4 Q. Look at the different, in your experience in
5 working with -- in this community, if somebody has an IND in
6 and they have a deep surgical site infection, especially this
7 MRSA where they had to get IV antibiotics, would they usually
8 generally follow-up with an infectious disease physician in
9 their offices?

10 MR. KERN: Objection, Your Honor.

11 THE COURT: Basis?

12 MR. KERN: 701.

13 THE COURT: Overruled.

14 You may answer the question to the best of your
15 ability.

16 THE WITNESS: Can -- can you repeat the question
17 please?

18 BY MR. LUGINBILL:

19 Q. Sure. One of your patients goes in, they -- they
20 develop a deep wound infection. They have to have an IND,
21 correct? That's how that would be done?

22 A. As an inpatient. Yes.

23 Q. Following the drainage, they're going to get some
24 IV antibiotics, correct?

25 A. I would defer that to infectious disease.

1 Q. Okay. In fact, all the treatment occur generally
2 gets referred infectious disease. In your experience in this
3 community?

4 A. Yes.

5 Q. And so when the patient's discharged from the
6 hospital, the follow-up for treating the infection is
7 generally with whoever Lowcountry or -- or a similar
8 infectious disease practice, correct?

9 A. If that was the plan of care then yes.

10 Q. And you as a surgeons, you are looking at the
11 incision and is the back itself okay, correct?

12 A. Yes.

13 Q. Is it also your experience and what you see that
14 somebody is going to follow-up and make sure the antibiotics
15 are being administered as they're supposed to and the patient
16 has no trouble with those and the infection didn't happen,
17 correct?

18 A. It depends on the plan of care. Yes.

19 Q. And that rheumatologist would generally talk with
20 you all's office and you all were talking to and not
21 rheumatologist -- sorry, infectious disease specialist to
22 talking with you guys, talk with them to make sure that we
23 have a all basis covered with that patient, right?

24 MR. KERN: Objection, Your Honor.

25 THE COURT: Basis?

1 MR. KERN: Argumentative. It's hypothetical. 701 is
2 another opinion.

3 THE COURT: You need to confine your questions to the
4 treatment of this particular individual.

5 Sustained. Rephrase.

6 BY MR. LUGINBILL:

7 Q. In your experience with this community --

8 MR. KERN: Your Honor, an objection if that was a
9 question.

10 THE COURT: He hasn't finished the question. I need to
11 hear it first.

12 MR. KERN: I could -- I couldn't tell if it was
13 finished or not.

14 THE COURT: He isn't, it seems like he's thinking.

15 BY MR. LUGINBILL:

16 Q. In your experience as a PA in this community, are
17 patients who have had deep site infections generally followed
18 by both specialists surgery and infectious diseases?

19 THE COURT: Objection, Your Honor.

20 THE COURT: Basis?

21 MR. KERN: He's asking that 701 and is asking for --

22 THE COURT: Sustained. Lack of foundation, 701. You
23 can't ask for hypotheticals.

24 BY MR. LUGINBILL:

25 Q. Are you familiar with the normal and customary

1 practice within Southeastern Spine of managing post-surgical
2 infections?

3 A. There's no protocol for that.

4 Q. In your experience in managing post-surgical
5 infection, especially deep-seated wound infection, people who
6 had to have INDs in managing those patients at Southeastern
7 Spine, do you have personal experience to do that?

8 A. Managing the infection?

9 Q. Managing those patients specifically as a part of
10 your practice.

11 A. Yes. Sure.

12 Q. And do some of them have courses of treatment as
13 in your plan of care? Do you have experience with patients
14 that is part of their plan of care at ongoing antibiotic
15 treatments?

16 MR. KERN: Objection, Your Honor.

17 THE COURT: Basis?

18 MR. KERN: Relevance (inaudible), 701.

19 THE COURT: 701, lack of foundation. Sustained.

20 BY MR. LUGINBILL:

21 Q. When you were treating Ms. McGougan, would you
22 have expected somebody to be treating her post-surgical
23 antibiotic regimen?

24 A. If that was the plan of care. Yes.

25 Q. When you were treating her, were you expecting her

1 to have a plan of care that included post discharge
2 antibiotic therapy?

3 A. I would defer that to the infectious disease
4 specialist.

5 Q. In your personal knowledge, when you looked at her
6 record that she gave you, you have looked to see what that
7 plan of care was at discharge, correct?

8 A. Yes.

9 Q. So you're looking to see if there is a plan of
10 care that includes post-surgical discharge, correct?

11 A. Yes.

12 Q. And you do hundreds of patients like that in a
13 year, correct?

14 A. Not hundreds of patients like this. No.

15 Q. Dozens?

16 A. Infections are very rare. Is that what you're
17 implying?

18 Q. No, I -- I think you have a lot of experience
19 here. I think you see a lot of post-surgical patients that
20 have infections?

21 A. I don't see a lot of postoperative patients that
22 have infections. It's the exception and not the norm.

23 Q. Do you feel like you're qualified to do it, to
24 treat those patients?

25 A. Superficial infections. Yes.

1 Q. Are you qualified to treat deep wound infections?

2 A. I do not treat deep wound infections. Infectious
3 disease specialists would do that.

4 Q. If you suspect that a patient had a deep wound
5 infection, what would you do?

6 A. I would relay that to my surgeon and let them take
7 over the plan of care.

8 Q. And in this case, at none of the visits did you go
9 to your surgeon and think Pat McGougan had a deep seated
10 surgical site infection, correct?

11 A. Not from what I could tell from her visits, no.
12 She did not present that way.

13 Q. But in reality she did have that, correct?

14 A. In hindsight, yes, she did.

15 Q. And you agree with me that anybody about the
16 draining wound can develop a deep surgical wound infection
17 because the drainage allows a path for the infection to get
18 there, fair?

19 A. If you have an opening in the skin, yes. You can
20 introduce infection.

21 Q. The MRI that you discussed, that -- that could
22 have been ordered. Those are all done on campus at
23 Southeastern Spine, correct?

24 A. Sometimes yes, sometimes no.

25 Q. When are they done there versus somewhere else?

1 What's the criteria?

2 A. Sometimes it's based on patient's insurance,
3 preference or cost.

4 Q. Is it fair to say that your entire evaluation of
5 Ms. McGougan and her infection, but we'll start with the
6 drainage was what you could see and her report of no fever,
7 no night sweats, no chills?

8 A. And very little pain.

9 Q. And little pain. And is it within your education
10 training experience to say whether or not those being
11 negative if you didn't have them, could have ruled out a
12 deeper surgical site infection?

13 A. Not definitively, but she presented in a benign
14 fashion.

15 Q. And all of those were negative. But you had blood
16 work that showed increasing inflammatory markers assuming you
17 had that. That would've worded you that something else is
18 going on, fair?

19 MR. KERN: Objection, Your Honor.

20 THE COURT: Basis? It is a hypothetical. Sustained.
21 Move on, lie the foundation.

22 BY MR. LUGINBILL:

23 Q. When you were treating Ms. McGougan, if you looked
24 at -- at her wound and heard her reports of no fever, no
25 chills, but you had been giving her CRPs instead and those

1 were trending up instead of down, that would've told you that
2 potentially something else is going on, correct?

3 MR. KERN: Objection, your Honor.

4 THE COURT: Basis?

5 MR. KERN: It's hypothetical.

6 THE COURT: Sustained.

7 BY MR. LUGINBILL:

8 Q. Is Bactrim effective for a deep wound infection?

9 A. I'm not an infectious disease specialist, but
10 typically deep wound infections require IV antibiotics.

11 Q. Did your responses to your direct examination, you
12 indicated a lot of times that -- that what you were doing
13 would've been typical. Do you recall that? You gave answers
14 to this is what I would typically do. This is typical. Do
15 you recall that?

16 A. I don't recall that. No.

17 Q. Ms. McGougan is an RA patient atypical from blood
18 stream; is that fair?

19 A. Yes, she has multiple comorbidities. Yes.

20 Q. And so you have an atypical patient who's had a
21 discectomy and now she's drained, draining atypical, although
22 it does happen, correct?

23 A. It is a normal part of postoperative wound
24 healing. Yes.

25 Q. So you're telling me that wounds are initially

1 healed and burst open are typical?

2 A. Yes. We see that all the time.

3 Q. Okay. And they -- they -- you've already told me
4 that the drainage itself is a potential source of infection,
5 correct?

6 A. The drainage itself, no. Is not a source of
7 infection.

8 Q. Does it provide a path for a pathogen to get from
9 the outside of the body to the inside of the body?

10 A. An opening in the skin would do that, yes.

11 Q. And if the drainage is coming from deep in the
12 wound, that means that that pathogen, that bacteria, that
13 MRSA can get to the deep part of the wound, right?

14 A. Say that again?

15 Q. The drainage is coming from the face of the wound
16 down in that vertebrae where that disc was removed.

17 A. Uh-huh.

18 Q. The drainage is coming all the way out, then a
19 pathogen can get all the way in?

20 MR. KERN: Objection, Your Honor.

21 THE COURT: Basis?

22 MR. KERN: Hypothetical.

23 THE COURT: Sustained lack of foundation.

24 Hypothetical, Rule 701 and 702.

25 BY MR. LUGINBILL:

1 Q. At no point in treating Ms. McGougan did you order
2 an MRI; is that correct?

3 A. That's incorrect. We did -- I did order an MRI.

4 Q. When did you order the MRI?

5 A. I would have to look at my notes, but I believe it
6 was prior to the September admission. I -- I -- I would have
7 to look at the notes. I don't know the exact date. It might
8 have been in December, but I did order an MRI for her at some
9 point in time.

10 Q. Right to that. So between August and September
11 did order an MRI?

12 A. I would have to look at the order sheet. I do --
13 I don't remember.

14 Q. In the interest of time, I believe that you
15 ordered a MRI on September -- on December 13th after a call.
16 Does that sound right?

17 A. I think so, yes.

18 Q. And then it was read on the 16th?

19 A. It -- that's what the document show.

20 Q. It actually formed and read on the 16th; is that
21 correct?

22 A. I'd have to see it, but.

23 Q. And so if that is true, that it is also true that
24 between her initial discharge from the initial discectomy
25 until she had to be readmitted in September for the incision

1 and drainage, you did not order MRI?

2 A. I did not. It was recommended at other visits and
3 it was declined.

4 Q. And so even though you saw her after Ms. Buck with
5 the records say ordered the MRI, you didn't repeat that
6 request or that you didn't recommend one yourself?

7 A. No, because she seemed to be doing much better.

8 Q. I noticed in your -- I'm going to show you
9 Plaintiff's Exhibit 3. You (inaudible) publish it. The date
10 of the visit and the date that you electronically signed are
11 they the same?

12 A. Yes, they are.

13 Q. And then the -- this explains Exhibit 5, are the
14 date of the visit and the date you signed it the same?

15 A. Yes, they are.

16 Q. And on September the 1st, Defense Exhibit 6 are
17 the date of the visit and the date you signed it the same?

18 A. Yes, they are.

19 Q. And on Exhibit 7, same question?

20 A. Yes.

21 Q. All right. From your recollection of working in
22 Southeastern's Spine, is that when you sign it -- in other
23 words, you reviewed your note and you clicked electronically
24 to sign it. That's the date that goes MRI?

25 A. It's the date that it goes to billing. It's

1 there, but it's been signed and finalized.

2 Q. Nobody at Southeastern Spine is allowed to come
3 back and change when you sign, correct?

4 A. Not to my knowledge. No.

5 Q. They certainly can't change what you put in there,
6 correct?

7 A. No.

8 Q. Now, you can -- you can go into your note and
9 amend it and resign it, correct?

10 A. I can.

11 Q. And when you're just looking at it printed out,
12 there's no way to tell that that's been done. We only see
13 the final product; is that right?

14 A. Are you referring to an -- an addendum?

15 Q. Unless you type it in and say addendum, somebody
16 reading it after is not going to know it's addendum. They're
17 just going to see the final product?

18 A. It depends on the electronic medical records.

19 Q. Specifically asking about Southeastern Spine.

20 A. I don't remember the format that they had.

21 Q. Fair enough. But you do remember you could go in
22 and make changes?

23 A. Yes.

24 Q. If you got something you wanted to add something,
25 you could do that?

1 A. Sure.

2 Q. We're going to show you Plaintiff's Exhibit 34.

3 If you'll look three down, you will see I believe the orders
4 in one I'm interested in -- in the third, which I believe has
5 been (inaudible). Do you recognize it?

6 A. The order for a wheelchair?

7 Q. The MRI.

8 A. The first order.

9 Q. I believe it the third down (inaudible).

10 A. This is for a wheelchair.

11 Q. Can you put -- you'll see it and I'll see it, you
12 said it even more. So Plaintiff's Exhibit 34, you looking at
13 this one right here. Did you put in that order?

14 A. It seems like I did.

15 Q. Everything after post-surgery that's cap. Is that
16 something you would've typed in?

17 A. I'm sorry, repeat that.

18 Q. Everything that's in capital, all caps starting
19 with post-surgery, is that something that you would've
20 manually typed in?

21 A. No, these appear to be formatted from the
22 hospital. Like when I put orders in for an admission they --
23 they don't look like this. This is something that the
24 hospital printed out to -- no, I would not have typed that.
25 I guess what I'm saying is I never -- I don't have access to

1 this specific document.

2 Q. And so where it says "Felt incision popped patient
3 now has fever" and it's repeated in all three of those
4 orders." That's not something you caused to happen?

5 A. I don't think so.

6 Q. Okay. When you were shown Defendant's 91, and I'm
7 not going to try to cross her, take it out, which one that
8 is, but there was a note and you mentioned that Ms. McGougan
9 in your note, Ms. McGougan was seeing her rheumatoid
10 arthritis doctor, was that management that she was seeing
11 Lowcountry Infectious Diseases, Dr. Ebama for her infectious
12 disease management. And then you mentioned that you were
13 continuing to follow-up or respond. Do you recall that note?
14 It's 2017.

15 A. 2017, her final one-year post-op visit.

16 Q. Is it your normal practice that is a patient is
17 seeing other providers that you document who they are so that
18 everybody knows who's on the care team?

19 A. Yes. I mean it's helpful but it should also be in
20 the patient's record.

21 Q. Your normal practice is the document, correct?

22 A. Which physicians that a patient is seeing, no.

23 Q. Not by name, but by specialty?

24 A. Not necessarily in this case because it was
25 pertinent to her history, I did.

1 Q. And that's the only time that you see that that
2 was documented anywhere in the Southeastern Spine records,
3 correct?

4 A. I'd have to look back through them all again. I
5 don't know.

6 Q. One last point make, I'm going to show you
7 Plaintiff's Exhibit 17. These were provided part 17. These
8 were lab bags from Mr. McGougan's primary care physician,
9 Dr. Harkins specifically showing the sed rate, which we've
10 been talking about, correct?

11 A. Yes.

12 Q. So you would've had the baseline for her
13 pre-surgery, correct?

14 A. From a month and a half prior. Yes.

15 Q. Knowing a baseline if you're doing trending of any
16 value is important, right?

17 A. Yes.

18 Q. It allows you to compare what has been with what's
19 happening now, correct?

20 A. It would.

21 Q. And so if you have patient's information from
22 fourth surgery, we had patient's information the day after,
23 and you have a better feel for where things are going, right?

24 MR. KERN: Objection, Your Honor.

25 THE COURT: Basis?

1 MR. KERN: Hypothetical.

2 THE COURT: Sustained. Lack of foundation. Rephrase.

3 BY MR. LUGINBILL:

4 Q. As a treating PA at Southeastern Spine, what do
5 you do if you have lab values that are going the wrong way?

6 A. I guess it would depend on which lab values were
7 going the wrong way.

8 Q. I will go with CRP and sed -- and sed rate.

9 A. I would let my supervising physician know that
10 there was a change in trend and trust that we would make the
11 appropriate recommendation for follow-up.

12 Q. Because then you would catch it, right? That's
13 the point.

14 MR. KERN: Objection, Your Honor.

15 THE COURT: Basis?

16 MR. KERN: Hypothetical.

17 THE COURT: I'm going to overrule latitude. So you can
18 answer -- you can answer the questions to the best of your
19 knowledge.

20 THE WITNESS: Can you repeat it, please?

21 BY MR. LUGINBILL:

22 Q. If you had those increasing sed rates, increase in
23 CRP, you would go get the position so that you guys can come
24 and plan to figure out why that's happening and do something
25 that if it is the infection to stop the infection, right?

1 A. It would be part of the puzzle.

2 MR. LUGINBILL: Okay. Give me one second. That's all
3 I have.

4 THE COURT: Any redirect?

5 MR. KERN: None, Your Honor.

6 THE COURT: Any exceptions of the witness being excused
7 from Plaintiff?

8 MS. FLUMIAN: No, Your Honor.

9 THE COURT: From the Defense?

10 MR. KERN: None, Your Honor.

11 MS. MAPLES: No, Your Honor.

12 THE COURT: Thank you.

13 Ma'am, you're excused.

14 Ladies and gentlemen, we're going to take advantage of
15 this break in testimony to take our lunch recess. We will
16 break -- we're going to break until 1:30. That gives you an
17 hour and five minutes for lunch. During the break, please do
18 not discuss the case. Please leave your note pads in your
19 seats. Have a good lunch and we'll see you at 1:30.

20 (Jury exits courtroom.)

21 THE COURT: Who's the Defense's next witness?

22 MR. HOOD: Dr. Frisch.

23 THE COURT: And then who are -- who are you going to
24 call after that?

25 MR. HOOD: We have Dr. Dailey and Dr. Glaser.

1 THE COURT: Okay. All right. Have a good lunch. See
2 you all at 1:30. You can leave your stuff in the courtroom.

3 (Off the record.)

4 THE COURT: Okay. You can be seated. Good afternoon.
5 All right. Plaintiff ready to proceed?

6 MS. FLUMIAN: Yes, Your Honor.

7 THE COURT: Is the Defense ready to proceed?

8 MS. HOOD: We're ready.

9 THE COURT: Okay. Call your next -- well get the jury
10 for me be right in time. But you can go ahead and call your
11 next witness so they can be waiting by the witness stand.

12 MS. HOOD: Sure. Call Dr. Richard Frisch.

13 THE COURT: Dr. Frisch, if you would go ahead and stand
14 by the witness stand for me. I appreciate it.

15 (Jury enters courtroom.)

16 THE BAILIFF: All jurors present, Your Honor.

17 THE COURT: Thank you. Ladies and gentlemen, I hope
18 you all have a pleasant lunch. We'll now resume testimony.

19 You may call your next witness.

20 MS. HOOD: This time, Your Honor, the Defense calls
21 Dr. Richard Frisch.

22 THE COURT: Please swear the witness.

23 THE CLERK: Please raise your right hand and place your
24 left hand on the Bible.

25 RICHARD FRISCH,

1 being duly sworn, testified as follows:

2 THE CLERK: Please be seated. Please state your full
3 name, spelling your last name directly in the microphone.

4 THE WITNESS: Richard Frisch, F-R-I-S-C-H.

5 THE COURT: You may proceed.

6 MS. HOOD: Thank you, Your Honor.

7 THE COURT: You're welcome.

8 DIRECT EXAMINATION

9 BY MS. HOOD:

10 Q. Dr. Frisch, on September the 20, 2016, you took
11 Ms. McGougan back to the hospital and eventually the
12 operating room.

13 A. Yes.

14 Q. Can you explain to the jury why you did that?

15 A. Yes. Ms. McGougan was a patient we had operated
16 on August 2nd, about six to seven weeks earlier for -- for
17 the discectomy. Postoperatively, she had some wound drainage
18 that we were following. At times it seemed she was doing
19 well and was making a good recovery. The last few days
20 before we took her to the hospital, she started having
21 increased pain and increased fever. She was reporting to us.
22 So at that point in time, I wanted to admit her to the
23 hospital so we could examine her more closely and -- and take
24 a look at everything.

25 Q. And before that, had you observed or heard or been

1 reported anything about fevers?

2 A. That was the first acknowledgment, the fevers that
3 I was aware of.

4 Q. All right. We jumped right in. Let me back up.
5 Tell us a little bit about yourself. Where you from? How'd
6 you end up here and -- and how'd you end up doing spine
7 surgery?

8 A. Sure -- sure. A little bit from all over moved
9 around a bunch as a kid, sort of claim Philadelphia is where
10 I'm from. Have been in this area since 2011 when I joined my
11 current practice. Currently I reside here in -- in the Mount
12 Pleasant area with my wife and -- and our three children.

13 Q. And what do you do for a living?

14 A. I'm an orthopedic spine surgeon.

15 Q. And we're going to talk about the spine surgery in
16 this case. Before we do that tell us a little bit about your
17 education and what brought you to spine surgery.

18 A. Sure. So I went to medical school at what was
19 then Medical College of Pennsylvania/Hahnemann. It's now
20 Drexel University. I did my orthopedic surgery residency at
21 Albert Einstein medical Center in Philadelphia. I did my
22 spine specialty training my spine fellowship at University of
23 California San Francisco.

24 My interest in spine started really with basic research
25 interest in -- in spinal cord injury. Then I did a good

1 amount when preschool, pre-medical school, and during medical
2 school and -- and after. And -- and that was really my
3 impetus to become involved.

4 Q. All right. We heard in the opening statement some
5 leadership positions that -- that you've held. Tell us about
6 those.

7 A. Locally here I've been the president of the South
8 Carolina Orthopedic Association the South Carolina Spine
9 Society.

10 Q. All right. How much of your time is spent
11 treating patients versus maybe, you know, teaching or
12 research and things like that?

13 A. At this point, pretty much 100 percent of my -- my
14 time is clinical. I've -- I don't do as much research as --
15 as I used to.

16 Q. And do you have a specific area within the field
17 of spine surgery that you -- you know, have a particular
18 sub-specialty?

19 A. I, you know, minimally-invasive surgery of all
20 types. I have a background of scoliosis surgeries and big
21 interest of mine has been doing those type of larger
22 procedures in minimally invasive ways. I'd say that's --
23 that's probably my main area of interest.

24 Q. All right. And minimally invasive the surgery
25 that we're going to talk about today, would -- would that be

1 one of those types of minimally invasive surgeries?

2 A. It was -- it was.

3 Q. All right. I want to jump right in. We -- I want
4 to sort of cover this in segments of time and then I want to
5 get you to answer some questions that we've -- we've heard
6 asked throughout the course of the week. And then let turn
7 you over to -- to the next lawyer to ask questions. First
8 segment of time is going to be the -- the preoperative phase.

9 A. Yes.

10 Q. Can you just walk the jury through the
11 presentation and your experience or your thought process and
12 your interaction with the patient that led to the decision to
13 go forward with surgery?

14 A. Sure. So Ms. McGougan presented to me, she was
15 referred to me by one of my partners at the time with severe
16 back and leg pain and weakness. Her symptoms had been
17 present for roughly three and a half weeks. On exam she had
18 significant loss of strength and function in her left leg.
19 And on her imaging she had a fairly large disc herniation at
20 the L4-5 level. What that means is it's pushing on the
21 nerves that supply the areas where her leg was weak.

22 And so, she had been having difficulty walking, said
23 she had -- had been dragging her leg around. And so we had a
24 discussion of -- of where do we go from there? What are our
25 options? And essentially that's no additional treatment,

1 injections and therapy or surgery.

2 As a surgeon in that situation where you see a patient
3 who has compression on their nerves and the neurologic
4 deficit, meaning loss of function, weakness, generally the
5 recommendation is for surgery to hopefully help prevent that
6 weakness from getting worse and give it a chance to get
7 better.

8 Q. You mentioned leg weakness. What significance, if
9 any, is a finding of leg weakness as you're evaluating the
10 patient?

11 A. So you could have a disc herniation that doesn't
12 cause leg weakness. It causes pain. If you have a disc
13 herniation, it causes weakness. You start to be worried
14 about the function and the health, the long-term impact of
15 the nerve. So that's a situation whereas for us as a spine
16 surgeon we become very concerned and -- and realize that
17 there's a degree of urgency that we need to remove that
18 pressure to hopefully allow that nerve to function again.

19 Q. And what's the downside to not relieving the
20 pressure?

21 A. The downside to not relieving the pressure is --
22 is the patient to get weaker and permanently lose the
23 function of those muscles in their legs were partially.

24 Q. All right. So before we talk about the surgery
25 itself, we've heard a lot about rheumatoid arthritis and --

1 and we've seen the -- the medical records. And you -- when
2 the witnesses went through that visit that you had, where it
3 is referenced, and were you aware of the rheumatoid
4 arthritis?

5 A. Yes.

6 Q. What impact, if any, did that have on your medical
7 judgment and decision-making?

8 A. Yeah, so you're aware of the rheumatoid arthritis
9 and in this situation, you know, that that's part of her.
10 But the most pressing situation is the compression on the
11 nerve and the potential loss of function of -- of the leg.
12 And so we operate on patients with rheumatoid arthritis
13 frequently. How they present dictates sort of what you do.
14 People that come in with dramatic emergencies, you just, it
15 doesn't matter. You do the surgery, you -- you move forward.
16 If you're operating someone for back pain, longstanding, you
17 can have time to get people off their medications for -- for
18 ideal periods of time.

19 The main medication that Ms. McGougan was on was -- was
20 Enbrel. From my understanding, by the time we would've done
21 the surgery, she would've been off of that for about a week.
22 Our normal recommendations are about a -- to be off of that
23 for a week or two. So at that point in time, I felt that the
24 most pressing thing was to get the pressure off the nerve,
25 understand that she has rheumatoid arthritis and follow her

1 appropriately afterwards.

2 Q. All right. Let's jump in and talk about the
3 surgery itself. We have marked as Defense Exhibit -- our
4 operative note, which is Exhibit 14. And we'll pull that up.
5 I don't really want to walk through it, but I want you to
6 have it in front of you in case you need reference to it.
7 You don't to have to blow it up. Blow up the description of
8 the procedure section please. All right. So walk us through
9 the discectomy for Ms. McGougan if you will, please.

10 A. Sure. So a midline incisions is made center over
11 the L45 displaced with a 15 blade scalpel.

12 Q. Okay. Stop. That doesn't help. I need you to
13 explain to all of us in -- in --

14 A. Sorry, I thought you wanted me to read it. My
15 apology.

16 Q. Seems like you're talking to Jamie.

17 A. Sure.

18 Q. It -- how does the surgery (inaudible)? What --
19 what happens?

20 A. Sure. So the patient is -- is laying prone with
21 their back up in the air, and then we use X-rays to localize
22 the area where we're going to make the incision, this case
23 over the L4-5 disc space. Once we localize it, then we make
24 a -- a small incision where we either -- we either dissect or
25 we push aside the -- the muscle to get down to the bone. The

1 lamina, which is what is the outer part of the canal, which
2 contains the nerves and the disc.

3 And what's happening is -- is the disc is pushing up on
4 the nerve. And so we remove that. Once we get down there,
5 we do is called the hemilaminectomy, or laminectomy, remove
6 that part of the bone to open the tube so we can visualize
7 the nerve. And underneath the nerve is where you see the
8 disc protruding up. And then very gently, usually under a
9 microscope or with magnifying loops, you remove the nerve and
10 then you remove the piece of disc to take the pressure off.

11 Q. Pretty simple stuff?

12 A. If -- if for a spine surgeon, is it surgery that
13 do we do routinely. Does it -- does it take a while to -- to
14 get there where it's -- I would say, I never call it simple,
15 but it's -- and this particular one was a little tricky for
16 -- I -- I don't want to kill you with details, but this
17 herniation happened to be in a very difficult place. So this
18 was a little bit a tricky one, but -- but things went well.

19 Q. All right. So one thing it says there is
20 "Telescopic guided imaging." Can you explain to the jury
21 what that means?

22 A. Yeah, so that's -- that's the part where we bring
23 the X-ray in to help us localize and make sure we're at the
24 right level.

25 Q. All right. I want to bring up -- should have

1 brought this up just a moment ago. Exhibit 10, we've heard
2 some testimony about screening for MRSA or hospital-acquired
3 infections. If you could blow up that first section, please.
4 Hand it, says Defense Exhibit 10. Can you tell us what we're
5 looking at here?

6 A. So it looks like an infection risk MRSA form.

7 Q. Okay. And whose form is this?

8 A. This is from East Cooper.

9 Q. All right. And is this a screening tool?

10 A. It is.

11 Q. And based upon the answers there they're all
12 circled. Now, what does that indicate in terms of
13 pre-screening for -- for Ms. McGougan?

14 A. That it is not indicated in this situation.

15 Q. All right. And that -- understood. Let's move on
16 to the Exhibit Number 12, if we could. Some of these things
17 I just want to provide a little bit of reference because
18 they're in evidence that the jury's going to have with them.
19 This is the consultation note. We're going to blow up the
20 first part there under date and reason for consultation.
21 Sorry, we could do the record of that please, sorry. So tell
22 us who this is and what's happening here?

23 A. Who the doctor is or?

24 Q. Yeah.

25 A. All I see is -- so up top it looks like it's Brian

1 Ward. That's the hospital. It's the internal medicine
2 doctor in the hospital.

3 MS. HOOD: Okay. Your Honor, can I approach the
4 witness?

5 BY MS. HOOD:

6 Q. I -- I can give you a copy of these exhibits.
7 It's easier for you to follow along there instead of
8 (inaudible) you're welcome to do that.

9 A. Sure.

10 Q. All right. So we Dr. Ward why -- why is he being
11 consulted?

12 A. All patients that we operate on, we have a
13 internal medicine doctor, a hospitalist consult with them
14 when they go to hospital to help manage any medical issues
15 that we have that are above or beyond our scope is orthopedic
16 spine surgeons.

17 Q. And under reason for consultation here were the
18 last two words indicated there?

19 A. Rheumatoid arthritis.

20 Q. All right. So when we look back on the second
21 page of Exhibit Number 12, under the assessment plan, how was
22 the rheumatoid arthritis addressed by the consulting
23 physician?

24 A. So he basically confirmed that she had -- had her
25 Enbrel was on hold until okay by Dr. Frisch.

1 Q. All right. So you went forward to the surgery
2 when -- were you comfortable with the surgical result?

3 A. I was.

4 Q. And the discharge from the hospital what were the
5 follow-up instructions for the patients?

6 A. The follow-up in two weeks.

7 Q. And that would get us to the August 16th visit?

8 A. Correct.

9 Q. All right. We've gone through the visits
10 specifically with the PAs who were there for each one. I'm
11 not going to do that again.

12 A. Okay.

13 Q. But I want to just cover with you your role as the
14 surgeon versus their role as the PA. If you could speak to
15 that and explain to the jury how you and your team work and
16 what your role is as a supervisor?

17 A. Sure. So in most instances, myself and my PAs
18 work in clinic side by side. We're literally three of us at
19 like a desk like this. And there's separate rooms that we go
20 into to see patients. Oftentimes we'll see them together.
21 Sometimes they'll see them by themselves, if there's issues
22 we're -- we're there and we talk about them and we address
23 them. If they have questions or concerns then -- then we go
24 over those and -- and make plans.

25 Q. All right. Or the -- the time of the 18th -- or

1 excuse me, the 16th visit which is Exhibit Number 19.

2 Ms. Buck testified to this earlier. Would she have relayed
3 the information from her visit with the patient to you?

4 A. From this August 16th note, this is her first
5 postoperative visit. This is a note that showed she's doing
6 well. We probably would've touched base and she would've let
7 me know she's doing well.

8 Q. All right.

9 A. Usually the first postoperative visit the PAs do
10 see.

11 Q. And were you -- I mean, hearing her testimony
12 about it familiarization with the record known to surgery,
13 where does this indicate that -- that the patient is in the
14 recovery process?

15 A. At this point I'd say she's appropriate for where
16 she's after surgery. The most positive thing here, which is
17 very fortunate, is that she's regained the strength of her
18 leg which is really the biggest concern. The real whole
19 reason why we were -- we're here to begin with. And to only
20 two weeks postoperatively. I've already regained that
21 strength is -- is a blessing.

22 Q. I want to ask you one specific thing about this is
23 the Medrol Dosepak?

24 A. Yes.

25 Q. Heard some testimony to that?

1 A. Yes.

2 Q. Could you explain to the jury whether you think
3 that's appropriate medication in this situation, and if so,
4 why?

5 A. I do think it's appropriate in this situation. We
6 give Medrol Dosepak to people routinely after surgery because
7 we'd be very helpful to decrease pain. While her pain was --
8 was minimal, she still was having pain, particularly at -- at
9 -- at night. When patients have pressure on their nerves
10 from any reason, disc herniations, tumors, trauma infection,
11 those nerves are going to be very angry for a while. And so
12 often we'll give a very low dose steroid to help decrease the
13 pain.

14 I think some of the concerns that have been echoed
15 earlier about immunosuppressants is, I think it's key to
16 understand at this point in time we would -- we're not
17 concerned about an infection. And two weeks postoperative
18 have them being offered our Enbrel I think this is a -- a
19 very low dose steroid that is very reasonable in this
20 situation to help decrease pain.

21 Q. Wait a second. You said you weren't concerned
22 about infection at this point?

23 A. Two weeks post-op no, there was no indication of
24 infection.

25 Q. Even though she's got rheumatoid arthritis?

1 A. Sure. We -- we operate on again, patients
2 frequently with rheumatoid arthritis. It doesn't mean that
3 they're going to have an infection at this point. There is
4 no sign of an infection.

5 Q. And -- and what is your expectation in terms of a
6 Medrol Dosepak impacting Ms. McGougan's ability to respond in
7 the event that she's confronted with an infection?

8 A. I -- I think it's a very minor low dose steroid
9 that I'm comfortable with and not concerned with in that
10 regard.

11 Q. In -- in terms of patient comfort at night
12 sleeping, what -- what significance, if any, is there for
13 that in terms of her recovery?

14 A. I think these are -- are normal postoperative
15 issues that -- that people experience. There's nothing out
16 of the ordinary there that I see.

17 Q. All right. We're going to jump to Exhibit Number
18 21, which is the August 23rd visit. And Ms. Buck testified
19 to this earlier today, and just by way of background, this is
20 where she came in complaining of a incisional drainage?

21 A. Yes.

22 Q. All right. So previous visit, there's no drainage
23 and now there is drainage. Tell me what you're thinking in
24 terms of this patient and where she is from the continuum
25 care?

1 A. Sure. So it's -- it's very frequent that we see
2 people with that will develop in this case, serosanguineous
3 drainage after surgery. It can very commonly be seen in
4 wounds as they're healing. And that's something that we
5 routinely see and note and -- and watch.

6 Q. So at this point, doctor, why don't you just take
7 the patient back to the operating room?

8 A. Right. So that's -- that's a -- a big decision.
9 So at this point I -- I -- I certainly didn't think it would
10 be indicated to go back to the operating room, but along all
11 these points of contacts, the decision making of when to do
12 that is -- is -- is -- is a big one because if and when and
13 -- and when we did eventually take her back to the operating
14 room, there's -- there's -- there's lots of risks that go
15 along with that.

16 And so, we -- I can talk about that more if you want,
17 but at that point in time, I -- I didn't -- I didn't think it
18 was indicated to go to surgery at that time. And certainly
19 to do so without a good reason is potentially exposing the
20 patient to unnecessary risk.

21 Q. There is reference to some medications being
22 administered here and she was prescribed Bactrim. Are you
23 familiar with that?

24 A. Yes.

25 Q. Well, let me first ask you, were you -- something

1 what we're talking about here, a patient who comes back in
2 after one week with incisional drainage?

3 A. Yes.

4 Q. Is that a touchpoint between you and your PA about
5 what's going on?

6 A. Yes. We're there together and discussing it
7 together.

8 Q. And -- and you're responsible for your PA?

9 A. Yes, I am.

10 Q. And so were you comfortable with the plan that was
11 developed by Ms. Buck based on the presenting symptoms?

12 A. Yes, it is common when we see people with any
13 postoperative drainage, even if we think it's normal
14 postoperative drainage there is an indication that there is
15 some degree of communication with the skin and so
16 prophylactically we will place patients on an antibiotic to
17 hopefully help prevent an infection.

18 Q. And prophylactic is like preventive maintenance?

19 A. Correct.

20 Q. So at this point, the Bactrim was started, was
21 there anything else that you observed in -- well, I think
22 this is one where she complains of some pain.

23 A. Yes.

24 Q. Six out of 10. So what is your thought process
25 regarding pain complaints plus this drainage?

1 A. Sure. So she was -- had rated her pain level at
2 six out of 10 that day with some return of left buttock and
3 lateral thigh pain, but reports had continued to be
4 significantly improved compared to what she was before
5 surgery. And so, again, as patients are recovering, it's
6 common to have waxing waning of pain syndrome, a pain
7 symptom, and the fact that this was much better than what she
8 started what was -- was not too concerning.

9 Q. Why did you start ordering labs or blood work or
10 whatever else at this point in time?

11 A. At this point in time, again, she didn't have any
12 indications of infection. She as -- as Ann went through in
13 her note, no fevers, chills, nausea, no constitutional
14 symptoms. The area around her incision looked good. It was
15 normal erythema of a healing wound, only one millimeter very
16 small, that's normal. Nothing was able to be expressed from
17 the incision. It wasn't red, it wasn't underrated and it was
18 non-tender to palpation. So at that point in time she was
19 not behaving as if she was infected.

20 Q. Well, at this point in time on the 23rd, did --
21 she did have drainage there, right? She did have pain.

22 A. Correct.

23 Q. Why not just start ordering labs or blood work?

24 A. Again at this point in time, I -- I -- I didn't
25 think it was indicated. I think you could question the value

1 you would get from those labs for several reasons. She had
2 just had surgery, so inflammatory markers are going to be
3 naturally elevated. She's a rheumatoid patient who are now
4 is off her medication so they're going to be likely
5 unnaturally elevated. And most importantly, at this point in
6 time, she was not behaving as she had an infection. And I
7 wouldn't order labs in this situation.

8 Q. If you were concerned enough to think about labs,
9 what would your reaction be in terms of next steps?

10 A. Yeah, if I'm at a point where I'm concerned that
11 someone has an infection where I'm going to order labs, I'm
12 going to take that patient to the hospital, we're not going
13 to order labs and just fall, I'm going to admit them to the
14 hospital, we're going to get labs, we're going to get blood
15 cultures, we're going to get the internal medicine doctors
16 involved to look at all kinds of things.

17 We'll get the infectious disease and doctor involved.
18 We're worried about infection. So if someone gets to the
19 point where I'm concerned for infection, I'm going to
20 recommend they go to the hospital and be evaluated. I -- I
21 wouldn't just get labs.

22 Q. Let's move to the next visit on the 30th. Patient
23 had come back and at this point she had taken the Bactrim for
24 a couple days and then stopped and then was prescribed a new
25 medicine. Do you remember that part?

1 A. I do.

2 Q. Was that in terms of following the patient, how --
3 how would you describe that?

4 A. So at our last visit on the 23rd, the plan was to
5 come back in a week, you know, somebody even though we think
6 this is fairly normal and routine drainage that we see we --
7 we certainly want to continue to follow them closely. So
8 there's a change where we're on top of it and we act -- we
9 can react appropriately. And so we asked her to come back in
10 a week and this was her one week follow-up visit from that.

11 Q. All right. Let me stop you there. So we're
12 looking at Defendant's Exhibit 22, which is on this counter
13 date of page 30. And we see zero out of 10 on her pain
14 scale. What -- in terms of, you know, evaluating where this
15 patient is on her progression what -- what does that
16 indicate, if any?

17 A. Oh, it's -- it's a good sign. It's says that she
18 doesn't have any pain, at least that day and at that moment
19 in time.

20 Q. Okay. So looking at the trend, how's the trend
21 looking since the last week?

22 A. It's -- it's looking good. It's looking like
23 she's improving from, I think it was six out of 10 the week
24 before now to zero out of 10. So that's -- that's a good
25 sign.

1 Q. Now, I want to pause here at 8/30 because I wrote
2 a flip chart that day with Dr. Davne because he -- he opined
3 that that was the day that the patient should been taken back
4 to surgery. So, doctor, why didn't you take Ms. McGougan
5 back to surgery on August the 30th?

6 A. Because there was no indication to do that.

7 Q. In terms of balancing the risk and benefits, was
8 -- what's the downside?

9 A. Sure. So we started to touch on that earlier,
10 obviously to take someone to the operating room. There's
11 risk associated with that. There's risk just of anesthesia,
12 heart attack, death, respiratory insufficiency.

13 In regards to the spine, certainly you never just
14 randomly take someone and cut them open. If you're going to
15 do that, you're going to be working around the nerves, the
16 bone, you could injure a nerve you could cause someone to be
17 weak and lose function of their legs. Suppose they don't
18 have an infection, you do the surgery and now they have an
19 infection. How do you explain that? So the decision to go
20 to surgery is -- is -- is a very serious one. And certainly
21 at this point in time there was no indication to do that.

22 Q. So I want to ask you on this point in time, on the
23 -- the 30th, she is reporting zero out of 10 pain. The
24 previous visit there had been six out of 10 pain and an MRI,
25 you know, was discussed.

1 A. Correct.

2 Q. Why isn't there an MRI recommendation discussion
3 here?

4 A. Well, I think she's improving pain-wise. Again,
5 her drainage is minimal and -- and typical for what we see at
6 this point in time. At her last visit, she had not wanted to
7 get the MRI. And so I -- I think at this point to continue
8 to observe is reasonable.

9 Q. All right. So why aren't you calling infectious
10 disease at this point?

11 A. There's no reason to call infectious disease at
12 this point. This is a normal postoperative wound that we
13 treat day in day out.

14 Q. If you get to a point where you think that an
15 infectious disease specialist is needed, what would your next
16 step be?

17 A. If I felt an infectious disease doctor was needed,
18 I would be admitting the patient to the hospital again to get
19 appropriate labs appropriate workout workup. And it would
20 likely also involve a -- a return trip to the OR to do a
21 appropriate culture.

22 Q. Then the labs in the -- what's the difference
23 between getting labs in the hospital and labs at Labcorp or
24 some other place?

25 A. The labs in the hospital, you get immediate

1 turnaround. You have a patient there where you can monitor
2 them. If you're -- if you were to send labs out to Labcorp,
3 you'd get those back in -- in a few days or however long it
4 would take, but again, if I thought someone was at a point
5 where they needed labs because I was confirmed concerned for
6 infection, I would be putting them in the hospital.

7 Q. Was there any need to put Ms. McGougan in the
8 hospital at this point in time on August the 30th?

9 A. At this point in time, I do not believe so.

10 Q. There's a short note on Exhibit 23, which was
11 September 1st, essentially showed up in essentially the same
12 condition. Does that give you any concern?

13 A. Well, I think, the way that we -- we structure our
14 practice is that if anybody calls with any the slightest
15 concern, we want them to come in. And if Ms. McGougan was
16 having concerns more drainage, we wanted to get her in. Now,
17 on the 23rd, she had been started on -- on Bactrim if you
18 heard. And -- and -- and had some difficulty with that. And
19 so that had been stopped before its full course.

20 On the 30th, we started her on a new course of
21 doxycycline again for prophylaxis. By this time she would've
22 only taken it two days. And so her incision looked similar.
23 Her exam was similar and so the plan was to continue to watch
24 her and see how -- how she did now taking the doxycycline.

25 Q. All right. Was there any need to -- based on her

1 condition on this 1st of September back into the operating
2 room that day?

3 A. Not in my opinion.

4 Q. Okay. So looking -- we've got another visit on
5 September 8th, which is Exhibit 24. And again, she's rated
6 pain zero. What is your impression of her condition on this
7 continuum? We've been talking about her recovery process
8 based on how she's presenting on September 8, 2016.

9 A. Appears to be going well again, she's having no
10 pain. At least she reports that day. She completed her
11 antibiotics, her incisions continue to appear to be doing
12 well.

13 Q. I don't -- I want to touch base on a couple of
14 things that are in a lot of these notes that I don't want to
15 go through from each one where it says, she's been walking to
16 tolerance. What -- what's the significance of any of that?

17 A. This means that she can ambulate independently to
18 a reasonable amount, you know, her strength is -- is better
19 and improved. And -- and she's doing what she can.

20 Q. Okay. In terms of recovery, is that a good sign?

21 A. Yes.

22 Q. Now, where it says strength is five out of five,
23 can you explain to the jury what that means and how it's
24 measured?

25 A. Sure. Again -- so when we talk about strength

1 exam in the lower extremities, there's really five muscles
2 that we examine. It's your hip flexor, your iliopsoas, your
3 quadricep, where you extend your knee out. Dorsiflexion
4 brings your foot up, plantar flexion, which brings your foot
5 down. We rate that on a scale of zero to five, with five
6 being full strength, zero being nothing, and everything else
7 in between.

8 So again, primary goal of surgery here. Initially the
9 primary concern was that she had weakness and loss of
10 function in her leg. And so the fact that she's maintained
11 full strength is -- is a very positive sign.

