NORTH CAROLINA
WAKE COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
15 CVS 12051

RAYMOND A. DA SILVA, EXECUTOR OF THE ESTATE OF DOLORES J. PIERCE,
Plaintiff,

vs.

WAKEMED, WAKEMED, D/B/A WAKEMED CARY HOSPITAL, AND WAKEMED FACULTY PRACTICE PLAN,
Defendants.

DEPOSITION OF: PAUL GENECIN, M.D.

DATE: JUNE 27, 2016

HELD AT: THE STUDY AT YALE
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DEFENDANT'S EXHIBITS
(for identification)

EXHIBIT:	PAGE:
No exhibits offered.	

S T I P U L A T I O N S

IT IS STIPULATED by the attorneys for the parties that each party reserves the right to make specific objections in open court to each and every question asked and the answers given thereto by the witness, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS STIPULATED and agreed between counsel for the parties that the proof of the authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED and agreed that the reading and signing of this deposition is not waived and any defects in the Notice are waived.

PAUL GENECIN, M.D.

(Deposition commenced: 2:00 p.m.)

Paul Genecin, M.D., called as a witness, having been first duly sworn by Samantha Howell, a Notary Public in and for the State of Connecticut, was examined and testified as follows:

MR. MADDEN: The stipulations that we're going to be using for today's deposition are the ones we've been using for other depositions in the case, and they are that the deposition is being taken pursuant to the North Carolina Rules of Civil Procedure, and pursuant to the terms of the discovery scheduling order that's been entered in this case.

DIRECT EXAMINATION

BY MR. MADDEN:

Q Doctor, do you want to read and sign the transcript when it is prepared?

A Yes.

Q Dr. Genecin, we met a moment ago; my name is John Madden, I'm a lawyer from Raleigh, North Carolina. I

represent the defendants in the case that's been filed by the estate of Dolores Pierce. It's my understanding that you are prepared to serve as an expert witness for the plaintiff in that case; is that correct?

A Yes.

Q You understand we're here to take your discovery deposition in that case?

A I do.

Q You've been through the drill before, you know what the procedure is, the Q and A that we'll be following this afternoon?

A Yes.

Q If any time during the course of my questioning you do not understand the question that I ask you, I mumble, use a term incorrectly, for whatever reason, would you ask me to repeat, rephrase or otherwise clarify the question?

A Yes.

Q And if you don't do that, I'm going to assume that you understand the question that you're answering; is that fair?

A Yes.

Q At any time during the course of the deposition you need to take a break, please let me know that. My only

condition on that is if I've asked you a question, I'll need you to answer the question before we take a break; fair enough?

A Fair.

Q Mr. Kash has provided me with a copy of your curriculum vitae and he provided me with, I think, another copy of the same document today. I have one that's dated January of 2016; is that the most current version?

A Yes.

Q All right. Is there -- I'm just going to hand you a copy of that. I'm not going to mark it as an exhibit since we all have it, but since we are now in late June of 2016, is there anything that needs to be added to or deleted from this CV dated January of 2016 to make it current?

A No.

Q Okay. Let me ask you a few questions about your background, if you don't mind. I see that you're board certified in internal medicine. I assume you passed your boards the first time; is that right?

A Yes.

Q Did you apply for medical school when you finished college at Princeton?

A No, I was not a premed student at Princeton, so I

went to School of General Studies at Columbia University and did premed courses and enrolled in medical school two years after I graduated from college.

Q Were you accepted the first attempt to become admitted to medical school?

A Yes, I was accepted.

Q All right.

A At Columbia University among others, and I enrolled there.

Q Excuse me, I didn't mean to talk over you. And if I do that, it's unintentional; I apologize in advance.

On your CV there are a few publications that are listed. Are there any that are relevant to the subject matter of this lawsuit?

A No.

Q All right. My understanding is that you're -- you attended a fellowship following your residency; is that correct?

A Yes.

Q And that was in gastrointestinal medicine?

A Well, digestive diseases is half GI and half liver disease at Yale, and then the second and third years were all liver disease and working in the lab.

Q Okay. I understand that you practice internal

medicine; do you have a concentration or area of interest?

A I did in early years. I saw patients with chronic liver disease in addition to general internal medicine, and I attended on consult service for liver disease at Yale, but in 1997 I decided to concentrate my clinical efforts in general internal medicine because I reduced my clinical time all together, and decided to focus where I was most interested.

Q Okay. So at one point in your career that was a focus, but no longer?

A It was a focus; it wasn't my only focus because I was a general internist.

Q Sure, I understand.

A But I dropped liver disease in 1997 and focused on my outpatient work as well as my hospital work in general medicine.

Q And I thought I saw some publications or presentations with respect to management of anticoagulate therapy; has that been an interest of yours or a focus of your practice?

A Well, it's a focus of teaching because I do a good bit of teaching of the students and house staff at Yale School of Medicine, Yale New Haven Hospital. And it's

one of the high risk types of treatments that we provide to patients, so it comes up frequently.

Q Has your practice changed since 2011 or 2012?

A No.

Q Relatively the same?

A (Witness nods.)

Q In the -- you understand that the care in question in this case occurred in October and November of 2012?

A Yes.

Q So I'm going to focus on the years prior to those events. So October, November 2011 to October and November of 2012 what was your practice mix at that time and how did you spend your professional time?

A I would say 18 to 20 hours a week of clinic work and direct patient care in outpatient setting at Yale Health Center. Also about 10 hours a month of work in a clinic associated with a neighborhood food pantry, and then two months of the year of hospital practice attending at Yale New Haven Hospital on teaching service. And then also the hospital work associated with my own practice and skilled nursing facility where I also see patients. So that's the overview; it's the same now.

Q All right, I must have missed something. You

said two months per year seeing patients in the -- hospitalized patients?

A Right. I work as an attending physician on the -- one of the teaching services in internal medicine at Yale New Haven Hospital.

Q Mm-hm.

A In that capacity I'm responsible for admissions, and work-up, and treatment, and discharge of the patients on our service, and as well as the education and supervision of residents, interns, and students.

Q And you mentioned some other activities, and I didn't hear a time frame or amount of time attached to that after you mentioned the two months per year working with inpatients at Yale New Haven Hospital.

A Right. So I mentioned the outpatient clinic, I mentioned the small amount of time I spend in the neighborhood food panty, I mentioned the hospital. Those are all my medical and teaching activities tied up together, and then the remainder of my time is administrative.

Q Okay. If you had to break it down percentage wise, what percent do you spend on administrative duties and what percent do you spend on the clinical duties that you've mentioned?

A I would say about 40 percent or so is administrative, and, you know, close to 60 percent is -- 50 to 60 percent is clinical, maybe a little more.

Q I'm sorry, 50 to 60 percent is clinical, and 40 to 50 percent is administrative?

A Yes, but, I mean, there's a lot of other clinical work that's hard to capture. I mean, there's results, and telephone calls, and refills, and all the different things that go into running a practice that I do concurrently even during my administrative time. So it's hard to draw a clear bright line between administrative and clinical work, but where, to the extent that you can draw a bright line, I would say it's more than half clinical; it could be up to around 60 percent.

Q And when you say "clinical," it's with Yale Health; is that right?

A It's with Yale Health. It's with the primarily indigent patients with Neighborhood Health Project, and it's with the general internal medicine population, not Yale affiliated at Yale New Haven Hospital which is the teaching hospital at Yale School of Medicine.

Q That would be the inpatient work that you did?

A That's right.

Q At Yale Health, what is that patient

population?
A That's a population of employees, faculty, staff, and their dependants, and retirees.
Q Of the university?
A Yes, of the university that are in my population. There are also students in our population and there are multispecialty clinics. There are a lot of different services, but I do primary care in internal medicine.
Q Okay. So of your clinical time, how much of it is spent in that practice at Yale Health, that internal medicine outpatient practice?
A 18 to 20 hours a week.
Q I'm sorry?
A 18 to 20 hours per week.
Q Which works out to be what percentage?
A I'm not sure. It's all together, if you add to together the Neighborhood Health Project, Yale Health and the hospital, that's -- if you add it all together it turns out to be about 50 to 60 percent of my time.
Q Let me -- I'm not following the math. How many hours do you spend professionally on an average week practicing medicine?
A Well, you have to take -- I have to do it per year because two of my months are in the hospital and

that's a pretty full-time commitment.
Q So let's do it per year and then --
A I'd have to.
Q Let me finish my question. We're talking about the Yale Health component. You've said it's 18 to 20 hours per week; if we're doing it per year, what does that work out percentage wise to be?
A I'm not sure. I would have to sit down with a piece of paper and add it all up again. I did do a calculation a year or two ago at the request of an attorney, not in North Carolina, some other state, and I added it up for the whole year, but I'd have to reconstruct the arithmetic; I don't remember.
Q Okay. We can do the math then with 18 to 20 hours per week in the outpatient clinic at Yale Health?
A Right.
Q Ten hours per month with the clinic associated with the food pantry?
A Right, so there's about two and a half hours per week.
Q And then two months out of the year is seeing inpatients at Yale New Haven Hospital, and I understand from what you said that patient population is different from your Yale Health internal medicine population?

A It is, but I also see my patients from the Yale Health in the hospital in that period, so it comes up to a lot of clinical hours.
Q Do you practice as a hospitalist?
A I practice as an attending physician. I have hospitalists -- people who become hospitalists on my service. I teach them, but our hospital service at Yale is different. The hospitalists are the employees of the hospital and they're not teaching services, so that's the only difference.
Q Right. You're not a hospitalist, though, correct?
A Right, that's not my title.
Q Never practiced as a hospitalist; correct?
A That's correct. I've been doing hospital medicine for 30 years, but not with the title hospitalist.
Q And you were not practicing as a hospitalist from October and November 2011 until October, November 2012; correct?
A That's correct, I was an attending physician responsible for inpatients.
Q Two months out of the year?
A In the hospital, right, that's correct.

Q Okay.
A And then in addition I also see patients in the hospital that are my own patients.
Q Sure. And Yale New Haven Hospital does have hospitalists on staff; correct?
A It does, correct.
Q And they are employed by the hospital; correct?
A Correct.
Q And you're not one of those people?
A That's correct.
Q Would it be fair to say that you do not spend the majority of your professional time seeing patients who are admitted to the hospital?
A That's correct.
Q And the patients that you admit to Yale New Haven Hospital, if you were not -- during that two month period where you're working in the facility, are those patients of yours then cared for by hospitalists on the staff at Yale New Haven Hospital?
A Ask again, I'm not sure I understood the question.
Q Sure. It sounds like you have patients at Yale Health?
A Yes.

