CARLOS ANTONIO BAGLEY, MD,

the witness hereinbefore named, having been previously duly sworn by the Court, testifies further under oath as follows:

DIRECT EXAMINATION

BY MRS. LEHMANN:

Q. Good afternoon, Dr. Bagley. Would you please introduce yourself to the jury.

A. Carlos Antonio Bagley. I'm a neurosurgeon here in town.

Q. Could you tell the jury about your education and your training and experience that allows you to even testify as an expert in this Court.

A. So, I did my medical school and undergraduate work at Duke University. Did my neurosurgery training and my fellowship in spine surgery at Johns Hopkins in Baltimore. Then I was on faculty at Duke University for eight years; and then recently joined the faculty here at UT Southwestern a year and-a-half ago, as director of the spine program.

Q. If you can guess, about how many spine surgeries have you done?

A. I think about 4300, or something like that.

Q. In fact, you were in surgery this morning.

A. Yes, ma'am.

Q. Okay. Now, we asked you to help us with Dr. Duntsch's case; is that correct?

A. Yes, ma'am.

Q. Okay. And we wanted you to educate us on various things, including the surgeries that have been discussed in this Court, as well as the culture of the surgical community; is that correct?

A. Yes, ma'am.

Q. Okay. Now, I want to talk to you about these cases that the State has presented to the jury.

The first one is Ms. Efurd's case. Did you review records on her case?

A. Yes, ma'am.

Q. And what is your opinion of Dr. Duntsch's performance on Ms. Efurd's surgery?

A. Very poor.

Q. Okay. And, just to cut to the chase, is that your opinion on each of them, including Mr. Passmore, Mr. Morguloff, Mr. Summers, Ms. Martin and Ms. Brown?

A. Yes, ma'am. The only exception to that would be -- somewhat a qualified poor would be the one that starts with an "M": Murgo -- Murgolow?

Q. Morguloff.

A. Morguloff. Again, the errors with the other cases were fairly egregious. That case, the outcome was suboptimal.

But, in terms of a glaring egregious error, I can't say

there is one thing that I would pinpoint in that case. Although, the outcome was suboptimal.

Q. Okay. Now, all of these errors that you have identified in Dr. Duntsch's surgeries, are they things that are known complications?

A. Yes, ma'am.

Q. Are they things that a poorly-trained, inexperienced surgeon could do?

A. Yes, ma'am.

Q. Are they things that a poorly-trained, inexperienced surgeon may not even be aware of?

A. In what regard?

Q. I guess, another way to phrase that question is: Does experience and good training, does that inform a surgeon's ability to forecast possible problems in surgery?

A. Yes, ma'am.

Q. And forecast possible risks.

A. Yes, ma'am.

Q. Okay. So if someone's not trained well and they don't -- they haven't put the reps in, so to speak, is it more likely they would be unaware of the risks that are posed by the particular actions that they take in that surgery?

A. Whether or not they would be more -- less or more aware is hard to say. I think they would be more likely, on

average, to make errors. But the awareness of the errors is more of an intellectual thing.

So you can know they exist but still not be skilled enough at avoiding them or not having them occur.

Q. Okay. And how does one come to know that those risks exist?

A. Part of it's your training. Neurosurgery training is fairly long. And that's part of the purpose of the training, is to expose you to enough of the field and enough of the literature to be able to be a safe and prudent physician when you go out and practice on your own.

Q. So if a surgeon hasn't had adequate training, it's possible they wouldn't be aware of a particular risk?

A. It's possible. Yes, ma'am.

Q. One of the things that you helped us understand is the personality or the personality traits of surgeons.

How would you describe the typical surgeon, in terms of personality?

A. Well, I would say most of us are -- I guess, the field sub-selects for folks that are very confident. In some ways you kind of have to be over confident, in a sense. We operate -- especially in neurosurgery, we operate in a place that we're not supposed to be. So we are in a privileged place, and we're operating on something that makes you, you.

So with it comes a certain amount of confidence that you have to have. It's difficult to do that on a daily basis.

Q. Okay. You have to feel really good about your abilities, right?

A. Most would. Yeah, you would have to, in order to last long in the field. Yes, ma'am.

Q. Okay. I think -- once, I heard you refer to neurosurgery as tap dancing --

A. Tap dancing on a razor blade.

Q. Explain that to the jury.

A. Well, a lot of what we do, the things that we do that are fairly routine, are literally millimeters away from, on the one hand, a patient walking out and living happily ever after; and then, on the other hand, a patient doing terribly and, in some cases, dying.

So it's a field where millimeters make the difference between you being, you know, a great surgeon and held up on a pedestal and you being on the far other end of that spectrum.

Q. Okay. Are there potential down sides to that type of self-confidence?

A. Yes. I think it's -- it can become a problem, if left unchecked. It's one of the -- it's not unique just to surgery. But I think it's in any field where you do things

that are hard and that people aren't -- not everyone can do.

At a point, it can also become self-perpetuating. Without being appropriately checked, can become, in a sense, kind of pathologic.

Q. And how is that type of overconfidence checked --

A. Well --

Q. -- in your profession.

A. Well, part of that is, you know, peer-reviewed, peer scrutiny. You know, an academic -- in academic medicine, where we have trainees and things like that, we always have kind of eager-prying eyes around. So folks are always watching what you're doing.