12 Q. And why is that being tracked over these physical
13 examinations?

14 A. Well, there's several reasons. One, it's routine.
15 We we're always checking people's strength. Two here,
16 obviously she had a deficit and so she went -- and she
17 improved and we want to see that she continues to improve.
18 In theory, if you're worried about infection -- infections if
19 there deep compress on nerves and cause weakness. So if she
20 was suddenly having an increase in weakness that would
21 trigger some concerns or some things to look into.

22 Q. All right. Here it says her incision appears to
23 be closing up?

24 A. Yes.

25 Q. And -- and is that again, a sign of what appears

1 to be improvement?

2 A. Yes.

3 Q. All right. So we've heard a Number of witnesses
4 or both of those witnesses talk about the pressing on the
5 wound and sort the physical part of that physical
6 examination. What's the purpose of that?

7 A. That's to examine the wound. If a wound has any
8 swelling, it could be a Number of things. It could be a sign
9 of infection, it could be a sign of bleeding, it could be a
10 sign of CSF leak, which is the -- the fluid around the nerves
11 where we work, if you have a leakage and so you're pressing
12 it to see if there's anything there. If it's fluctuance
13 meaning sort of buoyant something raised, you're concerned
14 that that's the case. If it's flat and normal healing
15 tissue, then you're not worried about something building up
16 there.

17 Q. Well, we know the patient was ultimately diagnosed
18 with a deep soft-tissue infection?

19 A. Yes.

20 Q. So what does pressing on the skin right here do
21 for that?

22 A. For that's not going to find a deep infection.
23 No.

24 Q. So when you're pressing on the back -- let me just
25 actually back up. We talked about these deep infections.

1 Can you give a sense of what the -- the depth that we're
2 talking about here?

3 A. Sure. So yeah, we hear that's a good point. You
4 keep hearing deep. How deep is deep? So probably from the
5 surface of your skin to your spine, it's different on
6 everybody. Some -- some skinny people, it's -- you're
7 talking about this much difference. Okay. From maybe more
8 average, it's about here. So I'd say maybe about three,
9 three and a half inches from the skin down to the level of
10 the spine.

11 Q. All right. So we saw from the physical
12 examinations that at no point in time was there palpate, they
13 weren't palpating anything?

14 A. No.

15 Q. What significance, if any, is there for you when
16 you realize they have these benign physical examinations?

17 A. That's -- that's usually a good sign.

18 Q. All right. So this day, what is your impression
19 in terms of her trend in the direction in which her recovery
20 is given?

21 A. So at that point in time, again, she's reporting,
22 she's having no pain. Her strength is completely returned.
23 She's walking to tolerance and -- and -- and -- and doing
24 well. So she's trending in a -- in a good direction from all
25 the data we have available to us then.

1 Q. All right. Did you see anything in the -- the
2 notes or description of her complaints that would suggest
3 that now is the time that she needed surgery?

4 A. No.

5 Q. All right. In the bottom there it mentions we'll
6 see her -- we'll follow-up with her at one to two weeks at
7 her originally planned six week post-op visit? Tell us what
8 that means.

9 A. That we would follow-up with her in -- in one to
10 two weeks. We say originally planned six stop post week --
11 six week post-op visit. Typically, the initial regimen we
12 set up for patients after surgery is we'll see them two
13 weeks, six weeks, three months, six months, and a year.
14 Obviously if there's anything, any issues or concerns, we see
15 them in between, but she was saying that would be just a
16 regularly scheduled six week postoperative visit.

17 Q. And true to two weeks she was back basically 14
18 days later, right?

19 A. Roughly.

20 Q. Roughly. I mean was she back on the 20th?

21 A. 20th, yes.

22 Q. Little less than two weeks. All right. So let's
23 shift gears and -- and explain to the jury if you could, the
24 significant -- what significant, if any, differences there
25 were on the -- on the 20th, which is Defense's Exhibit 30.

1 A. Uh-huh.

2 Q. That visit there.

3 A. So the -- so the big issues were that now she was
4 reporting that she had been having fevers at home and that
5 she's been having increase in pain.

6 Q. All right. So tell us about your -- your thought
7 process from your visit here with her?

8 A. All right. So we had been monitoring her. We had
9 obviously been watching her incision. Things seemed to be
10 going well, but since the last time we had seen her she had
11 had a change. Now she was having more pain, she was having
12 fevers and at that point it -- it was -- it was my
13 recommendation to go to the hospital and -- and -- and take a
14 closer look at things.

15 Q. All right. Now, doctor, this encounter date says
16 9/20/2016, but if we look at the date of electronic signature
17 at the bottom, what date is down there?

18 A. I can't see that on my end.

19 Q. Let's go.

20 A. That's 10/17/2016.

21 Q. So little over three weeks, almost four weeks?

22 A. Correct.

23 Q. Did you go back after the fact and paper the file?

24 A. And paper the file?

25 Q. I mean, were you doing this after the fact?

1 A. Doing the -- I'm not sure I understand.

2 Q. Notes -- notes.

3 A. Did I do the notes after I seen her?

4 Q. No. Let me -- let me back up. We just heard some
5 cross-examination about --

6 A. Uh-huh.

7 Q. -- the dates of the electronic signatures.

8 A. Correct.

9 Q. And that they weren't on the same date of the
10 treatment.

11 A. Correct.

12 Q. Your treatment date is 9/20. Your electronic
13 signature says 10/17. Explain why that is to the jury?

14 A. Sure. So -- so we dictate a note, we see the
15 patient me, the way I do it, I transcribe it, we have a
16 transcription. The student then dictates it and it -- and it
17 goes on the records, you know, day or two. If it's over the
18 weekend, maybe three days. And then at some point I have to
19 sign it. And oftentimes these records don't get signed for
20 several weeks. That's just what happens.

21 Q. How do you sign them? Have you -- have you
22 electronically signed?

23 A. If they're in a computer and you literally, you
24 have a huge list of notes because we're constantly dictating
25 and you just go through and hit a button that says sign --

1 sign. So it electronically signs it.

2 Q. What was happening on 10/17/2016? Do you
3 remember?

4 A. It's my mother's birthday. I know that.

5 Q. (Inaudible) celebrating that. Anything else going
6 on?

7 A. Nothing else that jumps to mind.

8 Q. All right. Let me -- by that point in time she
9 had the IND?

10 A. Yes.

11 Q. And she'd come back for a follow-up visit on
12 October 11th?

13 A. That sounds right.

14 Q. Yeah. And I'll pull that up. That's Exhibit 57.

15 A. Okay.

16 Q. Do you see the date of that?

17 A. I do.

18 Q. And this would've been after the surgery, when you
19 cleaned out the wound. This would've been a follow-up?

20 A. Correct.

21 Q. And how was she looking at that day?

22 A. Things were looking good for that point.

23 Q. So is there anything negative going on that would
24 somehow suggest that you were worried about the state of the
25 records and electronically signing it in October of --

1 instead of in September?

2 A. No.

3 Q. All right. Let's talk about, she's back in the
4 hospital now on 9/20, she had a readmission. I'd like you to
5 look at Exhibit 27, please -- excuse me it's 28. I'm sorry.

6 A. Uh-huh.

7 Q. All right. We looked at this same screening tool
8 earlier for your surgery?

9 A. Yes.

10 Q. And in terms of the screening tool you used at
11 this hospital, there's now a yes box circle. What is that a
12 yes box?

13 A. It's to attain a nasal swab for MRSA.

14 Q. And why is it?

15 A. For readmission in the past year.

16 Q. So explain to us what is the significant amount of
17 that.

18 A. So what they're -- so this is -- so a patient
19 comes into the hospital one of the things you assess, are
20 they at risk for MRSA where you would do a nasal swab to find
21 out if they have MRSA there. You can see that they have a
22 list of criteria here as was there before her first
23 submission. Whereas before she was not considered a
24 candidate for that. Now because she has been in the hospital
25 within the last year, she is considered a candidate for nasal

1 swab for MRSA.

2 Q. All right. So let's look at Exhibit Number 26 and
3 27. While they're pulling those up, did she eventually test
4 positive for MRSA on that screening test?

5 A. She did.

6 Q. Did that help inform you and the team on future
7 treatment for her?

8 A. Yes.

9 Q. All right. We'll explain -- we'll talk about that
10 in a second. All right. I just want to look at 26 and 27.
11 Can you tell us what these are?

12 A. So those are -- it's a CRP and a magnesium. Those
13 are blood levels of those quantities.

14 Q. All right. And so at this point you are -- you're
15 looking at what? What do we call these?

16 A. These are inflame -- well, this -- CRP is an
17 inflammatory marker.

18 Q. All right. We've been talking about labs. Is
19 this one of those labs?

20 A. That is.

21 Q. So the next Exhibit Number 27. Look at that one.
22 And what are these?

23 A. That's a CBC, Complete Blood Count. The most
24 relevant one to hear is -- is the white blood cell count.

25 Q. All right. So we were previously talking about if

1 you felt like labs were needed, you'd go to the hospital,
2 tell us is that what we're looking at here?

3 A. Yes.

4 Q. All right. So we're in the hospital, we got the
5 blood work done. What -- what else is -- is happening in
6 order to make, provide data points on what to do here?

7 A. We're getting an MRI scan.

8 Q. And?

9 A. And consulting infectious disease.

10 Q. All right. So Number -- Exhibit Number 29. Not
11 sure we've looked at this yet. This is the MRI. And if we
12 could go down to the impression of Exhibit 29, please. I
13 think that might be on the second page. Without reading the
14 impression, I'd like for you to explain to the jury what was
15 significant about the MRI to help give you a piece of
16 information on whether to go to surgery or not.

17 A. So there was found to be some fluid in the -- in
18 the wound above the prior laminectomy site and a differential
19 diagnosis of potentially being an abscess, potentially just
20 being seroma, which is a collection of blood.

21 Q. So what's that suggesting to you?

22 A. So that's suggesting that she may have a infection
23 in the -- the soft-tissues of her spine.

24 Q. Does it appear that it is involving any bone or
25 disc at this point based on this report?

1 A. No, it is not.

2 Q. So let's look at Exhibit Number 33 if we could.

3 And I'm not going to ask you to read that. I'm just going to
4 ask you what it is that we're looking at. You can blow up
5 the top notes, please.

6 A. Sure. It looks like a note from Dr. West and
7 infectious disease doctor.

8 Q. So why was he involved?

9 A. Any -- anytime we have concern for infection, we
10 get the infectious disease specialist involved.

11 Q. So here we are in September, patient comes back
12 with a fever and increased pain. And you take her to the
13 hospital, right?

14 A. Correct.

15 Q. Had the labs?

16 A. Correct.

17 Q. Infectious disease?

18 A. Correct.

19 Q. You got the MRI?

20 A. Yes.

21 Q. What does that picture suggest that you need to
22 do?

23 A. So at that point in time, it appeared she had some
24 fluid in her spine. She was having increased pain. It was
25 potential that this was an infection. So at that point in

1 time, my recommendation would be to take her back to the
2 operating room and under sterile conditions, under magnify
3 visualization, open her incision up, inspect her surgical
4 site and take cultures under sterile condition to assess if
5 she had an infection.

6 Q. And did you have a discussion with Dr. West about
7 when you would culture her and administer medications and
8 things like that?

9 A. Yes.

10 Q. Let's look at Exhibit Number 39, if you could,
11 please. And you can just blow up the description of the
12 procedure. What is this that we're looking at?

13 A. This is the operative note from the incision and
14 drainage surgery.

15 Q. All right. So tell us what happened in this
16 surgery. Could you rather than read that, can you describe
17 for us where the incision and -- and drainage is?

18 A. Sure. So essentially you're opening the area
19 where you did the prior surgery. So before as -- as we
20 discussed, you dissect down to the bone, you remove the bone
21 and then remove the disc. Here you're not doing that part of
22 it, but you're exposing everything that you had done.

23 So you make an incision, you usually make it a little
24 larger than the last incision. So you have room to push all
25 the tissues away. You expose the previous lamina of the

1 bone, you expose the nerves so you can see if where the
2 infectious material is, whenever you see it, you culture it,
3 but they kind of the culture apparatus are sort of like long
4 -- sorry, things just stick in your ears. I can't think for
5 (inaudible), but anyway, but they're long --

6 Q. Q-tip?

7 A. Q-tip, thank you. And you -- you put that and
8 take that out. And then you put that in a culture medium and
9 you do it four or five, six times. And then you send that to
10 the lab so they can grow it and see what it is. Then after
11 you've done that, then you irrigate the wound, you clean it
12 out, you remove what all, any infectious material that's
13 there. You see any -- any bone or any muscle or any skin
14 that you're concerned is infected, you -- you debride that
15 meaning you remove it.

16 Q. What's that?

17 A. Debride it, meaning you remove it.

18 Q. How do you remove it?

19 A. Variety of ways. You can cut it out with a
20 scalpel. You can use something called Bovie cauterization,
21 which is a heated probe that we use to cut tissue that
22 cauterizes it so it doesn't bleed. You can pick it out with
23 large jeweller tool that you can pull with. And then you --
24 you irrigate it, you clean it out to make sure there's
25 nothing grossly left behind.

1 Q. All right. So --

2 A. And then put a drain and close it up.

3 Q. We're going to ask about the drain in a second.

4 So you can look at this picture Exhibit 20. And how -- I
5 just want to understand how you can see all that inside that
6 what -- this hole where this incision right here?

7 A. I am not sure I understand the question.

8 Q. So when you did the -- the IND surgery procedure.

9 A. Uh-huh.

10 Q. How -- how large was the incision that you made?

11 A. So that -- that incision there, her initial
12 postoperative incision is we do that surgery maybe about an
13 inch, an inch and a half incision. Probably we open it up a
14 little bit more, I -- I can't say maybe another half inch or
15 an inch more. And then we, you know, re-disect down to the
16 spine so.

17 Q. All right. So --

18 A. And we're doing it under again, either usually
19 under a microscope or we wear loops that are very magnified
20 so we can see very well.

21 Q. So how did you look in that hole and see anything?
22 Is there -- is there tissue and everything in there?

23 A. Well, you're dissecting it away. So you're --
24 you're opening the area up to where -- to get to the level
25 where the surgery is. So you're basically pulling on the --

1 the muscle and moving it over to look at everything and --
2 and you have retractors in there that keep it open.

3 Q. And so, all that has to be with you?

4 A. It does.

5 Q. Is that one of the reasons why you need to be
6 judicious in deciding when to go back to surgery?

7 MR. LUGINBILL: Objection. Leading.

8 THE COURT: Sustained, leading.

9 BY MR. HOOD:

10 Q. That recovery process, how, if at all, does that
11 affect your medical judgment in deciding when is appropriate
12 to get surgery?

13 A. Right. So as we talked about before, there's --
14 there is always significant risk to take someone back to
15 surgery. A revision surgery, a second surgery is -- is -- is
16 always more risky than a first surgery because you're working
17 through tissue that's been already operated on. And so, yes,
18 one of the issues that can be concerning is that if you're
19 going through a same set of tissue, which has already been
20 trying to heal and you disrupt that healing process to -- to
21 do what you need to do, it becomes harder for that tissue to
22 heal a second time.

23 Q. Right. You mentioned a drain, what was that all
24 about?

25 A. A drain usually we put in after an IND just to

1 allow excess fluid and blood and if anything that's in there
2 to drain out.

3 Q. Okay.

4 A. It also helps to decrease dead space to allow the
5 tissues to heal together to prevent any open areas for -- for
6 something else to grow.

7 Q. Have you heard about the medications that were
8 antibiotics that were given? Can you speak to those briefly?

9 A. Postoperatively?

10 Q. Yes, sir.

11 A. Yes. So she had a -- depending on -- so roughly
12 five days of IV vancomycin followed by two weeks of oral
13 minocycline.

14 Q. And how -- how was that decision reached?

15 A. So Dr. West and myself spoke and after looking at
16 the data from the -- the cultures that showed that the Staph
17 aureus was susceptible to minocycline, he felt that was a --
18 an appropriate course for her. And I thought that was
19 reasonable based on his recommendations and the findings from
20 the cultures.

21 Q. Was there anything about that recommendation, that
22 prescription that gave you pause or concern in terms of the
23 effectiveness or likely effectiveness for Ms. McGougan?

24 A. There was not. It was -- so it was consistent
25 with postoperative antibiotic regimens I've seen recommended

1 before for soft-tissue infections.

2 Q. Let me stop you right there.

3 A. Yes.

4 Q. You said soft-tissue infection?

5 A. Correct.

6 Q. When you're saying soft-tissue infection, explain
7 to us what you mean by that?

8 A. So we -- we deal with infections in the spine.
9 There's -- there's a variety of different infections in -- in
10 locations that can happen. And how they're thought of in
11 terms of treatment antibiotic wise is -- is very different.
12 So as a spine surgeon very often we are using screws and rod
13 instruments to fuse people's spines.

14 If those patients get a postoperative infection.
15 There's very clear indications to be placed on IV
16 antibiotics, typically for six to eight weeks at the
17 discretion of the infectious disease doctors because we know
18 that those bacteria can linger, they can stay stick on the
19 hardware and -- and form films that can take a long way to
20 treat patients who -- who develop osteomyelitis for whatever
21 reason, whether it's seeded from somewhere else, whether it's
22 a postoperative complication and that situation, it's usually
23 recommended to be on IV antibiotics because it takes longer
24 time to -- to heal that. Someone has a discitis infection in
25 the disc it -- it's similar for that as well.

1 Soft-tissue infections implies that they're not
2 involving the bone, they're not involving the disc, there is
3 no hardware in place. And so the antibiotic recommendations
4 for there are -- are less stringent. And commonly -- well
5 I'm not an infectious disease expert, I've seen
6 recommendations for treatment with those -- with IV
7 antibiotics until a organism is known from the culture
8 followed by PO antibiotics.

9 Q. And then in terms of the physician Dr. West, were
10 you familiar with them?

11 A. Yes. And -- and that's the other component here.
12 And -- and I realized you guys haven't -- haven't met
13 Dr. West yet. And you might have heard in his opening
14 statement he's, you know, he's somewhat of -- of a godfather
15 of -- of infectious disease in this area. He is done some
16 amazing things, have been around for a long time, and is one
17 of the sharpest physicians I've ever met.

18 He's worked with our practice for many years before I
19 was a part of it. Has always done a great job taking care of
20 our patients and any interaction that I've had him with my
21 patients, he's -- he's always given solid medical advice, so.

22 Q. All right. So on that point.

23 A. Yeah.

24 Q. How did that impact your thought process, if at
25 all, about the regimen?

1 A. I -- I thought it was -- so as an orthopedic spine
2 surgeon, you know, I -- I know my limitations. I -- I'm an
3 orthopedic spine surgeon. I'm not an infectious disease
4 doctor. I have an understanding of the general thoughts as I
5 just went over about antibiotic treatment, but when it comes
6 to the actual decision, I -- I need -- I -- I rely -- it's --
7 it would be irresponsible for me to not have an infectious
8 disease doctor involved. And when especially when you have
9 one is with a track record like Dr. West, it's -- you're
10 obviously going to follow his recommendations.

11 Q. Now, let's move on. So the patient goes out
12 discharge, right?

13 A. Correct.

14 Q. When she come back October 11th, we've already
15 looked at that note?

16 A. Yes.

17 Q. And now things seem to be back on course?

18 A. Yes.

19 Q. We talked about the next visit which was November
20 the 28th. And we talked about that today with Ms. Buck?

21 A. Yes.

22 Q. Ms. Buck?

23 A. Yes.

24 Q. All right. (Inaudible). On the 28th we saw the
25 discussion about MRI again, where there was pain?

1 A. Correct.

2 Q. Why is the MRI being considered that far away from
3 the infectious disease -- or excuse me, the IND process
4 surgery in September?

5 A. Because Ms. McGougan was having increased pain and
6 with the history -- with her history in particular we would
7 like to get an MRI and see how things look.

8 Q. All right. I want to talk about that interim time
9 period there. Because there have been questions about
10 ordering blood work and labs.

11 A. Uh-huh.

12 Q. During that period of time. And so I'd like to
13 ask you why wasn't that done?

14 A. It is not our standard process to order labs after
15 PO antibiotics in that nature. It's not what we routinely
16 do.

17 Q. But what was the plan of care after the September
18 procedure?

19 A. So the plan of care was for her to continue to
20 follow-up at least with us clinically.

21 Q. And in that clinical setting, what would you be
22 looking at in terms of the patient's recovery?

23 A. So many of the similar things that we've talked
24 about in these other notes. Strength, pain, incision, is
25 there drainage, erythema, swelling, fevers, chills, nausea,

1 those things.

2 Q. Well, we saw the records earlier this week that in
3 January time frame after Ms. McGougan left the hospital that
4 -- that she was visiting with infectious disease consultants
5 in Myrtle Beach?

6 A. Correct.

7 Q. Why -- why were arrangements like that made during
8 this time period September and October?

9 A. At that point she had a -- a different problem.
10 At that point she had developed an osteomyelitis and a
11 discitis that was being treated with IV antibiotics and at
12 that point they -- they recommend labs involved.

13 Q. So would the soft-tissue abscess and then incision
14 and drainage to treat it, is it (inaudible) --

15 A. We --

16 Q. -- for you to do that blood work?

17 A. For our practice, no, we do not. We routinely
18 follow them clinically.

19 Q. All right. And if you felt like that was
20 necessary, what would you do?

21 A. I would admit them to the hospital. If I -- if
22 they were to a point where I was concerned that something was
23 happening, I would admit them to the hospital get labs,
24 likely get imaging, likely get infectious disease involved.

25 Q. All right. I'd like to jump to December the 16th.

1 There had been an MRI performed. And I look at that MRI
2 report for the 13th -- excuse me, the 16th is Exhibit 63. Do
3 you recall reviewing that?

4 A. I do.

5 Q. MRI. And then that same day, the 16th, you had a
6 -- a visit with the McGougans?

7 A. Yes.

8 Q. All right. Tell me about that -- that visit if
9 you would, and I can -- well first tell us what's significant
10 about exhibit, if anything, about Exhibit 63 in terms of her
11 condition at that point in time and response?

12 A. So she had been having increased pain, and so we
13 -- we were -- were able to get an MRI this time and I can
14 read it to you if you want, but the take home message from it
15 is -- is essentially it showed some granulation tissue in the
16 area where she had her prior surgery, which is -- is fairly
17 normal. No enhancement in the disc, meaning there was no
18 concern for infection in the disc or based on the -- this
19 image, but in some enhancement in the adjacent vertebrae,
20 these inflammatory changes are quite possibly standard
21 postoperative.

22 Q. All right. Thought you were giving a takeaway.
23 What's -- what's the standby there?

24 A. I'm sorry. So the -- the takeaway from this is
25 there's no obvious infection, but there's some things there

1 that with -- with her pain had me concerned.

2 Q. All right. Let's look at Exhibit Number 64. We
3 could -- this is -- we haven't seen this one yet. All right.
4 Let's look at the encounter date.

5 A. Yes.

6 Q. And then we're going to look at electronically-
7 signed date?

8 A. Yes.

9 Q. All right. This was December 16, 2016?

10 A. Yes.

11 Q. Correct?

12 A. Correct.

13 Q. All right. This -- what date was this document
14 electronically signed?

15 A. It was electronically signed at December 26th.

16 Q. Doctor, did you go back and put the books on this
17 record?

18 A. I did not.

19 Q. Let's talk about what's in this record under
20 treatment plan. And I really want to focus in, you told us
21 about the radiography and then the second paragraph there, it
22 says, we had extensive discussion about our options here. So
23 walk us through that conversation based on your recollection
24 of the interaction that you had with the McGougan's.

25 A. Sure. So -- so I think the big picture here is

1 that Ms. McGougan was having very significant pain at this
2 point. And -- and I was concerned. I wasn't at this point
3 sure why she was having that pain, but I -- my thought
4 process was, you know, we know she has a history of
5 infection. She's now back on her immunosuppressant
6 medications and she's having severe pain.

7 The MRI, while it didn't show obvious infection with
8 some of the edema in -- in the bone, I was -- at that point
9 in time, I -- I really wanted to get her into the hospital to
10 do a full look at workup and -- and try to figure out what
11 was going on and what we could do to try to affect to
12 hopefully correct the problem.

13 Q. All right. And then if you could speak to the
14 conversation about Christmas and coming in on Monday versus
15 Friday?

16 A. Sure. And so, you know, I -- I wanted her to go
17 to the hospital on Friday. They did not want to go on -- on
18 Friday, which I -- I get it. With everything she'd been
19 through at this point, I personally would -- I'd be just sick
20 of the thought of going back to the hospital. At that point
21 in time, she was neurologically intact, meaning she had full
22 strength.

23 What that -- what that means to us as spine surgeons at
24 times where we say something is urgent, something is
25 emergent, something is emergent where people are losing

1 function when they're losing control of their strength, their
2 legs, nerves. That's -- that wasn't the case here. She had
3 pain. As you can see she's a very reasonable individual. I
4 didn't feel like I was going to lose her to just not come
5 back.

6 And so we said all right you're not going to go in the
7 hospital, but let's talk Monday. If things aren't getting
8 better because she thought she possibly could control her
9 pain with the medications, then I'm going to want you to come
10 back in. That's going to be my -- what I'm going to ask you
11 to do. And then we've made a plan that if things got worse
12 over the weekend that she would call and come in or go to an
13 emergency room closer to her.

14 And so, that was -- that was a conversation I was
15 concerned. I understood her reluctance to want to come into
16 the hospital and we agreed to stay in close touch and I -- I
17 thought that was about as reasonable as we could be.

18 Q. All right. And just above that high big highlight
19 there, there's a section that starts with again, it says
20 "Again, however, I expressed my concern about her being more
21 immunosuppressive medication with a history of infection and
22 we cannot obtain a relief that I'm likely going to insist
23 that she proceeds with this workload." What is this
24 immunosuppression -- suppressive medication and what impact
25 does that have on your thought process here?

1 A. So she had a -- a history of infection that had
2 been washed out. She had been on antibiotics, she had been
3 off her immunosuppressant medication throughout the bulk of
4 that time, at -- at this point she had just started retaking
5 that medication a few weeks earlier. So now I know she's
6 back into an immunosuppressed state, which she had been
7 basically out of. You could argue that a little bit as she's
8 a little bit immunosuppressed, but it's the medications that
9 really cause the immunosuppression and -- and now she's back
10 on those, she's having pain and it's just got to be something
11 you're thinking about.

12 Q. All right. So we heard about the phone call on
13 Saturday to -- to somebody. And then again, Monday comes and
14 what happens when Monday comes?

15 A. I called her, we spoke and she was having pain and
16 -- and I asked her to come in.

17 Q. When you say, "Come in" what does that mean?

18 A. Come into the hospital. Come into East Cooper
19 Hospital, which is the hospital where we admit patients and
20 operate.

21 Q. And she did that?

22 A. She did.

23 Q. At that point in time, was there a surgical
24 solution like there was in September?

25 A. No, very fortunately at this point in time she did

1 not need surgery.

2 Q. So what was the treatment there?

3 A. The treatment here now is -- is antibiotics.

4 Q. And then she stayed in through the holidays?

5 A. She did, she stayed in past the New Year.

6 Q. And were you seeing her during that period of
7 time?

8 A. I was.

9 Q. So tell me how the -- that process works for
10 physicians or your PAs?

11 A. It -- it all depends we either both see them, one
12 -- one of us sees them -- the other one sees them sort of in
13 the clinic we talk about them. So, you know, it's -- it sort
14 of depends on the day and -- and the -- and the -- the issue.

15 Q. So who draws a straw for holidays, Christmas, and
16 New Year's (inaudible)?

17 A. Usually, around the holidays we the doctors will
18 -- will round and allow the PAs to be off most of the time.

19 Q. Did you see Ms. McGougan over Christmas?

20 A. I -- I --

21 Q. If you don't remember, that's fine.

22 A. If I saw it I -- it is possible.

23 Q. I got you.

24 A. Likely.

25 Q. I want to go to the next time, the next office

1 visit. So before I do that, I just close this chapter. In
2 terms of this hospitalization, I think they mentioned
3 discharge around early January?

4 A. Yes.

5 Q. The surveillance after that would've been with
6 whom?

7 A. Both our practice and Lowcountry Infectious
8 Diseases.

9 Q. Okay. Tell us about your practices surveillance
10 after that?

11 A. So our practice surveillance after that is -- is
12 essentially clinically. Again, how are you doing? How's
13 your pain? How's your strength? How's your function? Any
14 signs of the infection concerning for any signs of the
15 incision concerning for infection and reacting accordingly.

16 Q. All right. So we saw -- we heard about the visit
17 in -- in March. We just heard about that before lunch, and
18 then she came back again August of 2017 for the one year
19 visit?

20 A. Yes.

21 Q. Did you have a chance to see Ms. McGougan back in
22 the office after she was discharged from the hospital?

23 A. I did see her, I think it was back in January.
24 I'd have to see the notes. And then when she came back, I --
25 I don't recall what those dates if I saw her -- I would need

1 to see the notes.

2 Q. Got you. So we had the last visit that we heard
3 about at lunch -- before lunch was 8/11/2017 sort of one year
4 marker?

5 A. Yes.

6 Q. Has she been back treated since then?

7 A. I don't believe so.

8 Q. All right. So we walked through that entire time
9 line, sort of the pre-op surgery, the abscess and -- and
10 addressing that, and then the -- the second hospitalization
11 -- or the third hospitalization. My question is, how do you
12 go from having someone who's this active, picking up a loaf
13 of bread, having a disc surgery and ending up with a accused
14 (inaudible), how does that -- how does that even happen
15 today?

16 A. In this particular case?

17 Q. Yeah.

18 A. So unfortunately disc herniations can happen with
19 very minimal trauma. I always say that probably 99 percent
20 of the people that come into my office with a disc
21 herniation, they say, I -- I don't know what happened. I
22 just woke up, I rolled over and -- and boom, there it was.
23 And I think it's probably because of it's a function of
24 something that's slowly, gradually progressing in some minor
25 event, pushes it over the edge, but here that happened.

1 We -- we went through that and -- and why we did the
2 surgery and unfortunately the infection that -- that happened
3 afterwards, her infection got in her bone and in her disc.
4 And when that happens, that can weaken those structures.
5 When those structures are weakened over time, the bones can
6 settle down on top of each other and they'll -- they'll fuse
7 in -- in that alignment.

8 And fortunately, I would say here, they fused in -- in
9 the way that they did. Unfortunately, a lot of times
10 patients that develop osteomyelitis, we end up having to go
11 and do pretty major reconstructive surgeries. We're having
12 to remove large portions of bones, put cages, screws and
13 rods, and fuse people's spines up and down.

14 And so, well I can't tell you how much I -- I wish this
15 didn't happen to Ms. McGougan. The final outcome and the
16 position of her spine, I'm -- I'm very thankful for because I
17 -- I know how much hardship it can cause patients if -- if --
18 if they don't end up in that position.

19 Q. So -- so, Dr. Frisch, as we sort of wrap this
20 conversation up, is an orthopedic surgeon that's doing spine
21 surgery, who's treating patients with -- with these
22 conditions, what -- how often does this happen where you have
23 an infection and then you have this dormant period where are
24 -- eight-something days and then it comes back and it gets
25 into the blood. How often does this happen?

1 A. For me personally, I've -- I've never had it
2 happen before.

3 Q. But you do see infections?

4 A. We do see infections.

5 Q. And you do see soft-tissue infections?

6 A. We do see soft-tissue --

7 MR. LUGINBILL: Objection leading.

8 THE COURT: Sustained, leading. Rephrase.

9 BY MR. HOOD:

10 Q. Sure. In your experience as a orthopedic spine
11 surgeon, how many, if any, soft-tissue infections do you see?

12 A. As was mentioned earlier, overall spine section
13 spine infections are fairly rare. You know, you can argue
14 the Number s say maybe one to 3 percent per year, you know,
15 you'd have to do some math there, you know, been in practice
16 for 16 years, and so, I -- I see enough of them to -- to be
17 familiar with them, but fortunately they're not something
18 that we have to deal with every single day.

19 Q. And in terms of the method with the technique used
20 or strategy used to address them, as you're watching
21 patients, have you used that same strategy that you used
22 here?

23 A. Yes.

24 MR. HOOD: Please answer any questions these other
25 lawyers may have.

1 THE COURT: Mr. Foreman, ladies and gentlemen, you all
2 have been sitting for over an hour. I'm going to give you an
3 opportunity to have a brief comfort break. During the break,
4 please do not discuss the case and please leave your note
5 pads in your seats.

6 (Jury exits courtroom.)

7 THE COURT: Doctor, you could walk around if you'd
8 like. Just please don't discuss your testimony with anyone.
9 We'll be at ease for about five or 10 minutes.

10 (Off the record.)

11 THE COURT: The Defense is ready to proceed?

12 MR. SMYTH: We are, Your Honor.

13 MS. FLUMIAN: We -- we didn't discuss, I just grabbed
14 what I thought made sense.

15 THE COURT: Okay.

16 MR. SMYTH: I -- I'll get it in, Your Honor.

17 THE COURT: Thank you. All right. You ready?

18 MR. SMYTH: Yes, ma'am.

19 MR. LUGINBILL: Yes, ma'am.

20 THE COURT: They should be right behind me.

21 (Jury enters courtroom.)

22 THE BAILIFF: All jurors present, Your Honor.

23 THE COURT: Ladies and gentlemen, I hope you enjoyed
24 your break. We'll now resume with the cross-examination of
25 the witness.

1 MS. MAPLES: No questions, Your Honor.

2 THE COURT: Okay. You may proceed.

3 CROSS-EXAMINATION

4 BY MR. LUGINBILL:

5 Q. Good afternoon, Dr. Frisch.

6 A. Good afternoon.

7 Q. Can you address -- there's some discussion on kind
8 of how you spend your day and where you spend it taking
9 versus research versus publishing. You recall that?

10 A. Yes.

11 Q. You have it published before, correct?

12 A. Yes.

13 Q. That one of the journals had been publishing was
14 the journal "Spine"?

15 A. Many years ago, I believe.

16 Q. Is that one of the -- is that the publication that
17 goes along with the National Association Spine Surgeons?

18 A. I don't remember offhand.

19 Q. What spine surgery associations that you're part
20 of?

21 A. NASS is the main one. South (crosstalk) yeah,
22 South Carolina Spine Society Academy of, you know, orthopedic
23 surgeons.

24 Q. How much of your time do you spend involved
25 working on clinical trials?

1 A. Right now very minimal.

2 Q. You done a lot in the past?

3 A. I've done some.

4 Q. You're doing some in the latter half of 2016?

5 A. I may have been.

6 Q. How much time were you spending on those clinical
7 trials in 2016?

8 A. Minimal.

9 Q. When doctors of any kind work on the clinical
10 trial, they get paid for that, correct?

11 A. Sometimes.

12 Q. And when did you sell your interest in
13 Southeastern Spine?

14 A. So Southeastern Spine was sold in initially I want
15 to say 2017 if that's what when I had a -- when I was a
16 junior minor partner.

17 Q. And when it wasn't was sold, you no longer had any
18 control at the partner over the day-to-day operations at
19 Southeastern Spine, correct?

20 A. That's correct.

21 Q. You do still receive a proportion percentage of
22 the profit based on what you used, right?

23 A. It's different now. It's not really that, it
24 doesn't really work that way now.

25 Q. In 2006 -- well, immediately after the sale, was

1 that how it was done?

2 A. Yeah, we that's -- that's how it was done then,
3 yes. Percentage of collections.

4 Q. And do you -- at that time, were you doing your
5 own scheduling? Then were you setting your own surgery
6 schedule when you were in the office when do to surgery?

7 A. Yeah, I've -- we've pretty much maintained the
8 same schedule for my entire time there.

9 Q. Fair to say that as the surgeons more probable for
10 you to be doing the surgery is the one thing that only you do
11 versus being in the office seeing the patient?

12 A. Not necessarily.

13 Q. Is your testimony that you don't make more money
14 in the operating room than you do in the exam room?

15 A. I think that's probably a conversation for -- I'm
16 not sure is appropriate here, but there's a lot of things you
17 have to look at in terms of --

18 Q. I guess my time. I don't know. I don't get paid
19 for either one.

20 A. Right -- right. And -- but I don't -- I don't
21 think that's a completely accurate statement.

22 Q. Fair enough. Would you agree with me that a spine
23 surgeon has a duty to probably recognize and treat
24 postoperative infection in patients?

25 A. Yes.

1 Q. Got one other question. When you sold it, who'd
2 you sell it? Who does --

3 MR. HOOD: Objection, Your Honor.

4 THE COURT: Basis?

5 MR. HOOD: Relevance.

6 THE COURT: Sustained. Relevance.

7 BY MR. LUGINBILL:

8 Q. You would agree with me that spine surgeon has the
9 duty to properly recognize and treat postoperative infections
10 in these patients, correct?

11 A. Yes.

12 Q. And you also agree that you can delegate that
13 responsibility. I mean somebody can help you lead that
14 responsibility, but you can't avoid the responsibility for
15 making sure it's done?

16 A. I agree.

17 Q. And the statement would go for the medical care
18 that's provided by the PA who (inaudible), correct?

19 A. I agree.

20 Q. If a doctor who gets a consult from another
21 physician -- well you say that way. You would agree that a
22 doctor does ask for a consult, can't just rely on that
23 consult to be within the standard of care, you have to use
24 your own judgment to see it matches your approach?

25 A. I think that's reasonable.

1 Q. Now, because of Pat's rheumatoid arthritis status
2 and her taking of the meds, everybody agrees that when you
3 first saw her, she was an immunocompromised patient?

4 A. She did have a degree of immunocompromised. Yes.

5 Q. And there's a lot of discussions, a lot of
6 different (inaudible) taken, but that you also agreed that
7 rheumatoid arthritis of the disease itself is an
8 immunocompromised factor?

9 A. I think it can be, but I -- I don't think I'm the
10 appropriate specialty to give a full answer on that, but I do
11 believe it can be just a -- a certain extent.

12 Q. And that's why RA patients are different, correct?
13 They're not the regular run middle everyday (inaudible)?

14 A. RA patients have rheumatoid arthritis, you know,
15 and all patients bring different issues. So they're all
16 important. But yes, in Ms. McGougan's case she had
17 rheumatoid arthritis.

18 Q. Now, do patients have the right to see only a
19 doctor if they want only see a doctor versus seeing a PA?

20 A. I'm not sure the answer to that question.

21 Q. At Southeastern Spine at the time the patient
22 called in and said, I want to see the doctor and only the
23 doctor not a PA. Would they in fact make arrangements for
24 that?

25 A. I believe so.

1 Q. When did you become aware that Pat had asked to
2 see you twice rather than PA before you actually saw her in
3 office?

4 A. I believe when my deposition was taken after her
5 care with us.

6 Q. When did you find out that there was initially a
7 pop and a gush of fluid that was yellow in color and that's
8 what prompted her to come back in early in August?

9 A. I believe that would've been her August 23rd
10 visit.

11 Q. When -- did you know at that time that it was a
12 pop and that it was yellow tint?

13 A. I don't remember anything about a pop, but I
14 remember that there was concern that she had had some
15 drainage.

16 Q. And the color of drainage matter, right?

17 A. Yes.

18 Q. The yellow tinge, that's not the same as clear,
19 correct?

20 A. Yes. In this case I believe the drainage was
21 serosanguineous.

22 Q. Earlier, there was testimony that serosanguineous
23 meant blood tinge and it can break the word apart that
24 literally translate it, right?

25 A. It's blood and serum.

1 Q. And so if there's a hematoma or something like
2 that, it could be blood-tinged, correct?

3 A. Yes. So hematoma could be blood-tinge.

4 Q. If it is yellowish that's leaning more towards the
5 green and that's leaning more towards infection; is that
6 fair?

7 A. It -- it could be. But that's not how it was
8 described.

9 Q. And you never saw it at all, correct?

10 A. Again, I -- I don't -- on those visits, I'm not
11 sure if I had seen her on those days or not, but that was how
12 it was described by Anne Buck and very confident in her
13 abilities.

14 Q. And all you had in that description was
15 serosanguineous that's all you had, correct?

16 A. Correct.

17 Q. You did not see the infection or the serous
18 drainage that discharged itself, nor did you see any
19 (inaudible)?

20 A. I don't recall if I did or not.

21 Q. So the first time you actually laid eyes on it
22 would've been 9/20 when you put her in the hospital?

23 A. That was the first time I dictated a note, yes.

24 Q. When you were on direct, you mentioned that the
25 risk of going back into surgery was higher up until 9/20.

1 The risk of going back higher than her risk of infection up
2 until 9/20. Do you agree with that?

3 A. I'm not sure that's how I phrased it.

4 Q. Do you agree with that statement?

5 A. Could you repeat that?

6 Q. The -- the risks from going back into surgery to
7 obtain a culture to see if she was infected was higher than
8 the risks to her of being infected?

9 A. So at that time, based on how she had presented
10 with her symptoms, that as I indicated I didn't think
11 indicated taking her to surgery, I do think that I've done
12 surgery earlier, the risk would've been higher than not doing
13 surgery. Because I didn't think there was an indication to
14 do surgery. So yes, I agree if that's what you were asking.

15 Q. One other question I had on your initial visit
16 from 7/29, do you recall what her strength was on measuring
17 at that visit?

18 A. It was three plus and four -- to four minus and
19 knee extension dorsiflexion and plantar flexion I believe.

20 Q. Where would that have been recorded?

21 A. I would like to see the note, but in general it
22 would be under physical exam and assessment and plan and all
23 likelihood.

24 Q. And Plaintiff Exhibit 1 and this is the 7/29/16,
25 this is where we go the physical exam finding?

1 A. Yes.

2 Q. Am I correct that she was four minus over five?

3 A. Yes, that's what I said. Yes, correct. I agree.

4 Q. I believe you told me she was three plus to four
5 minus.

6 A. Right. And if you look at the treatment plan, it
7 says three plus.

8 Q. Why are they different?

9 A. The four minus -- so the physical exam there is --
10 done by Anne Buck, the assessment and plan is done by me.
11 Three plus four minus is essentially the same thing.

12 Q. And you consider that to be significant. And you
13 got to do it quicker than later?

14 A. Yes.

15 Q. Now, we try to go about the MRSA for a little bit
16 only sort of the baseline of concept. Why did they do the
17 nasal swab in the first place?

18 A. Believe it's to see if a patient is colonized with
19 MRSA.

20 Q. And the patient is colonized with MRSA, they are a
21 -- at a higher risk of getting a post-surgical infection of
22 that MRSA, correct?

23 A. I'm not sure I'm qualified to speak on that. I
24 know when some of the orthopedic literature with total joint
25 replacements because those are being placed in an avascular

1 environment, sometimes they will pretreat patients with
2 antibiotics in the spine world. I -- I can't say I'm aware
3 of any literature where it's been discussed.

4 Q. Thank you for that answer, doctor, my question was
5 the purpose for doing it's to find out if the patient's
6 colonized because if they are colonized, they have a higher
7 risk of being infected at surgery because you're trying to
8 hope, correct?

9 A. I will agree with you intuitively that makes
10 sense. But I'm telling you, I don't know if I have the
11 direct knowledge to tell you if that's true or not.

12 Q. And if they are colonized then there's a protocol
13 that is discussed by Dr. Blass on how to get rid of it,
14 correct?

15 A. I -- I would defer to the infectious disease
16 doctors about that.

17 Q. And is your testimony that you're not aware of any
18 orthopedic journals specifically dealing with spine that have
19 tracked whether that's effective for reducing surgical
20 infections in the spine patients?

21 A. I'm not saying it doesn't exist, I'm just not
22 unaware of it.

23 Q. Does the doctor have a duty to keep a grasp of the
24 latest developments in his specialty?

25 A. Yes, to the best of his ability.

1 Q. And if there were improvements and procedures --
2 the spinal surgery that would reduce post-spine surgery
3 infections, should the doctor (inaudible)?

4 A. That would be a good thing.

5 Q. In all of the office visits between the surgery
6 and 8/2 and until she goes into the hospital. Fever, chills
7 are one of the main indicators (inaudible) that am I right?

8 A. Those are some of the indicators that we're
9 looking for.

10 Q. The fact that fever appeared on 9/16 when you --
11 or 9/19 when you saw her, that's one of the reasons that she
12 went to the hospital, correct?

13 A. Is that with a combination of a significant
14 increase of pain.

15 Q. You would agree with me that fever by itself is
16 not a reliable indicator of presence of or absence of
17 infection?

18 A. It is a -- a piece of the puzzle.

19 Q. You could have an infection and not have a fever,
20 correct?

21 A. Correct.

22 Q. And in fact, you immunosuppressed the -- your RA
23 particularly, you may not run a fever even with infection?

24 A. I think you could apply that to anyone.

25 Q. You said you were comfortable with the

1 administration of a Medrol Dosepak two weeks after surgery in
2 a immunocompromised patient, correct?