Q Who may be admitted to Yale New Haven Hospital?
A Yes.
Q Okay. During the other ten months of the year when you are not working in the hospital, are those patients who did admitted -- patients of your practice who get admitted to Yale New Haven Hospital, are they cared for by the hospitals on staff at Yale New Haven Hospital?
A No, they're cared for during the week by a hospitalist on staff at Yale Health, but we also follow our patients.
Q Okay. But you're not a hospitalist at Yale Health, are you?
A No.
Q Okay. When was the last time you treated a patient with urosepsis?
A February 2016.
Q Did you admit that patient to the hospital?
A Several patients, yes.
Q Did you care for the patients when they were in the hospital?
A Yes.
Q Okay. And when -- was that the time that you were on that two month rotation?
A It's one month at a time; but, yes, I was on the

hospital rotation.
Q I beg your pardon. So the two months are not consecutive?
A That's correct.
Q All right. So you may, for example, work in February, and then again in November, for example, in --
A Yes.
Q And that would satisfy the two months of the year?
A Yes.
Q And the example you were just telling me about happened to be -- February of 2016, happened to be one of the months this year where you were working in that hospital service capacity; is that correct?
A That's correct, yes.
Q It sounds like if it was not one of the two months when you were working in the hospital service, if you had a patient with urosepsis that you saw at Yale Health or in your clinic, you would have them admitted to the hospital and they'd be cared for by one of the hospitalists, either at Yale New Haven Hospital hospitalists or a Yale Health hospitalist; is that true?
A It depends; I can also admit patients to our skilled nursing facility. And I often do that for

pyelonephritis and urosepsis. Unless the patient is hemodynamically unstable, I would generally admit them to the skilled nursing facility if it was just a matter of IV antibiotics.
Q All right. What physician would care for them in that scenario?
A I would.
Q And skilled nursing facility is obviously different than a hospital; correct?
A It is, yeah. It's on site where my office is at the Yale Health Center.
Q All right. In the course of your career, have you ever prescribed the antibiotic Levaquin?
A Yes.
Q Do you do that even today?
A Yes.
Q Okay.
A Many times.
Q You find that to be a -- an effective antibiotic?
A Yes.
Q My understanding is that you are going to give at the trial in this matter testimony that is critical of some of the employees of WakeMed; is that correct?

A Yes.
Q And here's a copy of the designation of experts that Mr. Kash has served on me. Again, I'm not going to make it an exhibit since we have it all. The part of the designation that focuses on you starts at the bottom of page one and continues on to pages two and three; have you had a chance to review this recently?
A No, but I can do so.
Q Why don't we go off the record and take a minute to read it to yourself, please?

(Off the record at 2:19 p.m.)
(On the record at 2:20 p.m.)

THE WITNESS: Yes.
Q (By Mr. Madden) Okay. Is the entry that applies to you accurate, as far as you can tell?
A Yes.
Q Did you have any role in preparing that entry that describes your testimony?
A I don't recall.
Q On page two it says -- I'm looking at the paragraph B -- subparagraph B, the fourth line down, and it says that, "It is anticipated that Dr. Genecin may testify

that in caring for and treating Ms. Pierce, defendant and their agent breached the applicable standards of care for physicians with similar training and experience practicing in their health care specialities in Cary, North Carolina or similar communities at the time in question;" did I read that correctly?

A You did.

Q And when it says defendant and it says their agent, who are we talking about? I mean, I know who defendant is, but when it says their agent, who are we talking about?

A Three physicians; one of them is Dr. Daud, one of them is Dr. Afridi, and one of them, I think his last name is Jenkins.

Q Okay. Tell me what you know about Dr. Daud's training and experience, if anything.

A Dr. Daud, he's an internist. He is also trained in geriatric medicine. He trained at Wake Forest. He's an internist, as am I. I'm not sure what else you're asking.

Q Just whatever you know about his education, training, and experience.

A Well, I read his deposition, I read what he said about it.

Q Anything else that you can recall, as you sit here today, other than what you told me?

A No. I'll be happy to refer to his deposition, if you'd like me to.

Q What about Dr. Jenkins' training and experience; what do you know about that?

A I recall that he's an internist. I don't recall the details about Dr. Jenkins. I have not read a deposition of Dr. Jenkins.

Q Okay. Is there anything you know about his training and experience, as you sit here today, other than that he's an internist?

A No.

Q What about, same question as to Dr. Afridi?

A Dr. Afridi, I looked at his CV, I looked at the CVs of all three doctors. He has internal medicine training, as well. He also has specialty training, and I don't remember if it's in geriatrics or pulmonary; I can't remember, some other field in addition to internal medicine. And he also is an internist. He comes from, I believe, India.

Q Okay. You can't recall what his specialty training is in?

A I don't recall.

Q As you sit here today?

A I don't recall. I looked at his CV, but I don't recall. I know that he's trained in internal medicine, but I have not read a deposition of his.

Q Tell me what you know about Cary, North Carolina.

A It's a town that is touching Raleigh, North Carolina. The population is, I think, similar to New Haven, it's about 150,000 people. The -- it's a town with a high average income, high level of education. I think that some 75 percent or more have a college education. And the average income is somewhere around $90,000 which is much more than New Haven. The average age is 36, which is young.

I know that Cary Hospital is part of the WakeMed system, is there, it's about 150 beds. It's part of a system of three hospitals, and, I think, rather similar to our Yale New Haven Hospital which also has its Saint Raphael campus, which is a much smaller hospital, located off site from mothership. I know that there's a good bit of technology work in that region, triangle region. I'm not sure what else you're asking.

Q Just want to know what you know.

A Yeah.

Q I can't tell you when to stop because I don't

know how much you know.

A Yeah.

Q Have you ever been to Cary?

A No. I've been to Durham, North Carolina, I've been to Greensboro, but I haven't been to Raleigh or to Cary.

Q Haven't been to Raleigh?

A Or if I have, I don't recall.

Q How many beds are there at the Yale New Haven Hospital, inpatient beds?

A On York Street about 900.

Q And that's when you have -- those two months of the year when you are seeing patients in the hospital, that's where you see them; is it not?

A Yes.

Q And since you've finished your training you've been in New Haven working for Yale Health; is that right?

A I've been in New Haven since my fellowship, so I moved here in 1985, I've been affiliated with the university as a fellow and then as an employee since that time.

Q Were you considered a Yale University employee working at Yale Health?

A Yes.

Q And when you see patients -- strike that.
You just told me when you see them now and in 2011, 2012 you see them at the Yale New Haven Hospital, which I think you said is about 900 beds, at any other time in your career have you seen inpatients at any other facility since you've been in New Haven?
A Sure, at the West Haven VA Medical Center, at the hospital called Griffin Hospital in Derby which is a town that's close by. It's a smaller hospital, about 200 beds. My time at the VA, I stopped practicing there in 1997.
Q And the other one was, I'm sorry, Fairby?
A No, no, Derby, Connecticut. Griffin Hospital, G-R-I-F-F-E-N, I think, or I-N.
Q So at the West Haven VA the last time you saw patients there was 1997?
A That's correct.
Q And what about at Griffin Hospital; when was the last time you saw patients there?
A Also at 1990s. I saw patients at the Saint Raphael campus which is -- I'm not sure how many beds are there.
Q I'm sorry, that's another hospital in the area?
A That's part of Yale New Haven Hospital. It's a part of the Yale New Haven Hospital system kind of like

Cary, or there's a third hospital that's a part of a WakeMed system.
Q And when was the last time you saw inpatients or cared for inpatients at Saint Raphael?
A April.
Q And you don't know the size of Saint Raphael?
A I think it's around 300 beds.
Q And I believe you said that February 2016 was the last time that you worked at inpatient service; is that right?
A That's correct.
Q And when are you next scheduled to have a month working on the inpatient service?
A I asked for the fall, I don't have the final schedule yet. Should come out any day.
Q And when you said that you see patients at Saint Raphael Hospital, are you working as a hospitalist or an inpatient service where you're seeing them, or is that just seeing patients that you have admitted there from your Yale Health practice?
A I'm an attending physician there as part of Yale New Haven Hospital; I see my own patients if they're admitted there as an attending physician.
Q During the two months of the year that you're --

A No, also during other times. If I have a patient in the hospital, I often go to see them. If they're on medicine, I certainly go to see them.
Q If they were admitted to Saint Raphael during a time where you were not -- during in one of those two months where you were working the inpatient service, those patients of yours would be cared for primarily by a hospitalist working on the staff at that hospital?
A Right, or on the weekends by my partners.
Q Right. So just to clarify, you see patients at Yale New Haven Hospital and at Saint Raphael Hospital when you're working those two months of the year where you're on the inpatient service from a standpoint of caring for the patients while they are in the hospital without a hospitalists being involved?
A That's not quite right.
Q Okay.
A I don't -- I only work on York Street, not on Saint Raphael campus while I'm attending -- I'm a hospital attending.
Q I'm sorry, I beg your pardon. So when you're a hospital attending, when you say York Street, you mean the Yale New Haven Hospital?
A Yale New Haven Hospital has two campuses; one is

on York Street, one is on Chapel Street. The one on Chapel Street is also called the Saint Raphael campus.
Q Okay.
A When I'm attending on the teaching service, I'm always at York Street, not at Chapel Street.
Q Okay. So you would not work as an attending at the Saint Raphael campus during those two months of the year when you're on the inpatient service?
A That's correct.
Q That's only at the York Street campus at Yale New Haven Hospital?
A That's correct.
Q That's the 900 bed facility?
A Yes, approximately.
Q Okay. What is the difference between Yale Health and Yale Medical Group?
A Yale Medical Group is the Yale faculty practice. Yale Health is basically a staff model HMO that belongs to Yale University. Our specialists are all members of the Yale Medical Group, but our primary care clinicians are employed staff.
Q It says on your CV that you're the executive director of Yale Emergency Medical Services?
A Right.

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Q Is that a rescue squad or EMS service?
A EMS, correct.
Q I assume the answer to the next set of questions is no; I don't mean anything by it, but I need to ask them. Have you ever been disciplined by any hospital which you had staff privileges?
A No.
Q No restrictions or suspensions of privileges for anything?
A No.
Q You ever had a medical malpractice lawsuit filed against you?
A I was named, but dropped from the suit many years ago; approximately 20 years ago. I was the ordering physician of a CT scan that was misread. I was dropped from the case after my deposition. That was the only one that was an actual lawsuit. I was also notified that I've been named in my administrative capacity, but a suit never materialized from another case that I was not personally involved with.
Q Okay. Have you ever had any claim that's been asserted, other than what you've told me about -- that's been asserted because of care that you've rendered?
A No.

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Q No matters ever settled on your behalf with respect to allegations of negligent medical care?
A No.
Q All right. Ever been convicted of any crime, other than a traffic ticket?
A No.

(Off the record at 2:35 p.m.)
(On the record at 2:39 p.m.)

Q (By Mr. Madden) Would you agree with me, Dr. Genecin, that it's different seeing patients in an office or clinic setting than seeing them in a hospital setting?
A Yes.
Q Okay. Tell me how long you've been serving as an expert witness in cases of alleged medical negligence; for example, when did you first start getting involved in that activity?
A Maybe 17 or 18 years ago, maybe 19 years ago; 19 years.
Q And can you give me an estimate as to number of cases you've reviewed? And I'm just talking about cases of alleged medical negligence. You may have looked at other

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types of cases, but just focusing on those over the course of that time.
A I don't know, I don't have -- kept count.
Q Any estimate you can give me?
A I would assume several hundred.
Q And how many depositions have you given?
A I haven't kept count.
Q Any estimate you can give me?
A I think more than 50, less than -- probably less than 75, but I don't have an exact count.
Q Okay. Have you testified at trial before?
A Yes.
Q How many times?
A Again, I don't have a count. I assume it could be 50 times, I don't know exactly.
Q Approximately 50?
A Well, approximately; it's a guess.
Q And most of those, when you've reviewed cases or given depositions or been at trial, have been as an expert witness for the plaintiff; is that correct?
A Yes, more often I do plaintiffs.
Q What's the ratio, if you can give me an approximation?
A I'm really not exactly sure. It would be a

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guess, but more than 90 percent in terms of testimony. In terms of cases I've reviewed, I would guess it's maybe three-quarters -- two-thirds to three-quarters plaintiff, but I have active defense cases, as well.
Q How many currently do you have?
A This year I read two or three, I think.
Q You read, reviewed two or three?
A Yes.
Q Are there any which you've been designated -- cases where you've been designated as an expert for the defendant that you have currently pending?
A Yes, I have one in Philadelphia.
Q And any others?
A It's coming up for the trial. That I can think of, I have one involving the hospital here in Connecticut in which I've been designated. A couple in New York state that I can think of that are active cases.
Q How many active cases do you have total?
A I'm not sure. I'm really not sure.
Q Give me your best approximation.
A It's several dozen.
Q Several dozen active cases?
A Yeah, a lot of them are inactive, but not resolved. In other words, I've done work and it goes on

for a long period of time before I get noticed that the case is either settled or that something more is needed. Usually they settle.