3 A. I was comfortable in that situation, yes.

4 Q. You knew that Ms. McGougan was a clinical nurse
5 for her occupation, correct?

6 A. I knew she was a nurse.

7 Q. You didn't know she worked on the floor with
8 patients?

9 A. In her current capacity at the time I wasn't sure.
10 I -- I don't recall exactly what she was doing.

11 Q. Are you aware of the studies have demonstrated
12 that people who work in hospital settings all the time are at
13 a much -- much higher -- they get colonized for MRSA at a
14 much higher rate than the general population?

15 A. I think that would be -- that would make sense.

16 Q. In fact, that's why on the screening form, repeat
17 hospitalization is an indicator to do the swabs because
18 you've been in the hospital so you've probably been exposed
19 to MRSA?

20 A. I'm not sure that's exactly why it's -- it's
21 there.

22 Q. It makes it more likely, correct?

23 A. That it, yes

24 Q. And because it's more likely it's in the patient's
25 best interest to investigate, find out if they're colonized,

1 whether than just guess whether they are or not, right?

2 A. I see what you're saying, but that's not our
3 standard procedure for preoperative patients.

4 Q. But it is the protocol at the hospital that they'd
5 been in a hospital we going to test, correct?

6 A. They had been admitted to a hospital as a patient.

7 Q. Within one year, correct?

8 A. Correct.

9 Q. So she spent -- and she only spent one day in the
10 hospital, the surgery and then she was discharged the next
11 day, correct?

12 A. Correct.

13 Q. And that period of time was enough to trigger her
14 getting swabbed?

15 A. By the guidelines, correct.

16 Q. And those guidelines are there to protect
17 patients, correct?

18 A. So have been previously admitted to a hospital
19 within a year, yes.

20 Q. Because we wanted to know if they colonized so
21 that we can get rid of that risk, correct?

22 A. Again, it may have been admitted to a hospital in
23 the last year.

24 Q. Was your opinion that it was appropriate to give
25 her a Medrol Dosepak change if you knew she was calling on?

1 A. I'd have to think about it. I'm not sure.

2 Q. But you didn't have that information, correct?

3 A. There was not an indication to obtain that
4 information.

5 Q. So the answer is yes you did not have that?

6 A. Because it was not a reason to have it, correct.

7 Q. All right. So on Plaintiff's Exhibit 4, this is
8 the 8/23 visit, she is seen by Ms. Buck and now we have
9 increasing pain in the left lateral buttock thigh, increased
10 fluid. Do you know today whether or not there was any fluid
11 at her first post-op visit?

12 A. Not that was reported, no.

13 Q. Ms. Buck would've been aware that she had taken
14 Medrol Dosepak, correct?

15 A. I believe she testified to that today.

16 Q. And now we have a patient who is
17 immunocompromised, who has a draining wound that has opened
18 up three weeks after surgery and has just finished a round of
19 an immunosuppressive drug and has an underlying
20 immunosuppressive condition. Is that a correct assessment of
21 the patient?

22 A. She has drainage that is very common to be seen
23 after surgery. She took a very low dose steroid and she has
24 been off her immunosuppressive medications for several weeks.

25 Q. Is anything I said incorrect?

1 A. I just would characterize it differently.

2 Q. But you admitted to me that then you have agreed
3 that RA status itself is an immunosuppressive condition,
4 correct?

5 A. As I mentioned, I -- I am not the best person to
6 speak on that. I -- I do believe it gives a small degree of
7 immunosuppression, but it -- it's the medications that are
8 the big issue.

9 Q. And her wound initially at two weeks post-surgery
10 was intact, correct?

11 A. Correct.

12 Q. There was no redness, there was no problem with
13 it, correct?

14 A. Correct.

15 Q. Why would increased healing cause it to burst
16 open?

17 A. So it had some drainage and we can see that -- we
18 see that quite often with incisions as they're healing.

19 Q. We didn't document interoperative report that she
20 had any problem with her tissue quality, correct?

21 A. No, I did not.

22 Q. So the sutures that you would've put in to close
23 that were below the skin, those should all be good because
24 you weren't anticipating any problems, correct?

25 A. Correct.

1 Q. You didn't see anything in there that would lead
2 you to believe that those wouldn't hold, correct?

3 A. On the first surgery?

4 Q. Yes.

5 A. Correct.

6 Q. And those -- those sutures actually resolve on
7 their own, correct?

8 A. That we used in the first surgery, yes.

9 Q. And by 8/3 it would mostly have been dissolved,
10 correct? Rather than not by three, but by three weeks
11 post-op?

12 A. Maybe, I'm not sure.

13 Q. And so something has to change in that wound for
14 fluid to start coming out and that changes more fluids being
15 produced, right?

16 A. Yes.

17 Q. What's causing more fluid to be produced if it's
18 not an infection?

19 A. As I -- as I've mentioned, we often see that with
20 wounds that are healing, they will produce serosanguineous
21 fluid.

22 Q. They're going to produce serosanguineous fluid for
23 big one when they're healing because they're going to do
24 that, they don't just start suddenly?

25 A. I disagree with that.

1 Q. You heard Dr. Davne's testimony. He said that it
2 is a deep surgical wound once it opens up --

3 MR. HOOD: Objection, Your Honor.

4 THE COURT: Basis?

5 MR. HOOD: Pitting.

6 THE COURT: Sustained pitting. You cannot comment on
7 the veracity of someone else's testimony.

8 BY MR. LUGINBILL:

9 Q. A surgical wound that opens after three weeks
10 after surgery has to be treated like it is a potential deep
11 surgical site wound until proven otherwise, yes or no?

12 A. I disagree with that.

13 Q. And the reason it has to be treated that way is
14 because if you rely on what you can see at the surface with
15 your naked eye, you will not detect that deep surgical wound,
16 correct?

17 A. With your naked eye you cannot see a deep surgical
18 wound I agree.

19 Q. And nothing here is other than the naked eye,
20 correct?

21 A. Right. Which is why we discussed obtaining an MRI
22 at that time.

23 Q. It's my understanding that taking an MRI at this
24 time would be and I quote, "Worthless." Is that correct?

25 A. That's not my opinion.

1 Q. It would be worthless because it is going to be
2 fluid in the area. The tissues are going to be still
3 inflamed because they are healing from surgery. So you're
4 not going to be able to tell normal fluid from infected
5 fluid; is that correct?

6 A. Not necessarily.

7 Q. Would it be a challenging MRI to interpret?

8 A. It depends on what the findings were.

9 Q. Why did PA Buck document the reason was that the
10 patient refused?

11 A. Because I believe that was their conversation.

12 Q. Did you document what the patient's position was
13 and why they supposedly did not want to get an MRI?

14 A. I don't see that.

15 Q. If you have a patient who just drove three hours
16 and they can hit the MRI that same day, wouldn't you document
17 as a normal course? Wouldn't you want your PAs to be
18 documenting as a normal course, why they refused that very
19 easy thing to have done?

20 A. Not necessarily.

21 Q. So you just don't care?

22 A. No, it was -- it was offered and it was deferred.
23 I mean I'm not sure what else you need to say about it.

24 Q. There's no documentation you'll agree of the risk
25 of getting the MRI versus the risk of not getting it,

1 correct?

2 A. No, there's nothing documented about that there.
3 No.

4 Q. Other than the fact she was prescribed Bactrim,
5 there's nothing in here. Let the patient know they might
6 have deep surgical wound infection, correct?

7 A. Well, I -- I agree with you. You can't tell that
8 by the naked eye. And the only other way to tell that at
9 that point would be to get an MRI, which was discussed or to
10 do a surgery and open it up, which was not indicated at that
11 time.

12 Q. Did you call the patient back and say, hey, I
13 really want you to get this after you were informed that your
14 patient refused medical advice? Allegedly.

15 A. Did I allegedly call her?

16 Q. No. Did she allegedly refuse this advice?

17 A. No.

18 Q. Did you call the patient back and -- and tell her,
19 hey, I really want you to get this?

20 A. I did not call her back, no.

21 Q. And this wound continues to drain through
22 September the 1st, September the 8th, October the 11th. And
23 it's still draining on November the 28th, isn't it?

24 A. On November what?

25 Q. On November the 20th. Sorry.

1 A. Is it draining now? (Crosstalk) it was -- it was
2 not draining on November 28th.

3 Q. I withdraw that question. I wanted to withdraw.
4 It's still draining on September the 1st and it's still
5 draining on September the 8th and then it is still draining
6 when you see her and put her into the hospital, correct?

7 A. When I saw her it was not draining. And it was, I
8 believe on the 8th there was some minimal drainage on the
9 bandage, but there was no active drainage.

10 Q. Is that from your independent recollection or your
11 review of your office note?

12 A. We -- review of the office note.

13 Q. I'm going to show you Plaintiff's Exhibit 40. Do
14 you recognize this as your HP -- I'm sorry, do you --

15 A. No, I believe that's Dr. West's HP.

16 Q. Absolutely. Grabbed the wrong one (inaudible).
17 Nope, I grabbed the right one. So this is Dr. West's HP, not
18 yours, right?

19 A. Correct.

20 Q. Okay. On your physical exam, this is where any
21 doctor, Dr. West, any other doctor is going to put what they
22 find on their exam, correct?

23 A. Correct.

24 Q. Okay. Her incision area does have a small opening
25 25 centimeters. I'm not currently seeing drainage. And what

1 date is this? This is on 9/20. This is the day after she
2 was reported, correct?

3 A. Correct.

4 Q. All right. I am going to show you Defendant's
5 Exhibit 31. And this one is your report, correct?

6 A. Yes.

7 Q. And this would be from the 21st of the
8 (inaudible). So this is your admit -- you're admitting
9 history of visit, correct?

10 A. Correct.

11 Q. All right. Let's get down to the physical
12 examination on this document. What does it say about skin?

13 A. Minimal drainage from her posterior incision with
14 no evidence of erythema, no swelling.

15 Q. So she did have drainage on that (inaudible)?

16 A. Well, at the time of the HOP it appears that, yes.

17 Q. So on 9/20 at the HOP she was draining, but you
18 just testified she wasn't draining that you saw?

19 A. Correct. I believe that HOP was dictated by
20 Ryan Aprill.

21 Q. The one in the office or the one in the hospital?

22 A. The one for the hospital.

23 Q. Did it just start draining again?

24 A. I would have to ask her.

25 Q. Do you trust her to make you -- you told us she's

1 a good PA, you trust her to -- to get that right?

2 A. She's a great PA, yes.

3 Q. So if it was draining, she wrote it down it was
4 draining?

5 A. I -- I would agree. When she saw her it could
6 have had some, as she said, minimal drainage.

7 Q. Let's talk about what information could have been
8 learned between the post-op week three and admission. The
9 wound has a drainage. That fluid is there and that fluid can
10 be cultured, correct?

11 A. I would not culture postoperative fluid drainage.

12 Q. My question was: "If you can?"

13 A. If you believe in bad medicine, yes it can be.

14 Q. I believe in bad medicine. When is it ever bad to
15 get more information than less?

16 A. When the information that's going to give you is
17 -- is going to be false and misleading and something you
18 cannot trust.

19 Q. And your concern is that if you did the Q-tip into
20 that opening in the skin and take out some fluid that it is
21 most likely going to be contaminated?

22 A. You would -- as a surgeon, you would never ever in
23 a non-sterile environment take something and put it into a
24 postoperative incision and expect anything positive to come
25 from that.

1 Q. I assume that when you take a swab and use for
2 collecting it's sterile when you use?

3 A. Yes.

4 Q. And so your patient is there in front of you in
5 your office and there's an opening from which fluid is coming
6 and your testimony to this jury is, it makes more sense to
7 not know what that is and to keep that sterile Q-tip put it
8 in, break it off, put it in tube and send it to the lab. Is
9 that your testimony?

10 A. I cannot emphasize how strongly I would disagree
11 with that. If you are going to -- if you have a patient at a
12 time that you do not think is infected, has some normal
13 postoperative drainage that we all commonly see and in a
14 non-sterile environment in an office setting where there's
15 patients in and out of the same room without an adequate
16 ventilatory system like such as an operating room and you
17 take something and you stick it into that wound and that
18 patient becomes infected, you are just wrong. So that's --
19 I'm going to be as emphatic as I can about that.

20 Then you say, all right well let's do it anyway. And
21 you get that information, you're doing that on a skin that's
22 exposed to every bacteria that's on our body. Any
23 information that you get from that is going to be unreliable.
24 You say, all right, well then sterilize it first, wipe it
25 down with Hibiclens, and then do it well then you potentially

1 killed anything that's there. So that's negative. There's
2 no information you can get from that.

3 Q. (Inaudible) stop there.

4 A. No. If you don't mind I -- please I'd like to
5 finish. So if you're going to do cultures and you are a
6 moral ethical surgeon, you're going to do it in the
7 appropriate way. You're going to take the patient back to
8 the operating room in sterile conditions. In a sterile
9 environment with a ventilated room because that's how the
10 vast majority of infections happens is through bacteria in
11 the air.

12 And you're going to do it under microscopic
13 visualization where you can see what you're doing and do an
14 appropriate culture and get appropriate information that
15 those decisions you make are accurate and capable.

16 Q. I understand your position -- your position. Now,
17 where I was going to stop you was, you can express fluid from
18 the interior of that wound out onto the skin and immediately
19 take that swab. You don't have to go in space, you can get
20 some information not as good as being in the operating room,
21 but you can get some information can't you?

22 A. It would be completely inaccurate and unreliable
23 information and I would never do it. Sorry. That would be
24 anti-surgery 101.

25 Q. You have deffered to infectious disease many times

1 today in your testimony, correct?

2 A. To Dr. West? Yes.

3 Q. But no other infectious disease doctors?

4 A. He's the only one that I interacted with.

5 Q. If that culture came back and had MRSA at a high
6 concentration and the only other thing that grew out was skin
7 cultures, why would that be useless?

8 A. You mean the theoretical culture that I said I
9 would never take the use that I should if it came back with
10 MRSA that would likely and completely, totally unreliable
11 information and then I would be then forced to take that
12 patient back to the OR and potentially perform an unnecessary
13 surgery.

14 Now, that she has MRSA, now that we know that we have
15 MRSA and now you're beholden to do it and then what happens
16 then? You have a complication then. How do you justify that
17 based off of a completely inappropriately-obtained culture?
18 How would you justify that?

19 Q. You don't disagree with me that you had done that
20 to this patient. You would've found she did have MRSA and
21 could have been treated right then and there, correct?

22 A. I disagree with that.

23 Q. You don't believe it would've been found or you
24 don't believe you could have been treated?

25 A. I don't know if it would've been found, but I

1 certainly wouldn't have believed anything that came from that
2 culture.

3 Q. Okay. Your plan following that surgery was to
4 follow her appropriately, correct? That's the words you
5 used.

6 A. After which surgery?

7 Q. After the initial discectomy?

8 A. Yes.

9 Q. You knew she was at increased risk of colonization
10 because of where she worked, correct?

11 A. That -- that's your statement.

12 Q. You knew she was an increased risk of infection
13 because she's an RA patient and at that time was still
14 immunocompromised from her medications and disease, correct?

15 A. From before surgery?

16 Q. Correct.

17 A. Yes, I knew she had a degree of immunocompromised,
18 correct.

19 Q. But she got no different monitoring or follow-up
20 or surveillance than any other discectomy patient did she?

21 A. She got follow-up that was consistent with any
22 patient that we had concerns of and that we saw her I think
23 six times in five weeks, we were monitoring her very closely.
24 Any call she had, we got her in and whether she had
25 rheumatoid arthritis or whether she was anyone else in this

1 room, that's what we would've done the same thing.

2 Q. You told me that surgery would be an unnecessary
3 risk for her at that time, correct?

4 A. At the -- as the symptoms and presentation were at
5 that time. Yes. That's my opinion.

6 Q. And no doctor could ever subject a patient to an
7 unnecessary risk, correct?

8 A. I think he would always want to hopefully avoid
9 doing that if possible.

10 Q. Okay. Do you agree with me that a sub deep wound
11 is a different wound than one on the surface, correct?

12 A. They're different areas of the tissue.

13 Q. They present differently why?

14 A. They can.

15 Q. And really sort of the defining line as I
16 understand it is the muscle layer, the (inaudible) is more of
17 a surface skin tissue, fat tissue related infection and below
18 it you're more concerned with structural infections, correct?

19 A. Or soft-tissue, deep soft-tissue.

20 Q. Okay. And deep soft-tissue is harder to treat
21 because it's deep. Your blood is got to get down to it.

22 It's just not as easy to treat as something on the surface
23 that's more easily vascularized?

24 A. I would disagree with that. I would say that the
25 muscle sub -- sub fascially meaning below the fascia is much

1 more vascularized than the fat above.

2 Q. You told me earlier that -- that you as a group
3 you never do labs unless that patient is going to the
4 hospital, correct?

5 A. If I'm at a point where I think a patient needs
6 labs, then they're going to go to the hospital.

7 Q. You would agree with me that any labs is a whole
8 lot cheaper than going to the hospital?

9 A. Not if they're unnecessary.

10 Q. The same labs that are necessary after they've
11 been infected and to the point where they have to go on IV
12 are unnecessary until they get to that point. Is that your
13 testimony?

14 A. In the setting of a concern for postoperative
15 infection. If you're at a point where you think that there
16 is potentially an infection, I would not get labs until I
17 would put the patient in the hospital and get labs. Because
18 at that point I want to get a whole lot more than just labs.
19 I'm not just going to get labs and say well let's see what
20 happens willy-nilly. If I think someone needs labs, it
21 things means like I'm have concerns that they're infected and
22 I'm going to put them in the hospital.

23 Q. And the way you look for infection, the decision
24 to make that you make to get labs and put them in means that
25 both probably the infections already there?

1 A. Well, you don't know until you evaluate.

2 Q. You can't say for sure, but unless you have a
3 strong infection for all a strong suspicion rather all the
4 reasons you just told us the risks, everything that goes
5 along with it, you're not putting that patient in there
6 unless you think they're infected, right?

7 A. Unless I think there's a chance they're infected.

8 Q. It has to be a pretty good chance otherwise it's
9 an unnecessary risk?

10 A. What? I'm not sure I understand it.

11 Q. If you don't really think the patient's infected
12 from what you've told us, I don't believe you're going to put
13 that patient through going into the hospital?

14 MR. HOOD: Objection.

15 THE COURT: Basis?

16 MR. HOOD: Counsel's opinion.

17 THE COURT: Please rephrase the question.

18 BY MR. LUGINBILL:

19 Q. Unless you believe that patient is probably
20 infected in their surgery in their surgical site, you're not
21 going to put that patient in the hospital, correct?

22 A. Right. So for my normal postoperative patients
23 who are not having complications or concern for infection,
24 I'm not going to put them in the hospital without a reason.

25 Q. And just drainage is not a reason for you,

1 correct?

2 A. Not as it presented in this case.

3 Q. And just drainage in a immunocompromised patient
4 is not enough for a reason, correct?

5 A. Not as it presented in this case.

6 Q. And pain that's gone up and come back out is not
7 enough, correct?

8 A. Well, what we did put her in the hospital was
9 because her pain was increasing.

10 Q. But not until it went up the second time. The
11 first time it went up, it came back down. You did not put
12 her in the hospital?

13 A. Well, the first time it went up it was still
14 better than her preoperative symptoms.

15 Q. The fact is you don't do labs to try to prevent an
16 infection. You do labs to prove there already is an
17 infection; isn't that right?

18 A. You do labs to help diagnose an infection.
19 Correct.

20 Q. And then in this case, once your patient did have
21 an infection and you washed her out appropriately and she was
22 discharged, you still didn't do any labs to see whether or
23 not the antibiotics that she was given were effective. Did
24 you?

25 A. No, we didn't. That was not indicated.

1 Q. You relied on the exact same things that you
2 relied on the first time that let you down, right?

3 A. Relied on clinical factors. Yes.

4 Q. Not one extra piece of information, not one extra
5 test, not one extra examination. You did nothing different
6 between the first surgery and the second surgery to see if
7 those antibiotics in that immunocompromised patient were
8 working, did you?

9 A. We followed her clinically, which is what it is
10 indicated to do at that time.

11 Q. What was the different thing you did? Give me one
12 different thing that happened at Southeastern Spine to that
13 lady between her discharge on 9/26 and her showing up and
14 have to go back into the hospital? One thing.

15 A. We continued to follow her clinically.

16 Q. You did that before. That's not new. Give me one
17 new thing you did. She's not the same patient, she's just
18 had an infection, correct?

19 A. Correct.

20 Q. So she's not the same patient, but you did the
21 exact same thing, correct?

22 A. Because that's what was indicated to do at that
23 time.

24 Q. And it let you down the first time and it lets you
25 down the second time, didn't it?

1 A. She did develop a second infection. Yes, I agree.

2 Q. In the same place. In the same way, correct?

3 A. It was in the same area. I agree.

4 Q. And that infection destroyed her back, didn't it?

5 A. It caused damage in the spine at that level. Yes,
6 it did.

7 Q. Collapsed her L4 absolutely destroyed the L4-L5
8 disc completely. And collapsed L5. And now she's going to
9 be in pain every day the rest of her life.

10 MR. HOOD: Objection. Move to strike.

11 THE COURT: Basis?

12 MR. HOOD: Argument.

13 THE COURT: Sustained.

14 BY MR. LUGINBILL:

15 Q. Do you have --

16 THE COURT: Rephrase. Rephrase the question.

17 Ladies and gentlemen, you're to disregard the last --
18 last question and give it absolutely no consideration in your
19 deliberations.

20 You may proceed.

21 MR. LUGINBILL: I apologize Your Honor.

22 THE COURT: Uh-huh.

23 BY MR. LUGINBILL:

24 Q. In your professional opinion as a spine doctor who
25 has been treating that particular patient and who has looked

1 at the MRI, her current status is a direct result of the
2 osteomyelitis she developed, correct?

3 A. Yes.

4 Q. And that osteomyelitis is a direct result of the
5 infection that was there in September, correct?

6 A. I think it's possible, but I can't say for sure.

7 Q. More likely than not?

8 A. I think it's likely.

9 Q. And if that infection is eradicated in September
10 or at any time thereafter, then that would've happened?

11 A. I think that's likely.

12 Q. And the pain that she has now every single day
13 that she testified to is because her back has collapsed and
14 now she has daily constant pushing and pressure and just
15 changed it (inaudible) L4 and L5 vertebrae that are no longer
16 coming out where they're supposed to, correct?

17 A. I think that can be a component of her pain, yes.

18 MR. LUGINBILL: Bear with me one minute.

19 Nothing else, Your Honor.

20 THE COURT: Any redirect?

21 REDIRECT EXAMINATION

22 BY MR. HOOD:

23 Q. Let you down the second time. I thought I heard
24 you earlier testify this was the first time you'd ever seen
25 this happen on your watch. Second infection.

1 A. It is.

2 Q. All right. He says everything was the same. And
3 the infectious process that you treated in September in the
4 hospital, did you open the wound up?

5 A. Yes.

6 Q. Did you clean it out?

7 A. Yes.

8 Q. Did you irrigate it?

9 A. Yes.

10 Q. What else did you do?

11 A. We consulted an infectious disease and placed her
12 on antibiotics.

13 Q. And so she received countless doses they counted
14 them before IV antibiotics?

15 A. Correct.

16 Q. And then she went home on a medication that was
17 matched up. So would it be cultured from inside that wound?

18 A. Correct.

19 Q. This wasn't the same treatment, was it?

20 A. That's correct.

21 Q. This was targeted towards her and her condition?

22 A. That's correct.

23 Q. So let's go to the last thing I'm going to cover
24 (inaudible) Exhibit 36 please. Because it sounded like you
25 were convinced there had to be an infection. And I'm looking

1 at the progress note here. You see that?

2 A. Yes.

3 Q. Is this yours?

4 A. It's one of our PAs'.

5 Q. Yeah. And you see it stamped right down there by
6 you?

7 A. Yes.

8 Q. Tell us what it says.

9 A. It says post-op wound infection possible --

10 Q. Stop. Why doesn't it say there's a post-op wound
11 infection?

12 A. Because at that point we do not know.

13 Q. Even though you were suspicious, but you didn't
14 know, did you still take her back to the hospital?

15 MR. LUGINBILL: Objection Leading.

16 THE COURT: Sustained, leading. Rephrase.

17 BY MR. HOOD:

18 Q. Doctor, could you tell us why this patient was in
19 the hospital if the post-op wound infection is noted only as
20 possible?

21 A. It was to evaluate her to see if she had an
22 infection

23 Q. And then it says consult ID that's infectious
24 disease?

25 A. Correct.

1 Q. And then it says possible IND of lumbar wounds?

2 A. Correct.

3 Q. And that's -- there's a P next to that on the left
4 hand side. What does the P stand for?

5 A. Plan.

6 Q. So at the time of admission what -- what was
7 known?

8 A. She was having reports of increasing fevers, pain,
9 she had some superficial dehiscence and had been having some
10 drainage at various points.

11 Q. And so what were you considering doing in the
12 hospital?

13 A. In the hospital was to get -- obtain labs, consult
14 infectious disease, do an MRI, and if warranted, then take
15 her to the operating room for an incision and drainage and to
16 obtain appropriate cultures.

17 Q. In that order?

18 A. I'd have to think about that, but yes.

19 Q. So it's the -- into the hospital?

20 A. Yes.

21 Q. Labs MRI does your data points?

22 A. Correct.

23 Q. If the data points suggested, then you go in and
24 do doctor surgery?

25 A. Correct.

1 Q. And then when you're in the surgery, you do the
2 cultures?

3 A. Correct.

4 Q. And the culture grows out whatever the bacteria is
5 and you treat?

6 A. Correct.

7 Q. Specific.

8 A. Yes.

9 Q. With the expert?

10 A. Yes.

11 MR. HOOD: Thank you. No further questions.

12 THE COURT: Sir, you may step down.

13 Ladies and gentlemen, why don't you all stand up and
14 stretch? It's very hard in a room that has no windows,
15 recirculated air, or fluorescent lights. Stand up and
16 stretch a little bit before we do the next witness. Is
17 everybody comfortable? Does anybody need a comfort break?

18 Call your next witness.

19 MR. HOOD: Thank you, Your Honor. At this time, the
20 Defense calls Dr. John Glaser.

21 THE CLERK: Please raise your right hand and place your
22 left hand on the Bible.

23 JOHN ARTHUR GLASER,

24 being duly sworn, testified as follows:

25 THE CLERK: Please be seated. Please state your full

1 name, spelling your last name directly in the microphone.

2 THE WITNESS: John Arthur Glaser, G-L-A-S-E-R.

3 THE COURT: You may proceed.

4 MR. HOOD: Thank you.

5 DIRECT EXAMINATION

6 BY MR. HOOD:

7 Q. John, what -- what do you do for a living?

8 A. I'm an orthopedic spine surgeon here in
9 Charleston.

10 Q. Where do you work?

11 A. I split my time between the Medical University of
12 South Carolina and the VA hospital in Charleston.

13 Q. All right. We're obviously here talking about
14 spine surgery and subsequent infection. Is that something
15 that you're familiar with?

16 A. Yes.

17 Q. And were you hired by -- by me and my firm to
18 review this case in order to formulate opinions with respect
19 to care and treatment rendered by Dr. Frisch?

20 A. Yes.

21 Q. Before I ask you by those opinions I'd like to you
22 briefly give the jury some flavor for your training and
23 experience (inaudible) at this point.

24 A. I did my medical school training at the University
25 of Rochester in Rochester, New York. Graduated in 1982. I

1 did two years of general surgery training in Rochester,
2 followed by four years of orthopedic training at the
3 University of Virginia. I did a fellowship in spine surgery
4 at the University of Iowa.

5 Q. Are you board-certified?

6 A. I am.

7 Q. And in what areas?

8 A. Orthopedic surgery.

9 Q. And when is the last time you had deal with the
10 re-certification process?

11 A. I believe it was 2021.

12 Q. And so do you say up-to-date with the current
13 practices in your field?

14 A. Yes.

15 Q. Tell us a little bit about your day to day work
16 either or both the VA and MUSC. How would you describe your
17 practice if you were in the elevator explaining the -- the to
18 kids what you do for a living?

19 A. Well, I'm -- I'm semi-retired now. I work three
20 days a week. And my practice is primarily clinical. I'm
21 doing a lot less research and less teaching than I used to.
22 There's still a little bit, we do a fair amount of teaching
23 with the residents and the students with us, but less of the
24 lecture didactic things. So those three days are generally
25 whichever institution I'm at. It's either a day of clinic or

1 a day in the operating room. Average about four days a month
2 in the operating room and the rest in clinic office hours.

3 Q. All right. Tell us about some of the education
4 that -- that you do with teaching around?

5 A. Well, we have a residency program in orthopedics.
6 We take five residents a year for a five year program. We
7 also at the university have a -- I'm not sure what would be
8 called a residency program, but for athletic trainers who
9 work a lot with us in clinic. We have two athletic training
10 interns that come in for a year at a time. We have medical
11 students that are routinely on the services working with us.
12 We do less than we used to with nursing and physical therapy
13 students, but we used to back in the day.

14 Q. All right. You mentioned the fellowship. What
15 was your fellowship again?

16 A. Spine surgery.

17 Q. Within spine surgery we talk about orthopedic
18 surgery and then you're talking about spine surgery. Those
19 two things viewed differently?

20 A. Spine surgery is one of the sub-specialties of
21 orthopedic surgery. Not all orthopedic surgeons do spine
22 surgery, but all orthopedic spine surgeons are trained in
23 orthopedics as well as spine surgery.

24 MR. HOOD: Got you. And -- well at this time, Your
25 Honor, I would call for Dr. John Glaser as an expert in the

1 area of orthopedic surgery.

2 THE COURT: Any objections or questions?

3 MR. LUGINBILL: None from the Plaintiff, Your Honor.

4 THE COURT: From the Defense?

5 MS. MAPLES: No, Your Honor.

6 THE COURT: So admitted without objection. You may
7 proceed.

8 BY MR. HOOD:

9 Q. All right. Dr. Glaser in my request, did you
10 review the medical records and depositions, things of that
11 nature in this case?

12 A. Yes.

13 Q. We -- we've obviously been through a lot of
14 medical records today. I don't think we're going to have to
15 do too much of that with you. Did you do that with an eye
16 towards formulating opinions with respect to care and
17 treatment rendered by Dr. Frisch?

18 A. Yes. And the physician assistants working with
19 him.

20 Q. All right. So let's start there. Well, first let
21 me take care of some business. You're obviously being
22 compensated for your time?

23 A. I am.

24 Q. All right. And in terms of expert work, how
25 frequently do you do that?

1 A. Very infrequently. Probably less than 1 percent
2 of maybe less than 2 percent of my time.

3 Q. All right. So with respect to this particular
4 case we're talking about Ms. McGougan in her indication for
5 surgery, did you formulate any opinions whether Ms. McGougan
6 in taking into account all of her situation, including her
7 arthritis, rheumatoid arthritis, et cetera, was there a
8 perfect candidate for the surgery that was ultimately
9 performed?

10 A. I believe she was.

11 Q. Was there a viable nonsurgical option?

12 A. You could always treat people nonsurgically and
13 there's certainly a chance she could get better with
14 nonsurgical treatment, but I believe her chances of
15 improvement were higher with surgery than without.

16 Q. And we know that she ultimately developed a
17 surgical infection. Surgical wound infection, right?

18 A. Yes.

19 Q. Tell us what you know in terms of performing
20 surgery and experiencing that complication. What -- what is
21 the typical rate that you -- you're familiar with seeing
22 coming out of spine surgery?

23 A. For her type of surgery, decompression without any
24 foreign material, without any hardware placed, the rate of
25 infection is quite low. I think somebody mentioned one to 3

1 percent earlier. I think that's about right.

2 Q. Okay. Why does hardware have anything to do with
3 it?

4 A. It's foreign material so it's not biologic. So
5 there's a -- a higher risk that if it gets contaminated that
6 the bacteria then won't be taken care of by the body.

7 Q. All right. So what about the surgery itself? Did
8 -- in your review of the medical records and the testimony,
9 did you formulate a figure where the Dr. Frisch complied with
10 the standard of care performing this particular surgery?

11 A. I believe he did.

12 Q. Now, I want to shift gears and talk about the
13 postoperative surveillance. We can spend a lot of time
14 talking about that from the time surgery until she comes back
15 in -- in September, is the time I focus on that. Did you
16 have a chance to review those records?

17 A. Yes.

18 Q. Okay. In terms of the cadence or the frequency
19 with which the Ms. McGougan was seen did that appear to you
20 to be reasonable and within the standard of care?

21 A. In her situation I think it was reasonable. She
22 was seen more frequently than somebody who wouldn't have any
23 complications, but in her situation, I believe it was
24 appropriate.

25 Q. Okay. We've heard a lot about the Medrol Dosepak

1 that was prescribed on August the 16th and she subsequently
2 comes back in on August the 23rd. Dr. Glaser, from -- from
3 your perspective as orthopedic surgeon for her complaints of
4 pain in that postoperative visit, was that Medrol Dosepak in
5 the appropriate medication?

6 A. I believe it was.

7 Q. What about her rheumatoid arthritis?

8 A. I think that the risk, the increased risk from a
9 Medrol Dosepak is very -- very small.

10 Q. Okay. So if we're talking, trying to quantify
11 things, how would you quantify that?

12 A. I think it probably it is hard to put a Number on
13 it because it's -- it's hard to say what we mean by the
14 results, but I'd say that a Medrol Dosepak given in that
15 situation probably increases risk, say of infection or a
16 wound problem by less than 1 percent.

17 Q. All right. So now we fast forward and we're at
18 August the 23rd. The patient comes in complaining of
19 incisional drainage. Do you recall that?

20 A. Yes.

21 Q. What does the standard of care require for an
22 orthopedic surgeon to do when confronted with incisional
23 drainage is reported for the first time that many days after
24 surgery?

25 A. Well, take a history and do a physical exam and to

1 get a -- a feel for what they think may be the source of the
2 drainage. And if they feel it needs treatment then to -- to
3 treat it.

4 Q. So what would that treatment look like? What are
5 the -- or does it depend on something else?

6 A. Well, I think the -- the main treatment most of
7 the time for drainage in that situation would be put someone
8 on some antibiotics. I guess now that you mentioned it,
9 maybe that's not treatment that's more prophylaxis, but --
10 but some oral antibiotics probably tell them not to get the
11 wound soiled to -- to keep it clean and dry and to check up
12 on it fairly regularly.

13 Q. All right. So I want to talk about drainage just
14 for a moment. We've heard about different types of drainage
15 and from your standpoint of the postoperative management of
16 patients, what -- what is the significance of the
17 serosanguineous drainage versus the purulent drainage?

18 A. Well, purulent implies that it's probably an
19 infection. And serosanguineous implies that it's got --
20 well, it says it's less risk of an infection. And as we
21 heard before, serous fluid is the -- like the fluid in a
22 blister. It's generally, pure serous fluid is clear. But to
23 get onto this topic of the yellow fluid, well most
24 serosanguineous fluid is yellow. It's not clear. It's from
25 the breakdown of blood products that turns things yellow,

1 it's like that's why your urine is yellow. So the yellow
2 part of it didn't bother me. So the serosanguineous is
3 generally felt to be not completely ruling out an infection,
4 but less likely than if you had a bunch of pus rolling out of
5 the wound.

6 Q. Okay. So can you help explain to the jury how and
7 why a wound would start to drain at some point two or three
8 weeks after surgery if it had been drained the whole time?

9 A. Yeah, a Number of reasons, but I think probably
10 the most common is that in the base of the incision there was
11 a collection of blood and over time the body it -- it clots
12 and then the body liquefies it. And then when it's more
13 liquid, it has more mobility and at the -- at those times,
14 some of those drain, some don't some just eventually turn to
15 scar, but some drain. And the two to three week time frame
16 is about what you'd expect.

17 Q. And what happens if -- if it doesn't drain, what
18 happens if it doesn't pop or come out and it just stays
19 inside the body?

20 A. Sometimes nothing. It -- it's -- it's not
21 uncommon to see someone if you do an MRI on someone who had
22 surgery years ago to see a pocket of fluid in there that's
23 really not causing any problems.

24 The other thing that may happen though is it may get
25 infected, it may press on nerves. It's -- it's hard to

1 predict, but just having some fluid at the base of the wound
2 in and of itself is not the worst thing in the world.
3 Because many people do have it.

4 Q. All right. So -- so we know we've got a new
5 fluid. What or how, if at all, does that change your --
6 again, your cadence of surveillance for how frequently you
7 going to see the patient?

8 A. I think the reasonable thing to do is see people
9 more frequently to check up on things and make sure it's not
10 going in the wrong direction.

11 Q. All right. So we -- we had a Medrol Dosepak the
12 -- the week before the patient comes in and we know she's got
13 rheumatoid arthritis and now she has drainage and she's
14 complaining of six out of 10 pain. Why in your opinion,
15 don't you have to go back and do surgery that morning?

16 A. It depends on the -- the whole picture of seeing
17 the patient and people after surgery with or without
18 rheumatoid arthritis often have a waxing and waning course in
19 terms of their pain. So it's one of the factors to take into
20 account, but it's not the only factor.

21 Q. All right. So can -- on that point, can you speak
22 a little bit and explain to us how you evaluate the
23 significance if at all of the rheumatoid arthritis as it
24 relates to Ms. McGougan's clinical force?

25 A. So this is where I -- I would also defer to a

1 rheumatologist as was mentioned before, but my understanding
2 of rheumatoid arthritis is that the immune system is revved
3 up and not immunosuppressed from rheumatoid arthritis. It
4 may not be as effective, but it's actually increased
5 activity.

6 So I personally am not a rheumatologist and I cannot
7 say that someone who has rheumatoid arthritis without being
8 on medications has a higher risk of infection. I think it
9 may be slightly higher, but I can't say that with certainty.
10 So the main thing with rheumatoid arthritis is the
11 medications, the immunosuppressant medications that I do
12 believe put people at somewhat higher risk.

13 Q. All right. When you say breath up, it's like high
14 RPMs low output?

15 A. Well, I guess I -- I'm not a -- I'm not a car guy,
16 but it -- it's the -- the autoimmune disorders like
17 rheumatoid arthritis, the -- the immune system is -- is an
18 overactivity. Now, that's not to say that they have less
19 infections or that they fight infections better, but I -- I
20 don't know and I would need to defer to a rheumatologist
21 whether they are at increased risk of infection just from
22 having rheumatoid arthritis.

23 Q. In terms of decision-making on the 23rd, based on
24 those factors that we've already talked about, do you believe
25 that it would -- that the PAs and Dr. Frisch complied with

1 the standard of care according to Bactrim and continuing to
2 follow-up?

3 A. Yes.

4 Q. So we then jumped to August 30th. And again,
5 we're -- we're still in this window of time, can you just
6 talk to the progression that you saw and the sort of trends
7 that you saw as you reviewed the records and how the patient
8 was doing over this course of time?

9 A. Well, it sounds like she had a waxing and waning
10 course. She initially did very well developed some recurrent
11 pain, developed some drainage, which also, as far as I can
12 tell, seemed to always be there, but seemed to be waxing and
13 waning as well. And then in September seemed to be getting a
14 bit more, we call it systemic, but total body effect, getting
15 -- getting sick from it where she said she had worsening
16 pain, getting the fever and things like that. And that
17 seemed to come on in September.

18 Q. What's the significance, if any, of pain looking
19 to see -- well strike.

20 What's the significance of pain in evaluating a
21 postoperative patient who has incisional drainage?

22 A. It's one factor. And we -- we know that everybody
23 who has surgery has some pain and therefore it's -- it
24 becomes difficult and everybody responds to pain differently.
25 But when you're -- when you're looking at someone who's

1 having some drainage and the postoperative course you think
2 of -- of you want to try and make a -- a judgment call as to
3 whether this is pain out of proportion to what you would
4 expect.

5 Q. Okay. So with respect to the standard of care,
6 we're talking about treatment dates that just coincide with
7 the dates that Ms. McGougan came to see the folks at
8 Southeastern Spine. But are there any hard and fast rules in
9 orthopedic surgery about dates, deadlines, indications,
10 anything like that that -- that are sort of transcend
11 patients that you have to follow?

12 A. Do you mean like if you see drainage after operate
13 within four weeks or something like that?

14 Q. Yeah.

15 A. Not that I know of.

16 Q. So in terms of the assessments that were being
17 performed for this particular patient, Ms. McGougan in this
18 window of time, were they looking at the right things?

19 A. I believe so.

20 Q. And then did you agree that September 20th, that
21 visit you were talking about at that point in time it was
22 appropriate to go back to the -- the surgery -- to the
23 hospital?

24 A. Yeah, I think now Dr. Frisch likes to get people
25 in the hospital, which I think is a very efficient way to do

1 things. You could have done that as an outpatient, but I
2 think being in the hospital probably got it done quicker and
3 more efficiently, but I think it is reasonable to do an
4 evaluation at that point.

5 Q. All right. Now, you mentioned two options there
6 because one right and one is wrong, one is good, one is bad?

7 A. No, both are -- are options that could be done.

8 Q. And the option that was taken here in the -- the
9 course of -- that you just heard about the blood work and the
10 MRI that sort of broke up. How does that line up with what
11 you would expect a reasonable physician who is suspicious of
12 infection to do in that situation?

13 A. I think this is what a reasonable physician would
14 do in that situation.

15 Q. In face of the MRI results that -- that were
16 obtained. What would your confidence level be going back
17 into a surgery that you're going to find something to remove?

18 A. Based on the MRI?

19 Q. Yes, sir.

20 A. And your exam and everything else? I would -- I
21 would think there would be a high likelihood at that point
22 once you get the MRI.

23 Q. All right. And then in terms of the plan of care
24 after that -- well, let me just back up. There was a
25 medication that was administered to address her infection

1 there in that hospitalization in September. Do you see that?

2 A. Yes.

3 Q. There are some IV Vancomycin, some oral
4 antibiotics that were prescribed the Bactrim. Do you believe
5 -- do you have an opinion whether Dr. Frisch complied with
6 the standard of care allowing this patient to be discharged
7 with that regimen?

8 A. Yes, he had gotten an infectious disease consult
9 and this was dictated by the infectious disease consult. I
10 think that's an appropriate response from Dr. Frisch.

11 Q. All right. Was there anything about this set of
12 discharge of orders or these orders that you believe sort of
13 raised red flags as an orthopedic surgeon that you would
14 basically need to get a second consult or second guess the
15 advice that was given?

16 A. No. I think there was some discussion earlier
17 about whether Ms. McGougan should have been seen by the
18 infectious disease service and I think that's up to the
19 treating physicians and what they feel comfortable with. She
20 certainly should have been seen by somebody in follow-up, but
21 I think that what was done was reasonable.

22 Q. All right. And so in that follow-up, the follow-
23 up end with Dr. Frisch and Ms. McGougan Southeastern Spine?

24 A. That's what happened, I think that's recent.

25 Q. So when we look at that time period from September

1 until the end of November, so basically a two month window
2 time, did you see anything in the records to suggest that
3 Dr. Frisch or his team should have expedited the process that
4 we ultimately see happening in December?

5 A. Without having 2020 vision?

6 Q. Correct.

7 A. Yeah.

8 Q. Like you're sitting there real time doing what
9 they're doing, you're looking at it, you don't know what the
10 future is.

11 A. Right.

12 Q. Is their conduct reasonable?

13 A. Yes.

14 Q. Is it within the standard of care?

15 A. Yes.

16 Q. Now, Ms. McGougan ends up with -- coming into the
17 hospital and she's then treated with IV vancomycin. Are you
18 familiar with that?

19 A. Yes.

20 Q. What -- in terms of the appropriateness for that
21 aspect of addressing osteomyelitis, is that something that
22 you as always being a surgeon to take care of?

23 A. No, we usually get an infectious disease consult.

24 Q. Like was done here?

25 A. Yes.

1 Q. And what's the difference between managing a
2 patient with osteomyelitis versus a deep -- deep soft-tissue
3 infection?

4 A. Osteomyelitis usually is more difficult to get rid
5 of. It's harder to treat.

6 Q. With respect to the -- the time frame -- well, let
7 me -- let me back up. There was a conversation between the
8 patient and Dr. Frisch on right around Christmas time,
9 December 16th, about her coming in Monday versus Friday. Are
10 you critical of Dr. Frisch for not forcing her to go to the
11 hospital?

12 A. No, I don't think it would've made any difference
13 in the outcome.

14 Q. That was going to be my next question. Do you
15 have an opinion of whether her going to the hospital on the
16 16th versus the 19th would've changed the (inaudible)?

17 A. I don't believe so.

18 Q. All right. So we'll go through the progression.
19 I'm just sort of going through the time line in my head.
20 There was a follow-up visit with Southeastern Spine in March
21 and then again August. And it sounds like Ms. McGougan was
22 sort of being seen up in Duke. With respect to that
23 surveillance was there follow-up visits, was that appropriate
24 given what had transpired?

25 A. I believe so. And I believe she was also being

1 followed by Dr. Ebama at that point as well.