Q And can you give me a rundown of what your fee schedule is, please?

A I charge $550 per hour. I charge a four hour minimum for deposition testimony. I have a $7,000 day for 24 hour period for trial.

Q The $550 per hour, is that for both reviews and deposition time?

A Yes, the same.

Q And the deposition fee is a minimum of four hours?

A Yes.

Q So if the deposition only takes two hours, you still charge for four?

A Yeah, because I can't, you know, use the time again.

Q During the last, say, three to five years, what amount of income -- not a percentage of your total, but a dollar figure -- have you generated from being an expert witness?

A I don't know exactly, but I estimate around 50 to $70,000.

Q Has it ever been higher than that?

A Rarely.

Q Have you ever earned as much as $100,000 per year as an expert?

A Not in the last ten years. Many years ago I did have a year or two years where I earned that much, but I don't remember exactly. Not in the last ten years.

Q And during the course of your career, have you earned as much as $1,000,000 from being an expert witness?

A Yes, I think so.

Q Do you serve as an expert witness for plaintiffs in cases of alleged medical negligence that are pending in the State of Connecticut?

A Yes.

Q Have you ever been designated as an expert witness in a case of alleged medical negligence and had your testimony excluded at a trial?

A No. I assume you mean something more than an objection and something is stricken?

Q Yeah, I mean, not allowed to testify at all?

A No, I've never been not allowed to testify.

Q And have you served as an expert witness in cases of alleged medical negligence pending in North Carolina

prior to this one?

A Yes.

Q How many?

A I don't have an exact count. I know I testified in another case for Mr. Kash.

Q So it's at least one other North Carolina case. Are you aware of any others that you've ever reviewed that were pending in North Carolina?

A There may be, I just don't recall.

Q You don't remember?

A Correct.

Q Have there been other depositions that you've given in cases of alleged medical negligence that were pending in North Carolina, other than the one you mentioned that you worked for Mr. Kash?

A Possibly, but I don't remember.

Q Have you ever testified at trial in North Carolina?

A No.

Q In a case of alleged medical negligence?

A No.

Q Do you think there might be other North Carolina cases in which you've been involved as an expert, other than the one with which you worked with Mr. Kash?

A I don't know. I'd have to do a search.

Q Do you remember who the defense lawyer was in that other case?

A No. I'm sure Mr. Kash knows, but I do not recall.

MR. KASH: John, I can tell you it was Dan Klem's (phonetic) firm and WakeMed was the defendant.

MR. MADDEN: Okay, thanks.

Q (By Mr. Madden) Do you advertise your services as an expert within any company, or clearinghouse, or broker?

A I don't advertise my services. I know that I have in the past taken cases from a couple of referral agencies; I'm not working with them currently.

Q What do you mean when you say you haven't advertised, but you've taken cases?

A Well, there are agencies that help attorneys to find experts for different types of cases, and I've taken cases from those agencies from time-to-time, but not recently.

Q When was the last time?

A Oh, I don't know; couple years, two, three years ago. One of them is called MedQuest, and one of them is called TASA, but I'm not working with either one of them at

the moment.
Q Did you have to give them your permission to list your name in their referral documents or referral lists?
A I don't know exactly. I'm not sure how it works. Usually they just email me and say here's a blurb, would you look at it.
Q And you never had any contact with that agency before, they just contacted you out the blue?
A I believe I was solicited from my CV.
Q Isn't it true that they'd have to contact you first to get your permission to list you before they can put you out there as a candidate to review cases for lawyers; isn't that the way it works?
A I believe so.
Q So you had to give your permission on the front end for them to list your name so they can then contact you about cases that might be in your specialty areas?
A I suppose so, I just don't know to what extent they make my name known to other -- I don't know whether they publicize my name or they keep that information.
Q In the case you worked on which you worked for Mr. Kash, did you give a deposition in that case?
A Yes.
Q And did that case go to trial?

A No.
Q Do you remember what the issues were in that case?
A Yes.
Q And what were they?
A It was a medication error in which a patient who belonged on thyroid replacement was allowed to go without thyroid replacement for an extended period of time. Elderly patient who was unable to really recover from that when it was finally discovered. She was not able to rally and passed away.
Q And were you testifying with respect to the care provided by or not provided by particular individuals?
A Yes.
Q And tell me the roles; were they nurses or were they physicians, and if they were physicians, what specialty areas?
A I don't have specific recollection, but it would have had to involve doctors like myself. I believe it was involving hospital care and a transition of care from a hospital to a nursing facility. There were doctors involved and nurses.
Q Okay. Were you testifying against the nurses?
A I don't recall.

Q Okay. Do you remember if you were testifying against the doctors?
A Again, I don't recall the specifics. It's reasonably likely that I was, but I don't recall the specifics.
Q And this was a patient who's being sent from the hospital to a skilled nursing facility?
A My recollection is it was a patient who was admitted to the hospital. The fact that she was supposed to be taking thyroid hormone was skipped or missed or neglected. There was then a hospitalization during which time she didn't have that medication, and, then, again, at the time of med reconciliation, it was again missed. And when the patient went to the second site of care, also was without thyroid replacement and became very severely hypothyroid.
Q Have you ever worked with any other North Carolina lawyers in cases of medical negligence besides Mr. Kash?
A Again, I don't remember.
Q Do you know how he got your name initially to have somebody who would review a case?
A I don't recall.
Q Would you agree that there's a national standard

of care that applies to internal medicine physicians?
MR. KASH: Objection.
THE WITNESS: I gather that in North Carolina there's a local standard of care as well as a national standard of care that is everywhere in the country, but I don't think that the one precludes the other.
Q (By Mr. Madden) So you think that there is a national standard of care?
MR. KASH: Same objection.
THE WITNESS: I do.
Q (By Mr. Madden) Do you believe that an individual physician's education, training, and experience really has very little to do with the standard of care that's applicable to that particular physician?
MR. KASH: Objection.
THE WITNESS: I'm sorry, could you repeat that question?
Q (By Mr. Madden) Sure. Do you agree with me that a physician's education, training, and experience has very little to do with establishing the standard of care that's applicable to that physician?
MR. KASH: Objection. Same objection.
THE WITNESS: I don't know how to answer

that question because I don't really understand it.

Q (By Mr. Madden) Okay, let me ask it again. Do you believe that a physician's education, training, and experience has very little to do with the establishing of the standard of care applicable to that physician?

MR. KASH: Same objection.

THE WITNESS: Well, I think that a doctor's education, training, and experience in a field would acquaint that doctor with the standard of care, and that that standard of care would be applicable to that doctor. So I don't see how they could have very little to do with each other, I think that we provide education, training, and experience to young doctors in order to help them to meet the standard of care.

Q (By Mr. Madden) So you would disagree with the statement that I just recited?

A I guess so, yeah. I mean, I'm not sure what the implications of the question are, but that's my reaction to it.

Q Tell me what materials you have reviewed in this case, Dr. Genecin.

A I reviewed very extensive medical records, including records of WakeMed Cary which was the hospitalization in question, but I've also looked at

outpatient records, rehabilitation records, nursing home records, ER records, numerous medical documents.

Q What other facilities, other than WakeMed Cary, have you reviewed records?

A I don't have the list with me. I'm sure Mr. Kash has a list of the records that I reviewed. I'd be happy to provide it to you, but I have not brought it with me.

Q All right. If you can do that and send it to Mr. Kash so he can send it to me. You don't recall, as you sit here today, what all you've looked at?

A I do recall the -- specifically records of the WakeMed admission at which Mrs. Pierce was treated with Levaquin for pyelonephritis sepsis. I know that she was -- underwent surgery, and I have records of the surgical treatment and follow-up of her Achilles tendon repair.

I have records of the physical therapy rehabilitation that she underwent in basically the January through spring 2013. I have records of the nursing home in which she was placed by her son in 2013. I've seen her death certificate. There -- I know there are other records, I just don't recall the names of the facilities of doctors.

Q Anything else you can recall, as you sit here?

A I have also read deposition testimony, as well,

but in terms of medical records, that's as specific as I can be. But I'd be happy to provide you a list.

Q That would be great. I'll get to the depositions in a moment. You understand that the admission in question began on October 30, 2012?

A Correct.

Q Okay. Have you reviewed any records of care and treatment that Ms. Pierce received prior to that date?

A I'd have to look at my list. I don't remember. I have a lot of her past history, but I don't recall where it was because of records that were sort of cumulative. I know that she had an extensive past medical history, I just can't remember what I have in the way of past records.

Q Have you looked at any prior records?

A I don't recall. I know for the preparation for today I did review the records starting with the admission, but I just can't recall if I have that.

Q In preparation for today's deposition, you didn't look for anything prior to October 30, 2012 and you don't know if you have anything prior to October 30, 2012; is that right?

A I just don't recall. I can give you a list of the records that I have, though.

Q You said you reviewed some depositions; which

depositions?

A Dr. Daud, Raymond Da Silva; I think that's all of the depositions so far.

MR. KASH: John, may I interject something? I think the witness is misspoken. I think he was provided with the deposition of Thomas Da Silva.

THE WITNESS: I'm sorry, yeah, I'm looking here at Raymond.

MR. KASH: Ray is the executor.

THE WITNESS: It's the younger son whose deposition I read.

Q (By Mr. Madden) That's fine, thank you. Any other documents that you have reviewed in the formulation of your opinions in this case, or in preparation for your deposition today?

A No.

Q That we haven't talked about?

A No.

Q Have you conducted any case specific research in preparing your opinions, or formulating your opinions in this case?

A I do have some literature on the topic, a couple of articles. I didn't pull them for this case, but I do have them.

Q That was my question.
A Yes.
Q Was that part of your keeping up with the medical literature, or was it for formulating your opinions in this particular case?
A It's for keeping up with the medical literature. It's a topic that I teach on in the hospital. And, in addition, I'm familiar with, although I didn't become familiar for this case, I'm familiar with the drug labeling information. I'm familiar with literature pertaining to the treatment of pyelonephritis, and the literature pertaining to the treatment of klebsiella infection. So all those are familiar to me, but not specifically for this case.
Q Okay. I'm sorry, any other documents, other than what we talked about, that you've reviewed?
A Yes. I reviewed a bunch of demographic documents of Cary and Raleigh, and the hospital -- Cary Hospital, which is one of the WakeMed Hospitals. I looked at the CVs of the three internists who were involved in her care at WakeMed Cary. And in the demographics were information about population for average age, and income, and the kinds of industry, and the diversity, and lots of statistics about the region.

Q Okay. Have you generated any notes or prepared a report regarding your opinions in this case?
A No, I have just the records.
Q Okay. You haven't made any notes on them or any separate notes?
A I did create the -- scanned some pages of notes and put them in a file electronically with some discharge summaries, but I did not write my own notes.
Q Okay. You lost me; you have notes, but you didn't generate them?
A Correct, they're per the medical record. So I just took part of the medical record, the PDF, put them in the file so I can refer to them.
Q I gotcha.
A Not notes.
Q So the record's clear, you didn't generate any notes yourself in review of the case?
A No, the hospital notes were generated. I just have them electronically so I can refer to them if Mr. Kash calls me and says what about Mrs. Pierce, I can look it up quickly and see which case that was.
Q You have taken some of the medical records that Mr. Kash sent you and put them in a PDF to create a file on your computer?

A That's correct, yes.
Q And it sounds like this file on your computer is not inclusive of all the records that Mr. Kash sent you; is that correct?
A By all means, it's not. It's just a few pages.
Q Which pages are in it or which pages constitute this computer file?
A Let me see if I can remember. There's an H and P for the hospitalization in October 2012. There's a discharge summary. There is a summary relating to the surgery that she had to repair her Achilles tendon, which I believe was late November 2012. There are some -- I can't remember what they are, some sort of legal form that I had to sign which I copied and pasted and put into my notes.
Q You have actual records from the repair of the Achilles injury?
A I do.
Q Anything else that's in your computer file?
A Not that I can recall. I probably have a list that Mr. Kash provided of the records, I usually have that.
Q Okay.
A I have a place to look and say have you read such and such, I can look that up.

Q But you haven't generated any report or anything like that?
A I have not.
Q Okay. Do you recall if you've reviewed the office records of Dr. Bruckert?
A The name rings a bell. I don't recall if I read the records. I know there are cardiology records, orthopedics records, problems with her back, with her hips, and knees, shoulders; I've read a lot of those records, but I don't recall the names.
Q Okay. And when Ms. Pierce suffered her Achilles tendon injury in late 2012, is that the first tendon injury that she had experienced?
A Well, not exactly the first in the sense that she had a lot of musculoskeletal problems, bad shoulder problems. She once had a history of tendinitis involving her Achilles tendon. I don't recall other instances, but that's not the only time in which she had a problem with her tendon.
Q In fact, she had several occasions where she had tendon problems, issues or injuries; isn't that true, prior to October 30, 2012?
A Yes.
Q How long had Ms. Pierce been taking Prednisone as

of October of 2012?
A I can't recall the exact duration, she'd been on it for at least -- she was on chronic therapy; I don't recall if it was months or how long it was. She had a chronic connective tissue disease called polymyalgia rheumatica for which she was on long-term steroids.
Q You can't recall whether it was months or years?
A I can't recall.
Q Anything else you can tell me about Ms. Pierce's prior tendon injuries or tendon problems, other than what you said?
A She had a lot of other musculoskeletal problems; I don't have specifics about other tendon problems. She had osteoporosis, vertebral compression fractures, knee surgeries, shoulder problems and shoulder surgeries.
Q Do you have an opinion as to what caused Ms. Pierce's tendon problems that she experienced prior to October 30th of 2012?
A Well, she had in the first place wear and tear from old age. She had polymyalgia rheumatica which is an inflammatory condition. She was on long-term steroid therapy which tends to be catabolic.
Q Tell me what that means.

A That means that those are not good for the integrity of bones, muscles, and joints. So she was certainly a patient who was at risk with respect to her tendons, but I don't have more specifics for you than that.
Q Would it be fair for you to say that those three items you just mentioned -- her age, the PMR from which she suffered, and long-term steroid use -- all can either cause or be risk factors for tendon injuries or tendon problems?
A Yes. And, of course, that's the basis for the contraindication for flouroquinolones in elderly patients on steroids. They're more at risk, so that's the -- actually, the reason why I think we're here.

(Off the record at 3:10 p.m.)
(On the record at 3:15 p.m.)

Q (By Mr. Madden) You would agree with me, Dr. Genecin, that patients in their 70s who are not -- have not ever taken a flouroquinolone can and do have tendon ruptures?
A Yes, there's a low background incidence of tendon rupture. It's not a common event; but, yes, that may

happen.
Q Well, in fact, it can happen and does happen in patients of that age group who have never taken Levaquin or any similar antibiotic; isn't that true?
A That's right. Flouroquinolones increase the risk that it will happen, but that also may happen from other causes, traumas the number one cause.
Q Right. And same thing with a patient with PMR can have tendon injuries or tendon ruptures even if they've never been given a flouroquinolone; true?
A Rarely that involves Achilles tendon, but it is reported. I did find a report of flouroquinolone induced tendon rupture in polymyalgia rheumatica.
Q But patients with PMR can have tendon ruptures, tendon injuries even if they've never been given a flouroquinolone; true?
A I've never read about Achilles tendon issue in PMR. Honestly, I've never read that.
Q So you're telling me it doesn't happen?
A No, I didn't say that. I said I've never read it. Big difference.
MR. KASH: Objection.
Q (By Mr. Madden) So it can happen and does happen; isn't that true?

MR. KASH: Objection. Mischaracterization of his testimony.
Q (By Mr. Madden) I didn't say what he said, I said it can happen and does happen; isn't that true?
A That's your testimony.
Q That's my question.
A Oh, I don't know. I have not encountered that as a manifestation of polymyalgia rheumatica.
Q And patients on long-term steroid therapy have, can, and do have tendon injuries and tendon ruptures, including Achilles tendon; isn't that true?
A Yes, rarely they may, yes.
Q I'm sorry, you said rarely?
A Yes, rarely. Overall it's an uncommon event, but the risk of it goes up with a variety of risk factors.
Q When did Ms. Pierce first receive Levaquin?
A I can't remember when she first received it. She had it in the past, but had not had any difficulty with it.
Q Had she -- strike that.
Do you know how many different times she had been prescribed Levaquin prior to October 30, 2012?
A I know it was at least once. I don't know the number of times, but prior treatment is not a risk factor.

It's an event that may or may not happen with any treatment.

Q And when she received Levaquin prior to October 30, 2012, she was also on Prednisone; isn't that true?

A Yeah, correct.

Q And do you know which physician or physicians prescribed the Levaquin for her while she was on Prednisone?

A I don't recall that.

Q Do you feel that that was inappropriate or breach of the standard of care for that physician to do so?

A Yes.

Q Have you reviewed any of Ms. Pierce's records from the Rex Rehab facility?

A I did if that was the rehab facility that she -- where she had her rehab in the winter, spring of 2013, yes. If it's not, I don't recall. I just don't know the name of it.

Q And I believe you said earlier that you had reviewed the records for the surgical repair of Ms. Pierce's Achilles tendon?

A Yes.

Q And that was Dr. Somers; is that right?

A Yes.

Q During the admission -- or, strike that.

When she came to WakeMed Cary Hospital on October 30, 2012, when did Ms. Pierce first receive Levaquin?

A Well, she received it on admission. I don't remember the exact hour she was given Levaquin and a dose of Vancomycin.

Q After she was admitted to the hospital?

A Yeah, she was started on Levaquin, continued on Levaquin.

Q Did she receive it while she was in the emergency department?

A I don't recall if she got a dose in the ER. I think she may have, but I don't recall for sure. And Dr. Jenkins was the doctor who admitted her, then Dr. Daud took over, but I don't recall exactly if it was the ER or -- probably was the ER.

Q If the records show that she received Levaquin when she was in the emergency department, would you have any reason to disagree with those records?

A No.

Q And when she received the Levaquin in the ER, she was also on Prednisone; true?

A That's right.

Q And are you critical of the emergency department physician for prescribing the Levaquin for her when she was on Prednisone?

MR. KASH: Objection. I'm going to object to this. As you well know, this witness is not intended as an expert in emergency medicine; but, to the extent you can answer that, Doctor.

THE WITNESS: Well, my answer was related to that. It was to state that I don't give standard of care opinions about the ER doctor, so I would defer to the ER doctor.

Q (By Mr. Madden) You think it was, regardless of who prescribed it, that giving Levaquin to a patient that was already on Prednisone was inappropriate?

MR. KASH: Objection.

THE WITNESS: I think it is, yes, that's my opinion. But regards to the standard of care of specifically doctors, I'll defer to a ER specialist.

Q (By Mr. Madden) Just so I'm clear, you would be critical, or you are critical of any internal medicine physician, who, prior to October 30, 2012, prescribed Levaquin for Ms. Pierce while she was on Prednisone; is that correct?

A That's correct, right. Although patients are on Prednisone should have alternative antibiotics chosen, not flouroquinolones.

Q And that's always the case?

A Well, for internal medicine physicians, absolutely. There could be an extraordinary occurrence in which a patient had resistance to every antibiotic, expect for flouroquinolone, in which case the doctor would have to approach that, but with informed consent informing the patient that he's forced to overlook a black box warning in the drug labeling in order to give it to the patient, but that it might be lifesaving.

Certainly if the situation where a patient can take a beta-lactam, a carbapenem or any of the multitude of other beta-lactam, beta-lactamase inhibitors combination, there'd be no reason to give the flouroquinolone.

Q So it's your opinion that except that one exceptional situation, it's always inappropriate to prescribe flouroquinolone such as Levaquin to a patient who is on Prednisone; is that correct?

A Right, I think, you know, that's a basic tenant of medication safety and patient safety, do no harm, and don't do things knowingly that could lead to harm to the patient.

Q Okay. Would you agree with me that every antibiotic has a side effect?

A Well, side effects are possible with any antibiotic. There are characteristics of antibiotics that make them better or worse choices based on the seriousness of the side effect. And very often the seriousness of the side effect is reflected in the box warning, and there are many warnings about different drugs.

Q Sure.

A There are drugs that are more associated with antibiotic associated diarrhea. There are drugs that cause renal failure. There are drugs that can cause this, that or the other thing. When the odds ratio of an adverse reaction goes way up when you do give a patient a drug as compared to the other drugs that don't have those characteristics, then other drugs would have to be the doctor's first choice.

Q Okay. So would you agree with me that all antibiotics have some type of side effect?

A Every antibiotic may have some side effect. They may have both idiosyncratic as well as predictable side effects.

Q Would you also agree that when a physician is analyzing the choice of antibiotics, he or she must go

through a risk benefit analysis in which they look at the potential benefits of the medication versus the potential side effects or downsides of the medication?

A Yes, that is required by the standard of care.

Q Is it your belief, and will it be your testimony at trial that a black box warning is an absolute contraindication to the administration to that medication in that situation?

A In that situation, yes. In a hypothetical situation in which there were no other antibiotic either available, or no other antibiotic that would be effective, then I think we would have a different scenario. But in the scenario in which the choice of antibiotics is vast and they're all equally efficacious with respect to what you're treating, then it's an absolute deviation from the standard of care to ignore a box warning and expose a patient to a known risk, not even get informed consent, that would certainly be a deviation.

Q Let me switch gears with you a little bit. You understand in this case that there are allegations, not only against the internal medicine physicians, the hospitalists who were caring for Ms. Pierce, but also with respect to at least one of the pharmacists who was working at the hospital; you understand that?

A I understand, yes, that the hospital has a system for medication safety that involves both pharmacy as well as physicians.

Q And when you were on one of your in-hospital rotations, the two months per year that you do that, are you on occasion contacted by a pharmacist about a potential side effect or contraindication for a medication that you have prescribed?

A Yes. In my service we actually have it -- usually a clinical pharmacy intern as part of my team, so I interact with clinical pharmacy daily. Yes, they do bring attention to adverse issues and choices that could be made that are safer. There are also systems that alert the doctors to contraindications when they order.

Q Sure. But in a situation where a pharmacist alerts the physician of a potential risk factor or concern about a medication that that physician has prescribed, and where the physician is already aware of that potential risk factor or side effect, would you agree with me that it is the physician's decision, the physician's responsibility about giving the medication as opposed to the pharmacist?