2 Q. As well?

3 A. Yeah, for the antibiotics and those -- those
4 things.

5 Q. So when you look at this -- this total picture, I
6 mean, how does this infection, this MRSA infection that is
7 diagnosed in September, how does it ultimately -- why can't
8 you all fix it? Why can't you all cure that?

9 A. I wish I knew the answer to that because then we
10 could cure everybody, but I think she is in a minority of
11 people who get reasonable treatment, but still have an
12 imperfect or a bad result. So I -- I don't know why we
13 couldn't get it completely taken care of in her situation.

14 Q. Did you identify anything, either actions taken or
15 lack of actions taken by the treating team that you believed
16 caused her ultimately to develop this osteomyelitis?

17 A. That -- I guess you could always say, well sure
18 you could have done a much more aggressive treatment plan
19 beforehand. So the way you asked the question, I think that
20 might be an answer, but -- but basically I think that I
21 didn't see anything that they didn't do that would be
22 considered wrong. That they -- that they really had a -- a
23 glaring error that wasn't done.

24 Q. All right. And it sort the opposite of that. In
25 terms of the standard of care, which is what we're here

1 about, was it your -- did you formulate opinion whether
2 through this course of time Dr. Frisch and his team with
3 respect to Ms. McGougan in the treatment render did in fact
4 comply with that standard of care?

5 A. I believe he did.

6 Q. Now, in terms of options, had -- had Dr. Frisch
7 chosen to take the patient back on September 19th or
8 September 21st or September 18th, had -- had that data point
9 that available, in the overall scheme of things, would --
10 would those days make a difference when you're dealing with
11 this type of situation?

12 A. I don't think those couple of days would've made a
13 difference.

14 Q. All right. So we know that she has an infection
15 that is treated on September -- in September. Why did she
16 appear to be getting better in your -- in your opinion, in
17 that September time frame?

18 A. Well, part of that I believe, was that he cleaned
19 out a majority of the infection. So there was less infected
20 stuff in there causing inflammation and pain. So I think
21 that's why she felt better. And then I think she ended up
22 feeling worse because it wasn't completely -- infection
23 wasn't completely eradicated.

24 Q. All right. And then let me back up. I think
25 we're talking about the wrong time.

1 A. Oh, sorry.

2 Q. So September --

3 A. Scratch that.

4 Q. So September 8th, she'd come in on the 23rd of
5 August, she had the drainage and then she came back. We --
6 we went through that sort of progression in September out it
7 appeared that things were improving and then they weren't.
8 So what's the explanation for why, if she has the infection
9 brewing, would she see and demonstrate improvement on exam?

10 A. Well, two possible reasons. One is just because
11 -- because some people do tend to wax and wane, but the other
12 is that the -- the fluid at that point may not have yet been
13 infected. When she first had drainage, it may not have been
14 infected.

15 Q. In -- in terms of trying to backdate when did she
16 -- was infected. Are you able to do that as orthopedic
17 surgeon? Is that something you feel are able to do?

18 A. Not really. Not with any reliability.

19 Q. Okay. All right. So then with respect to the
20 MRSA bug that was given, we -- we heard some conversations
21 about pre-screening nasal swabs and things like that. Back
22 in 2016, was the screening process that was described
23 earlier, it was from East Cooper Hospital anyway, you saw
24 (inaudible)?

25 A. Yes.

1 Q. All right. Was that screening process, was that
2 for a reasonable process to use?

3 A. It -- it sure seemed to me. I -- now, I -- I am
4 not an epidemiologist the people who look at infections and
5 the incidences and all those kind of things, but I have to
6 assume that a hospital like East Cooper Hospital would use
7 evidence to put together their screening process to decide
8 whether or not to screen somebody. So I believe it was a
9 reasonable screen.

10 Q. All right. Now, from the presentation that --
11 that Ms. McGougan had in the very beginning knowing the
12 option for surgery, was there any -- any reason not to be
13 cautiously optimistic that she could have a good surgical
14 outcome?

15 A. I think that the -- the typical result in a
16 situation such as hers with the problem she had is that the
17 outcome is pretty good.

18 Q. When we talk about shifting gears to this auto-
19 fusion that -- that we heard about, can you speak a little
20 bit to the -- the mechanism of how that happens in the --
21 after the infection is resolved?

22 A. Well, the process for some reason, and I can't say
23 that I really understand why either, but it does seem to be
24 fairly common that when you get an infection in the disc
25 space it maybe just revs up the -- the bony mechanisms for

1 the bones to fuse together, but it is not uncommon after an
2 infection of the disc space to get an auto-fusion. And I
3 happen to think that's probably not a bad result. Because if
4 it doesn't auto fuse, it's a degenerative segment that often
5 hurts whenever it moves.

6 So I think that maybe that's the body's way of sort of
7 helping this problem out. But I -- I apologize, I'm not
8 being very scientific here, but it's something that you see
9 fairly often and I can't tell you exactly why those bone
10 healing mechanisms get revved up in that situation.

11 Q. And obviously when the body does -- when we've
12 seen the imaging, the -- it's not going to align as if you
13 were in surgery and you had all the morals of modern medicine
14 in there, but when you guys are doing a fusion functionally,
15 how does it compare to an auto-fusion?

16 A. Well, it -- it's about the same thing. The --
17 well, the end result should be the same thing. We -- when we
18 surgically do a fusion, we try to get the bones to knit
19 together to become one solid piece of bone, sort of the same
20 biologic process, like a broken bone healing. You want it to
21 knit together so that it doesn't move.

22 And the Number of reasons we end up doing fusions, but
23 the -- one of the more common ones is pain and deformity.
24 And if it -- if it doesn't move anymore, it's not going to
25 deform anymore. And if it doesn't move anymore, it shouldn't

1 hurt as much.

2 Q. Okay. With respect to the auto-fusion here in
3 terms of potential outcomes for this osteomyelitis,
4 understanding that -- that's a complication, do you consider
5 that to be a favorable resolution in light of the totality of
6 the circumstances?

7 A. Yes. It's -- it's one of those somewhat nebulous
8 things but I -- I think after an infection in the disc space,
9 it's not a bad thing for it to auto fuse.

10 MR. HOOD: Doctor, those are all the questions I have
11 at this time. Please answer any questions these other
12 lawyers may have.

13 THE COURT: You may proceed.

14 MS. MAPLES: Thank you, Your Honor.

15 THE COURT: You're welcome.

16 FURTHER DIRECT EXAMINATION

17 BY MS. MAPLES:

18 Q. Good afternoon, Doctor. My name is Allie Maples
19 and I represent Dr. West. As an orthopedic surgeon, with
20 respect to questions of whether longer or other antibiotics
21 would have maybe eradicated the infection. You would direct
22 those questions to infectious disease, correct?

23 A. Yes.

24 Q. That's why you involve infectious disease in these
25 types of cases?

1 A. Yes.

2 MS. MAPLES: Those are all the questions that I have.

3 THE WITNESS: That was quick.

4 THE COURT: Any questions for the witness?

5 MR. LUGINBILL: Thank you, Your Honor.

6 THE COURT: You are welcome.

7 MR. LUGINBILL: I apologize I have stuff in three tiles
8 on (inaudible).

9 THE COURT: Be careful with that shelf because
10 sometimes it drops.

11 MR. LUGINBILL: That happened last night and did break
12 them.

13 CROSS-EXAMINATION

14 BY MR. LUGINBILL:

15 Q. Good afternoon, Dr. Glaser.

16 A. Good afternoon.

17 Q. I have to say I have -- I have in no way in my 20
18 years, 25 years almost practicing law ever had a chance to
19 meet you, sir.

20 A. That's probably a good thing.

21 Q. Okay. Thank you for being here and helping us
22 with your opinions in this case. Before we go through just a
23 couple of background things and then we'll get into the
24 meeting the hours. Dr. Glaser, as I understand it you have
25 never been a Plaintiff expert for a patient in South

1 Carolina; is that correct?

2 A. I was hired to review records on a case in Hilton
3 had of a missed fracture in the cervical spine many years
4 ago. And was willing to testify. I've had -- they had two
5 or three surgeons and they chose somebody else.

6 Q. So you've never been named (inaudible) and testify
7 against in South Carolina doctor in medical malpractice?

8 A. That's correct.

9 Q. And you have testified that you would not feel
10 comfortable testing against -- testifying against anyone you
11 know, correct?

12 A. Correct.

13 Q. And you know Dr. West obviously?

14 A. I don't know Dr. West.

15 Q. Okay. And do you know Dr. Frisch?

16 A. Yes.

17 Q. And you charged \$400 an hour to review; is that
18 correct?

19 A. Well, when this case was first filed, I did.

20 Q. Okay.

21 A. That's what I -- that's what I've been charging
22 for this. Yes.

23 Q. And \$1,500 to do a deposition, correct?

24 A. No, I think; is that right?

25 Q. Hood said that.

1 A. Sure.

2 Q. Okay.

3 A. Okay.

4 Q. So the reason you hired is because you had to deal
5 with somebody like me, right?

6 A. You said it.

7 Q. And how much do you charge for trial? How much
8 now were you charging for trial?

9 Q. Oh, that's what I -- I'm I apologize when you said
10 the 1500. Yes, that's deposition for trial preparation the
11 whole thing at 5,000.

12 Q. Per day?

13 A. Total.

14 Q. Oh, okay. All right. So I'm going to start with
15 opinion you gave that giving her a Medrol Dosepak two weeks
16 after surgery would increase her risk of infection by less
17 than 1 percent. Can you tell me what you based there?

18 A. Just experience. I don't know that as I think I
19 said this as a nebulous Number , I think that it's a very low
20 risk. If you had told me, well, it's closer to 2 percent. I
21 couldn't disagree with you, but I think it's a low risk.

22 Q. So you have no published authority for that
23 opinion, correct?

24 A. I don't have any literature I can fall back.

25 Q. And you've not done any personal testing in

1 monitoring your patients across your practice monitoring your
2 patients at MUSC? You have done nothing --

3 A. Nothing formal. No. It's -- it's my recollection
4 of 40-plus years now of taking care of postoperative
5 patients.

6 Q. Without doing it in a controlled setting. It is
7 possible to come up with a percentage of the effect of
8 Prednisone because you'd have to isolate every other variable
9 and test only Prednisone, correct?

10 A. If you're looking at a level one study, there's
11 different levels of evidence. This would be a very low level
12 of evidence case reports basically.

13 Q. And obviously you just treating your patients, you
14 would never not give them the other things that they needed
15 just so you could test how much more susceptible they were to
16 infection with Prednisone?

17 A. You mean would I withhold other necessary
18 treatment to do that?

19 Q. Correct.

20 A. I don't think I -- I can't think of a circumstance
21 where I would do that.

22 Q. And is that 1 percent for all your patients or
23 just your RA patients?

24 A. This would be all patients.

25 Q. Presumably a patient has been getting oral

1 steroids over time and had used them before pain has a known
2 response to this is going to be more immunosuppressed than a
3 regular patient?

4 A. The patient who had been using oral steroids over
5 time, did you say?

6 Q. All the patients who had been using them before to
7 treat flare ups and had been -- it had been proven that her
8 body responded to it, would more likely have a greater effect
9 from that Prednisone?

10 A. Greater effect or greater risk?

11 Q. Greater effect. The Prednisone works on that
12 lately, correct?

13 A. Oh, well we don't know if it works for
14 postoperative pain because she hasn't used it for
15 postoperative pain before, but if I'm not sure I -- I'm still
16 unclear. Do you want me to just say -- you're asking me if
17 -- if it's worked before for her, will it work again?

18 Q. Sometimes people take a (inaudible) including
19 Prednisone and they don't have a great response. It just
20 doesn't work for her. Their body doesn't respond to it,
21 correct?

22 A. Yes.

23 Q. Well, we know her body did respond to Prednisone
24 because she's been taking it on and off for years as part of
25 her RA med to cure flare ups, correct?

1 A. For the rheumatoid arthritis?

2 Q. Over rheumatoid.

3 A. So she did respond to route to the steroids for
4 rheumatoid arthritis. Yes.

5 Q. And if the steroid respond to that, it's likely
6 that the suppressive effects are working because that's what
7 the flare up is, correct? That's the overdrive immune
8 system. And so the steroids pushing it back down.

9 A. In the case of rheumatoid arthritis. Yes. In the
10 case of postoperative pain.

11 Q. (Inaudible) pain.

12 A. It's the -- I think that's not unreasonable. When
13 a nerve gets irritated, it gets inflamed. So the steroid is
14 an anti-inflammatory to calm it down.

15 Q. There is no free lunch with bio and biochemistry.
16 If it works to reduce the nerve inflammation, it's also going
17 to work to suppress the immune system, correct?

18 A. Most likely. You're talking about steroids?

19 Q. Yes.

20 A. Yes.

21 Q. And her immune system on between post-op week two
22 and post-op week three because of the steroid Medrol Dosepak
23 was diminished somewhat?

24 A. I -- I think that to say that there is zero
25 diminution would probably be an exaggeration. I just think

1 it's very small.

2 Q. Do you recall the description of the drainage that
3 the patient gave, Ms. McGougan?

4 A. I wasn't here for her testimony. I did read her
5 deposition, but I can't tell you exactly. My -- my
6 recollection is that she said that she had much more
7 drainage. I believe she was changing her dressing four to
8 six times a day at one point she said, but I don't recall
9 what she said about the consistency of it or anything like
10 that.

11 Q. And four to six times a day yellowish color,
12 correct?

13 A. Like I said, I don't recall what she said about
14 that.

15 Q. If it was four to six times a day and yellow-ish
16 in color, do that make it more or less likely that it was
17 infections versus more serous?

18 A. Okay. So a serous drainage can be infected, but I
19 think that it's still to me says it's at that point not
20 tipping me towards saying it's infection. Still saying it's
21 probably what I believe this probably was is a -- a liquified
22 hematoma that drained.

23 Q. When you were asked in your deposition, do you
24 recall that you said it was more likely infection, the way
25 the patient described it.

1 A. Yeah.

2 Q. And the way the PA described it?

3 A. The -- the --

4 MR. HOOD: Objection, Your Honor.

5 THE WITNESS: -- injuries volume makes me tip, oh --

6 THE COURT: Basis?

7 MR. HOOD: Hearsay. Improper use of the deposition.

8 THE COURT: Please repeat the question.

9 BY MR. LUGINBILL:

10 Q. Do you recall that you have previously testified
11 that the way the PA described it, you compare that to the way
12 the client or the patient described it, it was more likely to
13 be infectious?

14 A. Yes.

15 MR. HOOD: Objection.

16 THE COURT: You need to rephrase the question. The
17 answer stands. Please move on.

18 BY MR. LUGINBILL:

19 Q. What is your opinion on when it became infection?
20 Deep wound infection.

21 A. I believe Mr. Hood asked the same thing. I think
22 it's impossible to say exactly, but I think it's probably
23 somewhere between two and six weeks after surgery.

24 Q. And you based it on the fact that that's when it
25 began draining?

1 A. Yeah, it began draining somewhere around there and
2 then pretty clearly was infected at six weeks. So somewhere
3 in that range.

4 Q. If I understood your testimony, a draining wound
5 -- when you have drainage in the post-surgical wound, there's
6 two options. It's either infected or it's not infected?

7 A. I think you could say that about pretty much
8 everything. I mean, like my saliva is either infected or not
9 infected so.

10 Q. True statement or not true statement?

11 A. I -- I don't -- I think it's a true statement.

12 Q. Okay. So wound drainage is either infected or
13 it's not infected. If you're taking antibiotics and it is
14 infected, then we can assume that the antibiotic didn't work,
15 correct?

16 A. If you're taking antibiotics for wound drainage
17 that is infected or you're saying are you taking antibiotics
18 and then it gets infected?

19 Q. Taking antibiotics and then it becomes infected
20 before it starts draining, then those antibiotics were not
21 infected?

22 A. They did not. If you're taking antibiotics and it
23 gets infected, then they did not prevent the infection.

24 Q. Correct?

25 A. Correct.

1 Q. And if you then take different antibiotics and it
2 continues to drain, then the antibiotics aren't stopping the
3 infection if an infection is why it's draining?

4 A. If an infection is why it's draining. So the
5 answer I -- I think is yes and no. Because you -- you think
6 if -- well, if you give more antibiotics it should stop
7 draining. But if you've already got it tracted where the
8 fluid is draining out, even if the fluid becomes sterile, it
9 still may drain out. So it's not a definite, but it would
10 tend to -- make you tend to think that if it's due to an
11 infection, that if you give antibiotics and it continues to
12 drain, it's probably still infected, but you can't say that.
13 I can't say that with certainty.

14 Q. And you can't say that for certain by just looking
15 at it; is that correct?

16 A. Correct.

17 Q. But you could get some additional information.
18 You could culture the wound, you could culture the fluid
19 rather, correct? That all in hearing about what might be
20 wrong with it you can still do that.

21 A. Well, due to the late hour. I agree with
22 Dr. Frisch on that regard.

23 Q. And you could get blood work done and you could
24 check for inflammatory markers, correct?

25 A. You could. I don't think that they are a

1 necessary component to the evaluation, but you could do that.

2 Q. And that would give you more information and you
3 wouldn't be guessing whether that wound was infected.
4 Because if you had a really high sedentary -- sediment rate,
5 if you had a really high CRP, then probably there's an
6 infection going on that's causing more results, right?

7 A. Not necessarily, but it would lean towards it.

8 Q. And the further you got away from the surgery
9 itself, a high CRP or surgery would more strongly indicate
10 there was an infection?

11 A. It's -- it's one factor in looking at possible
12 infection.

13 Q. Didn't say it was only one I said you want one
14 more factor --

15 A. Actually it's two factors, sorry.

16 Q. More likely, correct?

17 A. If the inflammatory markers, the sedimentation
18 rate and the C-reactive protein are markedly elevated you're
19 more suspicious for an infection. But if that person had a
20 cold, the -- the C-reactive protein and the -- the
21 sedimentation rate are going to go up or if they had
22 pneumonia or if their immunosuppressive agents got changed.
23 So there's a Number of factors. I can't tell you that very
24 high inflammatory markers are definitively an infection in
25 her situation.

1 Q. Do you have to know a patient is definitively
2 infected before you intervene to treat that infection or
3 potential infection?

4 A. You don't know that they're definitively infect --
5 well, I shouldn't say that. Sometimes you do know, but most
6 of the time you don't know they're definitively infected
7 until you go look and you take deep cultures.

8 Q. I'm showing you Plaintiff's Exhibit 40, this is
9 Dr. West consult note before we -- consult note. She was
10 then discharged by Minocycline for 10, 40 days and there was
11 perhaps one suture that came out placed on Bactrim.

12 A. That -- that's another name for Bactrim.

13 Q. That's Bactrim. Right. So then she took the
14 antibiotic for approximately one said the following surgery,
15 that her pain was better (inaudible), the suture did come out
16 and now as noted, purulent drainage from where the suture did
17 come out and now has become more serous. Did I read that
18 mostly correctly?

19 A. I believe so.

20 Q. If the patient had serous drainage and that's what
21 was observed, she should have gone back for a washout period
22 and so, correct?

23 A. No. Well, in what time frame are you talking
24 about?

25 Q. You not -- between 8/23 and 8/30.

1 A. I don't understand why you asked that. You're
2 saying that the rest of her history, physical exam, the
3 opinion of the people evaluating her don't matter. It's just
4 serous drainage straight to the operating room?

5 Q. Purulent drainage.

6 A. Oh, I'm sorry. You said, "serous." I think he
7 said serous.

8 Q. I may have.

9 A. Yeah. Okay.

10 Q. Did I follow.

11 A. Purulent, well it is one more thing to say. I'd
12 think about it. It doesn't say how much purulent drainage
13 and also I believe they said the suture came out so you could
14 have a little bit of a, what's called a stitch abscess, which
15 is usually actually not pus, but looks like it.

16 So there's a few other options, but if a whole bunch of
17 pus came out of the wound, then I would've -- which does not
18 sound like it did from what I can tell from the other medical
19 records, then I'd say, sure, you should probably take her to
20 the operating room if a whole bunch of pus is draining out,
21 but I'm not getting that from the rest of the record.

22 Q. Would you agree with me that Dr. West's history
23 physical more accurately or more -- well, I say the line for
24 with the patient's description of her drainage than it does
25 was documented in the records in Southeastern Spine?

1 MS. MAPLES: Objection.

2 THE COURT: Basis?

3 MS. MAPLES: Pitting.

4 THE COURT: Sustained, pitting. Rephrase.

5 BY MR. LUGINBILL:

6 Q. You read the records, correct?

7 A. I'm sorry?

8 Q. You read the records, correct?

9 A. I didn't read every page of every record, no.

10 Q. You've read the office visits specifically on
11 8/23, 8/30, 9/1.

12 A. Yes. Yes.

13 Q. Okay. And in those, the drainage is noted, but
14 not really described in any way in terms of its color, it's
15 scarcity anything like that, correct?

16 A. I believe it's well, you'd I'd have to look at
17 each page, but I believe it was described as serosanguineous.
18 Is that --

19 Q. I'm not.

20 A. Is that wrong? No.

21 Q. Correct.

22 A. So they -- if that's the case then no, it wasn't
23 described. I'm trying to remember when -- when the PA, I
24 heard some of her testimony. I believe she said it was
25 serosanguineous, but I can't tell you that for sure. I --

1 you -- you'd have to look in the record.

2 Q. If there's an infection, you can have an infection
3 and you can have serous drainage, correct?

4 A. Correct.

5 Q. Whole thing can be happening at the same time?

6 A. They can.

7 Q. And so you can have an infected serous drainage
8 from infection and serous fluid together and coming out the
9 opening in wound, right?

10 A. Or serous fluid can get infected.

11 Q. All right. If the discharge instruction
12 (inaudible) you -- you agree that she could have been taken
13 to the operating room as early as 8/30, correct?

14 A. She could have.

15 Q. And that would've been reasonable?

16 A. Yes. I think -- I think both options would be
17 reasonable.

18 Q. Your opinion is simply that the standard of care
19 didn't require?

20 A. Correct.

21 Q. And as I understand every opinion you gave to
22 Mr. Hood, it's all you could do that, but the standard of
23 care didn't require, correct?

24 A. I -- I think that's a reasonable way to put it.

25 Q. So there really are no rules. The rules are

1 whatever the surgeon thinks he should do with what he's got,
2 correct?

3 A. Incorrect. I think that the care that was
4 rendered didn't break the rules.

5 Q. What sets of rules?

6 A. The standard of care rule is what a -- a
7 reasonable, competent physician practicing in this region
8 would have done.

9 Q. All right. Now, you also -- do you think it
10 would've made any difference had she gone back to the
11 operating room on 8/30 versus 9 --

12 A. Nine. Whatever it was.

13 Q. 9/1.

14 A. Yeah. So three weeks difference. I think -- I
15 think I was asked this in my deposition and I believe, I'm
16 still think the same thing. I -- I think maybe, I think that
17 the -- the chances of being able to eradicate the infection
18 may have -- may be a little higher by going in more
19 aggressive earlier. I can't put a Number on that.

20 Q. One thing that -- that really wasn't discussed
21 that I'd like to go over is this idea of -- of laboratory
22 studies in a post infection setting. Is it the standard of
23 care, meaning do most surgeons in most places in this
24 country, if they have to do an IND and they find purulent
25 MRSA in the bed of a -- of a discectomy surgeon space, that

1 they're going to be serially monitored -- that patient is
2 going to be serially monitored after discharge?

3 A. You're talking about seriously monitored --
4 serially monitored with labs?

5 Q. Yes.

6 A. Okay. Not just examination and or -- I'd say that
7 there certainly are surgeons who would I think that I can't
8 give you a statistic, you know, what percentage would and
9 what percentage wouldn't. I think that it is a reasonable
10 thing to monitor that after surgery. But I also once again
11 think that the main thing is to keep an eye on this person,
12 see how they're feeling, see how they're doing. And I think
13 that is more the standard of care than getting serial labs.

14 Q. If you're just looking at a post deep surgical
15 wound patient and all you're doing is looking and saying you
16 feel okay, I don't see anything there. I guess you're okay.
17 That's all you're doing is guessing, right?

18 A. I'm looking at the entire patient, not just a
19 postoperative patient. I'm looking to see how they're doing,
20 I'm asking them how they're doing and I'm evaluating their
21 clinical status.

22 Q. And use that method?

23 A. Which is what doctors have been doing for
24 generations.

25 Q. Well, I hope you get better as time goes on,

1 right?

2 MR. HOOD: Objection, Your Honor.

3 THE WITNESS: Well, I hope it becomes perfect, but --

4 THE COURT: Sir.

5 THE WITNESS: -- I don't think it ever will be --

6 THE COURT: There's objection pending.

7 THE WITNESS: Oh, sorry.

8 THE COURT: Question is stricken. Rephrase. No
9 commentary.

10 BY MR. LUGINBILL:

11 Q. Medicine advances.

12 A. I'm sorry.

13 Q. All the time, correct? We are trying to advance
14 medicine and make it better every day, correct?

15 A. To the best of our ability.

16 Q. That's why we have journals. This is why we have
17 research. That's why we fund research at universities.
18 That's why there is something called Big Pharma we are trying
19 to advance medicine, correct?

20 MR. HOOD: Objection, Your Honor.

21 THE COURT: Basis?

22 MR. HOOD: 403.

23 THE COURT: Sustained.

24 BY MR. LUGINBILL:

25 Q. I'll be (inaudible). Do you know Dr. Cuddy?

1 A. Dr. Brian Cuddy?

2 Q. Yes.

3 A. Yes.

4 Q. Are you familiar with his article that he
5 submitted to Neurosurgery Quarterly called Intervertebral
6 Disc Space Infection?

7 A. No.

8 Q. While on articles, are you familiar with any
9 learning journal that says post deep wound surgery patients
10 you've had a known infection and had a good irrigation. So
11 if somebody had been in the hospital, had an IND and
12 (inaudible) and is then discharged, you know, any study
13 anywhere that recommends that you don't follow them with
14 serial blood work?

15 A. I don't know the study that says you should or
16 shouldn't. That is a high level of evidence study.

17 Q. I'm going to show you --

18 MR. LUGINBILL: May I approach the witness, Your Honor?

19 THE COURT: You may.

20 BY MR. LUGINBILL:

21 Q. This is Dr. Cuddy's chapter and you know
22 Dr. McCutchen as well, I assume. Well, and MUSC?

23 A. I -- I remember the name. I can't remember a
24 specific spelling.

25 Q. Okay. Would turn to -- do not remember very well,

1 but page right there. Page 215.

2 MR. HOOD: Yeah. Your Honor. Objection.

3 THE COURT: Basis?

4 MR. HOOD: Hearsay.

5 THE COURT: I need to know what he's referring to.

6 What is it that you're referring? What is it that you're
7 seeking?

8 Mr. Foreman, ladies and gentlemen, I have a brief
9 matter of law to take up with Counsel. During the break,
10 please do not discuss the case. You can take them right out
11 in the hallway. It's not going to take for a second.

12 (Jury exits courtroom.)

13 THE COURT: Now, I assume you're showing him the
14 article that you just referred to?

15 MR. LUGINBILL: Yes, ma'am.

16 THE COURT: Now, you know he cannot read from that.

17 MR. LUGINBILL: I'm not asking --

18 THE COURT: So tell me what is it exactly you're trying
19 to elicit from him?

20 MR. LUGINBILL: I'm going to ask him if he agrees with
21 the article serial monitoring is recommended.

22 THE COURT: Is there an exception to that line of
23 question?

24 MR. HOOD: Yes, Your Honor. I don't think --

25 THE COURT: And what is the basis of the objection?

1 MR. HOOD: It's hearsay and it doesn't --

2 THE COURT: Well, he is not asking him to repeat it.
3 He's asking if he's read it. He's asked him if -- if -- if
4 the article in any way affects his opinions, which is really
5 the way you should ask the question, you don't get to publish
6 that article.

7 MR. HOOD: So then it would be -- it would be
8 irrelevant to ask him if an article that no one knows what it
9 is, is not in evidence. It helps --

10 THE COURT: Well, it would depend on whether and
11 actually the preparatory questions need to be asked. One is
12 --

13 MR. HOOD: No foundation.

14 THE COURT: Has he ever read it? Has he ever relied on
15 it and formulating an opinion? If he says no, then that's
16 the end of the inquiry.

17 MR. HOOD: Right.

18 THE COURT: You don't get to just publish hearsay under
19 the guise of somebody being an expert.

20 MR. LUGINBILL: Very well, Your Honor. I understand.

21 THE COURT: You can get the jury for me, please. So do
22 you think -- I need jury. You can go ahead and get jury.
23 Yes, ma'am. So if you think you can bring your questions
24 within those guidelines and you can ask them.

25 (Jury enters courtroom.)

1 THE BAILIFF: All jurors present, Your Honor.

2 THE COURT: Thank you. Ladies and gentlemen, we
3 appreciate your patience.

4 You may proceed.

5 BY MR. LUGINBILL:

6 Q. Dr. Glaser (inaudible) looked at the article?

7 A. Not every word.

8 Q. Fair enough. You had testified earlier that lab
9 work is useful, but not required, fair?

10 A. I'm sorry, useful, but what?

11 Q. Not required on the standard of care.

12 A. Correct.

13 Q. Have you relied on any articles at all to come to
14 that conclusion?

15 A. No specific articles. It's been mainly
16 experience, training.

17 Q. And serial lab work ESRs, CRPs, white blood counts
18 are actually important in a post infection setting where a
19 unique infection because you can't tell what's going on down
20 there from just the surface of the skin, correct?

21 A. So are you talking about the setting of a
22 postoperative discitis like they're talking about here or are
23 you're talking about the type of infection that Ms. McGougan
24 had?

25 Q. We'll start with the discitis.

1 A. Okay. They saying in the -- the study that it has
2 --

3 MR. HOOD: Objection.

4 THE COURT: Basis?

5 MR. HOOD: Lack of foundation to be publishing.

6 MR. LUGINBILL: I didn't ask.

7 MR. HOOD: Well, you handed him to -- sorry.

8 THE COURT: Was he -- I -- I understood him to be
9 explaining an answer and then he asked a follow-up question
10 in regards to what -- the answer he -- he gave.

11 MR. HOOD: So it sounded like the witness was reading
12 from the document. It's --

13 THE COURT: Why don't we just start over and you
14 rephrase the question. How's that? That works.

15 BY MR. LUGINBILL:

16 Q. In a discitis patient, serial blood work is
17 important because you can't tell what's going on by the naked
18 eye, correct?

19 A. You cannot tell what's going on by the naked eye.
20 Now you're talking about a postoperative discitis?

21 Q. Correct.

22 A. And one that has already been treated?

23 Q. Correct.

24 A. So you're talking about after she was readmitted?

25 Q. Yeah. Any patient once they've had discitis and

1 they've been treated serial for discitis, serial monitoring
2 required under the standard of care?

3 A. Well, first of all, just to explain to clarify --
4 sorry. Osteomyelitis and discitis I think all -- almost all
5 the time go together.

6 Q. Okay.

7 A. So interchangeable, but in her situation it's a
8 little unusual because the MRI even when she got readmitted
9 didn't show any obvious findings within the disc. So that
10 may not be relevant to her situation. I don't think it's
11 unreasonable to check serial sedimentation rates and those
12 things, but I don't think it's the only way to do it. And I
13 don't think it's required by the standard of care.

14 Q. And postoperative IV antibiotics in an amount more
15 than seven doses post-surgery and not including the
16 presurgical prophylactic dose is seven doses on an irrigation
17 and drainage of a known MRSA infection in the surgical site
18 of a laminectomy or a laminectomy and discectomy within the
19 standard care for a spine surgery?

20 A. Again, sorry, clarification. We -- we talk about
21 IND, some people call that incision and drainage, some people
22 call that irrigation and debridement. So you may be hearing
23 some different terms about that, but I -- as I said before,
24 would defer to infectious disease, but an infection that is
25 not definitely boney. There was no obvious osteomyelitis at

1 that time. I think, it was seven doses?

2 Q. Yes.

3 A. Seven doses of intravenous followed by the oral is
4 an option, a reasonable option.

5 Q. Doctor, have you testified that that's less than
6 what you normally see?

7 A. Yes.

8 Q. Is that in fact less than you normally see?

9 A. Yeah, the people that I've had are infectious
10 disease people I think are probably more aggressive.

11 Q. More is better, isn't it?

12 A. Not necessarily.

13 Q. She needed more in this case, we know that because
14 it came back, right?

15 A. Her infection came back and had she gotten more
16 antibiotics, would it have come back? I can't tell you the
17 answer to that, but as I have said a Number of times, I think
18 what she got was reasonable even though it didn't work in the
19 long run.

20 Q. And literature generally you do review the
21 literature in this field, I assume so?

22 A. I haven't reviewed the literature on how long to
23 give antibiotics for a good while I've deferred to the
24 infectious disease people.

25 Q. Are you familiar with studies that suggest or

1 demonstrate that four to six weeks has a 98 percent
2 successful?

3 MS. MAPLES: Objection.

4 THE COURT: Basis.

5 MS. MAPLES: This question contains hearsay.

6 THE WITNESS: I have to --

7 THE COURT: Sir, there's an objection.

8 THE WITNESS: Oh, I'm sorry.

9 THE COURT: The objection is sustained. Lack of
10 foundation, outside of his expertise. He's indicated he's
11 not familiar with the literature.

12 Ask your next question and the last question is
13 stricken from the record. Ladies and gentlemen, you give it
14 absolutely no consideration in your deliberations.

15 BY MR. LUGINBILL:

16 Q. Based on your decades of experience with spine
17 surgery and there is a sufficient course of IV antibiotics
18 following your deep surgery (inaudible), the patients very
19 rarely have a recurrence of that infection, correct?

20 MS. MAPLES: Objection, Your Honor.

21 THE COURT: Basis?

22 MS. MAPLES: Outside the scope of his expertise.

23 THE COURT: Sustained. Objection sustained. Ask your
24 next question. Outside the scope of his expertise, lack of
25 foundation.

1 BY MR. LUGINBILL:

2 Q. Do you track post-surgical infections of your own
3 patients?

4 A. I don't have a spreadsheet if that's what you're
5 asking. I follow them, but --

6 Q. Speaking of follow, you did testify that somebody
7 needed to follow Ms. McGougan following her September
8 surgery, correct?

9 A. Yes.

10 Q. And part of that follow-up needed to be whether or
11 not the antibiotics were effective, correct?

12 A. I think that's part of evaluating how she's doing
13 in general. So is that what you're getting at? I'm not sure
14 what you mean by that. In terms of whether the antibiotics
15 were effective. The -- when you look at the patient and see
16 how they're doing, you get a feel for how they're effective.
17 In terms of the general outlook, general clinical picture of
18 that human being.

19 Q. Did the patient need to be followed by somebody
20 who is monitoring the infectious disease component of her
21 treatment?

22 A. Do you mean does an infectious disease specialist
23 need to see her after the September surgery? Is that what
24 you're getting at?

25 Q. And if not infectious disease then does somebody

1 else need to see her?

2 A. Well, I think that assuming that the postoperative
3 course is okay, then I think that it was fine for Dr. Frisch
4 to follow her. He saw her after the surgery.

5 Q. And so it's okay to assume and do no blood work to
6 make sure and just wait to see if it comes back?

7 A. It is okay not to do blood work. And if someone
8 is doing relatively well, I think it's perfectly fine. Even
9 though it sounds a bit derogatory to say wait and see and do
10 nothing. I think continuing to observe somebody is
11 reasonable if they're clinically doing okay.

12 Q. And wait and see. You are waiting and seeing for
13 signs of infection to -- to return, but if those signs of
14 infection have returned, you already know it's a deep
15 surgical wound, that that patient is going to have most
16 likely an infection again in the deep surgical site, correct?

17 A. If they have recurrence of symptoms -- you're
18 asking if they have recurrence of symptoms, is it more likely
19 that they have a recurrent infection? Then I think the
20 answer to that is yes. Does it mean they definitely have a
21 recurrent infection? Then the answer is no.

22 Q. And the site of the location is most likely the
23 same place it was infected the first time?

24 A. You're talking about the infection or the pain?

25 Q. The infection.

1 A. The -- the -- the site, I think more likely than
2 not would be in a similar -- maybe not exactly the same, but
3 in a similar area.

4 Q. And this particular deep surgical site, when he
5 removed that purulent fluid, did Dr. Frisch remove the
6 purulent fluid from the bed of a discectomy and laminectomy
7 that purulent fluid would've been in physical contact with
8 both the discs and the lamina, correct?

9 A. Hard to say. The lamina was removed at least.

10 Q. Part of it.

11 A. Right. The -- well, I assume it was a partial-
12 laminectomy. Yes. I never liked the term, "Laminectomy."
13 So partial-laminectomy is the one I like. So the fluid most
14 likely was in contact with the remaining lamina. And I think
15 because the disc space did end up getting infected either the
16 fluid was in contact or there was some bacteria in there.

17 Q. And to a reasonable -- and it is your opinion that
18 the standard of care allows you to wait and see if the
19 infection is coming back and just hope that it doesn't get
20 into the disc and it's going this time?

21 A. I think the standard of care says that you keep an
22 eye on the patient and if things seem to be getting worse,
23 then you evaluate and treat it.

24 Q. And by the time they get worse it's probably
25 already in the disc and the bone it's exactly what happened

1 to Ms. McGougan, correct?

2 A. By the time her symptoms got worse it was -- well
3 it was -- it keep doing that. Most likely in the bone
4 because the MRI was suspicious for osteomyelitis. And given
5 that the disc space did collapse, I think it was probably in
6 the disc.

7 Q. And it was too late by the time her outward
8 symptoms made that apparent?

9 A. Too late for what?

10 Q. To stop it.

11 A. No. They stopped it with intravenous antibiotics,
12 but there was some damage done.

13 Q. It was too late to stop it before it did the
14 damage that she's living with today, fair?

15 A. Yes.

16 Q. But if it had been stopped in September or October
17 or even November, then she wouldn't be here today without an
18 L4-5 disc and with a collapsed auto fused and scoliotic
19 back, correct?

20 A. There's a higher likelihood that she would be
21 without that.

22 Q. More likely than not?

23 A. More or -- it's hard to say. I don't -- because I
24 don't know if there's enough evidence to tell you that one
25 way or the other.

1 MR. LUGINBILL: No further questions.

2 THE COURT: Any redirect for the witness?

3 Redirect EXAMINATION

4 BY MR. HOOD:

5 Q. You were just talking about treatment where
6 there's been a discitis, and you mentioned we have a discitis
7 should probably have osteomyelitis together?

8 A. Correct.

9 Q. When we're talking about that time frame and we're
10 talking about this case that would be in the December,
11 January, February, March time frame, right?

12 A. Yes.

13 Q. And at that point she went over IV antibiotics and
14 was seen regularly in the infectious disease office?

15 A. Yes.

16 Q. That's not in the September time frame different?

17 A. Right.

18 Q. Because her condition was different?

19 A. Correct.

20 Q. All right. You all talked about purulent. I just
21 want to pull that up if we could real quick Exhibit 32. I'm
22 going to help you out. All right. So we're trying to figure
23 out where this information came from. We take a look at the
24 note. That'd be helpful. It says "She said that following
25 the surgery that her pain was better and she seemed to be

1 doing better. She began -- she then began to have more pain
2 and noted purulent drainage where the suture did come out and
3 now has become more serous." Did I read that right?

4 A. I believe so.

5 Q. So when Counsel was asking you whether this story
6 aligns more with what the Plaintiff's saying, this story is
7 coming from the Plaintiff?

8 A. Correct.

9 Q. Where it says she said, right?

10 A. Correct.

11 Q. All right. Doctor, with respect to the opinions
12 regarding the care and treatment rendered by Dr. Frisch and
13 Southeastern Spine, did any of the questions Mr. Luginbill
14 ask you change your opinion? Did they comply with the
15 standard care in this case for this mission?

16 A. No. I believe they complied with the standard of
17 care throughout her treatment.

18 Q. Is that opinion one that you hold a reasonable
19 degree of medical certainty most likely?

20 A. Yes.

21 MR. HOOD: Thank you very much.

22 THE COURT: Any exception to the witness being excused
23 from Plaintiff?

24 MR. LUGINBILL: No, ma'am.

25 THE COURT: From the Defense?

1 MS. MAPLES: No, Your Honor.

2 THE COURT: Mr. Hood, any exception to the witness
3 being excused?

4 MR. HOOD: Oh, no, Your Honor,

5 THE COURT: Sir, you're excused.

6 DR. GLASER: Thank you.

7 THE COURT: You're welcome.

8 DR. GLASER: Do you get these back?

9 THE COURT: You leave them up there.

10 MR. HOOD: We'll take it.

11 THE COURT: Thank you.

12 Mr. Foreman, ladies and gentlemen, we're going to take
13 advantage of this break and testimony to take our evening
14 recess. We'll resume in the morning at 9:00. During the
15 break, please do not discuss the case. And please leave your
16 note pads in your seats. Have a great evening and we'll see
17 you in the morning.

18 (Jury exits courtroom.)

19 THE COURT: All right. Is there anything before we
20 adjourn for the evening, from the Plaintiff?

21 MR. LUGINBILL: No, Your Honor.

22 THE COURT: From the Defense?

23 MR. HOOD: We have a couple housekeeping items that we
24 just need to address, Your Honor.

25 THE COURT: Sure.

1 MR. HOOD: We had some exhibits that there were
2 objections to, I think --

3 THE COURT: Exhibits by Plaintiff or Defense?

4 MR. HOOD: Defense exhibits.

5 THE COURT: Bear with me just one second. I need to
6 look (inaudible). Okay. What Number s are you referring to?

7 MR. HOOD: It's probably, by way of example, the
8 easiest way to do is look at the Plaintiff's -- excuse me,
9 Defendant's Exhibit Number 1.

10 THE COURT: Uh-huh.

11 MR. HOOD: And --

12 THE COURT: So what are you trying to bring to my
13 attention?

14 MR. HOOD: This was objected to by the Plaintiff. And
15 so --

16 THE COURT: Have you made any effort to admit the
17 documents through a witness?

18 MR. HOOD: Well, I'm --

19 THE COURT: That's the only way I can take up the
20 objection.

21 MR. HOOD: Well, if, Your Honor, just hear me out.

22 THE COURT: Sure.

23 MR. HOOD: The -- the objection is that I believe the
24 word guarantor. Patricia McGougan under the theory that that
25 is a collateral source.

1 THE COURT: I'm sorry, say that one more time.

2 MR. HOOD: Yes, ma'am.

3 THE COURT: So what exactly are the documents?

4 MR. HOOD: These are medical records.

5 THE COURT: So why can't you just redact them?

6 MR. HOOD: We have redacted them.

7 THE COURT: I mean, what -- so what's the objection?

8 MR. HOOD: I -- I don't know.

9 MS. FLUMIAN: Your Honor, if I may?

10 THE COURT: Uh-huh.

11 MS. FLUMIAN: The objection is Plaintiff is putting in
12 the identical document. We have redacted by using a large
13 black box over the entirety of the area because that was
14 easiest to invest. If the Defendants are permitted to put in
15 without that black box. And there is the word guarantor,
16 which is synonymous.

17 THE COURT: Why not just black out guarantor. I don't
18 see what the big issue is.

19 MS. FLUMIAN: I don't care either. But I do not want
20 the word guarantor. I've expressed that to Defense Counsel.

21 THE COURT: You all can't just black out the word
22 guarantor.

23 MR. HOOD: I've done it. I'm just trying to move
24 things along.

25 THE COURT: All right. So why don't you show them

1 (inaudible) so she can see.

2 MS. FLUMIAN: Thanks. And then --

3 MR. HOOD: Who are these for?

4 MR. SMYTH: The court reporter needs them.

5 MR. HOOD: Another housekeeping item.

6 THE COURT: Uh-uh. We have to deal one at a time.

7 MR. HOOD: I'm sorry.

8 THE COURT: Have you looked at the -- at the documents,
9 Ms. Flumian?

10 MS. FLUMIAN: Your Honor, just to be absolutely clear
11 what Mr. Hood has handed me is exhibits related specifically
12 to McLeod physician's associates. And these look completely
13 appropriate. I just want to make clear that that was not all
14 --

15 THE COURT: I'm dealing with one through three. I
16 didn't ask more, it's late. I'm tired. I'm ready to go home
17 and eat. Probably way too transparent, but you know, I'm
18 real direct.

19 MS. FLUMIAN: You said it better than me.

20 THE COURT: Yeah.

21 MS. FLUMIAN: Thank you.

22 THE COURT: Yeah. And I assume you all are the same
23 place. So --

24 MR. HOOD: Can -- can I read off the Number s?

25 THE COURT: One through three is it -- we're going to

1 do them one at a time. I need to do this some orderly way.
2 Now, do you have the fact that he has removed the word
3 "Guarantor", does that resolve the issue you all had with
4 Defense one through three?

5 MS. FLUMIAN: Yes, Your Honor.

6 THE COURT: All right. So we can mark them with those
7 without objection?

8 MS. FLUMIAN: Yes, Your Honor.

9 THE COURT: All right. You would give those to the
10 court reporter so that she can do what she needs to do with
11 them.

12 MS. FLUMIAN: I'm so sorry.

13 THE COURT: And then we'll move to the next Number s
14 after that.

15 MS. FLUMIAN: You handed them to me. Perfect. And I
16 messed them up.

17 MR. HOOD: No problem.

18 MS. FLUMIAN: I'm sorry. There's -- there's one and
19 two, I'm sorry, oh one and three. Oh, see I messed it up.

20 THE COURT: And the next one I have was Number 55.
21 What was the issue with that?

22 MS. FLUMIAN: The same as one through three, Your
23 Honor.

24 THE COURT: So did you fix that for 55 and 58? And I
25 assume the same issue as 60 and 61?

1 MS. FLUMIAN: I can approve 55.

2 THE COURT: Pardon me?

3 MS. FLUMIAN: I can approve 55.

4 THE COURT: Uh-huh.

5 MS. FLUMIAN: I can approve 61.

6 THE COURT: Okay. So look at those and see if that
7 issue has been resolved.

8 MS. FLUMIAN: And it also appears with 58 and 60.

9 THE COURT: I need to deal with them one at a time.

10 MS. FLUMIAN: Yes, ma'am.

11 THE COURT: Have you shown her 55? And has the issue
12 been resolved? Have you shown her 55?

13 MR. HOOD: Yes.

14 MS. FLUMIAN: Yes.

15 THE COURT: Issue been resolved. So where is 55?

16 MR. HOOD: Fifty five bringing (inaudible).

17 THE COURT: Please give it to the court reporter, 55 is
18 marked and admitted without objection.

19 (Defendant's Exhibit 55 was admitted into evidence.)

20 THE COURT: That takes us then to 58. What is the
21 issue of 58?

22 MR. HOOD: 58 and 60 are good to go.

23 THE COURT: Is that correct?

24 MS. FLUMIAN: Yes, Your Honor.

25 THE COURT: Okay. So 58 and 60 come in without object

1 -- will you bear with me one second.

2 And what's the issue with 61?

3 MR. HOOD: It's the same thing. This one's good too.

4 MS. FLUMIAN: Yes, Your Honor.

5 THE COURT: That one's fine. Okay. All right. Then
6 according to my notes, that takes us to 88.

7 MR. HOOD: We're not offering that at this time. I
8 think its --

9 THE COURT: I'll mark that is withdrawn. That then
10 took me to 92. Is there an issue with that?

11 MS. FLUMIAN: Resolved. 92 is acceptable.

12 THE COURT: So you all have fixed that as well as 94,
13 I'm assuming?

14 MS. FLUMIAN: Yes, ma'am.

15 MR. HOOD: Still have no issue on that one.

16 MS. FLUMIAN: Yeah. I'm sorry. Did we move to 113?

17 THE COURT: Nope.

18 MR. HOOD: Ninety two and ---

19 THE COURT: Ninety four.

20 MR. HOOD: Objection to the medication list?

21 MS. FLUMIAN: Yep. It's the word "Co-pay."

22 MR. HOOD: Co-pay all.

23 MS. FLUMIAN: Thank you.

24 THE COURT: And 113. It had McLeod Loris' medical
25 list. What was that --

1 MR. HOOD: We're not offering that at this point. I
2 think --

3 THE COURT: So that's withdrawn.

4 MR. HOOD: No, we're just going to fix it.

5 THE COURT: Okay. So you -- oh, I --

6 MR. HOOD: My fix is not a fix. It's a half a fix.

7 THE COURT: You haven't dealt with it yet, and you all
8 deal with that. Okay.

9 MR. HOOD: We not completely. What was 117?

10 THE COURT: And then I had 117. What is that? A
11 functional capacity.

12 MR. HOOD: Yeah, we're -- we're not offering that this
13 time.

14 THE COURT: Okay. And then of -- so according to my
15 list that takes care of everything then, right?

16 MR. HOOD: Except for --

17 THE COURT: Oh, I'm sorry, I have this. No, that's
18 everything.

19 MR. HOOD: Yeah. Except for 113, 117, and 88.

20 THE COURT: Okay. I had that 117 was withdrawn.

21 MR. HOOD: That's right.

22 MR. KERN: That's correct.

23 THE COURT: One hundred and thirteen you said, "You're
24 working on?"

25 MR. HOOD: Yes, ma'am.

1 THE COURT: And 88 I had the -- I don't know why we
2 marked through that. So what's the issue with 88?

3 MR. KERN: Those are duplicates 117 and 88.

4 THE COURT: I had that 88 was withdrawn.

5 MR. KERN: It is.

6 THE COURT: Yeah. Okay. So that's the whole list
7 then, right?

8 MR. HOOD: It is.

9 THE COURT: All right. And what other housekeeping
10 matters is it?

11 MR. LUGINBILL: Nothing from us, Your Honor.

12 MR. HOOD: I think I've had enough housekeeping.

13 THE COURT: Is that everything?

14 MR. HOOD: Whatever it was, is gone it's like a
15 hummingbird.

16 THE COURT: Okay. You know we only have so much
17 capacity. We all been here since 8:30 and now it's 5:26. We
18 -- we -- I think we need to go home and get some rest and
19 start over in the morning. Everybody agree with me? All
20 hearts and mind switch. Have a good evening.

21 (THERE BEING NOTHING FURTHER, THIS HEARING CONCLUDED AT 5:26

22 PM)

23

24

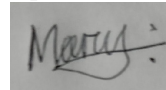
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CERTIFICATE OF TRANSCRIBER

I, MARY RAGSDALE, a court-approved transcriber, do hereby certify that the foregoing is a true, accurate, and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the South Carolina Circuit Court 9 of Charleston County, South Carolina, on the September 12, 2024.

I do further certify that I am neither of kin, Counsel, nor interest to any party hereto.

September 12, 2024

A rectangular box containing a handwritten signature in dark ink. The signature appears to be "Mary" followed by a stylized flourish or surname.

MARY RAGSDALE

Transcriber

1 CONTINUATION OF PROCEEDINGS - SEPTEMBER 13, 2024

2 THE COURT: You may be seated. Good morning.

3 MR. HOOD: Good morning.

4 MR. LUGINBILL: Good morning.

5 MR. SMYTH: Good morning.

6 THE COURT: I hope everybody is well. Is the Plaintiff
7 ready to proceed?

8 MR. LUGINBILL: We are, your Honor.

9 THE COURT: Is the Defense ready to proceed?

10 MR. HOOD: We are, your Honor.

11 MR. SMYTH: Yes, your Honor.

12 THE COURT: They should be finished. Who's the
13 Defense's next witness?

14 MR. KERN: Your Honor, call our last witness, Michael
15 Dailey. He's expert witness.

16 THE COURT: Is he present?

17 MR. KERN: He is.

18 THE COURT: Perfect. And I appreciate you all allowing
19 the jury a little bit of an accommodation. They don't get
20 the \$25 a day. I figured the least I can do is give them a
21 list. I use -- sometimes I do Wednesdays give more
22 motivation, but after I saw the looks on their faces last
23 night, I was like, I think Friday night (inaudible).

24 And then, Mr. Smyth, you have your client and two
25 witnesses as well, correct?

1 MR. SMYTH: Probably my client and one witness, Your
2 Honor.

3 THE COURT: Okay.

4 MR. SMYTH: Given the (inaudible) at this point.

5 THE COURT: Okay. And are there going to be -- and I
6 know this may take additional assessment, but does the
7 Plaintiff intend to call any rebuttal witnesses?

8 MR. LUGINBILL: Your Honor, the only rebuttal that I
9 would offer would be that designated portions of the other
10 deposition.

11 THE COURT: And I have to take that.

12 (Jury enters courtroom.)

13 THE BAILIFF: All jurors present, Your Honor.

14 THE COURT: Thank you. Good morning, ladies and
15 gentlemen, I hope everybody had a pleasant evening. We'll
16 now resume testimony. I would ask that you give Counsel your
17 attention.

18 You may proceed.

19 MR. KERN: Your Honor, at this time the Defense would
20 like to call Dr. Michael Dailey.

21 THE COURT: If the witness would come -- come forward
22 to be sworn.

23 THE CLERK: Please raise your right hand and place your
24 left hand on the Bible.

25 MICHAEL PARKER DAILEY,

1 being duly sworn, testified as follows:

2 THE CLERK: Please be seated. Please state your full
3 name, spelling your last name directly into the microphone.

4 THE WITNESS: Michael Parker Dailey, D-A-I-L-E-Y.

5 THE COURT: And, sir, you can pull the base of that
6 microphone moves so you can pull it closer to you.

7 THE WITNESS: Thank you.

8 THE COURT: You're welcome. You may proceed.

9 MR. KERN: Thank you, Your Honor.

10 THE COURT: You're welcome.

11 DIRECT EXAMINATION

12 BY MR. KERN:

13 Q. Good morning, Dr. Dailey.

14 A. Morning.

15 Q. Please give a jury a sense of your -- your
16 background as infectious disease doctor.

17 A. After undergraduate school I went to microbiology
18 graduate school and got a masters in microbiology. Following
19 this, I went to medical school. After medical school I was
20 -- this was in Detroit. It was after that it was
21 postgraduate training in Milwaukee leading to an infectious
22 disease certification after five years of postgraduate
23 training.

24 Q. Where do you currently live in?

25 A. Currently live in Alpharetta, Georgia.

1 Q. All right. Where -- where did you live in medical
2 school?

3 A. This was in Detroit at Wayne State University.

4 Q. And is that also where you did your residency?

5 A. No, the residency was at the Medical College of
6 Wisconsin in Milwaukee.

7 Q. And what does it mean in your role to be a
8 residency in infectious disease?

9 A. Well, the residency is usually in internal
10 medicine for the internal medicine specialties. So that
11 would be an internship in two years of -- of residency. It's
12 really a fellowship in infectious disease and that's two
13 years additional training.

14 Q. And where do you do that fellowship?

15 A. At the same place at the medical college in
16 Milwaukee.

17 Q. Okay. Are you currently board-certified?

18 A. Yes.

19 Q. What does it mean in practical terms to be a
20 board-certified infectious disease position?

21 A. When I started, there were no infectious disease
22 practitioners in community hospitals. I thought I was going
23 to be offered a job in infectious disease. They said they
24 didn't need anybody in infectious disease, so I was offered a
25 job in critical care. So the first 10 years I did critical

1 care and obviously I did infectious disease too, but they
2 just didn't think of it that way.

3 Q. So now how long have you been practicing medicine
4 in infectious disease?

5 A. Since middle of 40 years. Over 40 years.

6 Q. So in what capacity are you currently engaging in
7 your practice?

8 A. Currently, I -- I -- I started a practice 20 years
9 ago and I retired from that practice for full time. I still
10 work part time on weekends for the doctors there when they're
11 very busy. I still write papers in the infectious disease
12 arena.

13 Q. What is name of your practice?

14 A. It's Infectious Disease Services of Georgia.

15 Q. And what is the -- excuse me general description
16 of what you do?

17 A. It's unusual practice. The critical care training
18 led me to understand that patients did not do well if they
19 were forced to get to the hospital at the last second. So I
20 started a practice to do all the infusion therapy in an
21 office setting with referrals from the community doctors so
22 that they wouldn't have to go to the hospital. They could be
23 treated earlier.

24 Q. Over the course of your career, have you been
25 involved in any national or local medical societies?

1 A. Yes. I was involved with several medical
2 societies. I was probably the -- the latest one. I was
3 president of the in Infectious Disease Society of Georgia for
4 a couple of years.

5 Q. Have you done any other expert work for the state
6 of Georgia or Atlanta in the past few years?

7 A. No, the -- the state of Georgia was several years
8 ago during what was thought to be the first pandemic in 2008.

9 Q. What was that?

10 A. It was -- I was asked to actually to write two
11 papers that related to how do you treat a pandemic, how do
12 you treat patients during the pandemic that have emergency
13 medical problems? In other words, if the hospital is
14 overwhelmed, where do the patients go when they can't go walk
15 into the emergency room?

16 So we develop plans to create basically tent practices
17 on hospital grounds so that you could move all the equipment
18 for emergency medicine into the tent and divert patients with
19 non-pandemic problems into an outpatient setting.

20 MR. KERN: Your Honor, at this time, Defense would like
21 tender Dr. Dailey as an expert in infectious diseases.

22 THE COURT: Any objections to questions?

23 MS. FLUMIAN: No objection, Your Honor.

24 MR. SMYTH: No, Your Honor.

25 THE COURT: So admitted without objection.

1 You may proceed.

2 BY MR. KERN:

3 Q. So, doctor, what does an infectious disease
4 specialist do on a daily basis?

5 A. Well, it -- as I -- as I mentioned previously, it
6 was totally different in the beginning of my practice. Now
7 that there's a -- a full slate of sub-pspecialists in
8 virtually every community hospital most of the infectious
9 disease doctors have a full time practice of infectious
10 disease. There's sort of two tracks that -- that practice
11 has developed. One is a practice in which an infectious
12 disease doctor might go to six hospitals but not have an
13 office at -- at each hospital.

14 So he's more of -- of on -- on the road as opposed to
15 perhaps in a bigger community setting like Atlanta you might
16 be located with, you know, right across the street from two
17 hospitals and your entire practice would be at those two
18 hospitals as well as your office where there -- there were to
19 be much less travel.

20 Q. And do you have experience in your career treating
21 individuals like Mr. McGougan?

22 A. Yes.

23 Q. Like all in (inaudible) paid for your time here
24 today?

25 A. Yes.

1 Q. My law firm reached out to you. Did we hire you
2 to (inaudible)?

3 A. Yes.

4 Q. And at my request, did you review records and
5 testimony to render opinions in this case?

6 A. I did.

7 Q. Did that include the clinical chart at the
8 hospital records?

9 A. Yes.

10 Q. What did you conclude after reviewing the records
11 that we sent?

12 A. Which -- which part of the records?

13 Q. All right. That's a good question. What did you
14 conclude after reviewing the records following
15 Ms. McGougan's discharge from her discectomy for the next six
16 weeks until September 20th?

17 A. I thought that there was a relatively normal
18 postoperative course. It was roughly six weeks. The first
19 two weeks the patient was having some pain symptoms and
20 drainage and by the middle two weeks the patient was
21 significantly better and then problems developed at the very
22 end of the last two weeks.

23 Q. Okay. And what happened in the last two weeks?

24 A. The patient developed pain and fever and there was
25 an indication that there was an infection that most likely

1 was in the operative site and the patient was admitted to the
2 hospital for treatment of that.

3 Q. All right. Just real quick, before we get further
4 down into -- on that. Can you pull up Defense Exhibit 56?
5 Sorry, that's Exhibit 53. Yeah, 53, please sorry. That was
6 it. All right. Can you please blow up the last section
7 there? So this is Defense Exhibit 53. This is Dr. West's
8 care plan when she was admitted to the hospital. And it
9 says, "Minocycline 100 grams POBID times 14 days." Did I
10 read that accurately?

11 A. Yes.

12 Q. Do you have an opinion as to whether that
13 treatment Dr. Frisch should have intervened with that
14 treatment course?

15 A. No, there was -- there was more treatment than
16 just the Minocycline, but yes, that was --

17 Q. That this specific treatment course for when she
18 left the hospital, do you have opinion as to whether
19 Dr. Frisch should have intervened in that?

20 A. No, that was an appropriate treatment.

21 Q. Okay. Thank you. And what was the basis for that
22 opinion?

23 A. The most common postoperative infections after
24 surgery are related to Staph aureus as a bacteria. The
25 patient had an operative culture that was taken in a sterile

1 fashion. It showed that there was methicillin-resistant
2 Staph aureus and this was an appropriate drug for
3 methicillin-resistant Staph aureus.

4 Q. Okay. Thank you. All right. So I want to take a
5 step back and talk about Ms. McGougan's first preoperative
6 course before the discectomy. Okay? Have you read -- have
7 you read those records?

8 A. Yes.

9 Q. Did -- any did in reading those records, did you
10 develop any opinions as to whether an infectious disease
11 specialist should have been consulted before the discectomy?

12 A. I'm going to make sure I understand. You're
13 talking about before the surgery in early August?

14 Q. That's correct.

15 A. I -- there was no evidence that there was an
16 infection at that time.

17 Q. Okay. And is that -- is that the basis for your
18 opinion that infectious diseases are not been consulted?

19 A. Yes.

20 Q. And did you take into consideration in the records
21 Ms. McGougan's medical history, when you was making that
22 determination?

23 A. Yes.

24 Q. So why, I mean (inaudible). All right. So after
25 the discectomy, she underwent treatment for about six weeks

1 with Dr. Frisch's office. Do you recall that?

2 A. Yes.

3 Q. All right. Do you have an opinion about what
4 happened to Ms. McGougan between those discectomy September
5 20th and -- and whether that treatment was appropriate?

6 A. I think that the -- to summarize it, I believe it
7 was appropriate, but what happened was that she developed
8 drainage from the wound, which is a common postoperative. So
9 the issue is whether there was evidence of infection when
10 somebody has drainage and the -- these are well-known issues
11 in which that serous drainage or something that might look
12 like apple juice, for example, clear is not evidence of
13 infection. Serosanguineous, which is more like a mixture of
14 apple juice and a little blood is not evidence of infection,
15 pus is evidence of infection. Everybody knows when they have
16 a -- a boil for example, and that boil pops what that
17 drainage looks like. So it's -- these are relatively clear
18 issues in -- in my field.

19 Q. Okay. So you mentioned something called
20 "Serosanguineous drainage" or "Serous drainage"?

21 A. Yes.

22 Q. Is that related to a seroma?

23 A. It -- it may be related to a seroma. A seroma --

24 Q. Let me stop you. What is a seroma?

25 A. A seroma is a pocket of fluid that's somewhere

1 along the tract of the wound. How this develops is -- I can
2 tell you what it's all -- how people have always expressed
3 it. Supposing there's a little bit of vascular supply that's
4 left at the edge of the wound and that vascular supply weeps
5 into that area and fluid collects and typically it flows out
6 of the exit tract for the wound out -- out to the skin. And
7 so this can occur for weeks or even longer after surgery.

8 So just because there's serous fluid or the apple juice
9 clear fluid doesn't mean you have infection and it doesn't
10 mean you have a seroma. The seroma may occur because perhaps
11 that as the wound heals, it gets closed off and the whatever
12 blood supply is feeding that fluid starts to -- the fluid
13 starts to collect there. So the seroma would be the clear
14 fluid in the middle of this wound, that fluid could
15 subsequently get infected. It could actually be contaminated
16 with bacteria, but not infected. So it's -- it -- it can
17 happen either way.

18 Q. Is seroma different than abscess?

19 A. Yes. Abscess would be more typical. The pus of
20 that you would see with a boil that pops.

21 Q. Okay. So moving on. And you heard the testimony
22 and the records reflect that there was serosanguineous
23 drainage in that time period. Do you remember that?

24 A. Yes.

25 Q. And given the fatality of this patient's

1 presentation, would that tell you that in after the
2 discectomy before she went back to the hospital on September
3 20th, do you have an opinion that she needed to get serial
4 lab work during that time?

5 A. No, not from the standpoint of infection issues.

6 Q. And what is the basis for that opinion?

7 A. Well, you generally, you get laboratory because
8 you're -- you at a point where you're willing to act on the
9 results. If somebody has no signs or symptoms of infection,
10 you're not going to go down some other path until you have a
11 problem. Everything starts with a history and physical in
12 medicine and that's for a reason. It's so we don't go down
13 multiple paths at once in a -- in a fashion that is not
14 helpful.

15 Q. So from an infectious disease perspective, is it
16 the standard of care for serial labs or post discectomy
17 patients does not show the signs of infection?

18 A. No.

19 Q. Do you have an opinion as to whether it have been
20 appropriate for Dr. Frisch or either of the PAs to do a wound
21 swab in Dr. Frisch's office during that time period?

22 A. When you have postoperative drainage and it drains
23 on the skin, that skin is contaminated. We're all
24 contaminated with bacteria. If you nowadays they actually do
25 genetic swabs and we find out that there's 10 or 20 different

1 bacteria on our skin at any one time. These are not
2 important as far as infection is concerned.

3 So you don't -- you don't culture a site that is not
4 sterile unless you have that purulent drainage. If it's that
5 boil-type drainage that is coming out of a wound, that is
6 something that you can culture and get an idea of the
7 quantitative organisms and -- and what it means, but not to
8 -- not to culture serous or serosanguineous fluid.

9 Q. All right. Are there -- would there be, I mean
10 you just explained to us all the different types of bacteria.
11 How many different types of bacteria might be on somebody's
12 skin. I mean, would there be risks to a patient for swabbing
13 a wound in the office in an (inaudible)?

14 A. Well, the risk would be that you'd be foolish
15 enough to treat it. Because obviously -- because treatment
16 with -- with medications have their own risks, so you
17 wouldn't want to do that unless you have a -- a clinical
18 picture that's appropriate to do that.

19 Q. Okay. Okay. Thank you. Did you have a chance to
20 review the records to observe that Anne Buck, one PA Ryan
21 Aprill, the other PA ordered antibiotics in August of 2016?

22 A. Yes.

23 Q. And did -- were you able to develop any opinions
24 about whether prophylactic antibiotics or appropriate for
25 infectious disease prescription?

1 A. It's impaired treatment when somebody has
2 persistent drainage, you're worried that -- that fluid might
3 be collecting somewhere and it wouldn't -- is not
4 unreasonable to treat with the antibiotics at that point, but
5 it's -- it's -- it's not a diagnosis of an infection. We --
6 we do that, you know, in multiple circumstances where we
7 treat with antibiotics empirically a common area is somebody
8 develops a respiratory infection and they're getting better
9 and then five or seven days later you develop different signs
10 and symptoms. You don't do a culture at that point, you
11 treat empirically. So this is just another way of impaired
12 treatment.

13 Q. Did you find that that was within the standard of
14 care from infectious disease perspective?

15 A. I'm sorry.

16 Q. Did you find that that was within the standard of
17 care from infectious disease perspective?

18 A. Yes.

19 Q. Can treating a -- a -- an incision that appears to
20 have a bit of drainage with prophylactic antibiotics also
21 prevent bacteria from potentially getting into potential
22 opening?

23 A. It could.

24 Q. Would that be practice that would be within
25 standard of care from infectious disease perspective?

1 A. Certainly.

2 Q. Based upon your review of the medical records and
3 deposition testimony, do you have an opinion as to whether
4 Patricia McGougan showed objective evidence of an infected
5 abscess prior to September 20, 2016?

6 A. Did not. I -- I believe she did not.

7 Q. What do you base that on?

8 A. Well, at -- at that time she developed worsening
9 pain and fever. And that was the clue that there was
10 something different going on.

11 Q. All right. We've already talked about
12 hospitalization, medications provided to her at discharge by
13 Dr. West. So I just want to ask you a real quick question
14 about, again, about the August time period. Do you find from
15 an infectious disease perspective that there was a need for
16 Ms. McGougan to have a surgical procedure before an abscess
17 and her condition change on September 20?

18 A. No. The reason being is until you have evidence
19 of that problem, you would simply likely create the problem
20 by doing surgery, not solving the problem.

21 Q. All right. And we know that when she was
22 discharged she went and visited Dr. Frisch's office on
23 October 11th for clinical follow-up. Do you recall that from
24 the records?

25 A. Yes.

1 Q. Do you have any opinions about whether or not
2 Dr. Frisch and his team should have been ordering serial
3 laboratory work in October and November to monitor
4 Ms. McGougan?

5 A. I don't think that there was any indication to
6 order the laboratory.

7 Q. Why?

8 A. Because the patient was doing well.

9 Q. How do you know that?

10 A. Because the patient said so.

11 Q. So did it appear from your review of the records
12 that the problem had been solved on September 20th when they
13 identified an abscess?

14 A. Yes, it appeared that way.

15 Q. Okay. From reviewing the records, do you have an
16 opinion as to whether when she was discharged from the
17 hospital, the Dr. Frisch's treatment plan, from your
18 perspective, was appropriate to monitor her at moving
19 forward?

20 A. I -- I believe it was appropriate. I believe it
21 was standard of care. I believe it was standard of care from
22 the infection standpoint.

23 Q. Just real quick, what is a hibernating bacteria?

24 A. Could you repeat that?

25 Q. What is a hibernating bacteria?

1 A. Oh.

2 Q. Sorry, I'm speaking too fast.

3 A. So we -- we all have bacteria in our body. The
4 obvious one is in our gut and we know that every day, but
5 bacteria exists elsewhere in our body that, you know, may be
6 present. A commonplace is in our -- in our nose. And the --
7 the bacteria in our nose may be Staph and it may -- it may be
8 -- it may be associated with severe sepsis even in certain
9 cases, but that -- those bacteria, if they're not doing
10 anything, we don't want to disturb, we -- we want to leave
11 them alone.

12 The body can take care of them in various places, but
13 there's a lot of places within the body that do -- that do
14 not have blood flow and therefore the bacteria can just sort
15 of stay there without being engulfed by the immune system.

16 The obvious one in my career that led to a lot of
17 problems for us was heart valve infections. There's no
18 independent vascularity to the heart valve. So the only
19 blood flow is that the blood flow that's rapidly going by and
20 that created a lot of difficulty getting enough bacteria. We
21 have these spots elsewhere in our body in which a bacteria
22 may exist and may be there. It may not be accessible to the
23 -- to the bloodstream in any functional way. And it doesn't
24 do anything. And it could -- some of it can stay there the
25 whole patient's whole life, otherwise various things can

1 upset that equilibrium and cause a problem.

2 Q. Okay. So that's just something that we know about
3 human body?

4 A. Yes.

5 MR. KERN: That's all the questions I have for you at
6 this time. Thank you.

7 MR. SMYTH: May I please the Court, Your Honor?

8 THE COURT: Yes, sir. You may proceed.

9 MR. SMYTH: Thank you.

10 THE COURT: You're welcome.

11 FURTHER DIRECT EXAMINATION

12 BY MR. SMYTH:

13 Q. Morning, Dr. Dailey.

14 A. Morning.

15 Q. Todd Smyth, I represent Dr. West and his
16 infectious disease practice. I have a few questions about
17 his care. Did you have a chance to review the records that
18 involve Dr. West care as well?

19 A. Yes.

20 Q. In your review of the records, did Ms. McGougan
21 receive Vancomycin when she was in the hospital in September?

22 A. Yes.

23 Q. Is that an appropriate drug to give someone who
24 had the infection she had then?

25 A. Yes, the infection was methicillin resistant Staph

1 aureus Vancomycin is an intravenous appropriate drug for
2 that.

3 Q. Is it the gold standard for treating that type of
4 infection factor?

5 A. We have enough drugs nowadays that I hesitate to
6 say gold standard, but it's very -- very common in the
7 hospital.

8 Q. And I believe that was given to her through an IV
9 for five days in the hospital; is that correct?

10 A. Yes.

11 Q. And do you believe that that drug in that duration
12 was appropriate for methicillin care?

13 A. Yes.

14 Q. And you don't see any reason why she needed to be
15 on IV Vancomycin after her discharge on the 26th of you?

16 A. Well, she was being treated appropriately for the
17 standard of care for a soft-tissue abscess postoperatively.
18 If you were to change that, you could change that and do the
19 standard of care for some other diagnosis, but you'd have to
20 ask -- ask yourself what are the pros and cons of doing that,
21 but --

22 Q. There's risk associated?

23 A. There's risk associated with doing that. Yes.

24 Q. And did you see the records where Dr. West
25 described the Minocycline for Ms. McGougan at the time of her

1 discharge in September?

2 A. Yes.

3 Q. And that was 14 days, twice a day?

4 A. Yes.

5 Q. Do you have an opinion about whether that was
6 appropriate for the MRSA standard of care?

7 A. Yes. It was appropriate for MRSA. Yes.

8 Q. You made a -- a comment just a minute ago that I
9 wanted to follow-up on, you said that she had a soft-tissue
10 infection in September, correct?

11 A. Yes.

12 Q. Right. Is that different from having an infection
13 in the bone or in the disc from your perspective as an
14 infectious disease provider?

15 A. Yes. It's night and day difference and it's -- it
16 it's critical to know which is which that you're dealing
17 with.

18 Q. And does the fact that -- that it is either in the
19 bone or not in the bone, does that determine the pathway that
20 you go down as an infectious disease provider in terms of
21 what treatment to provide?

22 A. Yes.

23 Q. Ms. McGougan had an infection in the bone when she
24 returned in December, I believe, osteomyelitis, correct?

25 A. Yes.

1 Q. Right. And did you review the records from that
2 hospitalization as well?

3 A. Yes.

4 Q. Was more aggressive treatment given at that time?

5 A. Yes, I believe she was treated for three months
6 intravenously.

7 Q. And is that appropriate, does that meet the
8 standard of care?

9 A. Yes. For osteomyelitis in that area. Yes.

10 Q. Did you see any deficiencies where Dr. West in any
11 way deviated from the standard of practice for an infectious
12 disease provider? If you review this case.

13 A. I did not.

14 Q. You hold those opinions to a reasonable degree of
15 medical certainty as a board-certified infectious disease
16 provider?

17 A. I do.

18 MR. SMYTH: Thank you. That's all my questions.

19 THE COURT: Any questions -- excuse me. Any questions
20 for the witness?

21 MS. FLUMIAN: Thank you, Your Honor.

22 THE COURT: You're welcome. You may proceed.

23 CROSS-EXAMINATION

24 BY MS. FLUMIAN:

25 Q. Good morning, Dr. Dailey.

1 A. Good morning.

2 Q. Have you ever been hired by Dr. Frisch's law firm
3 before?

4 A. Yes.

5 Q. How many times?

6 A. I couldn't tell you, but it's probably a couple.

7 Q. Okay. And have you been hired by Dr. West law
8 firm as well?

9 A. Who -- who is Dr. West law firm?

10 Q. Well, that would be Mr. Smyth man who just spoke
11 to.

12 A. Yes.

13 Q. How many times?

14 A. Could be a couple.

15 Q. Have you ever testified on behalf of the
16 Plaintiff?

17 A. Which Plaintiff?

18 Q. Any.

19 A. Yes.

20 Q. How often?

21 A. The first -- this is -- this is varied over my
22 career that -- because of changes in the medical legal
23 issues, but in the first, let's say 10 years, there was the
24 -- the very first case was that I was asked to testify was a
25 criminal case. It was a sexually transmitted infection.

1 Subsequent to that, I was asked to testify on behalf of
2 a Plaintiff's case. And during that case, an attorney, a
3 Defense attorney who asked me questions during a deposition,
4 he then started to ask me to testify. So probably for the
5 first 10 years, it was probably an equal amount. It was
6 probably 18 cases of each when I actually looked at it the
7 one -- one and only time that I looked at it. So it's --
8 that's -- that --

9 Q. You were not hired in this case to provide
10 opinions regarding Dr. West's care, correct?

11 A. I -- I was asked to provide care testimony about
12 the treatment that the patient received from an infectious
13 disease standpoint.

14 Q. But you were hired to speak about Dr. Frisch, not
15 Dr. West, correct? How Dr. Frisch responded not doctor --
16 how Dr. West responded?

17 A. I didn't see a difference from looking at the
18 charts.

19 Q. So you seen as one and the same?

20 A. To me it was one -- it was one continuous problem,
21 yes.

22 Q. Dr. Frisch knew this patient had a sed rate of two
23 prior to surgery on August 2nd, correct?

24 A. I think -- I think so, yes.

25 Q. And he had that information because past primary

1 care provider had sent him her last records of giving him her
2 last follow-up appointment and her most recent labs, right?

3 A. I -- I don't remember who sent it to him.

4 Q. Will you believe me if I tell you the primary care
5 I'm happy to grab.

6 A. I -- I have no reason to doubt that.

7 Q. And he did that because that was in Pat's best
8 interest, correct?

9 A. I don't know why he sent that.

10 Q. What other reason would there be?

11 A. Well, sometimes you ask for records and someone in
12 your office just sends all the records.

13 Q. Do you have any evidence that Dr. Frisch requested
14 those records?

15 A. I -- I don't know anything about how they were
16 requested.

17 Q. But nevertheless, those -- those records provided
18 information about this patient and her medical status before
19 surgery, right?

20 A. Yes.

21 Q. And that included the day of her primary care,
22 obviously, right?

23 A. I -- I -- I accept that. That's true.

24 Q. And then of course that she had RA, right?

25 A. Yes.

1 Q. And the medication she was on, right?

2 A. Yes.

3 Q. And again, her sed rate, right?

4 A. Yes.

5 Q. And that was a snapshot of time showing what kind
6 of patient she was preoperatively, right?

7 A. That was the information.

8 Q. So he had a baseline prior surgery how Pat was
9 doing, right?

10 A. Yes. He had a baseline both on that as far as --
11 as well as examining her and doing what doctors do.

12 Q. And baselines are helpful, aren't they?

13 A. I won't disagree with that.

14 Q. Because they help you later compare how a
15 patient's doing when things change, right?

16 A. You have to be more specific.

17 Q. A baseline is helpful when a patient has a change
18 in the future and you begin testing again, you can compare
19 the two tests, right?

20 A. You -- you have to be more specific about what
21 you're talking about because there is hundreds to thousands
22 of tests in medicine and we don't do them all.

23 Q. No, you don't. But you -- if you had sed rates or
24 before surgery, correct?

25 A. Yes.

1 Q. Okay. So that's a baseline for sed rate, right?

2 A. Yes.

3 Q. Okay. So later on when sed rates were ordered in
4 this case, you can compare them, right?

5 A. Sure.

6 Q. And you testified earlier today that you try to
7 avoid putting a patient into the hospital if possible, right?

8 A. Yes.

9 Q. And that's why you do infusions in the outpatient
10 setting, right?

11 A. Yes.

12 Q. Because it is a hardship for a patient to go into
13 the hospital, right?

14 A. It's bad news usually.

15 Q. It's bad news. We agree. And so anything you can
16 do for a patient in the outpatient setting, you try to do
17 that for them, don't you?

18 A. You have to be more specific.

19 Q. Well, here you do infusions in the outpatient
20 setting, correct?

21 A. I do infusions if they're stable.

22 Q. Fair enough. If a fusion is indicated and safe to
23 do in the outpatient setting you do it, right?

24 A. Yes.

25 Q. Because you try to avoid putting a patient in the

1 hospital whenever possible, right?

2 A. I try to avoid the patient getting so sick that
3 they have to be in the hospital.

4 Q. You prescribe antibiotics not because of infection
5 with drainage, because of the risk of infection, right?

6 A. In which case are you talking about?

7 Q. Well, in this case in your prior deposition you
8 explained that infection is a soup. Do you remember that?

9 A. No.

10 Q. Would you like to see your deposition?

11 A. No. You can -- you can explain that to me.

12 Q. You said, because it is a soup that's lying in the
13 wound all the time.

14 A. Yes.

15 Q. You prescribe antibiotics not because of
16 infection, but because of the risk of infection?

17 A. Sometimes I prescribe antibiotics for a risk of
18 infection. Yes. If it's early postoperative and it's normal
19 serous drainage, there was no reason for me to do that.

20 Q. Okay. And -- and just a few minutes ago,
21 Mr. Smyth said to you that she had five days of -- of
22 Vancomycin, correct?

23 A. Yes.

24 Q. And does it matter to you that in fact she only
25 had three days?

1 A. I believe that she --

2 MR. SMYTH: Objection.

3 THE COURT: Basis?

4 MR. SMYTH: Some facts not in evidence.

5 MS. FLUMIAN: I can rephrase it.

6 THE COURT: Please do. Thank you.

7 BY MS. FLUMIAN:

8 Q. With addition to the one preop dose that was
9 provided on September 22nd, she then began to have doses of
10 Vancomycin on the morning of the 23rd, the afternoon of the
11 23rd, the morning of the 24th, the afternoon of the 24th, the
12 morning of the 25th, and the afternoon of the 25th, and the
13 morning of the 26th, correct?

14 A. I believe that's correct.

15 Q. Okay. So that would be one preop dose and then it
16 would be three days, but the last day the only one dose,
17 correct?

18 A. I believe that's what you said.

19 Q. That's not five days, is it?

20 A. Four days or five days I'll accept either one.

21 Q. Okay. You believe the patient had prolonged
22 drainage that had been present since September 1st, correct?

23 A. It was -- it was present intermittently after her
24 initial surgery and it got -- it was there for a while. It
25 got better for a while and then it got worse for a while.

1 Q. Do you remember in your deposition saying still
2 present?

3 A. If I -- if I said that I said that.

4 Q. And -- and do you recall in your deposition saying
5 that you thought that the Bactrim that had been ordered on
6 August 23rd had been ordered for something other than what
7 was in her actual medical record, right?

8 MR. KERN: Objection, Your Honor.

9 THE COURT: Basis?

10 MR. KERN: Hearsay. And improper use of deposition.

11 (Bench conference.)

12 THE COURT: The objection is sustained.

13 You may proceed.

14 MS. FLUMIAN: Yes, Your Honor.

15 BY MS. FLUMIAN:

16 Q. As a general rule, you believe that you have the
17 ability to do a meaningful culture and doctors should take
18 meaningful culture, correct?

19 A. I don't believe I agree with that statement.

20 Q. Why not?

21 A. Because not all patients have infections.

22 Q. Isn't it culture an a meaningful culture, would
23 that help you determine if they had an infection?

24 A. You have to start with a clinical situation in
25 which an infection is likely.

1 Q. How do we reach a -- a -- a clinical situation
2 without having lab work?

3 A. Because you start with a history and physical.

4 Q. Let's talk about history and physical. You'll
5 agree with me that my client's wound looked exactly the same
6 the day she was admitted to the hospital as it had every
7 single appointment at Southeastern Spine, correct?

8 A. I would say pretty close.

9 Q. Pretty close. You'll agree that there was no, and
10 I'm always going to say this word wrong, arrhythmia? No.
11 Say the word again.

12 A. Erythema.

13 Q. Thank you, sir. Okay. You'll agree with me that
14 she had no evidence of that and no swelling when she was
15 admitted to the hospital on September 20th, correct?

16 A. I -- I don't know that I saw a picture of that,
17 but --

18 Q. Well, did you see any pictures taken by any
19 medical providers in any of my client's records?

20 A. I saw only one picture that I recall, but --

21 Q. And that would be taken by my client, right?

22 A. I couldn't tell you who took it.

23 Q. But in the medical records that you were reviewed
24 before today and before your deposition, did you see any that
25 the doctors took and put in her medical records?

1 A. I don't know that I did.

2 Q. And -- and you know that doctors do that wound
3 photographs are placed in patient records, right?

4 A. I -- I was board-certified or certified in wound
5 care and hyperbaric medicine. With wound care, we take
6 pictures on a routine basis. In the absence of that wound
7 care, we did not take pictures. So routine postoperative
8 pictures aren't necessarily taken by doctors.

9 Q. Do you need to see a photograph of how past wound
10 looked to form opinions today?

11 A. It -- it's -- it's helpful. I can -- if I see a
12 picture, I -- and I'm asked a question. I -- it's helpful.

13 Q. Okay. And so the picture that you do have did not
14 show any of that redness and did not show any swelling,
15 correct?

16 A. I agree. It did not show evidence of infection.

17 Q. And you agree that her history and physical done
18 on September 20th by Dr. Frisch's group says that she had no
19 redness and no swelling, right?

20 A. Yes.

21 Q. And you also know that the hospitalist note from
22 9/20 also said that she had some of that dry pus on the
23 outside of that wound, right?

24 A. I don't recall that those words. Pus -- pus is a
25 different word.

1 Q. I know, but because that word is hard for me to
2 pronounce and because I think the jury probably knows pus
3 better. I'm going to use that word.

4 MR. KERN: Yeah, objection, your Honor. Move to strike
5 that.

6 THE COURT: Basis?

7 MR. KERN: How comments that are not part of the
8 record.

9 THE COURT: Overruled. Thank you.

10 BY MS. FLUMIAN:

11 Q. Okay. I'm now going to show you what has been
12 marked as Plaintiff's Exhibit 36. Are you familiar with this
13 document? Oh, actually, if I can put it on the wall for
14 everybody back up.

15 MR. LUGINBILL: Put it on the wall.

16 BY MS. FLUMIAN:

17 Q. Okay. Sir, may I please take it back from you so
18 I can put it on the wall so everyone can see it? I
19 apologize.

20 A. I mean, I have to have it to -- to -- to see.

21 Q. I -- you're going to see it right here.

22 A. Oh, okay.

23 Q. Is that correct? I apologize.

24 THE COURT: It's new technology.

25 BY MS. FLUMIAN:

1 Q. Okay. So, sir, I'm going to show you -- okay.

2 Have you seen this document before?

3 A. So this is the admission on 9/20.

4 Q. Yes, sir.

5 A. And it's the attending provider is Dr. Frisch and
6 who -- who actually is dictating this.

7 Q. Did you see the words authenticated by which is
8 below reformed by, like right here?

9 A. Authenticated by?

10 Q. You'll see.

11 A. Well, those are a bunch of people that if it says
12 authenticated it, I want to know who wrote it.

13 Q. Okay. You'll see that the document subject is
14 hospitalist. Does that help indicate for you?

15 A. Okay. So maybe a hospitalist wrote this?

16 Q. Correct. Okay. So the hospitalist was brought in
17 by Dr. Frisch, correct?

18 A. I believe so.

19 Q. Okay. And you see here under -- well, "PE" means
20 Physical Exam, doesn't it?

21 A. Yes.

22 Q. Okay. And so the hospitalist performed a physical
23 exam on my client, correct?

24 A. Yes.

25 Q. And what do we see for the skin physical exam?

1 A. "Low bag dressing removed, small pinhole area with
2 crusting of purulent drainage, no odor noted, some edema, and
3 redness noted."

4 Q. And so there was purulent drainage noted when she
5 came in on September 24th?

6 A. I don't -- I don't accept that.

7 Q. You don't accept this medical record?

8 A. No, I don't accept that -- that -- that your --
9 that your statement that this says that it is purulent, it
10 was a crusted wound. That does not indicate purulent.

11 Q. That's not what that says?

12 A. It says crusting. Pus is liquid, crusting is not.

13 Q. And when pus dries, what happens?

14 A. You -- you -- you -- you get crust, but you get
15 crust from a lot of different reasons.

16 Q. And -- but pus when it crusts does exist, right?

17 A. Sure.

18 Q. And that doctor's the one who wrote the note and
19 the one who did the physical exam, correct?

20 A. I -- I don't -- I accept that.

21 Q. Okay. And you're also familiar with Dr. West's
22 consult, correct?

23 A. Yes.

24 Q. Okay. And this is Plaintiff's Exhibit 40?

25 A. Yes.

1 Q. And you're aware that in this note he wrote, "She
2 said that following the surgery that she -- that her pain was
3 better and that she seemed to be doing better. She then
4 began to have some pain and noted some purulent drainage from
5 where the suture did come out and now has become more serous,
6 but she has had a temperature of a 100.6 degrees feels much
7 worse. And the pain is marked (inaudible)." Correct?

8 A. Yes.

9 Q. And your opinion relies on my client never having
10 purulent drainage, correct?

11 A. Purulent drainage -- persistent purulent drainage
12 has not been part of this picture, and I don't know of any
13 document that shows that it was.

14 Q. I just showed you two.

15 MR. KERN: Objection, Your Honor. Misstates the
16 evidence.

17 THE COURT: Please repeat the question.

18 MS. FLUMIAN: I can withdraw.

19 THE COURT: Question withdrawn.

20 BY MS. FLUMIAN:

21 Q. You made a comment earlier about how something
22 drainage that's -- that's cause versus serosanguineous that
23 that is clear in your field, correct?

24 A. Yes.

25 Q. And that's because you're an ID doctor, right?

1 A. I'm a doctor.

2 Q. Well, you have more knowledge about infectious
3 disease than a non-board-certified infectious disease
4 specialist, correct?

5 A. Well, that's true, but this isn't -- this is a
6 common issue with -- with doctors in general. All -- almost
7 all doctors treat this in their training.

8 Q. Fair enough. Isn't it also true that it is
9 possible for a patient to have an infection, a post-of
10 surgical site infection with drainage that's completely clear
11 and odorless?

12 A. Tell me how you would know that?

13 Q. Because you would culture it.

14 A. You don't culture a clear drainage.

15 Q. How do you determine if a patient is suffering
16 from an NTM infection?

17 A. A what?

18 Q. An NTM infection, a non-tuberculosis mycobacterium
19 infection.

20 A. A Nontuberculosis mycobacterium culture is a quite
21 different thing than a regular bacterial culture.

22 Q. I understand, but that is a clear fluid, correct?

23 A. That's not Staph aureus.

24 Q. It's not, but it's clear, right?

25 A. It's not usually -- I don't usually see a drainage

1 in my -- in my experience with tuberculosis.