A Yes. In fact, Dr. Daud testified that even if he'd been warned or had a pop up warning about it, he would have given the drug any way, he would have ignored the

warning. So in light of that, I guess it doesn't matter what the pharmacy would have done.

Q Right. So even if in a situation of where a physician already knows of a potential side effect or the potential risk of the medication in question, whether a pharmacist provide or doesn't provide any warning, alert or advise about the medication, it really doesn't matter because the physician already knows about it and the physician is going to make the decision about whether or not to give the medication; true?

A Yes.

Q Okay. You told me before that you were going to render opinion testimony critical of the three hospitalists in this case, Dr. Jenkins, Dr. Daud, and Dr. Afridi; is that correct?

A Yes.

Q Okay. Tell me the criticisms you have of Dr. Jenkins.

A Dr. Jenkins admitted and continued the patient on Levofloxacin, Levaquin rather than observing the medication safety conflict and using a safer alternative.

Q And what information did Dr. Jenkins have at that time as far as a safer alternative?

A Well, insofar as a doctor has to consciously

disregard a black box warning in order to provide a flouroquinolone in this setting, he had to consciously decide not to use a beta-lactam, beta-lactamase inhibitor drug. He could have used a Cephalosporin, a carbapenem; there's a wide array of drugs he could have chosen, but consciously disregarded that fact and instead chose a drug for which there's a black box warning for a patient who has exactly the risk factors for the complications she suffered.

I don't -- haven't read Dr. Jenkins' deposition testimony, so I don't know whether he'll say the same thing that Dr. Daud said. Dr. Daud certainly had conscious disregard. Whether that was Dr. Jenkins' case or whether he just was not aware of the problem with flouroquinolones, I don't think at this point, no, but the use of it is negligent.

Q What other antibiotic options were there for Dr. Jenkins?

A I listed a bunch just now. So a beta-lactam, beta-lactamase inhibitor combination. So, for example, piperacillin/tazobactam is a good one. Amoxicillin clavulanic acid, and there are a number of other beta-lactams with clavulanic acid that are available. There are Cephlorosporins that are very effective for gram

negative infections, which pyelonephritis is overwhelmingly likely to be. Carbapenems, monopenems, there are also -- Bactrim is another one.

So there's a number of choices in terms of treatment for a patient. Aminoglycosides are also possible. And to avoid aminoglycosides in elderly patients, but it's also an option. The -- there are in that list a number of drugs that are preferable to the flouroquinolones from a safety standpoint.

Q Have you reviewed the microbiology report of the culture and sensitivity test that was done?

A Yes.

Q On Ms. Pierce at WakeMed Cary?

A Yes, of course I have.

Q And I think Mr. Kash just put that in front of you.

MR. KASH: I didn't put it in front of him, I have it in front of me. You want me to show him?

MR. MADDEN: Sure, that would be great.

THE WITNESS: This is the antibiogram.

Q (By Mr. Madden) And you've looked at that prior to today?

A I have, indeed. This is a pan sensitive organism, the only resistance is the susceptible resistance

to ampicillin.

Q Do you have any quarrel or disagreement with the antibiotic options that are listed on this report?

A These are not clinical options, these are routine sensitivity testing that's done in the laboratory. From this list that's listed or another like it can be chosen, but this is not a menu for the doctor. This is only available two days later when the culture and sensitivities become available. However, there are a number of excellent antibiotics on this list that could have been chosen and a number of ones that I just mentioned.

Q Okay. Well, if we look at this would you agree it's a reasonable list of choices for antibiotics for a patient like Ms. Pierce?

A Yes.

Q Okay. And when we look at the list of antibiotics, the S in the right-hand column means that the organism that's been tested, in this case the klebsiella pneumoniae, excuse me, is sensitive to the ones where there's an S, and it's resistant to the one where there's an R; is that right?

A Yes, just with the caveat that they define that S as susceptible rather than sensitive. I'm more familiar with the term sensitive --

Q I beg your pardon. Yes, sir.

A -- but it says susceptible.

Q All right. So you would agree with me that ampicillin is not an option because the organism is resistant to ampicillin?

A Right, understanding, though, that that would be information that would come down stream from admission, no one would start ampicillin these days on a patient with urosepsis.

Q All right. What about let's just go down the list there. And I'll probably mispronounce them, so I'll let you do the -- Amikacin, the first one, is that an option?

A Amikacin. Amikacin is an aminoglycoside. It's similar in some ways to the second to last drug, Tobramycin and Gentamicin. Those are drugs that are highly active against gram negative infections, including klebsiella. They're drugs that I wouldn't use as a first choice.

Q Why not?

A They have a tendency to be nephrotoxic. I mean, glycosides are used sometimes for very specific indications, but they've been superceded by other antibiotics for most purposes. They also may have ototoxicity.

Q We've talked about the Ampicillin wouldn't be used because that shows the organism is resistant to that; correct?
A Yes.
Q And going back to the first one, that's not a medication you would use because of its nephrotoxicity; correct?
A Amikacin, that's correct.
Q And can it also cause respiratory issues?
A On occasion. Honestly, I've never prescribed it. It always shows up on antibiograms, but I've never used it in clinical practice, and I don't think I've ever seen it used.
Q Okay. And the next one in the list Ampicillin/sulbactam?
A Right.
Q Is that an option you're saying better than the Levaquin?
A Well, it is an option, but it wouldn't be a drug that you would start a patient on imperially, but it is a class of drugs, beta-lactams with beta-lactamase inhibitors of which there are many that are more likely to be used in clinical practice which would be appropriate. So, for example, piperacillin/tazobactam as an example. But

ampicillin bactam is a beta lactaid, that's the ampicillin with beta-lactamase inhibitors. If you were on a desert island and had nothing else to give the lady except ampicillin bactam, you'd be happy that you had it on hand.
Q Can that not -- what are the risk factors of that medication, or the possible side effects of that medication?
A Well, ampicillin is a penicillin, a derivative, and there are some patients who are penicillin allergic. Any antibiotic can cause an antibiotic associated diarrhea. There are any number of idiosyncratic reactions, but truth to tell, it's a very well tolerated drug.
Q Can it cause Stevens-Johnson syndrome?
A Well, any drug can cause Stevens-Johnson syndrome. It's not on the warning list. The warning list for Stevens-Johnson is not ampicillin bactam. It doesn't include some sulfa drugs, it does include lamotrigine, it does include NSAIDs, it does include a number of other possibilities, but it's not -- ampicillin bactam is not a heavy hitter in terms of Stevens-Johnson.
Q Has it been reported as causing Stevens-Johnson syndrome?
A Yes, but Stevens-Johnson syndrome has been

reported with a myriad of drugs.
Q I understand. That's one of them; correct?
A Yes.
Q And can it also impact blood count?
A Any drug may cause hemologic toxicity.
Q So the answer's yes?
A Yes.
Q Okay.
A There's no boxed warning about any of those things, though, so the doctor's not overlooking a boxed warning to use it. It would be negligent to use it on a patient in whom an allergy was known, and if a patient certainly had a prior instance of Stevens-Johnson, for example, and that was a candidate drug in terms of an offender, then, of course, you would never reuse it, but there's no contraindication in a non-allergic patient.
Q With respect to Dr. Jenkins, he did not have this report available to him when he prescribed the Levaquin?
A No, you're treating the patient imperially at the time of admission and you don't always get the positive.
Q So tell me what, in your opinion, Dr. Jenkins should have prescribed for Ms. Pierce instead of the Levaquin?
A Well, he could have used a beta-lactam,

beta-lactamase inhibitor combination, such as Zosyn or piperacillin/tazobactam.
Q I'm sorry?
A Piperacillin, P-I-P-E-R-A-C-I-L-L-I-N, tazobactam, or any one of these excellent cephalosporins of which cefazolin, cefepime, cefoxitin, and ceftazidime are all fine. The others are usually steroid -- nitrofurantoin is an outpatient drug. Trimethoprim/Sulfa, usually we don't get that, it can be given, but it's not generally used as a first line urosepsis drug.
Q Any others that, in your opinion, Dr. Jenkins should have prescribed for Ms. Pierce, rather than the Levaquin?
A No, the first choice is as I stated, were a beta-lactam, beta-lactamase combination -- beta-lactamase inhibitor combination.
Q I'm sorry, beta-lactam, beta-lactamase?
A Beta-lactamase inhibitor combination or a Cephalosporin; those are the most likely. When you get to Ertapenem and other carbapenems and onopenems you are getting into situations where you have a patient who's not responding to the antibiotic therapy, so those are more second line.
We said the Levofloxacin, Ciprofloxacin are drugs

to avoid in elderly patients on steroids. Tobramycin, Gentamicin, Amikacin are drugs that we, you know, may use if pushed to it, but they're generally avoided because of nephrotoxicity when possible. And Trimethoprim/Sulfa is a good choice.

Q Okay. I'm going to go through that list with you a little more slowly so I can get all that down.

A Yes.

Q Is the method of administration a consideration in choosing the antibiotic for the patient?

A To a limited degree. You only treat urosepsis with IV antibiotics, so you would never be really thinking of an oral antibiotic for urosepsis. This is an admission to a hospital IV antibiotic for the start of therapy.

Q What about if you're going to continue antibiotic therapy post discharge?

A Then you switch to an oral regimen. And in some instances it's the same drug, and in some instances you transition to a related drug.

Q Is it better to use the same drug if you can?

A Not necessarily. Not every drug has an oral equivalent, so when we make the transition to a drug that is -- to which the bacterium is sensitive, when we're making that transition, the patient's no longer septic,

they're ready for PO medication and we know sensitivities.

Q But if you know if a patient is on an IV medication and the IV antibiotic is being tolerated by the patient and effective for the patient, is it better to keep the patient on the same medication if it can be given PO, rather than switch medications to something else that the patient has not been on?

A No, not necessarily. There are a lot of IV drugs that are heavy artillery for treating serious sepsis and don't have an oral equivalent, or the PO equivalent is, in essence, a different drug because of the way it's absorbed.

Q So you disagree -- I'm sorry.

A So it's not necessary to do that.

Q Do you --

A One of the reasons why people like the flouroquinolone is they can be given IV as well as orally; but, again, you don't do that with an elderly patient on steroids.

Q Would you agree that keeping the patient on the same medication is preferable if it can be done, and that medication can be given IV and then PO?

A I would state it like this: That it's preferable

that the patient be treated with an antibiotic to which the bacterium is sensitive or susceptible. It doesn't have to be the same drug, and it's not necessarily; we're often making a decision about a transition from one IV regimen to a totally different oral regimen.

Q Right. And my question is: Is it preferable if you can stay on the same medication that can be given PO after the patient has been given that medication IV and not have to switch?

MR. KASH: Objection. Asked and answered.

Q (By Mr. Madden) No, it's been asked, it hasn't been answered.

A I keep saying no, it's not necessarily preferable.

Q Okay. It's not?

A No. It's fine to do that, but it's also fine to switch it as long as the bug is susceptible.

Q All right. Working our way down the list, the next one is the Cefazolin?

A No.

Q I apologize for my mispronunciations.

A I call it Cefazolin, but it's Cephalosporin. It's the first of one, two, three, four, five that would

have been fine choices. They all have similar activities in terms of gram negative coverage.

Q And is it administered IV?

A Yes, these are all IV.

Q And can it be given PO?

A Kefzol can, Cefazolin is given PO.

Q I'm sorry?

A Cefazolin is given PO, yes. There's another oral Cephalosporin that's not one of the ones on the list here, but it's a perfectly acceptable one, which is Cefuroxime Axetil, and that's a perfectly acceptable oral agent.

Q The next one on the list, I'm going to ask you to pronounce that one.

A Cefepime.

Q Cefepime?

A Yes.

Q And, in your opinion, why is that preferable to Levaquin in this case?

A Well, there's no black box warning about safety relating to Cefepime. It's not -- the choice of Cephalosporin is very often a hospital preference, different hospitals usually have a pharmacy benefits manager that gets one of them or the other, it's a preferable formulary drug.

I haven't used Cefepime very often, but certainly it's a perfectly good drug, as are the others, in terms of empiric treatment. They're -- all of them safer in terms of black box warnings than a flouroquinolone for an elderly patient on steroids.

Q You said imperially; what about after you have the culture and sensitivity report back?

A Well, then it's a question of whether the patient still needs to be on IV antibiotics. And if they do, you can choose any of those, or if having chosen it, you can continue it. They're all fine in terms of activity with respect to klebsiella.

Q And the Cefepime, is that given IV or PO?

A Cefepime is IV.

Q IV only?

A As far as I know.

Q Okay. And this Cefoxitin --

A Cefoxitin is an IV Cephalosporin.

Q And why is it preferable to Levaquin in this case?

A It's a safer -- it's, you know, a general hospital preference in terms of which is on formulary. One or two of these two will be on formulary, and they're safer for an elderly patient on steroid therapy. For

flouroquinolone it's contraindicated.

Q Is the bottom line to your opinion in this case that because there's a black box warning that a flouroquinolone, such as Levaquin, should never be prescribed to a patient like Ms. Pierce unless there's no other option from an antibiotic standpoint?

A That's correct.

Q Okay. And so it's your view that it's an absolute contraindication and should never be given except in that one situation?

A Well, in a patient with these characteristics, a 76 year old woman on chronic steroid therapy with urosepsis, it's an inappropriate choice. And the reason is that you expose the patient to a risk of a Achilles tendon or other tendon rupture. If you've seen that, you know that that's a lot worse than it sounds.

And allowing an elderly person to be put at risk for a complication that becomes much more likely if they take the drug as compared to not taking it, then, of course, you have the duty to do the safe thing.

Q Is the Achilles tendon injury, in your opinion, worse than or better than kidney damage?

A Well, I don't think that anyone would be wanting for a patient to have kidney damage, so treating with an IV

antibiotic in this situation, a pyelonephritis or complicated urinary infection, would be required by the standard of care because not to do so would be a risk of death really.

Q You're not going to give them medication that is potentially nephrotoxic; correct?

A Not if you don't have to.

Q Correct.

A But there's a risk and benefit analysis in a patient who is tolerant of alternative medicines and who has two contraindications, possibly three if you look at the connective tissue disease, than the -- they can't meet the standard of care in ignoring a drug that's known to have associated with it a complication, which, if it occurs, is life altering for the patient.

If a patient has an idiosyncratic reaction, that is to say an unpredictable one, God forbid that she gets Stevens-Johnson or something like that, there the duty is to stop the drug at the first sign of rash, right, but that's a different question. But choice of the drug about which there's a black box warning explicitly talking about the risk factors that this patient has, that's the patient where use of this drug is contraindicated.

Q Does the black box warning say in layman's terms,

do not use this medication?

A Yes, alternative medications are recommended because of safety, that's what it means.

Q Does it say to never use that medication in a patient with those characteristics, or does it --

A Not in a patient who can safely take other antibiotics. So rule of thumb with an elderly patient, once steroid is urinary infection pending culture results, use a drug effective, or drugs effective against gram negative infection, don't five a flouroquinolone.

Q Ever?

A Right, exactly. Imperially you would not select flouroquinolone because of this tendinopathy risk.

Q Okay. The next one on the list is Ceftazidime?

A Yes.

Q And, in your opinion, that would have been preferable to Levaquin in this case?

A Yeah, it's usually the drug in my experience that you reserve for patients where a patient has a pseudomonas infection, but it is a very effective broad spectrum.

Q And is that given IV PO or both?

A IV.

Q All right. And then the next one?

A Ceftriaxone.

Q Ceftriaxone?
A That's at least in my hospital the Cephalosporin of choice. That's a drug that can be given IV or intramuscular, not oral. Excellent drug, excellent broad spectrum, useful for many purposes. That would be a drug that would be preferable to a flouroquinolone. There are no known black box warnings about Ceftriaxone.
Q And each of these, as we go down there it's your opinion that it's preferable because there's a black box warning for the flouroquinolones and there's not one for these other medications?
A Right. Not just a black box warning, but a black box warning for exactly the patient with these characteristics, elderly and on steroids. And if you want to add connective tissue disease to that, I think it's probably appropriate.
Q Does the black box warning include connective tissue disease?
A No, it mentions steroids, it mentions elderly, and it mentions organ transplantation.
Q Okay. The next one is Ciprofloxacin?
A Yes, that can be given IV or orally. That's a good drug with good broad spectrum in terms of a good gram negative coverage. You don't have as good gram positive

coverage. It's a very good choice for UTI. It's related to flouroquinolone so it's a drug you wouldn't give to a patient, though, who has the same contraindications as Levofloxacin. And then the other one on the list is -- there's another one, Cipro -- I don't think they have it on this list.
Q So in a patient like Ms. Pierce, you would or would not use Ciprofloxacin?
A You wouldn't, that's the same warning as with Levofloxacin or Ofloxacin. They're all flouroquinolones and they're to be avoided with elderly patients on steroids.
Q So it sounds like you're saying that, and I apologize if I'm repeating myself, with the black box warning it's an absolute contraindication and that precludes the risk benefit analysis we're looking at before. You just don't give it if it's a medication that has the black box warning; is that true?
A Well, yeah. I mean, you have to understand that when you do a risk benefit analysis that's something you do with the patient, and you think about the patient's safety. So if you have a choice between the drug that's not covered by a black box warning because of the characteristics of this particular patient, then it's preferable to a drug

that is.
Q Okay. What about the next, Ertapenem?
A Ertapenem is a drug that's usually reserved for resistant infections, it's not a first line drug. But it's a class of drugs that are Carbapenems and that are also excellent. They're usually not -- excuse the expression -- overkill; you don't want to kill the patient, you want to kill the bug, but usually not needed for empiric treatment of urinary infection.
Q You keep saying empiric treatment. I'm talking about the situations where we have the culture and sensitivity report.
A Oh, you don't need to use Ertapenem. There's many much more first line drugs available, so you wouldn't need a back up drug like Ertapenem.
Q That can cause seizures, can it not?
A Seizures, yeah, I'm not sure. I'd have to look that up. I don't recall.
Q All right. Gentamicin is the next one?
A Gentamicin is similar to Amikacin, the first on the list, and is similar to Tobramycin which is the second to last on the list. Main thing is renal toxicity. It may also cause otoxicity.
Q And that's IV only; correct?

A Yes.
Q The one where we had just talked about, the Ertapenem, I understand why you said you wouldn't use that as the first line, that's also IV on; correct?
A Yes.
Q And the next one, the Imipenem?
A Imipenem like Ertapenem is a drug that you would reserve for -- usually for resistant infection or a patient that's not improving; it's not a first line drug.
Q That's IV only; correct?
A Yes.
Q And can that also cause seizures?
A I believe that Carbapenems are associated with seizures; I just don't remember the details.
Q And Levofloxacin is the Levaquin that we've been talking about?
A That's correct.
Q The next one, the Nitrofurantoin?
A Nitrofurantoin.
Q I'm sorry, I mispronounced that one, too.
A Yes, that's oral antibiotic. And you wouldn't use that for pyelonephritis, that would be for cystitis. Not the drug I would choose in a sepsis hospital situation.

Q And you mentioned the Tobramycin, but tell me again why.
A It's an aminoglycoside, it's -- again, it has the nephrotoxicity is the main thing. It may also causes ototoxicity.
Q And that's given IV only; correct?
A Yes.
Q The Trimethoprim/Sulfa, the last one?
A Yeah, that's Bactrim or Septra. It's a drug that can be given IV, it can be given orally. Usually you wouldn't treat imperially with IV Septra for a urinary sepsis, but it's an effective drug. Good concentration in the kidneys, and in urine, and the bladder.
Q Can that cause nephrotoxicity also?
A Rarely.
Q But possible?
A Anything's possible. So, in other words, when you read the PDR adverse drug effects that are reported, there may be many, but there's -- it's a drug that we commonly use, it's a first line drug for urinary infection. For recurrent cystitis, for example, there are people who take it long-term, there are patients who use it for UTI. It's very commonly prescribed.
Q But it can -- has been reported as causing kidney

problem; correct?
A Yes.
Q Can also cause Stevens-Johnson syndrome?
A That's right, because it's a sulfonamide, Trimethoprim/Sulfamethoxazole it does carry with it, but, again, tiny risk relative to a patient who develops a rash on a sulfonamide needs to have the sulfonamide stopped immediately. If they have a rash, then it has to be marked sulfa allergic, and they should never be given another sulfa drug, but there's not a black box warning with tendinopathy with Trimethoprim/Sulfa.
Q Can it cause liver problems also?
A Yes, very rarely.
Q And this is not a medication you would give to the elderly, typically; true?
A Trimethoprim/Sulfa, not in particular. The oral Trimethoprim/Sulfa, certainly; I usually give it IV.
Q You said it can be given IV or PO?
A Yes.
Q And has it been reported as causing seizures also?
A I -- that I don't know.
Q Excuse me?
A That I don't know.

Q Okay. We've been through the list that's on the microbiology report from WakeMed Cary Hospital dated October 30, 2000 -- I'm sorry, the specimen collected October 30, 2012; does this indicate that the results were available on November 6, 2012 or were they available earlier or do you know?
A In general, culture and sensitivity reports are available within about 48 hours.
Q Do you know when they were available to the physicians in this case?
A I don't know exactly which day.
Q Okay. But you would agree with me that Dr. Jenkins did not have this information on this report when he was involved in Ms. Pierce's treatment; correct?
A That's true. That's right.
Q Do you have any other criticisms of the care rendered to Ms. Pierce by Dr. Jenkins, other than what we discussed?
A No.
Q As to Dr. Daud, what criticisms do you have of the care and treatment that he rendered to Ms. Pierce?
A He failed to stop the Levofloxacin and substitute a drug that was safer for her given her age and the fact that she was on chronic steroid therapy.

Q And would the options that he should have exercised, are those the ones that you already told me about?
A Yes.
Q Okay. I don't need to have you repeat everything if you've already said that.
A That's correct.
Q Okay. Anything else about Dr. Daud's care and treatment of Ms. Pierce about which you are critical?
A No.
Q And same thing as to Dr. Afridi; the criticisms that you have of his care?
A Well, the criticisms are, number one, that Dr. Afridi did not substitute a drug for which there was no contraindication, and, number two, he was the discharge physician, so he was responsible for the transition to oral. And so the most days that she was on Levaquin were days in which Dr. Afridi was the prescribing physician.
Q What's -- I'm sorry, I failed -- I guess I failed to appreciate the second criticism. The first one you said is he failed to stop the Levaquin and substitute with a safer drug?
A Yes.
Q Which is similar to the criticism you have of Dr.

Daud?

A He continued it as an oral agent for additional days in short-term rehab, so that Dr. Afridi was, in a sense, responsible for more days of the drug than any of the others. Dr. Daud is responsible for three days of therapy, Dr. Jenkins for just one night of therapy, but Dr. Afridi was responsible for the entire oral regimen following her -- the IV, so she had three days of IV plus the oral medication.