2 Q. Right. So for an NTM infection, that's a clear
3 odorless fluid, right?

4 A. What type of tuberculosis are you talking about?

5 Q. I'm referring to NTM, which is Nontuberculosis.
6 It's non-tuberculosis.

7 A. If it's Nontuberculosis. What are you talking
8 about?

9 Q. About NTM. Are you not familiar with NTM?

10 MR. KERN: Your Honor.

11 THE COURT: Basis?

12 MR. KERN: Objection. There's 403. This is just --

13 THE COURT: I didn't ask for a speaking objection. The
14 objection is sustained.

15 Rephrase. Move on.

16 BY MS. FLUMIAN:

17 Q. A fever is an unreliable indicator of infection,
18 right?

19 A. It's only one indicator.

20 Q. But in and of itself it's not reliable, right?

21 A. Well, people have fever for a lot of reasons.

22 Q. And people cannot have fever and have an
23 infection, right?

24 A. That's true because fever is cyclic during the
25 day.

1 Q. I'm sorry, say that again.

2 A. Fever is cyclic during the day, during the morning
3 we have less fever and during the night we have more fever
4 so.

5 Q. And some patients, like a patient with
6 immunocompromised status, may not have infection or excuse
7 me, may not have fever in the same way that an
8 immunocompetent patient?

9 A. That's true.

10 Q. So fever is an unreliable indicator in a patient
11 like that?

12 A. It's not an unreliable indicator. It's just one
13 indicator.

14 Q. But not the same type of indicator as if she
15 would've been an immunocompetent patient, right?

16 A. You're -- you're talking about a negative, it's
17 something that's a negative isn't an -- an unreliable
18 indicator. It's just not there.

19 Q. It's just not there. And a patient can have a
20 postoperative surgical site infection and not have an
21 elevated white blood count, right?

22 A. Yes.

23 Q. And because of that, that's why the standard of
24 care requires a sed rate and CRP, right?

25 A. Not true.

1 Q. Is your testimony that the standard of care does
2 not require a sed rate and CRP to determine if there's a
3 postoperative surgical site infection?

4 A. It does --

5 Q. Specifically for spinal surgery?

6 A. In the field of infectious disease, those tests
7 are not required to diagnose a postoperative infection.

8 Q. They're helpful in diagnosing postoperative
9 infection, correct?

10 A. I'd -- I'd have to be shown how that would be.

11 Q. You are aware that the doctor you're defending
12 ordered those tests, right?

13 A. I would have to be aware of the circumstances, how
14 that would help diagnose an infection as opposed to some
15 other inflammatory condition.

16 Q. Why do you think he ordered them?

17 A. You'd have to ask him. The patient had
18 inflammatory conditions for which a sed rate and a C-reactive
19 protein or may be commonly elevated.

20 Q. In this case, is it your testimony that Dr. Frisch
21 ordered those specific tests to check her status of her RA?

22 A. I do not know why he did that.

23 Q. And you don't see any indication in the record any
24 of his notations about why he did that?

25 A. I don't remember any indication, no.

1 Q. Do you remember that he ordered it?

2 A. I do not remember that.

3 Q. Would you like to see those orders or the progress
4 note responding to it? Those -- do you recall what the --
5 the sed rate was?

6 A. No.

7 Q. Does it matter to you what the value of the sed
8 rate and the CRP was?

9 A. Well, if it's -- if it's present, I'll -- I'll --
10 I'll look at it, but I'm -- what I'm saying is, that is not
11 how you diagnose in a postoperative infection.

12 Q. And you're not aware of any standards of care, any
13 studies from any hospitals that indicate the usefulness of a
14 sed rate, and a CRP, and a post-op spinal surgery patient?

15 A. I -- if you are asking me, of all those articles
16 written in -- in the United States, that have to do with
17 postoperative infections, is there one on that? I would not
18 know the answer to that.

19 Q. And you did not seek out any literature about how
20 postoperative spinal surgery infections could be monitored,
21 correct?

22 A. I -- I did not look at any issue related to those
23 parameters, no.

24 Q. And again, Dr. Frisch knew her baseline, right?
25 On sed rate?

1 A. You -- you told me it was two.

2 Q. Right. He -- so it mattered that he already had
3 that baseline if he was going to compare it, correct?

4 A. Didn't matter why.

5 Q. That he was going to compare it?

6 A. I -- I don't know the answer to that question. I
7 -- if you are asking me why he did it, I -- or why he looked
8 at it, I do not know why.

9 Q. And you know that Dr. Ebama, the doctor who
10 followed her Lowcountry Infectious Diseases in Myrtle Beach
11 beginning of January through March, had those tests run
12 weekly on my client?

13 A. If he did, that's fine.

14 THE COURT: You need to make it a question please,
15 Ms. Flumian, not a statement.

16 MS. FLUMIAN: Yes, ma'am.

17 BY MS. FLUMIAN:

18 Q. I apologize, sir, can you give me your answer one
19 more time? I apologize.

20 A. Could you repeat the question one more time?

21 Q. No, I'm sorry. I didn't hear what you just said.

22 A. You'd have to repeat -- repeat the question. I've
23 forgotten that.

24 Q. So going back, you were not aware that Dr. Ebama
25 had been ordering weekly sed rates and CRPs beginning in

1 January through March on my client?

2 A. Well, he -- he might have, but he might have had a
3 reason to do it at that point. We're talking about
4 diagnosing a new infection.

5 Q. She ordered them, I believe most likely to
6 continue to monitor --

7 MR. KERN: Objection, Your Honor.

8 THE COURT: Basis?

9 MR. KERN: Speculation.

10 MS. FLUMIAN: (Crosstalk) I'll rephrase it.

11 THE COURT: Yeah. Thank you.

12 BY MS. FLUMIAN:

13 Q. She ordered those tests as she was continuing to
14 treat the infection, correct?

15 A. I don't know why she ordered it.

16 Q. Was she still treating the infection January
17 through March?

18 A. Yes.

19 Q. And was it important in that treatment for her to
20 know if her treatment was effective?

21 A. Well, it may have been because at that point, at
22 the time that she presented, maybe the sed rate was very --
23 very high and she wanted to follow it coming down.

24 Q. And what would that indicate, sir?

25 A. Well, it would be one indicator of many that

1 inflammatory processes might be improving.

2 Q. And if those markers were coming down, that would
3 mean that her infection was being treated, right?

4 A. It's one indicator of inflammation.

5 Q. And one indicator of inflammation is an indicator
6 for infection, correct?

7 A. Well, the patient had multiple issues related to
8 inflammation.

9 Q. Right. But specifically Dr. Ebama was treating
10 this infection, correct?

11 A. Yes.

12 Q. She was not treating her RA, right?

13 A. Okay.

14 Q. And so her ordering those tests was to determine
15 the effectiveness of these antibiotics and to determine if my
16 client's infection was going away, right?

17 A. Okay.

18 Q. RA can cause pain, right?

19 A. Yes.

20 Q. And so pain is an indicator of a post-op surgical
21 site infection, correct? And -- and specifically it's spine
22 surgery?

23 A. It may be a -- pain may be an indicator, yes.

24 Q. And so for path relying on pain might be hard, it
25 might have less clinical significance, correct?

1 MR. KERN: Objection, Your Honor.

2 THE COURT: Basis?

3 MR. KERN: Speculation.

4 THE COURT: Please rephrase the question.

5 BY MS. FLUMIAN:

6 Q. Is it possible for a doctor to determine -- strike
7 that.

8 You indicated earlier, I believe that if can order a
9 meaningful culture, you will perform meaningful culture,
10 correct?

11 A. Yes. By meaningful, I mean a sterile site
12 infection.

13 Q. And sterility is something that a physician can
14 account for in a -- an office setting, correct?

15 A. To some extent, yes.

16 Q. To some extent. And that would permit he or she
17 to perform an effective, meaningful culture, correct?

18 A. In -- in what circumstance?

19 Q. In a circumstance of a postoperative culture in a
20 patient like Pat.

21 A. With what clinical picture?

22 Q. In a clinical picture of a patient who's reporting
23 a pop of an incision, right?

24 A. A what?

25 Q. A pop of an incision. You are aware that she

1 reported that to her clinicians, correct?

2 A. Could you tell me when you're talking about?

3 Q. Yes, she said that this happened actually when she
4 took that photograph. So that's going to be approximately
5 August 19th.

6 A. So August 2nd was the surgery?

7 Q. Yes, sir.

8 A. August 19th you're talking about? Yes.

9 Q. She reported that she felt a pop of an incision
10 and then a gush of fluid, right?

11 A. Okay.

12 Q. I'm giving you the clinical picture from when you
13 do the -- the culture, sir. So at that point, is it
14 appropriate to do a sterile culture?

15 A. Tell me how you do a sterile culture at that
16 point.

17 Q. Well, you are the doctor, I'm going to defer to
18 you as to how an infectious disease doctor would perform a
19 culture.

20 A. You can't do a sterile culture at that point.

21 Q. Why not?

22 A. Because the patient has contaminated skin and you
23 are not culturing a closed space in which you can get at the
24 fluid, you know, in a sterile fashion. In other words, if
25 you have a fluid collection in -- in the middle of the skin

1 and you can clean it, and then approach it in a sterile
2 fashion after cleaning the skin and getting a sample and you
3 know you have a sterile as close as you can get a sterile
4 sample and then you confirm that by what you find in the
5 laboratory.

6 Q. Could you aspirate it?

7 A. Pardon me?

8 Q. Could you aspirate it?

9 A. Could I aspirate what?

10 Q. The fluid.

11 A. What fluid? From -- from what patient when?

12 Q. Pat McGougan after her incision popped and she
13 reported a gush of fluid and increased pain on August 23rd,
14 could she have been referred to an infectious disease doctor
15 for a meaningful culture, sir?

16 A. No.

17 Q. She couldn't have been referred for that?

18 A. No, because it had already drained out.

19 Q. She could -- is it your testimony that the
20 drainage stopped at that time, sir?

21 A. The drain -- if -- if you're talking about one
22 gush of fluid and then it's back to the same drainage pattern
23 on the skin, it's contaminated fluid. If you want to get at
24 that area, you can get at it surgically perhaps, but you have
25 to first do an imaging study to find out where a collection

1 might be.

2 Q. And do you have any evidence in the record that
3 Dr. Frisch spoke to Pat McGougan about having an MRI in the
4 month of September prior to her admission to the office?

5 A. I -- I believe that that was -- that that happened
6 once, but I don't remember the date.

7 Q. And you know that Pat lives three hours away from
8 Southeastern Spine, correct?

9 A. I do not know that.

10 Q. And she followed up on August 30th, September 1st,
11 and September 8th, correct?

12 A. Yes.

13 Q. And every single one of those appointments,
14 there's no documentation that anyone offered her an MRI,
15 correct?

16 A. I -- I don't believe so. Other than that one
17 time.

18 Q. Earlier we were discussing sed rates. I'm going
19 to show you Plaintiff's 40, this again is when Dr. West's
20 consult note -- her sed rate was noted to be 76 and her
21 C-reactive protein was 10.4. Were those Number s being used,
22 sir?

23 A. They're both elevated.

24 Q. And that would indicate what?

25 A. That some inflammatory process is going on.

1 Q. And we knew at that time that she had some fluid
2 that was being investigated, correct?

3 A. Rephrase that.

4 Q. We know at that time she had some fluid, it was
5 seen on an MRI, right?

6 A. Yes. That was -- that was the hospitalization
7 where they did the IND?

8 Q. Correct.

9 A. Okay.

10 Q. And that was the intention when they brought her
11 into the hospital, right? To perform that IND.

12 A. Yes.

13 Q. And that's why they ordered those tests to help
14 get more pieces to the puzzle to determine if it was a seroma
15 versus an infection, right?

16 A. Or versus an inflammatory process otherwise.

17 Q. When Dr. Frisch and Dr. West were treating my
18 client after September 26th -- excuse me, during her
19 admission in September, Dr. Frisch and Dr. West knew that my
20 client was not receiving her RA medication, correct?

21 A. I believe that's correct, yes.

22 Q. And of course they knew Dr. Shanahan's name,
23 right? Her rheumatologist.

24 A. I don't know who he Dr. Shanahan is.

25 Q. But you -- you are aware that my client had

1 provided them with that information?

2 A. I'm certain that she did.

3 Q. And there's no indication in the record whatsoever
4 that either of those two doctors reached out to Dr. Shanahan,
5 correct?

6 A. You're talking about the time that they knew she
7 had a fluid collection on an MRI with signs and symptoms of
8 infection?

9 Q. Yes.

10 A. No, not to my knowledge.

11 Q. And they did reach out to her primary care,
12 Dr. Harkins, correct?

13 A. I -- not that I'm aware of.

14 Q. And they knew the longer that she stays off her RA
15 meds, the more likely it is that her symptoms are going to
16 start reappearing, correct?

17 A. I'm not an expert in rheumatology, but I believe
18 that that's probably true.

19 Q. And when her symptoms get worse, it's likely that
20 she's going to need to go back on those RA meds eventually,
21 right?

22 A. If she has major RA symptoms, she's going to need
23 some therapy for it, yes.

24 Q. And the medication that they have to use to help
25 her with her RA is immunosuppressive, correct?

1 A. Some of them are immunosuppressive to varying
2 degrees, yes.

3 Q. And the ones that they were using with her
4 specifically Arava, Enbrel, and prednisone, all three of
5 those are immunosuppressive, correct?

6 A. Yes.

7 Q. And they knew that it was a matter of time before
8 those meds were going to be put back on board, correct?

9 MR. KERN: Objection, your Honor. That's speculation.

10 THE COURT: Lack of foundation. Sustained speculation.
11 Rephrase.

12 BY MS. FLUMIAN:

13 Q. They were aware that she was receiving those
14 medications from her rheumatologist and her primary care in
15 the past, correct?

16 A. Yes.

17 Q. And those medications were put on board
18 specifically because of her RA symptoms, correct?

19 A. The steroids were put on for other reasons
20 postoperatively, but the other two, yes.

21 Q. You're aware, sir, that for years prior when my
22 client had RA flares, prednisone specifically was the acute
23 drug of choice, right?

24 A. Yes. And what I'm saying is I don't know when the
25 prednisone or other steroids were being used and what they

1 were being used for, and it's not always RA.

2 Q. Right. But I'm speaking about Dr. Harkins and
3 Dr. Shanahan, the rheumatologist primary care, when they
4 ordered those meds, it was for RA, correct?

5 A. Yes.

6 Q. And they, meaning Dr. Frisch and Dr. West knew
7 when they discharged this patient, she was not on her RA --
8 RAs, correct?

9 A. Correct.

10 Q. And so it was reasonable for them to believe that
11 her RA symptoms would -- would resurface, correct?

12 A. I think that it's reasonable. I don't know the
13 half life of those drugs and I don't know how long it usually
14 takes for symptoms to recur with RA.

15 Q. And they made no effort whatsoever to speak to
16 either of those physicians to coordinate care for Pat and to
17 see what impact this infection and her RA and those meds may
18 have on this infection, correct?

19 A. Well, at that time, the patient was off
20 immunosuppressive drugs and she was doing well at the time
21 that she developed that infection in September. So it
22 wouldn't be necessarily a pertinent issue at that moment.

23 Q. What do you mean?

24 A. I -- I believe that maybe what I said.

25 Q. I didn't understand you.

1 A. If the patient gets better postoperatively and
2 then in -- in mid Sep -- late September develops acute
3 evidence of infection, at that point she's off her
4 medications. At that point, you're not -- you're not going
5 to -- your first thought is not to put her back on
6 immunosuppressive drugs in the middle of infection. So you
7 are where you are.

8 Q. And is it one of the ways for you to know where
9 you are to order lab tests?

10 A. How can you separate the two?

11 Q. Is there value in serially monitoring those lab
12 tests, sir?

13 A. How can you separate infection from rheumatoid
14 arthritis on those tests?

15 Q. Is there a benefit to the patient for an
16 infectious disease doctor in that situation to reach out and
17 speak to the rheumatologist to -- to get more information to
18 help this patient?

19 A. They're certainly welcome to do that if they need
20 to.

21 Q. Is there any evidence in this record that you've
22 seen that either Dr. Frisch or Dr. West ever spoke to any of
23 my clients, other treatment providers to help get more
24 information?

25 A. I don't know of any evidence to that effect.

1 Q. The standard of care for an infectious disease
2 doctor requires that they anticipate what a patient's
3 comorbidities are going to do in the -- in the time period
4 after a discharge, correct? If it is impacted by the
5 infectious disease area.

6 A. Is -- I'm sorry, is that a question?

7 Q. Yes.

8 A. And the question again is what?

9 Q. So if an infectious disease doctor is treating a
10 patient like Pat, who is a comorbidity, just because that
11 patient has an infectious disease doesn't mean that
12 comorbidity is going to go away, right?

13 A. No.

14 Q. And it's possible that the treatment for the
15 infectious disease is going to impact that comorbidity,
16 right?

17 A. It -- it might.

18 Q. And the standard of care requires that an
19 infectious disease doctor think about that and create a -- a
20 plan of care for that patient that takes that into account,
21 correct?

22 A. I -- I don't know of any standard of care that
23 says that. I -- I believe that if the infectious disease
24 doctor is aware of problems that need to be impacted by the
25 rheumatologist, he needs to talk to the rheumatologist, yes.

1 Q. You said earlier that there was no reason to order
2 labs because she was doing well, right?

3 A. I said that at a particular point in time.

4 Q. Right. I think you're saying that after September
5 26th, correct?

6 A. I was -- I was saying that between the August
7 surgery and the September drainage.

8 Q. So is it your testimony that there should have
9 been serial monitoring after September 26th?

10 A. After September 26th, but now a different period
11 of time. So you have an infection that's being treated and
12 the -- the question is, you know, what needs to be done at
13 that time related to the infection? How is the infection
14 doing?

15 MS. FLUMIAN: Thank you, doctor. No more questions.
16 Hold on.

17 BY MS. FLUMIAN:

18 Q. I apologize. One more question. The IND
19 procedure, you've reviewed that procedure room?

20 A. Yes.

21 Q. And so you'll agree with me that the pus was
22 touching the vertebrae, correct?

23 A. I don't agree with that statement.

24 Q. Okay. What was it touching?

25 A. It was touching the soft-tissue in that space.

1 The vertebrae isn't usually visible at that point. You can
2 see the tissue down there, but the -- the bone is not
3 visible.

4 Q. And so your testimony is that no pus was touching
5 the vertebrae or any of those structures inside of that
6 surgical site?

7 A. I'm saying that based on the MRI, there was a
8 soft-tissue infection that was confirmed at surgery and --
9 and that was drained and treated and the patient was treated
10 with antibiotics postoperatively.

11 Q. And an MRI is a good idea. It's a good picture,
12 but there is nothing that beats actually looking into the
13 surgical site, correct?

14 A. I disagree with that statement.

15 Q. You think an MRI gives you a better field of view
16 than actually opening the patient up and looking inside the
17 surgical site?

18 A. If -- if the -- if the surgeon were actually go
19 down and look at the bone, he would take the bacteria right
20 into the bone, he would cause the problem.

21 MS. FLUMIAN: Thank you. No more questions.

22 THE COURT: Any redirect?

23 MR. KERN: Yes, Your Honor.

24 THE COURT: You may proceed.

25 REDIRECT EXAMINATION

1 BY MR. KERN:

2 Q. Just briefly, Dr. Dailey, you're asking questions
3 about Dr. Ebama ordering serial labs at a point in time after
4 December, right?

5 A. Yes. Yes.

6 Q. Versus Dr. Frisch or Dr. West ordering serial labs
7 at a point in time after September 20th?

8 A. Yes.

9 Q. All right. In December and January when this
10 Dr. Ebama's treatment was going on, had she been diagnosed
11 with an osteomyelitis and discitis?

12 A. Yes.

13 Q. Is that different from a soft-tissue infection on
14 September 20th?

15 A. Totally.

16 Q. And so would the monitoring and treatment for that
17 condition be different than what might be expected for the
18 standard of care as of September 26th?

19 A. It's totally different.

20 Q. And -- and why is that?

21 A. Well, the -- if -- if you -- if you look for the
22 standard of care, right? For a soft-tissue infection
23 postoperatively, you'll get a certain procedure and
24 antibiotics. If you look at the -- the standard of care for
25 an osteomyelitis, it's totally different. We're talking

1 about a couple weeks of antibiotics versus several months of
2 antibiotics. The -- the treatment for osteomyelitis needs to
3 be done when you can actually diagnose osteomyelitis.
4 Otherwise you would be treating many patients with six up to
5 -- up to three months of antibiotics. With all the side
6 effects of the antibiotics, people die of clostridium to
7 physio colitis on antibiotics. They die of central line
8 infections while they're on antibiotics. So you have to --
9 you have to know for sure which one you're dealing with at
10 all possible.

11 Q. Okay. So is that important to contextualize how
12 that series of questions just played out to you? The
13 difference --

14 A. Yes. Yes. It was --

15 Q. Go ahead.

16 A. Once somebody has osteomyelitis and you do a sed
17 rate, and it's like I say 100, then of course you can follow
18 that down and maybe if it goes down it's helpful, but maybe
19 if it goes down, it's related to the -- to the RA, but it's
20 only one indicator of how somebody is getting better so. But
21 it's certainly more reasonable and appropriate when -- if
22 somebody has osteomyelitis.

23 Q. All right. And shifting gears a little bit to
24 before this -- this initial discectomy do you recall being
25 cross-examined on the primary care physician ordering a sed

1 rate sometime prior to that?

2 A. Yes. The -- the -- the two?

3 Q. Yes.

4 A. Yes.

5 Q. Do you -- do you have an understanding that at
6 that time when that labs was taken, that she was still on her
7 rheumatoid arthritis medication?

8 A. I assume it was taken sometime prior to her
9 stopping the rheumatoid arthritis medications.

10 Q. And so she also -- that was before the sed rate.
11 Was that before her discectomy?

12 A. Yes.

13 Q. And can going off of your RA medications and
14 having a surgery impact inflammatory markers?

15 A. Yes. Going off the umbrella and -- and other
16 treatments can make the sed rate go up.

17 Q. So does that -- from an infectious disease
18 standpoint, if those labs were taken, would that give you any
19 reliable data?

20 A. No, I wouldn't use that. I would have to use
21 other information, you know, to, you know, make a diagnosis
22 of infection or to suspect it even.

23 Q. There were some questions offered to you about
24 whether Dr. West or Dr. Frisch reached out with her primary
25 care physician after the IND to talk about following. Do you

1 recall that?

2 A. Yes.

3 Q. Can you please go to Exhibit 55, this is Defense's
4 Exhibit 55. This is a progress note from Dr. Harkins on
5 September 28, 2016. Do you see that?

6 A. Yeah. So -- so that is just after the surgery.

7 Q. Two days after she was discharged?

8 A. Yes. Yes.

9 Q. So she went two days after her discharges appeared
10 that she saw her primary care physician?

11 A. Yes.

12 Q. All right. September 20th, you were asked
13 questions about her presentation on that day and tests that
14 Dr. Frisch ordered, do you recall that?

15 A. Yes.

16 Q. Among those were some -- some cold blood cultures
17 when she came in?

18 A. That's -- that's when she came into the hospital
19 for the -- at -- at the soft -- with the -- the soft-tissue
20 infection on the MRI.

21 Q. So you can read to it. In addition to the lab
22 tests, did he also ordered additional testing when she got
23 into the hospital?

24 A. Yes.

25 Q. And did she have a different presentation on

1 September 20th, which she did told you that would've prompted
2 additional testing?

3 MS. FLUMIAN: Objection.

4 THE COURT: Basis?

5 MS. FLUMIAN: Leading.

6 THE COURT: Sustained, leading.

7 BY MR. KERN:

8 Q. Was there anything different about her on
9 September 20th?

10 A. When she was admitted in the hospital, she had
11 signs and symptoms of -- of infection, which were very
12 important that led to her admission to the hospital. The --
13 the studies that were done in the hospital were appropriate
14 for that infection, suspected infection.

15 Q. And so you said something earlier about separating
16 inflammation from the infection on the laboratory results?

17 A. Yes.

18 Q. Is that something that is reliably that you would
19 expect in a patient like Ms. McGougan in this particular
20 case?

21 A. Well, it's -- it is difficult to separate the two
22 with certain tests. You can't separate them based on a sed
23 rate and a C-reactive protein.

24 Q. Yeah, so it's -- it's two -- is that two parts
25 inflammation and infection?

1 A. Well, there's inflammation from infection and then
2 there's inflammation from rheumatoid arthritis or other
3 inflammatory conditions. In a given patient you can have
4 both of those or even more than that because some patients
5 have more than one inflammatory condition.

6 MR. KERN: Thank you very much for your time today.

7 THE COURT: Any objection to the witness being excused
8 from the Plaintiff?

9 MS. FLUMIAN: No, your Honor.

10 THE COURT: From the Defense?

11 MR. SMYTH: No, your Honor.

12 THE COURT: Any exception to the witness being excused?

13 MR. KERN: No, your Honor.

14 THE COURT: Sir, you're excused.

15 Ladies and gentlemen, you all have been sitting about
16 an hour and a half. I'm going to give you a brief restroom
17 break. During the break, please do not discuss the case.
18 Please leave your note pads in your seats.

19 (Jury exits courtroom.)

20 THE COURT: Does the Defendant have any additional
21 witnesses or are you resting?

22 MR. HOOD: There any out in the hallway. I might grab
23 some, otherwise I'm planning to rest.

24 THE COURT: Okay. Well, if you going to do it, go
25 ahead. I would assume you need to go ahead and do it now so

1 I can hear motions or do you all want wait and have --

2 MR. HOOD: Well, I'll -- I'll tell you what I'll do.

3 THE COURT: Uh-huh.

4 MR. HOOD: The -- on behalf of Dr. Frisch and
5 Southeastern Spine, we would rest.

6 THE COURT: Uh-huh.

7 MR. HOOD: And we would incorporate our prior motions
8 by reference and ask for the Court's and Counsel's permission
9 to argue those motions at the close of all evidence.

10 THE COURT: Any exception?

11 MR. LUGINBILL: No, ma'am.

12 THE COURT: All right. We'll be out about, I guess
13 I'll take about 10 minutes.

14 MR. HOOD: Okay. Thank you.

15 THE COURT: You're welcome.

16 (Off the record.)

17 THE COURT: Okay. Are we ready to resume testimony?

18 MR. SMYTH: Yes, Your Honor. Dr. West is going to be
19 our first witness is all right if you guys take --

20 THE COURT: Sure. All right. Please get jury for me.
21 I'm sorry. I should have told you to bring them beforehand.

22 (Jury enters courtroom.)

23 THE BAILIFF: All jurors present, Your Honor.

24 THE COURT: Ladies and gentlemen, I hope you enjoyed
25 your recess. We'll now resume testimony.

1 You may call you next witness.

2 MR. HOOD: At this time, Your Honor, the Defense for
3 Dr. Frisch and Southeastern Spine rest.

4 THE COURT: Motions will be reserved.

5 Going to call you next witness.

6 MR. SMYTH: Thank you, Your Honor.

7 THE COURT: You're welcome.

8 MR. SMYTH: Defense calls Dr. Timothy West to the
9 stand, please.

10 THE CLERK: Please raise your right hand and place your
11 left hand on the Bible.

12 TIMOTHY EUGENE WEST,

13 being duly sworn, testified as follows;

14 THE CLERK: Please be seated. Please state your full
15 name, spelling your last name directly in the microphone.

16 THE WITNESS: Timothy -- Timothy Eugene West. My last
17 name is spelled W-E-S-T.

18 THE COURT: You may proceed.

19 MR. SMYTH: Thank you, Your Honor.

20 THE COURT: You're welcome.

21 DIRECT EXAMINATION

22 BY MR. SMYTH:

23 Q. Good morning, Dr. West.

24 A. Good morning.

25 Q. Please introduce yourself to the jury and tell me

1 a little bit about yourself.

2 A. I'm Timothy West. I was born in Indianapolis,
3 Indiana. I really came to South Carolina in -- to do my
4 internship in residency. I went to college, undergraduate
5 work in Arkansas at a Harding University. My father was a --
6 a minister, and he worked at the Harding Graduate School of
7 Theology in Memphis, Tennessee. I am a preacher's kid and
8 have some notoriety that way, and infamous, I think that way.
9 Anyhow, he was a minister in Indianapolis, Indiana, and flew
10 down to take the job there. So that's where I met my wife at
11 in Arkansas. And we were married just on graduating from --
12 from college.

13 I then went to medical school at Indiana University,
14 which is in Indianapolis. From medical school, as I've
15 already sort of stated. I ended up in -- in Charleston and I
16 did an internship in Charleston at Medical University of
17 South Carolina.

18 I also did my -- I did a residency here. I then did a
19 fellowship first in cardiology, and I decided that wasn't my
20 bag. So I changed to infectious diseases then. And did two
21 years of infectious disease fellowship here in Charleston at
22 -- at Medical University.

23 I did some research that I became interested in, and so
24 I ended up taking a position after that in Buffalo, New York.
25 That was about 1981, that I went there. I was assistant

1 professor of medicine at State University of New York at
2 Buffalo.

3 In 1981 in June, they had a meeting for all the new
4 faculty members and new people. And this individual handed
5 me this article. It was from the notoriety MMWR, from the
6 CDC. And it said that they had noticed several individuals,
7 gay at that time, who developed Pneumocystis pneumonia.
8 The resident that showed me that at this meeting said, I've
9 never seen Pneumocystis pneumonia before in an individual.
10 He says, well, we just got one that has Pneumocystis
11 pneumonia. He was hospitalized here because he came back to
12 his parents that lived in Buffalo.

13 Nothing really happened with AIDS as it was called at
14 that time, until about 1983 when everywhere in the United
15 States. It burst on the scene and it became very notoriety.
16 And -- and everybody talked about it, and they were scared,
17 and nurses were scared. They didn't want to dialyze them.
18 They didn't want to do procedures on them.

19 And it differed from COVID because this was a group of
20 people that could be easily prejudiced against. And that
21 added to all of the trauma of AIDS. The hospital that I was
22 in, Erie County Medical Center also had a lockup ward.
23 Western New York is noted for its collection of prison
24 systems. We received a lot of the hardcore prisons into
25 Western New York from downstate Rikers Islands become sort of

1 infamous. Attica is a prison for the hardcore, and then
2 there's Collins and a whole bunch of them.

3 I started a clinic at that time for AIDS patients at
4 that time. They fascinated me. They fascinated me as a
5 diseases and of the people when you get to know them, they're
6 heartrending. There's -- they're -- they're very touchy. So
7 that came and went.

8 And I then -- also the major reason why I went to State
9 University of New York was because I was interested in
10 research. And my research was Staphylococcal infections.
11 Bacteria have a special way of being virulent. You have
12 bacteria that live on you that don't do much, that just kind
13 of sit around on you. And it's good to have in your GI
14 tract. God knows what they -- they do. They add to diseases
15 sometimes, and they may keep us -- keep us from having
16 diseases.

17 But my research interest was like I said,
18 Staphylococcus and I became -- I had an -- an NIH grant at
19 that time, and they're very difficult to come to -- to get an
20 NIH grant and so I studied virulent factors in Staph aureus.
21 I published some papers, but I ended up the -- the idea was
22 capsules of -- of -- of whether it provided Staphylococci
23 with virulence and made it like pneumococcus is.

24 Q. Okay.

25 A. I'll let you. Sorry.

1 Q. That's all right.

2 A. Then I had a life here back.

3 Q. Well, I was going to ask you a little bit about
4 that. You're married to Marsha?

5 A. Yes.

6 Q. Is she here with you this week? And she's been by
7 your side for 54 years; is that right? And you have two
8 boys?

9 A. Yes.

10 Q. And they're grown?

11 A. Yes.

12 Q. All right. Have you been involved in the
13 community locally since you've been in Charleston?

14 A. Well, I think that's one reason why I came back to
15 Charleston. I noticed I missed the friends that I had here
16 in Charleston and a lot of the residents and people that I
17 was acquainted with and now gone into private practice. So I
18 found a place in private practice and sort of fit right in
19 and just loved it.

20 Q. Great. Let me ask you just a couple of questions.
21 Are you -- you mentioned your fellowship in infectious
22 disease. Are you board-certified in that area?

23 A. Yes.

24 Q. And how long have you been board-certified in
25 infectious disease?

1 A. I think I was board-certified about 1981, maybe
2 1982.

3 Q. And you mentioned that you came back to practice
4 in Charleston in what year?

5 A. I think it was 1986. My wife says we spent five
6 winters in Buffalo, and that was enough.

7 Q. Don't forget that. I understand. And so you
8 practiced in the Charleston area from 1986 until what point?

9 A. I retired in June of 2018. I was 70 years old at
10 the time, and I did keep up some work at a clinic for myself,
11 for the HIV patients that I had followed for years. And --

12 Q. That was on a volunteer basis?

13 A. Yes. And then in 2020 when the COVID was becoming
14 so rampant, I went back to work. They needed more people to
15 help them. So I worked for another two years until the Delta
16 variant which was such a disaster was in 2022. And I worked
17 at Mount Pleasant Roper and at East Cooper during that period
18 of time. So it's pretty much full time during that -- those
19 two years again.

20 Q. And you mentioned some hospital affiliations.
21 Tell the jury what your experience has been working in this
22 community in terms of hospital affiliations?

23 A. I've been mainly associated with Roper St. Francis
24 system, also with East Cooper. I have been head of infection
25 prevention at both the Roper System and at East Cooper for --

1 since, I don't know when, 19 probably '88 something like
2 that.

3 Q. Have you ever published anything in your field?

4 A. It's -- it's very unusual. As you know, in
5 academics it's a publisher parish world, not so much in -- in
6 private practice. You don't think about that. That doesn't
7 make you high or get more patients or anything like that.
8 But I -- over infection prevention, there was sort of the
9 outbreak of MRSA and Roper was affected.

10 Q. Hold on just a second. What is -- tell me what
11 MRSA is please?

12 A. MRSA is Methicillin-Resistant Staph Aureus. It
13 came of age because of our consistent use of antibiotics.

14 Q. And so you mentioned that we're talking about
15 publications. Did you actually do any research into the very
16 bacteria --

17 A. Yeah.

18 Q. -- that we're here about this week?

19 A. We had the problem too, and I sort of took it
20 personal and I saw patients that got MRSA infections and they
21 didn't do well. And so we tried to eradicate it in the --
22 the Roper system. And what we ended up doing after we did
23 many things to sort of see what we could do, we did a study
24 to see if we could put people on isolation, who we should put
25 on isolation, and what that would do to our MRSA infections.

1 So we -- we went through and did all of that. We found that
2 we could pick out carrier population, we could screen them,
3 we could put them under isolation, and it decreased our
4 population of MRSA and we saved lives and we saved the
5 hospital money. We saved them on having passed infections on
6 to people about \$1.5 million.

7 I'm not so sure that Roper really thanked me for that,
8 but it happened and it was published. It -- it was
9 published, it was peer reviewed, and it was published in
10 Infection Control and Hospital Epidemiology, which is the
11 main journal of SHEA, the Physician Oriented Epidemiology
12 group.

13 And it won the Barry Farr Award for the year. And it
14 was given to me at a national meeting of SHEA. So it -- it
15 also had effects beyond just our hospital system. Other
16 people also saw that that was a system that worked. It was
17 not as extremely costly. And it -- it went for quite a
18 while.

19 Q. And have you had other publications in your field
20 as well textbooks or chapters --

21 A. I've had chapters and textbooks in the past. None
22 of that has really been an increase since I -- I went into
23 private practice. Most of all of that was done when I was at
24 -- in state University of New York.

25 Q. All right. Let's turn our focus to why we're here

1 this week. We've obviously been sitting in over here at
2 Counsel table for a week listening to the people talking
3 about your care.

4 A. Right.

5 Q. You have a chance to explain your care of Ms.
6 McGougan in this case?

7 A. Well, I do a lot of work with Southeastern Spine.
8 We have a -- a good relationship with them. And this was a
9 person Ms. McGougan was that was admitted on the 21st, 22nd
10 of September of 2016.

11 Q. And how is it that you get involved in this
12 Ms. McGougan care. You weren't involved in the surgery
13 itself, right?

14 A. No. Nothing at all.

15 Q. So when you came on the scene, this was in
16 September, and I put a calendar here. I know it's been
17 confusing. We've all with these dates, not everyone else
18 has. Now this is approved with put Counsel, so everybody is
19 on board here. So this is a -- a calendar kind of the five
20 months that we're -- we're talking about. So just to orient
21 ourselves, the -- the surgery that happened was in August,
22 correct?

23 A. Yes, August the 2nd.

24 Q. All right. And then she comes into the hospital
25 on the 20th of September?

1 A. Yes.

2 Q. All right. And you get involved the next day?

3 A. Yes.

4 Q. Okay. All right. Now, let's talk a little bit
5 about what you did once you got involved?

6 A. Well, the major thing I did was that she -- I
7 looked at her and she had on -- on her back. It was just a
8 small pinpoint that I could see at that time. Of course, it
9 seems like it's gone back and forth from what they said in
10 testimony this week. But there didn't appear to be
11 appreciable drainage when I -- I looked at it and of course
12 it did change, but she was -- had an MRI scan done before I
13 saw her. And I did review that with Southeastern Spine.

14 Q. All right. I want to show you exhibit that's
15 already in evidence. Defendant's Exhibit 32. I'll just give
16 you a paper copy so you can have it to read. I'm going to
17 put it up on the screen as well. Back up so we can see what
18 this is. Can you tell the jury what Defendant's Exhibit 32
19 is, please?

20 A. It -- it looks like it's -- it's my consultation
21 that was done on September the 21st. Usually what I did was
22 I would see a patient, I would write out my first impressions
23 and -- and put that in the chart, and then I would dictate
24 it. Also, at the same time, I didn't wait on dictating all
25 of this. So this is the admitting history and physical from

1 -- from me.

2 Q. All right. And I'm going to ask you specifically
3 about the physical part. Did you conduct a physical
4 examination of Ms. McGougan for the first time you met her?

5 A. I had to. I -- I did look at her back. I do have
6 that pointed down here. What I said about seeing her back
7 was distinctly different, it seemed like, than what everybody
8 else was doing. So I don't think I just accepted that from
9 somebody else. Now, it may be at this time that we did a
10 culture on her. When she came in, we did a nares culture
11 because she had been re-hospitalized, and that's one of our
12 categories to do that on a re-hospitalization coming from a
13 nursing home, are having chronic renal failure and being on
14 dialysis catheter.

15 So she was screened and she was found to have be
16 carrying MRSA in her nares. So by all of our standards, we
17 put her on gloves, gowns, hand washing, face masks
18 precautions is what we did to try to then spread. Everybody
19 did it. Physical therapy nurses, everybody followed that
20 protocol.

21 Q. So based on her positive MRSA swabs, she was put
22 in what you call contact isolation?

23 A. Yes, that's correct.

24 Q. All right. Does that prevent you from going in a
25 patient's room and doing a physical exam?

1 A. It doesn't prevent you, it just makes it more
2 difficult. And that was one of the problems with putting
3 people in isolation. As time has gone on, we have less MRSA
4 infections that are spread in the hospital. So there's been
5 a movement to sort of trim that away to some. Now, we still
6 -- it's still done at the Roper system and also at East
7 Cooper.

8 Q. Okay. I want to look at the physical exam that
9 you -- we've got highlighted here on the screen. Can you
10 tell the jury a little bit about what you did in order to
11 gather that information from Ms. McGougan?

12 A. Well, I would've talked to her and the major thing
13 is I would've listened to her and it would have been
14 important to listen to her heart and look at her back and
15 look at her extremities and -- and all of that. Those
16 would've been the main things that I would've done.

17 Q. It's been suggested earlier this week that you
18 only stuck your head in the door and didn't do an exam. Does
19 that -- is that consistent with what you're reading there?

20 A. No, I don't think it -- it is. And I -- I hope
21 that I didn't give anybody that impression because it always
22 irritated me since I was the head of infection prevention,
23 that some people would do that. Some people would just stick
24 their head in the door and say, how you doing? And then
25 stick their head back out the door, but I tried not to do

1 that. It doesn't mean that I would put on gloves, gowns, and
2 everything and go in and hug the person.

3 Q. Right.

4 A. But I did try to step in, get by the -- the bed
5 and talk with the individuals.

6 Q. Let's look at some of the things that -- that are
7 contained in your physical exam. There's vital signs there
8 are those signs that you would've obtained?

9 A. Probably not. I probably would not -- I -- I
10 would not have obtained the blood pressure, that's for sure.
11 I would not have obtained the temperature or anything. All
12 of that would've been taken from the notes.

13 Q. You said you listen to her heart. Is that what
14 you see where no gallops and her notes?

15 A. Right. That -- that's --

16 Q. What -- how do you -- how do you listen to that?

17 A. Well, sometimes they have a dedicated we would put
18 a dedicated stethoscope in the -- the room. Otherwise
19 sometimes we would use our own stethoscope, but it would
20 that's more difficult. We would have to clean the -- the
21 stethoscope afterwards.

22 Q. But it involves putting a stethoscope on the
23 patient?

24 A. Yes.

25 Q. Okay.

1 A. That's what that would involve.

2 Q. And then there's a comment there under extremities
3 about her incision. Did you actually look at the incision
4 site?

5 A. I would imagine that I did. It's been eight years
6 ago, but I -- I -- I believe that I did because my
7 examination was a little bit different than what everybody
8 else wrote.

9 Q. Right. And the last sentence of that says, "I do
10 not see anybody at present." Does that help you remember
11 whether you would -- would've looked at the wound?

12 A. I can't -- I can't really recall.

13 Q. Okay. So based on the information that you had
14 from talking with Dr. Frisch and talking with the patient,
15 what did you do as a consultant and infectious disease at
16 this point?

17 A. Well, the -- the major thing was, I -- I did he
18 had a Southeastern Spine had a group of very good nurse
19 practitioners. And we -- they were much better at looking at
20 MRIs than -- than I was. And so I usually went over the MRIs
21 with them, and I could learn a lot just from going over these
22 studies with them and seeing what the radiologist said. So I
23 would've gone over that. And she Ms. McGougan seemed to be
24 stable. She seemed not to be in any critical shape or blood
25 pressure, and vital signs were okay. So I thought the best

1 thing to do is make sure that we obtained the best cultures
2 possible.

3 So doing that, I decided to wait on antibiotics. She
4 was stable again, as I said. And it surgery we could get a
5 culture there, and then we could empirically or --
6 empirically means you just take your best shot. And it was
7 that this was probably infected with MRSA. So then I had her
8 started on Vancomycin. Vancomycin is usually, it is a drug
9 that's given every 12 hours, and it would've continued
10 throughout her hospitalization. At that day, if surgery was
11 done in the evening, she may have got -- may have received
12 just one dose of Vancomycin, and then she would've received
13 two doses of Vancomycin each day until the day she was
14 discharged.

15 Q. Right. I want to go back and just clarify one
16 point. So the reason that you waited to start an antibiotic
17 until you had culture is what?

18 A. Well, we wanted to know the exact bacteria that
19 was there. That was sometimes you see people getting all
20 kinds of different antibiotics and then down the road they
21 go, well, maybe we should have drained that or something.
22 And then it's like, well, what was the real pathogen there?
23 What are you really treating? What are you doing? And then
24 you're -- you're stuck with giving a whole lot of
25 antibiotics, usually, like the cause of MRSA. We don't like

1 to give broad, what they call broad spectrum antibiotics.
2 Something that covers everything in the world. We don't like
3 to give things like (inaudible) if we don't have to really
4 tough antibiotics. We like to be simple, straightforward and
5 hit the -- the only pathogen that's there causing problems.

6 Q. Okay. And you mentioned that you probably
7 would've talked to someone from Southeastern Spine above the
8 MRI results. Was there anything important that you learned
9 about the MRI in terms of where this abscess was located that
10 informed your treatment?

11 A. Well, it was at the site where she previously had
12 the -- the discectomy at L4-5. In looking at the MRI and
13 looking at it with other people and with the radiology
14 report, it seemed like it was a fairly localized infection
15 there. There did not seem to be fluid in anything in the
16 bones which was extremely important that there was nothing
17 there.

18 Q. I'm going to stop you there for a second. Why is
19 it important that there was no infection there in the bones
20 of the disc construction at that time?

21 A. Well, that gives the idea that -- that's
22 osteomyelitis, which is a -- a major problem that we would
23 deal with. It -- it is one thing to take care of just a
24 localized abscess. Abscesses, like on your arm you could go
25 into the emergency room, it would be drained, and sometimes

1 they don't even give you antibiotics, but the draining is the
2 main thing. As long as you've got a localized abscess, it's
3 not going to be able to get antibiotics into it. And your
4 own body immune system, like with white blood cells, is not
5 going to be able to clear it up. It has to be drained.
6 That's the primary thing that you have to do to get rid of
7 it. It's got to be drained.

8 Q. And you use the term localized. Does that mean
9 it's just contained?

10 A. Right.

11 Q. It's in a specific area?

12 A. And actually I talked to Dr. Frisch after the
13 surgery. It was probably a couple days after the surgery,
14 but he described it to me. He says, oh, it's small, it's no
15 big deal. He says, I looked all around it. I -- it -- it's
16 just really small, contained I drained it. So I don't think
17 this is really going to be a big problem.