Q Hypothetically, if Dr. Daud had stopped the Levaquin and substituted it with another medication, do you have an opinion as to whether Ms. Pierce would have suffered her Achilles tendon rupture?

A It would have lowered the risk if she did. Stopping the medication reduces the risk of a tendon rupture.

Q Would it have lowered it -- strike that.

You said it would have lowered the risk; how low would it have gotten?

A More days, more risk, but it's impossible to state. I don't know exactly the degree of risk, it's not a statistical factor that we use in practice. In practice we use the pharmacological characteristics of the drug in order to decide is it safe or not. There isn't a certain

number of days that are safe and then unsafe beyond that. It's a drug where you avoid all together in elderly patients on steroids.

Q So if Dr. Daud had stopped the Levaquin, you can't say whether or not Ms. Pierce would have suffered her Achilles tendon injury; all you can say is it would have lowered the risk?

A It would have decreased the risk of a harm from tendinopathy by reducing the amount of exposure to the flouroquinolone.

Q I'm sorry. And the same thing with Dr. Afridi, if he had stopped it; you can't say that would have avoided the tendon rupture, all you can say is it would have reduced the chance that she would have had it?

A That's correct.

Q And I guess the same thing with Dr. Jenkins; if he had discontinued the prescription for Levaquin, which had been started by the emergency room physician, you can't say that that would have avoided Ms. Pierce having a tendon rupture; it just would have reduced the chance, lowered the risk?

A It would have reduced it radically in the sense that after she only had a dose or two, the likelihood of getting tendon rupture wasn't very high; but allowing her

to take ten days more, or two weeks more was negligent.

Q Okay. Any other criticisms you have of any of the three hospitalists, Dr. Jenkins, Dr. Daud, or Dr. Afridi that we haven't discussed so far?

A No.

Q And do you plan to render any criticisms, opinions that are critical of anybody else who was caring for Ms. Pierce at WakeMed Cary Hospital such as the pharmacists, nurses, any other hospital personnel?

A Well, if the doctors -- if Dr. Daud hadn't testified as he did that he didn't care what the pharmacist told him, I don't think it -- would have been a rhetorical moot point of what the pharmacist did or didn't.

Q All right. So from a -- it wouldn't have mattered what the pharmacist said to Dr. Daud based on his testimony that he would have still selected to give Levaquin to the patient; correct?

A Right. Let me put it this way, though: It is the responsibility of a pharmacy to let doctors know about boxed warnings of drugs. So my understanding, based as an internal medicine doctor working with clinical pharmacists, is that that information has to be made available to the prescriber either in an electronic system by a warning or by notification by a clinical pharmacist. However, there

are instances in which clinical pharmacist does not have complete access to information or whose advice is overridden.

Q But in this case, based on Dr. Daud's testimony and if Dr. Jenkins and Afridi were to testify similarly, would you agree with me that the failure of the pharmacist to have given a warning to the physicians wouldn't have mattered, wouldn't have changed the outcome in the case because those physicians already knew about the particular issue, and would have decided to give the Levaquin any way?

A In that hypothetical, yes, it wouldn't have mattered.

Q What is your understanding of the circumstances of Ms. Pierce's Achilles injury?

A I don't have clear information about the circumstances of it. I'm unable to tell. She was in rehab at that point; I don't know whether it was an injury sustained in rehab or whether it was unrelated.

Q You --

A I don't know specifically.

Q You don't know what she was doing, where she was or any of the details about that?

A That's correct.

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Q Have you reviewed the Rex Rehab records for Ms. Pierce?
A I think you asked me about --
Q I'm sorry if I did.
A Yes, if those are the records of her rehabilitation that extended from approximately January to April or May, I did review them.
Q Okay. I think these were earlier than that.
A I can't remember.
Q She was discharged from WakeMed Cary Hospital on November 5, 2012 and sent to a rehab facility; did you review any of those records?
A I did, I just don't recall the details. I didn't rereview them. I looked at the hospitalization at WakeMed in which she had the Levaquin and the notes about the surgery, I don't recall the rehab.
Q Do you know if she was continuing to receive both Prednisone and Levaquin at the rehab facility?
A Yes, she was.
Q Was she being cared for by internal medicine physicians at the rehab facility?
A I don't know. I haven't seen testimony about that.
Q If she was being cared for by internal medicine

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physicians at the rehab facility and was receiving both Levaquin and Prednisone, are you critical of those physicians?
MR. KASH: Again, I'll object to the ambiguity of which rehab you're --
MR. MADDEN: The Rex Rehab facility.
MR. KASH: And the dates of --
MR. MADDEN: Beginning on November 5, 2012.
THE WITNESS: Problem is, I haven't seen deposition testimony; but, you know, what discipline, who was --
Q (By Mr. Madden) And that's why in my question I said if she was cared for by internal medicine physicians and was receiving both Levaquin and Prednisone, would you be critical of those physicians?
A Yes.
Q And the reason would be, as you stated, regarding the hospitalist at WakeMed?
A Yes. Understanding, though, that the duration of therapy and the administration at the end of her course gave them less opportunity to intervene to reduce the risk of harm.
Q I understand about reducing the risk, but the fact that the medications were given concomitantly, I

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believe you said, was the problem; correct?
A With the fact that the Levaquin and Prednisone were given concomitantly --
Q Yes, sir.
A -- was the problem, the opportunity, though, at rehab to reduce the risk of harm was less because she already had six days of high dose IV Levaquin, and only a few days left of oral therapy to complete her course.
Q But your criticism is the same about the giving of those two medications together?
A That's right, exactly.
Q Would you agree with me that the Levaquin effectively treated Ms. Pierce's urosepsis?
A Yes.
Q And the urosepsis from which she was suffering can be a life threatening illness; true?
A Yes. Certainly antibiotic therapy was mandated by the standard of care.
Q How often do you have occasion to treat patients with this klebsiella organism?
A Oh, a few times a year.
Q Is it a fairly common thing that you see?
A It is a common bacteria, both in community acquired infection as well as in hospital infection.

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(Off the record at 4:23 p.m.)
(On the record at 4:48 p.m.)

Q (By Mr. Madden) Dr. Genecin, how frequently do you use the medication Levaquin?
A Fairly frequently; it's a commonly used drug. It's a first line drug for a variety of respiratory infections where I usually use it. It's also a good drug in the hospital, frequently used for community acquired pneumonia as well as for urosepsis.
Q So would you say it's a commonly and routinely used first line antibiotic?
A Yes.
Q You had told me about the criticisms you have about the hospitalists at WakeMed Cary for prescribing Levaquin to Ms. Pierce given the circumstances, and is it your plan to testify at trial that the administration of Levaquin to Ms. Pierce caused her tendon rupture -- her Achilles tendon rupture?
A Yes.
Q Okay. Tell me about that; what's the basis for you giving that opinion?
A The prescription of flouroquinolone to elderly

patients with steroid therapy significantly increases the risk of tendon rupture as compared to a baseline risk of tendon rupture of no apparent precipitated cause. So that's sometimes expressed in odds ratio which is the amount of risk that is increased as compared to baseline, and it's the number that's somewhere between ten and twenty.

So it's way more likely that she had a tendon rupture than if she weren't taken Levaquin, and it's likely a substantial contributing factor to her tendon rupture.

Q You said ten to twenty; you're talking about ten to twenty percent?

A No, more likely as compared to the baseline evidence of a tendon rupture in people who are not given flouroquinolone.

Q I missed where the -- ten to twenty what?

A The odds ratio.

Q Okay.

A So the odds ratio, that is a statistical term to indicate the increase in risk over the amount of risk that exists in the normal population. The timing is classic for flouroquinolone induced tendinopathy, it's almost always within a month, almost always. It a classic tendinopathy that's the most common tendinopathy, so it's got all the

characteristics of flouroquinolone induced tendinopathy.

Q The Achilles tendon injury is the most common tendon injury when one is given these medications together?

A It's the classic injury, although other tendons may become inflamed, but the Achilles tendon rupture is the dreaded complication. Very hard to get an elderly patient steroid dependent well from a Achilles tendon rupture.

Q So it's your opinion that Ms. Pierce's tendon rupture was a result of her receiving the Levaquin while she was on chronic Prednisone therapy?

A Yes.

Q Okay. Are there any other opinions you plan to give at trial, other than what we talked about so far?

A With respect to standard of care, no.

Q Or anything?

A I don't think so. I think just with respect to the difficulty that she had, and inability to resume walking, the debility that resulted from that, and her death which happened really less than a year after she really given up walking and became bedridden and debilitated, I think it was a substantial contributing factor to her debility that placed her at increased risk for things like pneumonia, which was the immediate cause of

her death. That was secondary to her debility as it's written on the death certificate, and I agree with that.

Q It's your opinion that the debility was a result of the Achilles rupture?

A It was partially as a result of it -- largely a result of it.

Q What about her long history of compression fractures in her vertebrae?

A Well, she did have a history of compression fractures of the vertebrae, and there's no doubt that that caused her pain. What caused her to lose the ability to walk, to become independent in terms of activities of daily life, to be able to drive, to be able to travel was the Achilles tendon rupture. And absent the Achilles tendon rupture, she was an independent living member of the community. Not without health problems, of course, she was 76 and had health concerns.

However, once a tendon rupture occurs in a patient like her, the likelihood of getting well is very low because patients on steroids don't heal well. Achilles tendons don't heal well in elderly people, they get infected, as hers did, it's a mess. So it resulted in a patient that couldn't walk and became essentially bedbound.

Q And it's your opinion that but for the Achilles tendon injury, she would not have become bedbound?

A Well, all patients eventually decline, so, you know, I don't think that we want to be saying that a lady with multiple medical problems had a prognosis of a additional 70 years; that's foolhardy. However, there's no reason to think absent the tendon rupture that it was her time to be immobilized and to become institutionalized, which she was within a few months and unable to rehab.

It sounds like, if I'm to believe the testimony of her youngest son, and the information about her in the medical record up until the point of this hospitalization, she was living in the community, she was shopping, driving, doing things for her grandchildren. She was not in a state of steep decline. She was not without health concerns, but she was not in a state of steep decline. If you take a patient in that condition and take away her mobility, then you would cause her to go down hill very rapidly.

The loss of bone, loss of muscle, the atrophy, the inactivity results of patients not taking deep breaths, they get atelectasis and end up with pneumonia, so it's sort of a classic downhill course.

Picture if a patient like that is able to preserve function, whereas if she had, for example, had an

unusually good return of function, which occasionally happens, then, you know, she, of course, could have done much better. It's the debility, the inability to walk which is very lethal, particularly for an elderly person on Prednisone.

Q And what is the source of your information about Ms. Pierce's condition and level of activity prior to October 30, 2012?

A Well, if her son is giving accurate information, she was able to travel to either Alaska or Europe in the summer of 2012. He testified to her level of activity function. So that's my primary source; but, of course, the information elicited by nursing throughout her home situation at admission, she was not an institutionalized patient, was not living in a nursing home unable to fend for herself.

Q Do you have any source of information, other than her son's deposition?

A Just what's written in the medical record by the nurses about her baseline level of function.

Q What is it you remember about her baseline level of function?

A Well, that she lived at home, that she was independent in terms of her ADLs, she didn't require home

services.

Q How often was she driving and for what distances?

A I don't know the details.

Q How often was she shopping and where did she go?

A Oh, I don't know the details.

Q And you said it's your understanding that she traveled to Alaska or Europe in the summer of 2012?

A That's what I think her son did testify.

Q What other things did she do on a daily or regular basis as far as activities prior to October 30 -- in the months prior to October 30, 2012 that you know about?

A Well, she kept a dog and was active in the USO, and took the dog to the hospital to visit people.

Q When was the last -- sorry, go ahead.

A I don't know. She said she rode a bicycle, I mean, I don't know.

Q Do you know when the last time she rode a bicycle?

A No.

Q Do you know when the last time she took her dog to the nursing home?

A No.

Q Do you know the last time she went and greeted troops as part of the USO?

A No, I don't.

Q So your information about her preadmission condition is her son's deposition and the prior medical records?

A Yeah, if that information is accurate then she was ambulatory and able to be independent in her ADLs. She was able to help her husband, who was ill. So it was a whole different picture than a patient who lost the ability to ambulate, and also suffered pain as a result of that.

Q Okay. Anything else with respect to -- any other sequelae of her receiving the Levaquin while on chronic Prednisone therapy that you're going to talk about at trial that we haven't discussed here today?

A No.

Q Have you reviewed any of the records from her rheumatologist about the extent of her PMR in 2012 and 2013?

A No, I don't recall if I have; I don't think so.

Q Have you reviewed any records from any orthopedists caring for her with respect to the vertebral fractures from which she suffered?

A Yes. I know that she had several vertebral fractures on admissions for pain control and osteoporosis, that's, of course, an adverse affect of aging, female gender, Prednisone, and she certainly did have problems with her bones.

Q Is it your opinion that the vertebral fractures were not debilitating Ms. Pierce?

A They are -- most vertebral compression fractures are debilitating. They're usually not permanently debilitating, they're acutely painful and tend to become progressively less so. They're unlikely to cause, for example, spinal cord problems or immobilization as far as age is concerned, but they certainly are debilitating when they're acute.

Q Sure.

A And anyone who had one would say so.

Q And when one has chronic vertebral fractures?

A Well, they don't heal. The problem is vertebral body doesn't grow back, however, once the bone settles, then the pain subsides.

Q Is it your opinion that she was not experiencing pain, except during the acute period following the vertebral fracture?

A We know that she had chronic pain, she had

polymyalgia rheumatica, so she was a chronic pain patient. She did have acute pain relating to her back. She may well have also chronic pain. What she wasn't was disabled with respect to her independence as far as walking was concerned. She was still able to get around, go to the store, drive, do activities of daily living.

Q And that's based on the records you looked at and her son's deposition?

A Yes, she lived at home, she was not institutionalized, didn't require nursing care.

Q Would you refer to an infectious disease specialist with respect to a choice of antibiotic in a given situation?

A I would defer in a situation where the issues of antibiotic selection are outside the scope for a general internist. ID, though, is a subspecialty of internal medicine, and there is some overlap in the standard of care. So I don't defer to any ole ID doctor about everything, but I would certainly defer in situations where I needed help, because I was at the limits of my knowledge of how to handle a patient with infectious illness.

Q Would that include the choice of antibiotic and the duration of the antibiotic therapy?

A I frequently have cause to consult a ID

consultant in instances where I have a question about those things. I would curbside my ID consultant or have a formal consultation depending on the circumstances.

(Off the record at 5:06 p.m.)
(On the record at 5:08 p.m.)

Q (By Mr. Madden) Just a couple more questions, Dr. Genecin. Do you know when the trial of this case is scheduled?

A No.

Q Do you plan to come to North Carolina when the trial takes place to testify?

A If the trial takes place, I will certainly come.

Q And are there any other opinions that you certainly hold, and about which you plan to testify at the trial of this matter that we have not discussed?

A I don't have anything that comes to mind.

Q Are there any bases for the opinions that we have discussed that you haven't mentioned?

A My education -- training, education, experience as an internal medicine physician, familiarity with the medical literature, interaction with ID physicians are the

bases of my...

Q You talked about the black box warning; are there other specific pieces of medical literature that you rely on in formulating your opinions in this case?

A Well, the black box warning is based on findings from the medical literature. I have some of those papers.

Q Do you have any that you can refer me to that would substantiate the opinions that you've rendered today?

A I'd be happy to provide them for you. I don't have them at my fingertips, but I do have access to them at Pipeline, articles that I referred to.

Q Are those commonly -- I mean, if I did a Medline search, would I be able to find those?

A Sure, sure. If you look at the bibliography of the -- the labeling information, you'll find articles on this topic.

Q Okay. All right. Have you understood all the questions that I've asked you, except where you specifically told me that you didn't understand?

A Yes.

Q Okay. Are there any answers that you want to change?

A Not that I can think of.

Q Okay. All right. That's all I have. Thank you.

CROSS-EXAMINATION

BY MR. KASH:

Q Just a couple follow up questions. You mentioned, Doctor, that you had reviewed the CVs of Drs. Afridi, Jenkins and Daud; would those be -- let me show you -- licensure information from the North Carolina Medical Board for Dr. Jenkins, Dr. Afridi, Dr. Daud?

A Right.

Q Is that the information that you reviewed?

A Yes, it is.

Q And does that information show the education, training, and experience of these three physicians?

A It's not comprehensive. It does show what their license status, what their training is in, where they trained, where they went to medical school; that sort of thing.

Q And did you find that education, training, and experience to be similar to your own?

A Yes, absolutely.

Q The materials you reviewed on Cary, North Carolina and WakeMed Hospital Complex and WakeMed Cary, did that enable you to determine whether or not, or to give you an idea what the medical technology, medical specialties were that were capable of being provided by this community?

A Yes.

Q And did you find that similar to communities you've practiced in, including New Haven?

A Yes, very similar.

Q Did you also -- in the materials you were provided, do you also recall reading the North Carolina General Statute 90-21.12 that defines the standard of care?

A Yes.

Q And I'm going to read that to you. It essentially says that "If a health care provider cannot be found to commit a malpractice unless there's testimony from a health care provider, that the care the health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training, experience situated in the same or similar communities at the time of the alleged acts giving rise to the cause of action;" is that the standard that

you're using here?

A Yes.

Q And giving your testimony about the standard of care violations?

A That's correct.

Q In addition to -- you said you've been in North Carolina; did you go to North Carolina to attend CME?

A Yes.

Q And that was at Duke?

A At Duke.

Q Did you also --

A I've been there twice.

Q You've been to Duke twice?

A Yes.

Q When was the last time you were at Duke?

A Within the last two years.

Q Do you know and consult with physicians that practiced in North Carolina?

A I do, yes.

Q Would any of those physicians be at Duke or UNC?

A At Duke, yes.

Q Do you treat patients from North Carolina, Doctor?

A Yes, I have colleagues from North Carolina who are here at Yale.

Q Pardon, I'm going to jump around a little bit and I just want to make sure I clarify a couple of points. Drs. Daud, Jenkins, and Afridi are all internal medicine specialty doctors?

A That's correct.

Q And that's your specialty?

A That's correct.

Q Can you distinguish for me the difference between a hospitalist and an internal medicine doctor in a hospital attending scenario?

MR. MADDEN: Objection.

THE WITNESS: It's the difference in title, and at least at Yale the hospital services are not teaching services. The standard of care with respect to patients is identical. My residents become hospitalists. I have several people I've trained who are on staff as hospitalists at Yale New Haven Hospital at this point.

Q (By Mr. Kash) Are internal medicine physicians used interchangeably with hospitalists as attending physicians for a patient such as Ms. Pierce?

A Yeah.

MR. MADDEN: Objection.

THE WITNESS: Hospitalist is a title that describes an activity of hospital care for patients. Doctors who do both hospital care as well as outpatient care don't generally call themselves hospitalists, but they have the same standard of care because they do the same work.

Q (By Mr. Kash) I see. And in terms of the work that Dr. Jenkins, Dr. Afridi, and Dr. Daud did, that's the same type of work that you described you do when you're on your two months of rotation with New Haven Hospital?

A That's correct. I'm responsible for admitting, I've admitted several hundred patients per year at a minimum. I'm responsible for doing diagnostic work-up, prescribing treatment, obtaining consults, assessing the patient's ability to go home or need for other kinds of levels of care, discharge planning. All those different activities are my responsibility, one-on-one service.

Q You talked -- sorry, Doctor. Is it your understanding that at the time of Ms. Pierce's discharge from WakeMed Hospital, she was discharged by Dr. Afridi with orders of discharge, that she was discharged to another rehabilitation facility?

A That's correct.

Q And the orders of discharge provided by

PAUL GENECIN, M.D.

Dr. Afridi at Rex Rehab would have included the orders for the PO Levaquin?

A That's correct.

MR. MADDEN: Objection.

Q (By Mr. Kash) And is that -- that's part of the basis for your criticism, I understand; is that correct?

A Yes, yes.

Q And your understanding of a rehabilitation facility and a patient being discharged from a hospital to a rehabilitation facility with orders that include specific medications, generally a rehabilitation facility is going to follow those discharge orders, including prescription orders from the hospital?

MR. MADDEN: Objection.

THE WITNESS: Yes.

Q (By Mr. Kash) You were asked, Doctor, about whether or not you would defer to an infectious disease physician in choice of antibiotics in certain situations. The facts of this case, and the facts of the black box warning involving Levaquin in this case being prescribed to Ms. Dolores Pierce, who's a 76 year old lady, who's had commonly been taking corticoid steroids, would you defer to any infectious disease doctor who indicated that it was appropriate to administer Levaquin to this patient?

PAUL GENECIN, M.D.

A No, of course not. That would be a deviation from the standard of care for an internist of any sort.

Q That's all the questions I have.

(Deposition concluded at 5:18 p.m.)

*****

JURAT

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Paul Genecin, M.D.

Subscribed to and sworn before me on this _____ of _____ 2016.

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My commission Expires:

ERRATA SHEET

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Date Paul Genecin, M.D.

Sworn to before me this _____ day of _____, 2016.

_____

Notary Public

My commission Expires:_____

C E R T I F I C A T I O N

STATE OF CONNECTICUT:
COUNTY OF HARTFORD:

I, SAMANTHA M. HOWELL, a Notary Public duly commissioned and qualified in and for the State of Connecticut, do hereby certify that pursuant to Mr. Madden there came before me on the 27th of June, 2016, the following named person, to wit: Paul Genecin, M.D., who was previously duly sworn to testify to the truth and nothing but the truth; that he was thereupon examined upon his oath; that the examination was reduced to writing by computer under my supervision and that this transcript is a true record of the testimony given by said witness.

I further certify that I am neither attorney nor counsel for, nor related to, nor employed by any of the parties to the action in which this deposition was taken, and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the outcome of this action.

In witness whereof I have hereunto set my hand this 8th day of July, 2016.

_____
Samantha M. Howell
Notary Public

My Commission expires
September 31, 2016

CHAIT DIGITAL REPORTING & VIDEO
6 Landmark Square
Stamford, Connecticut 06901
(203) 323-7779

July 8, 2016

Gregory M. Kash, Esq.
Law Offices of Gregory M. Kash
434 Fayetteville Street, Suite 1640
Raleigh, NC 27601

Dear Mr. Kash,

Enclosed please find your copy of the deposition transcript of Paul Genecin, M.D. taken on June 27, 2016. The original jurat and errata sheets are also enclosed. Please note that the witness is allowed 30 days to read and sign the deposition as the rules provide. Please return only the original notarized jurat and errata sheets to Mr. Madden, along with a copy to all counsel present. Thank you for your prompt attention to this matter.

If you have any questions, please feel free to call me.

Sincerely yours,

Samantha M. Howell, LSR 00462
Chait Digital Reporting & Video

CC: John D. Madden, Esq.