18 Q. Okay. So as I understand it, your next
19 involvement would be once they've already done the incision
20 and drainage and sent it out for cultures?

21 A. Yes.

22 Q. And did you --

23 A. Well, I saw her every day, that's for sure.

24 Q. What -- I was going to ask next question.

25 A. Yes.

1 Q. I'm going to show you what has already been marked
2 and entered as Defendant's Exhibit 4 -- or 44 excuse. And do
3 you recognize that document?

4 A. Well, this was written from the 23rd. So I did
5 point out that the day before that there was surgery wash
6 out. That means he -- he drained it, cleaned it all out
7 inside. I put down some of the medications. She was on a
8 medication for acid secretion, hyperacidity. And I kind of
9 liked a different one because it had immunologic effects that
10 might be advantageous. And I put that I started her on
11 Vancomycin, one gram at surgery, and I put down what her
12 renal function laboratory values should, because Vancomycin
13 is renal toxic. And then I put --

14 Q. Renal meaning kidneys?

15 A. Kidneys, yes. And -- and I put down that the
16 cultures pending and that yes, she is MRSA colonized. So
17 much likely she has been infected with MRSA. And I put down
18 that the Vancomycin dose was 1.25 grams, IV every 12 hours.

19 Q. Okay. And above that where it said add
20 Vancomycin, what -- what does that say?

21 A. Feels much better. There's nothing like having an
22 abscess drain to make you feel better.

23 Q. Right. And was that the result that you wanted
24 when -- when the plan was to do the IV you want the patient
25 to start feeling better once that --

1 A. Yeah.

2 Q. -- infection was removed?

3 A. I think improvement usually becomes very quick
4 with something like that. Even though it's -- it's -- it was
5 relatively small abscess, it was I think three centimeters by
6 one and a half by two, something like that. So that's, oh,
7 maybe an a little bit more than an inch in size.

8 Q. All right. You mentioned a couple of times that
9 the -- this language that culture for pending, does it take
10 some time for you to get culture results back once they've
11 been sent to the lab?

12 A. Yes, it usually does. Sometimes when you get
13 cultures out of a -- out of a person, these the bacteria is
14 been under assault when it's in your body. You've tried to
15 get rid of it. So even when you get the cultures and you
16 plate them out, they're under a certain amount of stress and
17 you don't culture them out like you might out of something
18 else, because it -- it takes a little while.

19 Q. When you say a little while is it three, four
20 days, five days in class?

21 A. It -- it could be. And we've been known --
22 depending upon the pathogen, we've been known to keep them,
23 oh, like, for six -- six days, six weeks, things like that.
24 To -- to try to -- to figure out what's in there.

25 Q. Again, you're waiting on that information to

1 decide which antibiotic --

2 A. Yeah.

3 Q. -- is applicable?

4 A. Well, I felt fairly comfortable with Vancomycin
5 anaerobic bacteria. Bacteria that do not like oxygen. They
6 sometimes have to be continued to be incubated for many days
7 especially.

8 Q. Next exhibit is Defendant's Exhibit 45. Did you
9 recommend that?

10 A. This would've been from the next day from the
11 24th. Her blood pressure is good. She's got a heart rate of
12 73, and I put down that she is on Vancomycin 1.25 grams still
13 every 12 hours. They did a gram stain on the fluid that they
14 obtained at surgery. You know, a gram stain is something
15 that shows what sort of a rough idea, what type of bacteria
16 it is. Is it an E-coli? Like it would be from your stool,
17 which is a gram-negative, or -- or is it a Staph? A Staph
18 would be a -- is a gram-positive, much like a strep is.

19 And this says rare GPCs is what it says. So it's a
20 rare Gram-positive caucus. And I put down that "She's much
21 improved and she's been up walking which is all a good sign.
22 And I await culture results. She doesn't have a fever. Her
23 heart rate's 69" and all of that.

24 Q. Okay. And it looks like we've got the next day's
25 notes --

1 A. Yeah.

2 Q. -- below that?

3 A. Right. This is from the 25th. And it basically
4 says about the same thing. She doesn't have a fever, she's
5 got a heart rate of 69. She is on Vancomycin and 1.25 grams
6 IV every 12 hours. And on that date, it still seems like
7 there's no growth of the bacteria from this abscess that
8 there, and I said that it's still a GPC not really any change
9 or weight identification of the GPCs.

10 Q. Okay. And then below that under "9/22" -- I'm
11 going to highlight this area and ask you to translate your
12 writing for us, tell us what that say?

13 A. I'm -- I'm confused under --

14 Q. The -- the two lines I just highlighted there.

15 A. Oh, the -- the -- at the bottom?

16 Q. Yes.

17 A. It says, "She had problems with her IVs that --
18 and she evidently" -- I don't know whether I'm saying she's
19 frustrated or I'm frustrated, "I've got frustrated with IVs
20 going out." And that --

21 Q. Is that the IV that she's getting the --

22 A. The -- the Vancomycin, yes. And that's always a
23 problem with giving IV drugs.

24 Q. And -- and what does it say below that?

25 A. "Otherwise no change."

1 Q. Okay. All right. And did you see Ms. McGougan
2 again the next day?

3 A. I did see her. I really I saw her that morning on
4 the 26th, and I put down again that she's on Vancomycin 1.25
5 grams IV every 12 hours. I did put down that she had a white
6 blood cell count of 7,000. Hemoglobin was nine, which is a
7 little low, and hematocrit was 31.4. And her platelet count
8 313,000. She -- 9.6 was her hemoglobin. That's a little bit
9 low. It's not horrible.

10 Q. Let me stop you there. What -- why are you --
11 what do those Number s matter to you?

12 A. Well, you -- you kind of want to know maybe she
13 had excessive bleeding from surgery, but that's -- that
14 really didn't happen. And just to give you an idea, we
15 always check CBCs.

16 Q. Okay. That routine for --

17 A. Routine, yeah.

18 Q. Okay.

19 A. No, not a -- not a real big concern or anything.
20 And I just put, again, doing well probably could go on
21 Minocycline 100 milligrams PO BID for 14 days. That didn't
22 mean she was going to go right then. And I -- I actually,
23 going on, I'm --

24 Q. Yeah. I -- I was going to ask you next, was that
25 the last time you -- this is the day she was discharged?

1 A. Right.

2 Q. Did you see her again that day?

3 A. Yeah, I came back and saw her again. And there's
4 several reasons why I came back to see her. It's -- it's not
5 easy to come back and see her because day -- day is fairly
6 long day and other people would be waiting to see me, but
7 also on her -- her side of the coin she has a long way to
8 travel, three hours. And it was frustrating for her to wait
9 to see me. And so I came back to see her. I -- I wanted to
10 make sure that she obtained the right antibiotic. Surgical
11 Southeastern Spine they're more used to giving Doxycycline.
12 I wanted Minocycline. And there's all kinds of reasons why I
13 would've picked Minocycline, which probably we we're going to
14 go into.

15 Q. Exactly. Let's talk about that now. So you're at
16 the point of discharge. Do you have the culture results
17 back?

18 A. I had the culture results back, and the culture
19 results go through and they show what antibiotics that the
20 Staph aureus is sensitive to it. It identified it as
21 methicillin-resistant Staph aureus. The Staph aureus was
22 sensitive to some of the drugs. You would think it would be,
23 it was sensitive to Vancomycin. It was sensitive to
24 Linezolid. It was sensitive to Minocycline. It was
25 sensitive to Doxycycline.

1 The -- the thing that you have to go through is, well,
2 that's nice, what do you do now? What one do you think would
3 be best? What -- what should we give her? How long will we
4 treat her? So you have to -- that the laboratory gives you
5 this information, but they don't really tell you. They take
6 it down to where it's most -- it's sensitive, but they don't
7 take it down any further to show you maybe which antibiotic
8 it's most sensitive to.

9 Like with Doxycycline, Doxycycline usually hits MRSA,
10 but not to the same level that Minocycline does. If you
11 wanted to use say Doxycycline, it may have -- they -- it --
12 it usually and I'm -- I can't speak from the results, but
13 usually the results would be at one level that it takes a
14 higher amount of Doxycycline in the bloodstream or in the
15 tissue, especially a higher amount than it would take of
16 Minocycline. Minocycline would be it would take much less
17 antibiotic in the tissues are in the blood to have activity
18 toward the Staph aureus.

19 Q. Okay. And you chose Minocycline for Ms. McGougan?

20 A. Yes, there was a lot of reasons why I chose
21 Minocycline. It's extremely well absorbed. It goes to a
22 level of two micrograms per milliliter in the serum. But the
23 major thing I wanted to do was to achieve tissue levels,
24 because that's where the infection was. I wanted to achieve
25 good tissue levels of very active antibiotic. So --

1 Q. Let's stop you there for a second. You say
2 achieve good tissue level, you talking about getting the
3 antibiotic into the area where the infection is?

4 A. That's right.

5 Q. Okay.

6 A. Now, if it -- now Minocycline has a 10 to one
7 ratio, it gets 10 times the amount into the tissues that it
8 gets into the serum. It usually achieves a serum level of
9 about two -- two micrograms per milliliter. So into the
10 tissue, it's going to be 10 times that it'll be 20. So it's
11 just killing the beast out of it.

12 It's -- and also Minocycline likes to go to bone
13 especially the recommendations on taking Minocycline is don't
14 take it with milk because the calcium absorbs it, and it
15 might not be absorbed once it gets to into your stomach. So
16 that's a major advantage if you're pregnant. If you have
17 small children, usually they recommend not taking Minocycline
18 because it can discolor their teeth because it's at a time
19 when the Minocycline can go to the bone and to the teeth.

20 They also -- it can affect the growth of bone when
21 they're very small like that. So it's extremely able to go
22 there. Now, you go, well, it's not in the bone, the
23 infections not in the bone, but I'm trying to get an
24 antibiotic that covers that whole area. I want to have
25 something that surrounds it with antibiotic. So I want it to

1 go to the bone, and I want it to go to fat. And it's what
2 they call lipophilic. It will get into the fat, it will stay
3 there, and it has extremely good sensitivity to it. The --
4 the literature states that it's the only drug that's really
5 more sensitive than -- than it toward MRSA is Daptomycin.
6 You know, you're trying to compare though an oral drug to an
7 IV drug. They give it a little boost when you give it IV.
8 But this is given oral, and it gets extremely good. It's
9 extremely good orally. We give it a lot in orthopedic
10 patients.

11 The other thing that's very interesting about this is
12 in the treatment of rheumatoid arthritis. There's a
13 collection of drugs which that can be given to help control
14 rheumatoid arthritis that are not immunosuppressive. This is
15 one of the mainstays of that. She has been on
16 Hydroxychloroquine in the past, which is one of the drugs
17 Tetracycline or Minocycline.

18 Minocycline especially is given to help control
19 rheumatoid arthritis. It is slightly or somewhat -- oh,
20 moderately anti-inflammatory, slightly anti-inflammatory.
21 Certainly not a much -- not a match to give a person an
22 infection like the Enbrels and all of those do. So I wanted
23 to give her something that might start her on a course of
24 going without her major RA drugs, and that would help take
25 care.

1 Q. Did you remember she had rheumatoid arthritis and
2 was not taking RA medicine at that time, right?

3 A. Yes.

4 Q. And so your choice antibiotic had something to do
5 with wanting to help her with her rheumatoid arthritis?

6 A. Exactly. Now, the -- there's been a lot of
7 discussion. Shall I go into tuberculosis now, or?

8 Q. Well -- we'll get to that. Just one second. So
9 you made the decision to discharge her on the 26th. So she
10 -- this whole time period she's -- she's getting the
11 Vancomycin while she's in the hospital?

12 A. Yes.

13 Q. Okay. And then when she goes home on the 26th,
14 was she to start the oral Minocycline that you spoke of just
15 a minute ago?

16 A. Yes.

17 Q. Okay. That was two weeks?

18 A. Yes.

19 Q. And is that a treatment regimen that you've used
20 in your 35, 40 year career in infectious disease successfully
21 in treating an infection in a soft-tissue like this?

22 A. That's correct. We've used it a lot, especially
23 in orthopedic patients. It -- it's a great drug. You have
24 to give it. And sometimes people come in with small
25 infections or things on their hands and stuff that you're

1 worried a little bit about bone being involved. You give
2 Minocycline if -- if it's Staph that's involved.

3 Q. So you weren't guessing that this would be
4 effective?

5 A. No, no. It was based on everything. It's also
6 based on feedback from orthopedic surgeons, especially about
7 the effectiveness of the -- the antibiotic.

8 Q. Okay. So we've heard a little bit about labs and
9 whether labs should have been drawn or tested. When you send
10 the patient home on oral Minocycline, what has been your
11 practice in terms of whether that's necessary or not?

12 A. Well, if we're dealing with a -- a simple
13 infection, like a simple infection like you might have on
14 your arm that's drained, that puts you on an antibiotic for
15 14 days a week usually you don't draw laboratory. It -- it's
16 not necessary. If a person is being treated for an
17 osteomyelitis we would draw laboratory to follow that, and
18 they would be followed for it all.

19 Q. So with -- with the soft-tissue infection like
20 this was --

21 A. It would --

22 Q. Did you draw any labs when needed?

23 A. No, it would not be needed by us.

24 Q. At the time of discharge, did you tell Ms.
25 McGougan that she should never come see you again? Could not

1 call you, could not have any access to you going forward?

2 A. No, of course I did. Just the opposite. And I
3 think one of the -- to me it was a major problem to come back
4 to the hospital to -- to see Ms. McGougan. And I -- I wanted
5 to achieve just the opposite of that. I wanted to show my
6 concern about it, about her infection. I wanted to reach out
7 to her and tell her that she can call me. And I'm the type
8 of person that when I get a call, I don't wait to answer it
9 again if I can. Some doctors, it'll be another few hours
10 before they return the call.

11 Q. Did you give her any instructions about whether
12 she should resume her rheumatoid arthritis medicines that
13 she'd been taking previously?

14 A. No. I told her exactly the opposite. I said
15 that, yeah, we can take care of this -- this abscess, the
16 major therapy is really cleaning out the abscess like
17 Dr. Frisch did. That you take away the pus. This is the
18 major treatment of something like that is to clean it out.
19 Just like if you had the infection, the major treatment is
20 cleaning it out. I told her though that, you know, there's
21 going to be other bacteria in there around it. They're not
22 going to be -- it's not going to bring an abscess, but
23 there's still going to be some bacteria left that --

24 Q. Why -- why is that?

25 A. It just can't be helped. Bacteria is small little

1 boogers that are out to get us. They're not -- not there to
2 be friendly to us. And especially inside her, where this
3 was, it's -- it's going to be -- it's going to be there. And
4 that's the way it is with many infections that they're going
5 to hang around. And with the way it is with rheumatoid
6 arthritis this will lie dormant Staph aureus does that. I
7 wanted it will just kind of sit there.

8 Now, antibiotics are good. They do a lot of great
9 things, but they seem to get bacteria and kill things when
10 they're reproducing when they're turning over, like they
11 affect the cell wall and the bacteria falls apart and dies in
12 -- right in Minocycline, it affects what another active part
13 of them called the ribosomes. And that's when they work
14 most.

15 Bacteria, when they're under assault, they just sort of
16 sit there. They don't turn over. They just sit there. And
17 what happens is the body does try to get rid of it, but it's
18 not always complete. And they get caught inside some of our
19 tissue fighting infection, fighting cells, white cells and
20 what have you. And they sit there and they become the term
21 is entuned.

22 It's tough to get the antibiotics to them. It's tough
23 for the immune system to further get to them. So it takes a
24 long time. And the mopping up of all of this is a prolonged
25 period of time to get rid of every drop, every single

1 bacteria out. And it takes an immune system to do that. It
2 -- it takes a very active immune system to take care of all
3 of the bacteria that might be left there. They're not in an
4 abscess, but they're in sort of individual white cells that
5 are scattered around there. And we try to surround it with
6 the Minocycline to take care of it.

7 And so I wanted to stress to her that that's a real
8 problem. It's not a -- we didn't cure her. We got rid of
9 the -- the abscess that was there by surgery and by getting
10 as rid of as much bacteria as we could with the Minocycline,
11 but it's not going to be complete. Well, when would it be
12 complete? You might ask, I don't know. And that -- that's
13 the real problem. If you gave IV Vancomycin for six weeks,
14 is that going to get rid of all the bacteria in there? It --
15 it don't know. And there's no recommendations or guidelines
16 on that. It still could be in there. And when her immune
17 system is depressed, it's going to take advantage of it and
18 come out from hiding again. And that's the whole problem
19 with taking care of these immune-suppressed people.

20 Q. Let me stop you there. You mentioned a second
21 ago, there are no guidelines in terms of the treatment
22 regimen that you recommended for Ms. McGougan, were there any
23 guidelines that you had in mind or were following how you
24 recommended this treatment?

25 A. I -- in 2011, there's these guidelines, and we

1 even have apps that talk about the -- the -- the guidelines
2 that we have. So we have various guidelines that come out.
3 How do you treat clostridium difficile? How do you treat
4 this or that? But then in 2011 the guidelines from the IDSA
5 society that I'm a member of infectious diseases, came out
6 with guidelines on MRSA.

7 One of the -- the guidelines was what to do with skin
8 soft-tissue infections. This could be anything from just a
9 superficial wound to a deep wound infection. And there was a
10 category on that, what you do with a -- and they called it
11 complicated skin soft-tissue infection. And this, they call
12 these are hospitalized people that put it under that
13 category. And these are people that have abscesses in their
14 skin soft-tissue. It did not involve their bone. Does not
15 involve their bone. What is the recommendations? And the
16 recommendations was to give seven to 14 days of antibiotics.
17 It didn't -- and she -- we followed the guidelines. In fact,
18 we did exceed them because she did get eight doses of
19 Vancomycin early. So she really received around 19 days of
20 antibiotics, including the -- the Minocycline. So this is
21 what is usually recommended to get it. But then again, we
22 would have to anticipate that she is not going back on her
23 immunosuppressive drug.

24 Q. And I want to talk to you about that a little bit
25 too. We've heard a lot about Enbrel and Arava as being the

1 drugs that she was taking for rheumatoid arthritis. To your
2 knowledge, are there other -- other medications that do not
3 suppress the immune system that work on rheumatoid arthritis?

4 A. It's usually there's another category. Steroids
5 are one of the worst drugs you can give to have infections.
6 The -- the category that does not cause significant
7 immunosuppression is Minocycline, Hydroxychloroquine there's
8 a group of sulfa drugs, and she did have a reaction to one
9 sulfa drug, so you probably wouldn't use that.

10 And then the other drug that sometimes uses
11 Methotrexate. So she -- and then you would think, well,
12 maybe we could just give her pain medicine. They don't
13 generally like to give Aspirin, Ibuprofen that class of drugs
14 to rheumatoid arthritis patients because it can damage their
15 kidneys. So they could give Acetaminophen, Tylenol, but the
16 -- the major thing they could give is this class of drugs
17 Hydroxychloroquine, Tetracycline. And they could perhaps
18 start Methotrexate.

19 You -- you would have to do it in steps and you could
20 follow the person and to do that. And at some point you
21 might not start with Methotrexate. You might just start with
22 continuing Minocycline, maybe giving Hydroxychloroquine,
23 which he has used before, and going on that for a while and
24 see how she does.

25 Q. That's the conversation that you have had with Ms.

1 McGougan?

2 A. I tried to -- I -- I tried to do that. And I --

3 Q. And so at the time of discharge, what was your
4 expectation in terms of how Ms. McGougan's care would be
5 handled going forward?

6 A. Well, certainly the people that have seen her in
7 the past were the -- the spine people. Now, if she's a three
8 hour drive from us, it's easy. And -- and she was going to
9 be seen by them to come see me would be about another hour
10 almost. So it's kind of inconvenient. But the spine, people
11 know me. They have my phone Number s and everything, and
12 they would be following her. The thing is, I'm going to be
13 of very little assistance as far as seeing her. If she does
14 have evidence of an infection or anything, then we're
15 probably going to get MRI studies and things like that on
16 her. So I did not think that I was an essential in doing in
17 -- in -- in doing that and seeing her.

18 Q. Okay. So she was discharged on September 26th.
19 Did you hear anything more from Ms. McGougan in September,
20 October, or November?

21 A. No, she evidently went it really sounds like a
22 good two months without -- without anything, you know, it
23 sounded like she was improving, doing well, walking, and
24 feeling much better within two months. Two months you
25 certainly, you think that the -- the infection was controlled

1 that she has responded and that maybe her immune system,
2 she's not on any immune suppressive drugs that she's doing
3 well on it, and it's doing what you want it to do. It's
4 mopping up the infection, it's taking care of it -- it's
5 getting some of the little nodules of stuff out -- out of
6 her.

7 Q. So when is the next time you would've had any
8 interaction with Ms. McGougan?

9 A. Well, I didn't have any more interaction with her
10 until she was readmitted to the hospital in, I think it was
11 the 20th of December.

12 Q. 19th of December?

13 A. Yeah. 19th.

14 Q. And how was it that you got involved at that
15 point?

16 A. Well, she had developed a major infection at that
17 time. And --

18 Q. When you say major infection, what do you mean?

19 A. It was Staph aureus, it was -- would be expected.
20 And --

21 Q. How was it different than the prior infection?

22 A. Well, previously it was just a small abscess.
23 This looked like it was what we call a bacteremia. She --
24 she looked very toxic. She looked very sick. It looked like
25 she could have bacteria in her bloodstream, and she did. So

1 she did culture out MRSA out of her bloodstream. She looked
2 extremely sick, and certainly I didn't wait for any other
3 cultures. She was put right on Vancomycin at that time
4 because of the way she looked. We didn't wait.

5 Q. Does that condition require a different treatment
6 than what you've given her previously in September?

7 A. Oh, yes. Number one, you worry in somebody that
8 gets a Staph aureus in her bloodstream. What's always that
9 it has affected her heart endocarditis. And because of the
10 way Staph aureus strep like to go to heart valves, they will
11 go to them and they can tear them up in no time at all. So
12 you worry about that. And that right there is an indication
13 for six weeks of IV antibiotics at the least. And if it's a
14 bone infection you -- sometimes there has to be extensive
15 debridement of the bone to take --

16 Q. When you say debridement means --

17 A. Yeah. Cutting out whatever is infected and making
18 it so that to cure it as much as possible. And usually
19 there's repeated surgeries to do that. Sometimes there --
20 there might not be, and I leave that to the decisions of Dr.
21 Frisch and Southeastern Spine, but that's -- that's a major
22 concern right there.

23 Bone infections entail a prolonged treatment with
24 antibiotics. And again, you don't want her back on her
25 immunosuppressive drugs because they're lethal in people with

1 infections, they -- it's everywhere said that it's even
2 television ads that where they talk about the biologics.
3 Enbrel was heavily advertised on television. It went through
4 how happy people were. And then it says, then they give this
5 fast thing, but it wasn't so fast with their -- their
6 commercials with, they say, you always have the risk of
7 infection. They talk about, especially tuberculosis can
8 raise its head. You must not take this if you've had a
9 recent hospital infection related to it.

10 And also, whenever you get a prescription filled it's
11 going to put warnings about using this in the presence of an
12 infection. And generally the rheumatologist and everybody
13 else will warn you about that.

14 Q. You understand that the Plaintiffs in this case
15 have sued you because they said they didn't think your
16 antibiotic treatment in September was appropriate.
17 Minocycline, I think their expert referred to as -- as an
18 acting drug. Is the fact that Ms. McGougan developed a
19 recurrence of an infection in December, mean your treatment
20 in September was not effective?

21 A. I think that it was effective. She went two
22 months at least without problems and -- and improving. What
23 happened was that she was put back on her immunosuppressive
24 medications and that brought it back. It -- it's a
25 well-known phenomenon. It's what even said is said on the

1 commercials that this will recur if you do it.

2 And as far as when it might be safe to put her back on
3 her immunosuppressive is -- is not really known. I think I
4 had a -- an attending one time, he was a rheumatologist, and
5 he said, the essence of medicine is to alleviate pain. And I
6 think that Ms. McGougan she knew that there was problems with
7 going back on her immunosuppressive drugs. She said that in
8 her deposition. She knew that it was possible hazardous, but
9 then you're a patient in pain.

10 And I can't imagine what it would be like to have
11 rheumatoid arthritis. I'm pretty lucky, but she is having
12 pain. And I think that -- and the rheumatologist on the
13 other side of the coin, there's -- I looked at the guidelines
14 of the -- from the rheumatology societies, and what do you
15 give people when they have an, you know, infections and it
16 says low data is what it says, it's got low data, they have
17 something in there, and then it says low data. So they don't
18 know really what to give you.

19 And -- and I think as far as a physician, you -- you
20 want to please people. You want to get rid of pain, you want
21 to do what you can to help them. And so I think we -- in a
22 way, you were -- she was in pain. She wanted help. The
23 rheumatologist wanted to help her. And so they took the risk
24 of giving her major immunosuppressive drugs. They gave her
25 Arava, they gave her Enbrel, and they gave her steroids. And

1 not only did they just give her oral steroids, they injected
2 it her with a steroid into that general area. They gave her
3 80 milligrams of Depomedrol, which is going to hang around.
4 So she was given way her immune system just was really
5 kicked.

6 Q. All right. And go back to that just a second. I
7 do want to ask you one question. If Minocycline has been
8 characterized as just a drug to treat teenage acne, is that
9 consistent with your understanding of how that medication is
10 used?

11 A. Well, I think that -- that individual that -- that
12 said that it was irresponsible, he is kicking out a whole
13 class of antibiotics that are lifesaving. Rocky Mountain
14 spotted fever is a lethal infection. It's the only treatment
15 is Tetracycline for Rocky Mountain spotted fever. There's
16 also a variety of -- of rickettsial borne diseases. You get
17 hiking and we've seen, and they are primarily treated with
18 Tetracyclines.

19 The -- and these type of tuberculosis related bacteria
20 are becoming more common. We see people with lung
21 involvement from what they call atypical mycobacteria. They
22 come from showers into people that they inhale and the -- the
23 bug -- the bacteria is within the faucet. Sometimes they
24 inhale it -- it gets into their lungs. And if you have a
25 pulmonary disease, these can just sort of sit in there and

1 keep going and -- and cause a problem. It takes types of --
2 of Tetracyclines to get rid of them.

3 In Charleston, we have -- I like oysters. I go to
4 oyster roast and I open them up, and I'm not a fisherman, but
5 we have mycobacterium marinum present in water. So people
6 that get water associated cuts maybe -- I've seen this
7 individual that locally had -- had great fame about able to
8 shuck oysters, and he got it on his hands. These are nodules
9 that come out. They're related to atypical mycobacteria.
10 They respond to Tetracyclines.

11 We also sometimes have people that come in and they
12 look very -- very sick, and they probably have gotten it from
13 -- and we can't get a diagnosed on. They probably have come
14 from a rickettsia, which are tick-borne diseases. And so we
15 call it he had a Tetracycline responsive fever. And because
16 a lot of them just aren't known what they are. So
17 Tetracyclines are extremely valuable. They're -- and
18 becoming more and more valuable as days go by. And not only
19 that, a lot of our newer antibiotics like Tigecycline came
20 out -- are based upon the same structure as other
21 Tetracyclines. They have great advantages because they get
22 to anaerobes, they get to MRSA.

23 Q. So you -- you mentioned Tetracyclines is
24 Minocycline in the family of Tetracycline?

25 A. Yeah, Minocycline is in the family (crosstalk) but

1 it's just -- it has -- its distinctiveness because Number
2 one, it has some literature using it in rheumatoid arthritis.
3 And it -- there's a resistance gene that Minocycline doesn't
4 pick up from other Tetracyclines. And it's more active
5 against MRSA than -- than almost all antibiotics except for
6 Daptomycin.

7 Q. Has Minocycline been used to treat things like the
8 plague?

9 A. Has been -- has been used to treat things like the
10 plague. It also -- there's some gram negatives now, which
11 we're having problems with because of multi resistance.
12 Alcaligenes is one, and it's -- it's usually -- you have to
13 use a Tetracycline on it. So I don't know what you would do
14 if you just using Tetracyclines for acne. If somebody comes
15 in and sees you with Rocky Mountain spotted fever, what do
16 you give them? There's nothing to give it Tetracycline. And
17 I've seen kids with -- with Rocky Mountain spotted fever.

18 Q. You mentioned this idea that the bacteria may have
19 still been present, but (inaudible) I think, tell -- tell us
20 a little bit about that. How does that work? Are there
21 other examples that we might relate that to?

22 A. Right. Tuberculosis is the great one, and that's
23 on the ads of Enbrel is what they -- they use the
24 immunosuppressive drugs will bring back tuberculosis.
25 Tuberculosis it's inhaled. It comes in through the middle

1 parts of your lungs. It goes everywhere, all over your body,
2 your kidneys, your liver, everything. And you might feel a
3 little bit of fever at the time, or you might feel a little
4 bit sick, but it's -- it's gone all through your tissues and
5 you beat it back.

6 Your immune system beats it back a little bit, but they
7 stay there. The little boogers stay there and your fighter
8 cells engulf it and take it in. And it still just sits
9 there. They're not reproducing. They're just sitting there
10 and nothing is going to kill it. And -- and you -- you just
11 have this -- this pathogen waiting in you to -- to come back
12 out.

13 As you get older maybe you become an alcoholic, you're
14 sleeping under the bridge at night, and your immune system
15 takes a -- a hit from that. And it reactivates, it
16 classically reactivates in the effaces of your lungs. That's
17 where the -- the blood system is the -- the least. And so it
18 creates these huge cavities sometimes in the upper part of
19 your lungs. And they're coughing and they cough this stuff
20 out. So everybody that these people are surrounded with gets
21 tuberculosis.

22 Tuberculosis is particularly high in the southeast.
23 And one that you probably all know is varicella zoster,
24 chickenpox. You get chickenpox as a child, and you get all
25 of these vesicles all over you maybe, or just in a few

1 places. But then it's -- it's spread throughout your body,
2 but it mainly goes to your nerve roots on your spine, and it
3 -- it stays there. And it's a virus. It's not a bacteria,
4 but it stays there. And then you get older, your immune
5 system kind of peters off a little bit and you get shingles.
6 It will -- it will come back from one nerve root and it will
7 follow the -- the nerve out to your hand or your eye or
8 someplace, or all over you.

9 If you're real immunosuppressed. And it's going to
10 cause shingles. Now, we get vaccinations now, and the
11 vaccinations will take care and help you from getting it
12 again -- getting shingles. But it's related to the -- the
13 chickenpox that you got as a child.

14 The other thing about rheumatoid arthritis is that when
15 you have rheumatoid arthritis, you respond to vaccinations.
16 And what they have to do and should do is have them take
17 vaccinations before they start them on Arava and all these
18 other immunosuppressive drugs. One of the infections that
19 some of the infections they get later on in life is maybe
20 they were vaccinated while they're on immunosuppressives, but
21 then it's these meningitis that they could have been
22 vaccinated against, but they got it while they were on
23 immunosuppressive drugs. They don't do well with
24 vaccinations unless their immune system is good. And you've
25 got to understand that it's the immune suppression that makes

1 them better. It makes them feel good and maybe stops some of
2 the progression of rheumatoid arthritis. But it's like we
3 all say it's a two-edged sword. It cuts both ways.

4 Q. And based on your knowledge and treatment of -- of
5 -- of Ms. McGougan, and when she began taking these
6 medications, I think that you established that she started
7 the Arava on the 20th.

8 A. 20th.

9 Q. Of November? And then the Enbrel on the 28th of
10 November?

11 A. That's what I understand.

12 Q. All right. And is there anything about the time
13 ago when she started those medications and when she ended up
14 back in the hospital that makes sense to you?

15 A. Well, she started on the 20th, and I did find it's
16 difficult to find articles on this, but I did find one
17 article where these people were all rheumatoid arthritis
18 people. And the drug was Tocilizumab and to -- and the --
19 the people all started back on the immune suppressive drug
20 after surgery. They all had sort of orthopedic surgery. And
21 so some of them became infected with the -- the surgery and
22 all of that. Like you would expect not a whole lot, but
23 usually the people became showing their infection a mean of
24 4.5 weeks. So this and the median I think was 3.5 weeks. So
25 I think I may have had that backwards, but it -- it usually

1 in her point, from when she was started on Arava to the time
2 when she got the infection was 3.7 weeks.

3 It was right in the time when you would expect somebody
4 to have recurrence of their infection after they received
5 their immune suppression drugs. So I think there's -- there
6 is no doubt that what happened to her was she was treated.
7 She went two months at least, with feeling better improving.
8 And then she was started back on her immune suppressive drugs
9 Arava, Enbrel, and -- and steroids. Her immune system didn't
10 have a chance and this bacteria was still hanging around
11 waiting for its time to do its thing.

12 Q. All right. And so she's hospitalized again in
13 December. Did you care for her during that hospitalization?

14 A. Yes, I did. And we started her Vancomycin. It
15 took a while for her blood cultures to become negative. I've
16 added Gentamycin at the time, which is something that you
17 don't like to do because Gentamycin, although it works -- it
18 works well with Vancomycin. It also is somewhat harmful for
19 the -- the kidneys. And you have to watch levels very
20 closely in her. And some of her kidney function studies very
21 closely that this does not happen.

22 I also consulted cardiology, Lars Renquist to make sure
23 that she did not have endocarditis, and he did a -- what they
24 call a transesophageal echo which is the -- about is the
25 major study that you can do to make sure there's no

1 endocarditis. It doesn't -- in a way, it doesn't really
2 matter because we're going to treat her for it. And she had
3 the back infection, so we're going to treat her a long --
4 long time. And she needs to be off of her immunosuppressive
5 medication during that time.

6 Q. And was the treatment that you gave her in that
7 hospitalization until January 3rd, was that effective in
8 treating the infection she had?

9 A. It -- it was. Her blood cultures became negative.
10 I think she -- she felt better. And we did have, at this
11 time we had a -- a partner that was in Myrtle Beach, Dr.
12 Ebama, who was very good and that she very much liked and --
13 and bonded with. And it was a very good relationship. And
14 this time she went through all of these weeks of no
15 immunosuppression and all these antibiotics and seems to have
16 come out very well. I can't say very well, but -- but still
17 it was a -- an awful thing to go through.

18 Q. And the reason that she would continue to see Dr.
19 Ebama after this kind of infection as opposed to one she had
20 in September as well?

21 A. Well, she had her bone infection. She had a -- a
22 deep seated infection. This was obviously totally different.
23 What she had was a small abscess previously when I saw her in
24 September. This time she's got two fairly large vertebral
25 bodies that have been infected. The disc that exists between

1 the two vertebral bodies is dissolved by being eaten away
2 from by the bacteria. And then they sort of fused together
3 is what happens.

4 Q. Right. And Dr. Ebama was monitoring her labs and
5 those types of things because she's on the IV antibiotic?

6 A. That's correct.

7 Q. Wrapping up here, doctor, during the course of
8 your two interactions with Ms. McGougan, did you ever utilize
9 a treatment that did not perform with the guidelines of
10 community rule?

11 A. No.

12 Q. Do you believe you gave Ms. McGougan good quality
13 care?

14 A. Yes.

15 Q. Taking Ms. McGougan's condition into account, did
16 you believe you treated her appropriately?

17 A. Yes.

18 MR. SMYTH: Thank you, Doctor. I think those are all
19 the questions that I have. We're ready for a lunch break.

20 THE COURT: Yeah.

21 MR. SMYTH: Okay.

22 THE COURT: Mr. Foreman, ladies and gentlemen, as you
23 know, we ordered your lunch on yesterday. This arrived we've
24 placed it in the jury room. We're going to break until 1:30
25 that gives you an hour for lunch. You're welcome to eat in

1 the jury room. Also, you're welcome to go outside, get some
2 air take your lunch break as you normally would. I just need
3 you all to return promptly to your jury room by 1:30, at
4 which time we'll resume testimony. Enjoy your lunch. Please
5 do not discuss the case. And please leave your note pads in
6 your seats.

7 (Jury exits courtroom.)

8 THE COURT: Dr. West, you may also take your lunch
9 break. Just please don't discuss your testimony with anyone.

10 All right. We'll be at ease until 1:30 at which time
11 we'll resume the cross-examination. Anything you need to
12 take up before we go for lunch, from Plaintiff?

13 MR. LUGINBILL: No, ma'am.

14 MR. HOOD: No, Your Honor.

15 THE COURT: Mr. Smyth?

16 MR. SMYTH: No, Your Honor.

17 THE COURT: All right. Guys. Have a good lunch. See
18 you at 1:30.

19 MR. KERN: Thank you.

20 THE COURT: You're welcome.

21 (Off the record.)

22 THE COURT: You may be seated. Plaintiff ready to
23 proceed?

24 MS. FLUMIAN: Yes, Your Honor.

25 THE COURT: Defense ready to proceed?

1 MR. HOOD: We are, Your Honor.

2 THE COURT: All right. They should be right behind.

3 (Jury enters courtroom.)

4 THE BAILIFF: All jurors present, Your Honor.

5 THE COURT: Thank you. Ladies and gentlemen, I hope
6 you all had a pleasant lunch. We'll now resume testimony of
7 the witness.

8 And, Mr. Hood, do you have any cross-examination of the
9 witness or Mr. Kern? I apologize.

10 MR. HOOD: Thank you, Your Honor.

11 CROSS-EXAMINATION

12 BY MR. HOOD:

13 Q. I just want to ask you a few questions, sir. You
14 mentioned that Minocycline gets into the tissues?

15 A. Yes.

16 Q. What -- what did you mean by that?

17 A. It diffuses into the tissue, like a sponge, I
18 guess might be a adequate comparison. It -- it's very good
19 about it. Like I -- I think I said it's a 10 to one. It
20 goes into the serum and then from there into the tissues,
21 especially the fat hydrophilic and also bone. And it is
22 taken up by bone because of the calcium in bone. And the
23 orthopedic surgeons have told me that after a person has been
24 on Minocycline for a while and they go back and do surgery
25 that the color of the bone changes because of the

1 Minocycline.

2 Q. Okay. And how -- how does that affect whatever it
3 is that that drug is doing that you're describing? How does
4 that factor into your thought process for prescribing it for
5 Ms. McGougan?

6 A. Well, it -- it makes it so that some antibiotics
7 don't really do much in the way of tissue penetration. So it
8 -- it would make me think that this is a high level of
9 antibiotics in the tissue and this is going to help all that
10 much more to rid themselves of the infection.

11 Q. Okay. And just one more point of clarification, I
12 wanted to ask about you and Mr. Smyth were talking about
13 fluid inside of the -- the wound. Do you remember that?

14 A. Yes.

15 Q. Okay. And so for this surgery, it was a
16 microdiscectomy, so it was a small opening, right?

17 A. Yes.

18 Q. So they would've gone in and done surgery. So as
19 the fluid is in there, it pushes the tissues out?

20 A. Well, I think you're -- you're -- oh, you mean it
21 pushes the -- the disc out?

22 Q. Well, no.

23 A. From the -- when it --

24 Q. Let me -- maybe a easier way of me to ask it. How
25 do you -- you talked about that you get pain relief when you

1 drain it.

2 A. Uh-huh.

3 Q. Why do you get pain relief when you drain it?

4 A. Well, I think it would be like everything. It's
5 this -- this pocket that's not supposed to be there of a
6 foreign bacteria, and it gives you a fever, it makes you feel
7 sick all over. And I -- you know, I guess it would be, it's
8 an abscess and it's down there and there probably is some,
9 maybe pushing against nerves or whatever that maybe is
10 causing some pain.

11 Q. Right. And so --

12 A. It's all speculation for me, but just thinking
13 about Southeastern Spine and -- and looking at these MRIs and
14 everything that -- that seems like maybe what's happening and
15 it's trying to get bigger in a way.

16 Q. All right. So it sounded like from walking
17 through your progress notes that Ms. McGougan, during the
18 September hospitalization where she was cleaned out that your
19 observation was her improving --

20 A. Yes.

21 Q. -- over that course. In terms of understanding
22 how effectively or ineffectively the procedure was. What
23 does that indicate to you in terms of treating her previously
24 identified pocket?

25 A. Well, it -- it shows improvement. It shows, you

1 know, that this back and forth about -- well, it's draining.
2 No, she doesn't feel good. She had a fever today. She
3 didn't have one. I -- I think this back and forth that was
4 happening. It -- it gives a -- a clear reason for it. And I
5 think that anything even that small can -- can really
6 systemically affect you.

7 MR. HOOD: Okay. Thank you, sir. Those are all the
8 questions I have.

9 THE COURT: Any questions for the witness?

10 MS. FLUMIAN: Thank you, Your Honor.

11 THE COURT: You're welcome.

12 FURTHER CROSS-EXAMINATION

13 BY MS. FLUMIAN:

14 Q. Good afternoon, Dr. West. My name is Julia
15 Flumian. Do you remember meeting me a few years ago?

16 A. No.

17 Q. At a deposition?

18 A. I'm sorry, I do not.

19 Q. It's okay. In 2016, you were an employee of
20 Lowcountry Infectious Diseases; is that correct?

21 A. I don't know. I used to have a -- a -- my own
22 practice and then we -- I -- I joined Lowcountry Infectious
23 Disease. I don't know, it probably was back around 2016
24 because I went back over the records and my coverage, I think
25 was the -- some of the people there. I think Greg Thomas

1 came by.

2 Q. Were you a -- a -- a part owner, a partner, or an
3 employee? Can you help us?

4 A. I think I was a partner.

5 Q. And you testified earlier today that you retired
6 in June of '18; is that correct?

7 A. June the -- of 2018. That's correct. 2018.

8 Q. Isn't it true that you were also still seeing
9 patients in your HIV clinic every Tuesday morning for several
10 years after that?

11 A. I did until December of 2023.

12 Q. And you were also still the epidemiologist and
13 head of infection prevention for East Cooper Hospital after
14 you retired, right?

15 A. No.

16 Q. Do you remember discussing this in your
17 deposition?

18 A. Pardon me?

19 Q. Do you remember discussing this in your
20 deposition?

21 A. No. I don't recall that I was -- I continued
22 being over infection prevention at East Cooper. I could be
23 mistaken because it didn't take much, but I didn't and if --
24 if I did it may have just been a year that I continued that
25 because I had a nerve -- I don't know. I had a nurse that

1 was pretty active, but I -- I can't -- I can't tell you right
2 now whether I continued on as being over infection prevention
3 at East Cooper.

4 Q. In -- in -- in 2016 during the time period in
5 which you treated Pat McGougan you were, if I'm correct, you
6 were the chief epidemiologist for Roper; is that correct?

7 A. Yes, I was. Then at 2016, you were talking about
8 2018, and I didn't if I'm mistaken I do not believe I
9 continued that after retirement.

10 Q. Right. We're talking just about 2016 now.

11 A. 2016. Yeah. I -- yes, I was over infection
12 prevention at that time in both places.

13 Q. Okay. So both places, so you were also at East
14 Cooper, correct?

15 A. Yes, that's correct.

16 Q. And you had an outpatient clinic, correct?

17 A. Yes.

18 Q. And so you were also seeing patients in those
19 hospitals, correct?

20 A. In 2016, yes I was.

21 Q. And so you were seeing patients like Pat McGougan
22 in the office outside of the hospital, right?

23 A. Yes. I can't say exact. I think she was rather
24 unique with her infection, the rheumatoid arthritis, and all
25 of that that -- that she was not a common patient to see.

1 Q. But you did see --

2 A. I saw infections, I saw MRSA infections, I saw HIV
3 patients. I saw hepatitis patients, the run of the mill.

4 Q. In the office?

5 A. Yes.

6 Q. Right?

7 A. Yes, I did.

8 Q. Okay. I -- I'm going to draw your attention to
9 Plaintiff's Exhibit 37, which is a copy of the MRI report
10 from September 20, 2016. Can you see this okay?

11 A. Yes.

12 Q. Okay. And then on the second page, we have the
13 impression, are you familiar with this document?

14 A. Yes.

15 Q. And so can you explain for us what it means when
16 we read that, "There's fluid collection just posterior to the
17 laminectomy site with moderate adjacent soft-tissue edema.
18 In addition, there is a 1.2 centimeter epidural component."

19 A. I just -- I'll -- I -- I'll have to, you know,
20 I've looked at the -- the films that if they had been
21 presented during this courtroom. And my idea was that there
22 was swelling there in that area that this was posterior to
23 the site. I'm not a neural radiologist or anything of that.
24 It seems like there was a fluid collection there. I can't --
25 it did not touch bone. It was fairly well localized. It

1 says it was 3.5 centimeters peripherally enhancing fluid
2 collection. So it's not just the abscess. There's some
3 edema surrounding the abscess, is how I understood that in my
4 sort of grade school interpretation of this.

5 Q. And so as you know, we have also produced some
6 demonstratives regarding this MRI.

7 MR. LUGINBILL: Ma'am Clerk, can you switch to the HDMI
8 for just a second.

9 MS. FLUMIAN: That might take a second.

10 BY MS. FLUMIAN:

11 Q. And you reviewed the information regarding this
12 MRI I believe you said, with Southeastern Spine, correct?

13 A. Yes.

14 Q. And by that you meant a mid-level provider,
15 correct?

16 A. They have their physician assistants. The main
17 one that I usually looked at these with was Danny. Now, it's
18 been eight years ago. I don't know that I saw it really with
19 Danny, but it was a golden opportunity for me to go over
20 these with him because it gave me a certain knowledge. And
21 it also gave me somewhat of an idea of what I'm looking at in
22 an MRI.

23 Q. I just want to make sure you didn't -- you did not
24 discuss it with Dr. Frisch, did you?

25 A. I saw and talked with Dr. Frisch, and this was a

1 couple of days later when he -- we passed each other in the
2 hall. And this -- this is uncommon because we -- we live
3 such separate worlds. But I think I reviewed -- I think we
4 talked about the MRI. We didn't look at the MRI together,
5 but we talked about the MRI and we talked about what he found
6 at surgery with Dr. Frisch.

7 Q. Okay. And now you can see on the screen we have
8 Plaintiff's demonstrative exhibit regarding the spinal
9 infection, correct?

10 A. Yes.

11 Q. And does that help you better understand the
12 location of the infection and its relation to the bone?

13 A. Yes. And again, I'm not an expert at this.

14 Q. And did you ever discuss this with the
15 radiologist, Dr. McCaid?

16 A. No, I did not.

17 Q. And Dr. McCaid is local, correct?

18 A. I don't know Dr. McCaid.

19 Q. And you recall you were told by Dr. Frisch that it
20 was really small, contained, and not going be a big problem,
21 correct?

22 A. That's what he talked about on the fluid that was
23 removed that was about an inch in size.

24 Q. And again, that's what we're -- what's been
25 highlighted and colored on this image, correct?

1 A. Well, it has a nice yellow line pointing to this
2 area, which I guess I'm going to agree with is the abscess.

3 Q. And that's what's in the epidural space or
4 adjacent to it --

5 A. That --

6 Q. -- as described in the report, correct?

7 A. That's correct.

8 Q. Okay. You could have had a radiology -- or excuse
9 me, you could have had a rheumatologist involved in Pat
10 McGougan's care in September, correct?

11 A. Well, actually I'm fairly good friends with the
12 rheumatologist and we put in a consult for the rheumatologist
13 and Frank Harper is the rheumatologist that I'm -- I'm close
14 friends with. And he was back and forth with a partner. I
15 -- not -- we did not have any contact with them, even though
16 we put in a consult.

17 Q. I think you're referring to December, sir. Does
18 that seem, correct?

19 A. It could be.

20 Q. But you did in fact, think it was a good idea to
21 have a consult with a rheumatologist in September, right?

22 A. Yes.

23 Q. And one was not obtained, correct?

24 A. We put in for a consult, but it was a no-show.

25 Now, what I did hear was that I think that the rheumatologist

1 felt like his involvement would be to see about the
2 immunosuppressive drugs. I heard by hearsay that he may have
3 come by, saw that she was not on one of these medications and
4 said he was not needed and left. I cannot swear to that.
5 Like I said, that's hearsay, but that's what I heard.

6 Q. Have you seen any evidence in this case, sir, that
7 supports that there was a rheumatology consult request
8 performed in September?

9 A. Yes, I put in the request and I saw the -- a form
10 that had the request ordered.

11 Q. And so you believe that you filled out a request
12 for a rheumatologist in September?

13 A. I don't believe it. I know it.

14 Q. Okay. And you never spoke to that rheumatologist,
15 did you?

16 A. You -- you have friends that are physicians that
17 are rheumatologists. You go, listen, what do you think about
18 this? We -- we don't keep things to ourselves. And if
19 somebody's walking down the hall and we know them and we can
20 ask them, we do it. And I did that.

21 Q. So you had what we call a drive by consult; is
22 that fair?

23 A. I did, but also I put through a for real consult.

24 Q. Okay. And that for real consult, you believe
25 there's some evidence of that in the record, right?

1 A. I saw evidence of it in the record.

2 Q. Okay.

3 A. Now, maybe it doesn't exist now in this courtroom,
4 but there was evidence of it.

5 Q. Nevertheless, no rheumatologist ever actually laid
6 hands on my client in September in the hospital, correct?

7 A. I told you a couple times no rheumatologist came
8 by. I told you the hearsay that probably existed. No
9 rheumatologist came by and saw the patient. No
10 rheumatologist physically stood there while I was there.

11 Q. And you never called my client's rheumatologist,
12 correct?

13 A. I never called your client's rheumatologist that I
14 know. It's been eight years ago. There was times when I
15 thought I did try to get ahold of him and was unsuccessful
16 again. That was eight years ago. And I do not recall the
17 exact instance that I did it or why I couldn't get ahold of
18 him now. That's it.

19 Q. Do you have any evidence, sir, to support that you
20 ever attempted to call Dr. Shanahan?

21 A. No, I don't have any evidence of that.

22 Q. Did you ever try to contact Dr. Harkins?

23 A. No, I didn't. I actually did not know about Dr.
24 Harkins.

25 Q. You were not aware that my client had a primary

1 care physician?

2 A. No. I -- I did not. You know, we see patients.
3 They have several different physicians. I don't always know
4 who all of the physicians are.

5 Q. But her primary care, you didn't know who her
6 primary care was?

7 A. No, I did not know.

8 Q. And you weren't aware of any information that my
9 client had to provide the hospital, such as who her primary
10 care physician was?

11 A. I take a history physical, we get down her
12 medications, we get down all of these things, and she also
13 did not tell me who her primary care physician is. I assumed
14 I was mostly dealing with her rheumatologist.

15 Q. Did you write down in any of the notes that you
16 wrote anything about my client's rheumatologist or her
17 primary care physician?

18 A. I believe I did mention who the rheumatologist's
19 name was.

20 Q. Okay. And but again, you have no evidence that
21 you ever actually attempted to contact either of those
22 individuals, correct?

23 A. That is correct.

24 Q. Not all patients have primary care providers,
25 right?

1 A. That's correct. Some people don't have
2 physicians, period.

3 Q. It's helpful when they do, right?

4 A. Sometimes.

5 Q. And are some of those times when you have a -- a
6 patient like Pat McGougan who has a lot -- lot of -- of
7 preexisting issues that need to be addressed after a
8 hospitalization?

9 A. Sometimes.

10 Q. You had an office located in Myrtle Beach in
11 September of 2016, correct?

12 A. I don't believe I did in 2016.

13 Q. Where was Dr. Ebama practicing?

14 A. Oh, I'm sorry. I was thinking about a different
15 -- I did have an office in Pawleys Island in which I saw some
16 of the HIV-infected patients for a Number of years. When I
17 joined Lowcountry Infectious Diseases didn't have that. And
18 we did have sporadically an office in Myrtle Beach.

19 Q. But you had a relationship with Dr. Ebama in
20 September of 2016, did you not?

21 A. Yes, I did.

22 Q. And Pat of course, lives much closer to Myrtle
23 Beach than she does here, correct?

24 A. Yes.

25 Q. It would've been much more convenient for her to

1 follow-up with Dr. Ebama than with you down here in
2 Charleston, correct?

3 A. The follow-up was done with Dr. Ebama in December.
4 That's when she was sent. As far as what you're getting at
5 is in September, could she have gone there. She did not see
6 anybody in Charleston in for the -- the two month interval
7 there until she started getting sick again. So I did not --
8 really, there wasn't any reason for her to even see Dr. Ebama
9 during that period of time.

10 Q. Dr. Ebama, I believe you're correct, she -- she
11 was available in September. Is that what you just testified
12 to?

13 A. I don't know the exact dates when she came. I
14 liked her very much, but I don't exactly know when she
15 started down in Myrtle Beach. She did not last that long in
16 Myrtle Beach because she had other plans and other
17 obligations.

18 Q. When did you first learn that my client was going
19 to be discharged during the September admission?

20 A. I think we thought about it. I was first
21 approached about it when I talked with Dr. Frisch, and that
22 may have been like, it may have been the 25th, it may have
23 been the day before that, the 24th. It's when I found out
24 that -- and we talked in passing in the hall and in
25 discussing it further about how she's doing. How's the thing

1 -- how's everything look? And that's when we started
2 thinking about maybe if she feels okay and everything we
3 could look toward discharging her.

4 Q. Did you know on September 26th that she was going
5 to be discharged that day?

6 A. That day in the morning is when I first thought
7 she is going to be discharged. When I got back to the office
8 and started thinking about the discharge and everything I
9 wasn't clear on the antibiotic sensitivity to the MRSA. And
10 also there's a tendency to maybe that the hospitalist or
11 somebody they would've discharged her on Doxycycline.

12 Q. I'm now showing you what is Plaintiff's Exhibit
13 Number 49. Is this the sensitivity you're referring to?

14 A. Yes.

15 Q. And this is what you were not able to recall while
16 you were back in your office?

17 A. I could have called microbiology, or I could have
18 -- when I got back to the hospital have looked it up. I'm
19 not sure of your point here.

20 Q. No. I'm trying to understand what you just said.
21 You needed to review this when making your Minocycline
22 prescription, correct?

23 A. Yes.

24 Q. And so when we look at this, and we've talked
25 about this a bit throughout this trial, but these are all the

1 drugs that this particular bug was and was not susceptible
2 to, correct?

3 A. It is a diagram a printout of the antibiotics to
4 which the MRSA was sensitive to and to which antibiotics it
5 was not sensitive to.

6 Q. So for example, we see that it was resistant to
7 clindamycin, correct?

8 A. Yes.

9 Q. And it is susceptible to rifampin, correct?

10 A. Yes.

11 Q. And just because a drug is susceptible, or this
12 medic -- just because this document says that a drug would be
13 susceptible or the bug would be, doesn't mean that it's
14 within the standard of care to order it for a particular
15 patient, correct?

16 A. The bug?

17 Q. Yeah. It's not --

18 A. Which bug or -- oh, the MRSA. Excuse me. And
19 could you repeat that?

20 Q. Sure. Just because a drug is listed on this
21 susceptibility report does not mean that it's within the
22 standard of care to prescribe it to Pat McGougan, correct?

23 A. There goes a lot into determining which antibiotic
24 is the best one to use. So I'm not sure that I understand
25 your point. I mean, it -- it -- it could be sensitive to one

1 of them, but like Clindamycin, I know it's resistant. You
2 might -- it also becomes resistant quite quickly. Also, some
3 of the antibiotics we use may not -- like Rifampin. It also
4 becomes somewhat resistant. So why wouldn't I give Rifampin?
5 What is the bone penetration? What's the serum level? How
6 long does it last? How sensitive is it?

7 Now, if you look at this, you can tell that it stops at
8 one level, like Minocycline is at less than 0.5. Well, how
9 much less than 0.5 is it? What about some of the others?
10 They don't -- they don't go down to its absolute lowest point
11 of how sensitive it is. So it -- it takes a certain amount
12 of knowledge that knows that Minocycline is usually more
13 active than like Doxycycline or plain Tetracycline.

14 Because it's got Tetracycline listed as at a
15 susceptible level of less than one. My guess would be it
16 ends about there, whereas Minocycline goes even less than
17 0.5. It probably goes down a lot lower than that, and it's
18 going to be a lot more active than plain Tetracycline.

19 Q. And how would you have given this infection was
20 susceptible to Linetony -- Linezolid, correct?

21 A. Yes, it was.

22 Q. And, for example, it was susceptible to Rifampin
23 as well?

24 A. Yes, it was.

25 Q. But Rifampin should not be prescribed as a single

1 medication, correct? It can't be monotherapy.

2 A. Not against Staph aureus. No.

3 Q. So just because it's on a susceptibility chart
4 doesn't mean that that's within the standard of care, right?

5 A. You're always using the standard of care. Could
6 we just say something besides standard of care? No, we
7 wouldn't use it as a rational thinking human being that's
8 practicing infectious disease.

9 Q. And when -- when did you first review Dr. Frisch's
10 discharge summary from the September admission?

11 A. I have no idea.

12 Q. Okay. I'm going to show you what's been marked as
13 Plaintiff's 102. This is the discharge summary from the
14 December admission. Have you seen this document?

15 A. Yes.

16 Q. Okay. And so I'm just showing you, it's a two
17 page document. It discusses, you know, just SOAP note. Can
18 you explain what a SOAP note is for the jury?

19 A. Subject objective assessment plan.

20 Q. Okay. And the plan includes what?

21 A. "We discharged this patient from the hospital
22 after clearance by the hospitalist, as well as infectious
23 diseases. She will follow-up in our office in two weeks for
24 a recheck of her symptoms. It has been recommended by
25 infectious disease that she continue his three month

1 antibiotic regimen consisting of Vancomycin, Erythromycin.
2 She will follow-up with Dr. West as an outpatient. At this
3 point, discharge instructions were discussed with the patient
4 and she understands." And -- and of course that's incorrect.
5 And that's what -- what you're trying to point out to me.

6 Q. And now I'm going to show you Plaintiff's Exhibit
7 61, which is the discharge summary from the September
8 admission, correct?

9 A. I didn't see the date on the last exhibit that you
10 had.

11 Q. Okay. This is 102.

12 A. Okay. That I'm getting confused on these. This
13 is December the 19th of 2 -- of 2016.

14 Q. Right.

15 A. So wait a minute.

16 Q. Yes, sir.

17 A. All right. Date of discharge. So this was the
18 discharge for -- on January the 3rd. She was not discharged
19 on Erythromycin.

20 Q. Okay. So that's two mistakes. She did not
21 follow-up with you, correct? She was going to see Dr. Ebama?

22 A. Yes.

23 Q. And she was not discharged on Erythromycin,
24 correct?

25 A. Right.

1 Q. Okay. Now, I'm asking you about Plaintiff's
2 Exhibit 61. This is the discharge summary from the September
3 admission, correct?

4 A. Well, on this, all I see is an admission date of
5 September the 20th of 2016.

6 Q. But you do see that it is identified, the
7 discharge summary, right?

8 A. Yes, I do.

9 Q. And then you see that -- that Dr. Frisch dictated
10 it and authenticated it, right?

11 A. On our -- okay, I see that.

12 Q. And there's -- unlike the December admission,
13 there is no discussion here about her aftercare plan,
14 correct?

15 A. No, but I -- I don't know that -- that usually
16 there's also nurses that are involved in the plans for the
17 discharge and discharge medications are sometimes listed on
18 separate sheets.

19 Q. Sure. But this discharge summary, unlike the
20 December discharge or January discharge summary, does not
21 include her aftercare plan, right?

22 A. It does not include the exact Number , name of the
23 antibiotics and things like that.

24 Q. Well, to be fair, it doesn't mention that she's
25 going to have any antibiotics on discharge, does it?

1 A. No, it doesn't. That doesn't mean she didn't get
2 it. I mean, there's also a prescription that I personally
3 wrote that was in there on Minocycline 100 milligrams POBID,
4 and that's -- that's in the chart.

5 Q. When you saw my client in your consult, you took
6 note of her sed rate and CRP, correct?

7 A. Yes, I did.

8 Q. And were those diagnostically valuable to you?

9 A. The -- I, you know, there's so many things that
10 affect those acute inflammatory reactions, which you have
11 heard about the whole five days now. The acute inflammatory
12 processes that she has is rheumatoid arthritis, a small
13 abscess, and also a surgical procedure. Now, I may have -- I
14 can't really go back over my thinking at the time of getting
15 those and how valuable they would be and what good it did me.
16 I don't know that I would've drawn any really great insight
17 over those values.

18 Q. But they're pieces of the puzzle, right?

19 A. They're pieces of something. Maybe it's not a
20 puzzle. I'm not trying to really put things together and say
21 that she doesn't have an abscess. They're not telling me
22 that they may be confirming an abscess. But also we also
23 have sed rates and C-reactive proteins that go off the wall a
24 day, maybe it depends upon what phase of the moon it is, and
25 then they come back down. They're somewhat unpredictable at

1 times.

2 Q. You know that Lowcountry Infectious Diseases had
3 weekly sed rate and CRPs ordered by Dr. Ebama after she was
4 discharged in January?

5 A. Isn't that wonderful? Because she had a bone
6 infection at that time. And that's when we usually draw
7 those tests to follow. She had an osteomyelitis, she did not
8 have that during the -- the admission in September.

9 Q. And she --

10 A. She also has rheumatoid arthritis. And sometimes
11 the rheumatologists draw those tests to see how active the
12 rheumatoid is. She has not been on anti-immuno-suppressive
13 drugs during her being followed by Dr. Ebama. And so maybe
14 she was trying to draw those to help the rheumatologist or
15 Dr. Harkins. I don't know. I'm not sure that she would draw
16 that much information from it regarding her bone infection,
17 but it might be worth a try. That's up to her.

18 Q. So Dr. Ebama still found diagnostic value in those
19 tests, despite the fact that my client is an RA patient and
20 wasn't receiving any of her RA meds during that time period,
21 right?

22 MR. SMYTH: Objection, Your Honor.

23 THE COURT: Basis?

24 MR. SMYTH: Speculation.

25 THE WITNESS: I agree. I can't read her mind.

1 THE COURT: I'm going to let the answer stand, but make
2 sure. Uh-huh.

3 THE WITNESS: I can't read her mind. I don't know what
4 was going through her head. Sometimes lab tests are just
5 drawn and -- well, why did you do that?

6 BY MS. FLUMIAN:

7 Q. And you're not aware of any standard of care that
8 requires it specifically for osteomyelitis?

9 A. I'm not aware of -- there are -- I'm not aware of
10 a standard of care that requires it.

11 Q. Okay.

12 A. We do usually get it for -- we probably almost
13 always get C-reactive protein and sed rates when we can with
14 following chronic osteomyelitis.

15 Q. And we heard earlier that her sed rate that was
16 provided to Dr. Frisch preoperatively was from June, and that
17 was faxed over for by Dr. Harkins, correct?

18 A. I don't know.

19 Q. And Dr. Frisch, if he had wanted a second baseline
20 after she had been off her Enbrel, could have ordered it at
21 East Cooper?

22 MR. SMYTH: Objection, your Honor.

23 THE COURT: Basis?

24 MR. SMYTH: Speculation.

25 THE COURT: I didn't hear the whole question, but I

1 need --

2 MS. FLUMIAN: Can I rephrase?

3 THE COURT: Yes, ma'am.

4 BY MS. FLUMIAN:

5 Q. You had the ability to order a sed rate at East
6 Cooper, correct?

7 A. I'm on staff there.

8 Q. And is it fair to say that any doctor who's on
9 staff there can order a lab test there?

10 A. I don't know that I can totally answer that. They
11 are probably other people that maybe can't draw it, but I
12 don't know that to be true.

13 Q. Dr. Frisch ordered a sed rate in September, did he
14 not?

15 A. I don't know who ordered the -- the sed rate that
16 I saw I think maybe two sed rates during that admission.

17 Q. And if it was Dr. Frisch he ordered it. Does it
18 make sense that he had privileges and had the ability to
19 order it?

20 MR. SMYTH: Objection, Your Honor. Foundation.
21 Speculation.

22 THE COURT: Sustained, foundation.

23 BY MS. FLUMIAN:

24 Q. Okay. You spoke earlier about a specific practice
25 guideline in -- and I believe you said that, "It helped

1 formulate your decision-making", correct?

2 A. That's correct.

3 Q. And we're talking about the IDSA guidelines,
4 correct?

5 A. Let me see it. I think this is from 2011. Yes.

6 Q. And that's the guideline that you specifically
7 referenced earlier when you were explaining to the jury about
8 which antibiotic you chose for my client, correct?

9 A. I said that this defined what we were looking at,
10 this fit into a class of complicated skin and soft-tissue
11 infection, is what I said. I did not say that it suggested
12 exactly one antibiotic to -- to treat.

13 Q. In fact, it offers several antibiotics to treat,
14 does it not?

15 A. Yes, it does.

16 Q. I've put a sticky on the relevant section.

17 A. Yes.

18 Q. And so is this particular section relevant to my
19 client, Patricia McGougan in September of 2016?

20 A. Well, down here on paragraph five, it says, "For
21 empirical coverage of MRSA and outpatients with skin soft-
22 tissue infections, oral antibiotics options include the
23 following, Clindamycin, Trimethoprim/Sulfamethoxazole,
24 Tetracycline and Linezolid."

25 Q. Doctor, I -- I'm going to ask you to look at

1 seven.

2 A. Okay.

3 Q. Okay. And -- and paragraph seven is in reference
4 to surgical site infections, correct?

5 A. It says, "For the hospitalized patients with
6 complicated SSTI" --

7 MR. SMYTH: Objection.

8 THE WITNESS: -- "defined as patients with deeper soft-
9 tissue infection" --

10 THE COURT: Basis?

11 MR. SMYTH: 801.

12 THE WITNESS: -- surgical traumatic wound infection --

13 MR. SMYTH: 801.

14 THE COURT: Sir.

15 THE WITNESS: Pardon me?

16 MS. FLUMIAN: I didn't ask him --

17 THE COURT: There's an objection.

18 MS. FLUMIAN: I didn't ask him to --

19 THE COURT: The question elicited that. Sir, please
20 don't read anything from any of those records. Thank you.

21 Ladies and gentlemen, the last question and answer will
22 be stricken, you're to give it no consideration in your
23 deliberation.

24 The objection is sustained. Hearsay.

25 BY MS. FLUMIAN:

1 Q. You agree that paragraph seven and this guideline
2 does not identify any Tetracycline derivative as being
3 appropriate standard of care, correct?

4 A. You have to define that a little bit better. This
5 is on hospitalized patients. When she was hospitalized, I
6 gave her Vancomycin.

7 Q. And --

8 A. And so when she was discharged, and there's
9 another page in here on Tetracycline's in their utility and
10 treatment, which you've left out.

11 Q. Sir.

12 A. Right now. So she was hospitalized. She got the
13 antibiotic, which was recommended for hospitalization.

14 Q. For how long, sir, is it recommended?

15 A. She got it for --

16 MR. SMYTH: Your Honor.

17 THE COURT: Let him finish (crosstalk) don't interrupt
18 him.

19 THE WITNESS: She got it as an outpatient for 14 days.
20 She got it as an inpatient for five days.

21 BY MS. FLUMIAN:

22 Q. How long is the standard recommend for my client
23 to have received IV Vancomycin?

24 A. It doesn't recommend IV antibiotics. It
25 recommends antibiotics for seven to four -- 14 days. It

1 doesn't say IV or PO, but she was in the hospital and it
2 usually recommend -- it recommended IV while in the hospital.

3 Q. And she was in the hospital in September, correct?

4 A. You know that to be true.

5 Q. And you know that that list does not include a
6 Tetracycline derivative for hospitalized patients, correct?

7 A. She's not getting it in the hospital. She got
8 Vancomycin in the hospital.

9 Q. And this standard requires seven to 14 days of IV
10 Vancomycin, does it not?

11 A. It doesn't require it necessarily in the hospital.

12 Q. This standard also requires that decision making
13 rely on the patient's clinical response, correct?

14 A. That's correct.

15 Q. And that includes outpatient follow-up, does it
16 not?

17 A. No, it does not.

18 Q. And again, this standard does not include
19 Tetracycline or Tetracycline derivatives for surgical site
20 infections?

21 A. All right.

22 MR. SMYTH: Objection.

23 THE COURT: Basis?

24 MR. SMYTH: Asked and answered.

25 THE COURT: I'm going to give a little latitude, but

1 please try to --

2 MS. FLUMIAN: It's the last one.

3 THE COURT: -- not ask the same question a different
4 way. I'll allow to ask the question to his answer.

5 Sir, do you remember the question? Do you need it
6 repeated?

7 THE WITNESS: I need it repeated.

8 THE COURT: Please repeat the question.

9 THE WITNESS: Do you want my answer repeated?

10 BY MS. FLUMIAN:

11 Q. The standard does not list Tetracycline or any of
12 its derivatives for surgical site infections, correct?

13 A. This standard right here, this paragraph is
14 referring to hospitalized patients. If you turn another page
15 or two, there's several paragraphs listing the utility of
16 using Tetracyclines.

17 Q. And again, seven to 14 days without IV is what the
18 recommendation is, correct?

19 A. It doesn't say it says seven to 14 days of
20 antibiotics. It doesn't say that it has to be IV.

21 Q. And Linezolid is listed as well, correct?

22 A. Linezolid is listed.

23 Q. And that's PO or IV, right?

24 A. It is PO or IV.

25 Q. And so my client could have been placed on PO

1 Linezolid for 14 days pursuant to that recommendation,
2 correct?

3 A. She could have, but I think that was not the right
4 antibiotic to give her. Would you like my list of reasons
5 why I did not think Linezolid was good and why you probably
6 would've used it?

7 Q. Sir, when we were previously discussing
8 Tetracycline, you don't deny that is a common acne
9 medication, right?

10 A. The -- that is a unfair term. You're -- purposely
11 denigrated a very valuable antibiotic. And that's what was
12 done previously by your expert witness. It's uncalled for.
13 It's not necessary. And that means like if somebody comes in
14 with Rocky Mountain spotted fever, it's the major, it is the
15 only choice to give that person. So what are you going to
16 say? I'll give it to you if you've got acne? So that an
17 acne, Rocky Mountain spotted fever patient comes in, you're
18 going to give it. That is not necessary. It is harmful to
19 the community. It's harmful to -- to this audience to hear
20 you talk like that.

21 Q. Tetracycline is commonly prescribed for acne,
22 correct?

23 A. No, that's why we have Accutane. I haven't seen a
24 child. And it really is disturbing not to see too many
25 children with pimples anymore or acne anymore. It was a

1 major problem when I was a kid and now they don't have it.
2 All the psychological benefits they must have now because of
3 Accutane, it's disturbing.

4 Q. Accutane carries a serious risk of suicide, does
5 it not?

6 A. Not that I know of.

7 Q. And it requires frequent blood monitoring, does it
8 not?

9 A. Not that I know of. I don't usually give it, but
10 I know my children got it.

11 Q. And you discussed pulmonary NTM earlier, didn't
12 you?

13 A. By NTM, you're talking about?

14 Q. Non typical.

15 A. Atypical -- atypical mycobacteria.

16 Q. And you spoke at length about how Tetracycline is
17 an appropriate treatment for that, right?

18 A. It is one of the appropriate treatments for that.
19 And that depends usually upon finding out exactly what the
20 many atypical mycobacteria there are, and there's probably
21 about 50 to 100 of them. And to find out exactly what their
22 sensitivities are. And then usually you have to pick two or
23 three to -- to treat it with.

24 Q. Yes. Lowcountry Infectious Diseases is currently
25 undergoing or participating in clinical trials for multiple

1 new antibiotics, specifically for pulmonary NTM, right?

2 MR. SMYTH: Objection, Your Honor.

3 THE WITNESS: I don't know.

4 THE COURT: Sir, there's an objection pending.

5 Basis of objection?

6 MR. SMYTH: 403 and 401.

7 THE COURT: Uh-huh. I need you to repeat the question,
8 please.

9 MS. FLUMIAN: Lowcountry Infectious Diseases is
10 currently participating in multiple clinical trials related
11 to pulmonary NTM?

12 THE COURT: The objection is sustained. Relevance.

13 BY MS. FLUMIAN:

14 Q. And you discussed that you have treated NTM
15 patients, correct?

16 A. I have treated some people with atypical
17 mycobacteria.

18 Q. Have you treated non atypical?

19 A. I've treated tuberculosis.

20 Q. And you're familiar, I think you spoke previously
21 about how there is NTM with oysters in town, correct?

22 MR. SMYTH: Objection, Your Honor.

23 THE COURT: Basis?

24 MR. SMYTH: 401 and 403.

25 THE COURT: Sustained.

1 BY MS. FLUMIAN:

2 Q. When you treated my client, you understood that
3 she had an immunocompromising condition, correct?

4 A. She has rheumatoid arthritis. It is an
5 immunocompromised state when people are on immunosuppressive
6 drugs like steroids, like Arava, and like Enbrel, that is
7 when it is an immunocompromised state. Otherwise, the -- a
8 person that comes in de novo with rheumatoid arthritis does
9 not have an immunocompromised state. It's when she gets the
10 medications that she is, and there's some medications which
11 they can receive in which it's not immunocompromising and
12 predisposes them to less infections.

13 Q. The studies that -- well, you referenced earlier
14 that Minocycline can be given for RA patients, right?

15 A. Yes, it can. It should and can be done. It is
16 somewhat -- it is approved for the treatment of rheumatoid
17 arthritis.

18 Q. And specifically for patients who are within the
19 first six months of a diagnosis, correct?

20 A. I don't know. I don't know that detail about
21 rheumatology. But she is not within six months of a
22 diagnosis of rheumatoid arthritis.

23 Q. Correct. And so prescribing Minocycline for her
24 specifically because of her RA was not indicated or
25 warranted, correct?

1 A. No, I don't know that.

2 Q. And you didn't speak to her rheumatologist about
3 it before you prescribed it?

4 A. I guess not. But I was treating at that point her
5 MRSA that was in the abscess that was drained.

6 Q. And you discussed other drugs that you say she
7 could have been treated with for her RA, correct?

8 A. She has been treated with Hydroxychloroquine. I
9 found that in the records.

10 Q. And why wasn't that a regular medication for her,
11 sir?

12 A. I don't know. It's not -- sometimes like I tried
13 to say rheumatoid arthritis is a very painful situation, a
14 very difficult one to treat. And you feel empathy for them
15 whenever they have it. She -- the -- and rheumatologist, I
16 think feel very strongly about trying to help them get rid of
17 the pain. And I think that they sometimes take a leap in
18 going on to medications that can be ultimately harmful to
19 them.

20 Q. And again, you did not communicate with her
21 rheumatologist, correct?

22 A. You -- I have said that.

23 Q. And you did not see her as an outpatient, correct?

24 A. No, I did not see her as an outpatient. She had a
25 wound that was drained. She didn't have problems for at

1 least two months that really even warranted being seen in an
2 outpatient clinic because it looked like she got better and
3 that she was doing fairly well and she was advancing pretty
4 well as an outpatient. So she really did not need to take
5 the three-hour trip back to Charleston to see us.

6 Q. And she wouldn't have called you?

7 A. But she could have called us and --

8 Q. She could have gone to Myrtle Beach, sir, couldn't
9 she?

10 A. She could have.

11 Q. So it wouldn't have been three hours for her,
12 right?

13 A. I still -- we did not understand that. I don't
14 even know that she really needed to until she really got
15 sicker. And really, she has a spine problem there, and
16 that's where most of her problem is. So it would be more
17 cognizant of time to come and see the people that have done
18 the surgery before and it would probably get an MRI on her.

19 Q. But they're not infectious disease doctors, right?

20 A. No, but -- but they're spine doctors and that's
21 where a lot of the -- the problem is happening.

22 Q. Yes, but --

23 A. I mean, if she comes into our office I go, well,
24 that's fine and I'll talk to you and everything like that.
25 And then, well, I think you need to go see Dr. Frisch.

1 That's the extent of what would happen.

2 Q. So you never gave her your card, correct? When
3 you saw her?

4 A. I don't usually keep cards.

5 Q. Right. So she --

6 A. I'm sorry. That's a problem I have with cards.
7 Sometimes I write them on the napkin or something and give it
8 to them. Also I'm easily found as far as -- and it can -- my
9 office bothers me to death with phone calls.

10 Q. What is the half-life of Minocycline?

11 A. Of Minocycline it is 24 to 26 hours.

12 Q. So it's not going to keep working after her last
13 dose, right?

14 A. It will for the -- the time that the half-life
15 dictates.

16 Q. And then stops, right?

17 A. Yes.

18 Q. So she wasn't receiving any kind of antibiotic
19 treatment or infectious disease treatment after the first
20 week of October or so, right?

21 A. Antibiotics are not the only thing that treats
22 abscesses and -- and bacteria that's indolent and lying
23 there. It's your immune system that's most valuable. The
24 immune system is what does the mopping up and cleaning. I
25 see you have a nice frown on your face. That's very pretty.

1 Q. My client is now permanently disabled as a result
2 of this infection. Is she not, sir?

3 A. It is not because of the infection. It's because
4 of the decision to put her back on immunosuppressive drugs,
5 which released a drug -- a -- a bacteria that was lying
6 dormant within her. That is why she is now disabled.
7 Because that decision was made. It wasn't made by me. It
8 was discouraged by us. It was told don't do that.

9 Q. And you never spoke to her rheumatologist?

10 A. I spoke to her. She is a nurse. She has had
11 education. She knows what immunosuppression is. She can
12 explain it also and say, listen, I just got out of the
13 hospital with a Staph aureus infection. This is everywhere.
14 It's on the news media and everywhere that if you have a
15 recent hospitalized with an infection, do not go back on
16 these drugs. And specifically on the Enbrel commercials, it
17 will say people have died with it and that is why she is
18 disabled.

19 Q. And she also told her rheumatologist that you said
20 that there was no need for follow-up, right?

21 A. That was --

22 MR. SMYTH: Your Honor, hearsay.

23 THE COURT: Sir.

24 THE WITNESS: I don't know that to be true.

25 THE COURT: Sir, don't answer the question. There's an

1 objection pending.

2 Sustained hearsay and pitting.

3 BY MS. FLUMIAN:

4 Q. She -- when she went to a rheumatologist informed
5 them of for admission?

6 MR. SMYTH: Your Honor, same objection.

7 THE COURT: Sustained.

8 Lack of foundation. Speculation. Hearsay.

9 BY MS. FLUMIAN:

10 Q. I'm showing you what has been previously marked as
11 Plaintiff's Exhibit 63. Are you familiar with this document?

12 A. I don't believe so.

13 Q. Have you reviewed Dr. Harkins' records?

14 A. I did not have his records. And just in the last
15 day or two, I have picked up a couple of them. I do not know
16 exactly which days that I have reviewed.

17 Q. And you see, did -- they were holding per Enbrel
18 and Arava, correct?

19 MR. SMYTH: Objection, Your Honor. Foundation.

20 THE COURT: Sustained. Foundation.

21 BY MS. FLUMIAN:

22 Q. Okay. You're aware that my client received that
23 MRSA screening when she returned in September, right?

24 A. Yes.

25 Q. And that of course showed that she had heavy

1 growth, right?

2 A. We -- you know, it's a rough quantis -- quanti --
3 quantity of getting the cultures. Yeah, she had heavy
4 growth. I don't know that that means much if you're trying
5 to about light growth, heavy growth, that doesn't mean much
6 to us. She did have the MRSA.

7 Q. As a result of that screening. She got a
8 different prophylactic antibiotic, didn't she?

9 A. I started her on Vancomycin when she had surgery.

10 Q. You didn't prescribe or suggest the prophylactic
11 antibiotic, did you?

12 A. I put an order in for Vancomycin the day of
13 surgery.

14 Q. Yes. But you didn't order the prophylactic
15 antibiotic, did you?

16 A. There's a standard prophylactic antibiotic that's
17 ordered that goes to surgery in a way I had maybe I did not
18 have any specific input on her getting another antibiotic
19 before surgery.

20 Q. And the choice of -- of Vancomycin specifically of
21 prophylaxis for that surgery was impacted by the MRSA
22 screening, was it not?

23 A. No, it was impacted by me figuring that MRSA was
24 the most likely infection and if it was going to and Staph
25 aureus is usually the cause of these and I don't even know if

1 I knew the results of her screening before I ordered the
2 Vancomycin.

3 Q. And so you're denying that that order was actually
4 done by the surgical team and not you, right?

5 A. Which -- what are you talking about?

6 Q. The prophylactic antibiotic before her.

7 A. What prophylactic antibiotic did she get?

8 Q. Vancomycin.

9 A. That wasn't prophylactic. That was me writing it
10 to give it to her for an impaired starting.

11 Q. Do you understand, sir, I'm --

12 A. I don't understand you, no.

13 Q. Can you please identify for me the anesthesia
14 report so we can clarify? You previously testified, did you
15 not? That you were responsible for ordering the cardiology
16 consult?

17 A. Yes.

18 Q. It wasn't you, was it? It was the hospitalist who
19 ordered that.

20 A. Well, that's just terrible.

21 Q. But it wasn't you who did it, correct?

22 A. It wasn't me, but it was me that suggested it
23 then. I don't recall whether I was the -- the one that
24 really ordered it or not. I thought I was.

25 Q. And actually the Vancomycin that was put on board

1 in December wasn't also your order. That was actually the
2 hospitalist order, correct?

3 A. That doesn't make a bit of difference, because I
4 also would've communicated with them talking in the hallway
5 maybe. And they would've done that because of what I
6 suggested and wanted to do.

7 Q. And again, all of these conversations that you had
8 with drive-bys, et cetera, you didn't document any
9 correspondence or any communication with the two doctors who
10 knew the most about my client, Dr. Harkins and Dr. Shanahan,
11 right?

12 A. I did not communicate with them. But certainly
13 there's a value of knowing, having friends that are other
14 doctors. I'm sure attorneys do that sometimes themselves.

15 MS. FLUMIAN: No further questions.

16 THE COURT: Any redirect?

17 MR. SMYTH: Briefly, Your Honor.

18 THE COURT: You may proceed.

19 REDIRECT EXAMINATION

20 BY MR. SMYTH:

21 Q. Dr. West, we've established that Ms. McGougan,
22 after she got out of the hospital the second time in -- in
23 January.

24 A. Yes.

25 Q. She transferred her care to the Myrtle Beach

1 office?

2 A. Yes.

3 Q. Was she able to call your office and do that?

4 A. Yes, I believe so.

5 MR. SMYTH: No further questions.

6 THE COURT: Sir, you may step down.

7 Mr. Foreman, ladies and gentlemen, you all have been
8 sitting about an hour. Does anyone need a comfort break?

9 All right. Call your next witness.

10 MR. SMYTH: At this time, your Honor, we call Dr. Brian
11 Simmons to the stand.

12 THE COURT: Sir, you would come forward to be sworn.

13 BRIAN PAUL SIMMONS,

14 being duly sworn, testified as follows:

15 THE CLERK: Please be seated. Please state your full
16 name, spelling your last name directly in the microphone.

17 THE WITNESS: I'm Brian Paul Simmons, S-I-M-M-O-N-S.

18 THE COURT: You may proceed.

19 MR. SMYTH: Thank you, your Honor.

20 THE COURT: You're welcome.

21 DIRECT EXAMINATION

22 BY MR. SMYTH:

23 Q. Good afternoon, Dr. Simmons. How are you?

24 A. Good.

25 Q. I hear your voice is a little bit scratchy. Have

1 you had a recent medical diagnosis that makes it a little
2 harder to talk?

3 A. Yeah.

4 Q. Can you tell the jury about that?

5 A. I have parkinson's disease, something I've lived
6 with for a couple of years, and I've developed a very raspy
7 voice and I'm not sure why.

8 Q. Okay. Well, if -- if I can't hear you very well
9 from time to time, I might let you know that, just because we
10 want the jury to hear your -- your testimony. Okay. If you
11 stay close to that microphone. Please introduce yourself to
12 the jury and tell them a little bit about where you're from
13 and what you do.

14 A. I'm an infectious disease physician. I went to
15 Duke University undergraduate, Vanderbilt University Medical
16 School, Penn State at Hershey for my internal medicine
17 training, three years at the Center for Disease Control in
18 the hospital infections program where I wrote the CDCs first
19 guidelines for the prevention of surgical site infections.
20 And then I did my fellowship at Emory University and then
21 went to Memphis, Tennessee, where I practiced infectious
22 diseases and hospital epidemiology. Hospital epidemiology is
23 the study of what effects bad outcomes. And if you know what
24 -- what things lead to it, you can interfere and improve
25 patient care.

1 Q. Okay. And how many years did you practice
2 infectious disease medicine?

3 A. Over 30 -- I think 32.

4 Q. All right. And were you licensed to practice
5 medicine in any particular states?

6 A. Pretty much Tennessee, Arkansas with the two I
7 practice in, but I also got a Wyoming medical license that is
8 lapsed.

9 Q. Okay. Are -- are you retired now?

10 A. Yes.

11 Q. All right. And you are still actively treating
12 patients in 2016 when this case happened?

13 A. Yes.

14 Q. Okay. And are you board-certified?

15 A. Yes.

16 Q. What are you board-certified in?

17 A. Internal medicine and as a sub-specialty offered
18 internal medicine infectious diseases.

19 Q. All right. And have you been involved in your
20 field of practice in any professional organizations?

21 A. Yes. I've been a member of the Infectious Disease
22 Society of America and some of their committees. I also rose
23 to -- was elected National President of the Society for
24 Health care Epidemiology of America. That's the -- it's
25 called SHEA, S-H-E-A. That's the organization that aims to

1 prevent bad outcomes in hospitals. The -- when I became
2 president, I was -- I was elected on a national basis.

3 Q. Since you've kind of stepped back from the active
4 practice of medicine, have you stayed up-to-date on the
5 literature and -- and done anything else with regard to your
6 profession?

7 A. Yes.

8 Q. Tell the jury what kind of things you've done most
9 recently?

10 A. I wrote a chapter that was published in 2023 in a
11 book called Hospital Epidemiology. I -- I guess that's the
12 most recent activity.

13 Q. Did you -- did you take care of patients in
14 Memphis during the COVID pandemic?

15 A. No, I -- I did and I retired in 2018 and from
16 seeing patients all together and 2019 COVID hit.

17 Q. Okay. And have you held any academic appointments
18 in -- in your career?

19 A. I am a -- a clinical associate -- clinical
20 professor of medicine at the University of Tennessee School
21 of Medicine.

22 Q. Okay. Have you taught other doctors about the
23 practice of infectious disease?

24 A. Yes. And --

25 Q. All right. You -- you mentioned that you'd done

1 some work for the CDC. Did that have anything to do with the
2 bacteria that we're here about this week?

3 A. Yes. MRSA, or as you call it MRSA, has been on
4 the forefront of concerns about preventing infections and
5 thus it's like the Number one topic for the Center for
6 Disease Control. I was with a panel in Tennessee that looked
7 at from a -- a local point of view what we could do to
8 prevent MRSA in our locality.

9 Q. And have you taken care of patients in an
10 inpatient setting like Dr. West did for Ms. McGougan in this
11 case? Has that been part of your experience?

12 A. Yes, I did for 30 years -- 32 years.

13 Q. Okay.

14 A. I was very much involved.

15 MR. SMYTH: All right. At this time your offer -- Your
16 Honor, we would offer Dr. Simmons as an expert in infectious
17 disease.

18 THE COURT: Any objections or questions?

19 MS. FLUMIAN: No.

20 MR. KERN: None from us, Your Honor.

21 THE COURT: Admitted without objection.

22 You may proceed.

23 MR. SMYTH: Thank you.

24 THE COURT: You're welcome.

25 BY MR. SMYTH:

1 Q. Dr. Simmons, did I hire you to look at this case
2 from a infectious disease standard of care point of view?

3 A. Yes, you did.

4 Q. All right. Are you being paid for your time here?

5 A. Yes.

6 Q. And is -- is this something you've done before
7 acting as an expert witness?

8 A. Yes.

9 Q. Does the fact that I'm paying you to be here today
10 to testify, is that going to affect the content of your
11 opinions in any way?

12 A. Not in -- not in any way.

13 Q. All right. So let's get right down to it. I feel
14 like the -- the jury's been here all week and -- and we want
15 to get -- get to it. Did you have a chance to review the
16 medical records of Ms. McGougan and -- and Dr. West's
17 treatment of her?

18 A. Yes, I did.

19 Q. All right. Did you formulate any opinions about
20 whether Dr. West's treatment of Ms. McGougan both in the
21 September hospitalization and in the December hospitalization
22 met the standard of care?

23 A. Yes, I did.

24 Q. What -- what is your opinion, please?

25 A. My opinion was he met the standard of care.

1 Q. All right.

2 A. There was no -- no deviation on the part of the
3 neurosurgeon or Dr. West.

4 Q. Would you like some water? All right. So I think
5 you said there was no deviation from the standard of care by
6 Dr. West; is that correct?

7 A. Uh-huh.

8 Q. All right. And so let's go through a little bit
9 about what his treatment was. Let's start with the September
10 hospitalization when she's -- she's already had the spinal
11 surgery and then she presents in September with the
12 infection. What was your opinion about Dr. West's treatment
13 of her during that first week of hospitalization in
14 September?

15 A. It was -- it was appropriate. He started her --
16 the patient on Vancomycin early in the hospital stay, gave
17 her five days of intravenous therapy, which by itself meets
18 the standards for antibiotic therapy and then gave her an
19 additional 14 days of Minocycline.

20 Q. Okay. And is that a recognized treatment in your
21 profession for the bacteria she had?

22 A. Yes. And the journal up-to-date, which is almost
23 university used for keeping up -- up-to-date. The
24 recommendation is for Doxycycline for five or more days.

25 Q. Okay. Are there any particular guidelines that