A lot of that is external. Some of it should be internal. In an ideal case, you should have enough self-awareness to scrutinize your outcomes, good or bad, and look for areas of improvement. But a lot of that is by external entities.

Q. Okay. Because surgeons aren't the most self-aware group of people. Would you agree with that?

A. As a whole, I would say we're not. Yes, ma'am.

Q. And what do you attribute that to?

A. Again, I think it's somewhat of a self-selection of the personalities that go into surgery and that is somewhat necessary, I think, in order to be a surgeon.

Again, there's a fine line between having supreme

confidence and appropriate supreme confidence in your abilities.

And, on the flip side of that, being unaware of your significant faults and weaknesses are kind of your Achilles' heel, per se'.

Q. So it's possible for a surgeon, you know, whether it's earned or not, to feel really, really good about himself and not be aware of his errors?

A. Yes.

Q. Okay. Have you seen that type of -- have you seen that before in colleagues?

A. Yes, ma'am.

Q. Have you ever known any surgeons to blame something else, other than their poor technique, on a bad surgical outcome?

A. Yes, ma'am.

Q. And why do you think that happens?

A. In some ways, it's a coping mechanism. It's easier to blame everything else than it is to blame oneself, when something bad happens.

It's a very difficult thing to have a patient that, you know, in some cases where you come in, you talk to the patient, you counsel that patient and you have a relationship with the patient. And to have something catastrophic happen, and to own that, it's a very, very

difficult thing to do.

Q. Now, do medical schools and/or fellowships play a role in developing self-confidence in students or in collecting students who naturally have that type of self-confidence?

A. Yes, ma'am.

Q. And can you talk about that.

A. I think, as you progress through medical school and folks gravitate towards different disciplines, there's certain personality traits that tend to fit well and feel like surgery versus feels like pediatrics. And so there's somewhat of a natural self-selection.

As you get into your training and -- your formal training in residency and internship and fellowship, those traits are kind of -- are, essentially, fostered to grow them and, in some cases, reign them in. But, in other cases, help develop them so that you can be a confident and competent surgeon.

Q. Okay. And you brought up pediatrics. What would make someone a good pediatrician but maybe not a good neurosurgeon?

A. I think in pediatrics -- and I say this, because I'm intimately related to a pediatrician.

You know, there's a different degree of empathy in patients and just the operating mechanism versus a surgeon,

which tends to be very directed and it's very outcomes-based: problem, see problem, fix problem, move on to next problem.

And also in pediatrics -- as an example, in pediatrics, you rarely have a patient that you've taken care of that dies.

In neurosurgery, it's rare that someone would make it through their training that hasn't had multiple patients die, whether it be from trauma or a malignant tumor, or something like that, despite all of our best efforts, that things don't go our way.

So it's a different -- the different day-to-day personality that you need.

Q. Okay. And that's the resilience that you have discussed; that neurosurgeons have to be resilient, they have to be able to move on when there's a bad outcome, because you will have bad outcomes.

A. Yes, ma'am. There's a degree of resilience. It's necessary for -- to be in the field. Just because -- again, sometimes we deal with very malignant things. So when someone has a malignant brain tumor, we know that, based on 2017 technology and treatments, despite our best efforts, a high percentage of them will die.

So you have to be able to accept that and be able to still get up and deal with the next patient that comes in

with the same problem, that you're going to give your best effort for.

Q. Okay. In terms of, I guess, practical application of resilience, if a surgeon has a catastrophic outcome, they have to pull themselves up by their bootstraps and keep going.

A. Yes, ma'am.

Q. They can't sit there and dwell in it.

A. There's a degree of self-reflection that is necessary and, again, kind of owning that event. But then there's also the need to be able to push forward.

And it's something, in our trainees, we have to be able to instill that in them and ensure that they have that so that when they do go out in practice, emotionally they can deal with the rigors of the job.

Q. Now, you're familiar Semmes Murphey clinic?

A. Yes, ma'am.

Q. And what is that?

A. It's the clinic associated with the University of Tennessee. They're in Memphis. That is a neurosurgical training program.

Q. And are you aware that Dr. Duntsch, he trained there?

A. Yes, ma'am.

Q. Under Dr. Foley.

A. Yes, ma'am.
Q. And do you know Dr. Foley?
A. Yes, ma'am.
Q. Okay. How do you know him?
A. He's a spine surgeon. Neurosurgery and spine is a fairly-small community. So, pretty much, everybody -- if you don't know someone, you know of someone that knows him. So it's a fairly-small community.
Dr. Foley is well known in the neurosurgical circles, and one of the folks that developed minimally-invasive surgery.
Q. Now, you actually visited Semmes Murphey, the clinic.
A. Yes, ma'am. During my fellowship.
Q. Okay. For about a month?
A. Yes, ma'am.
Q. What were you doing there?
A. An observership. During my fellowship, I wanted to get more exposure to practice where they did more minimally-invasive surgeries than we did at Hopkins. So I spent a month there, kind of learning from them and seeing how they did things.
Q. So you did your fellowship at Johns Hopkins?
A. Yes, ma'am.
Q. And how long was that fellowship?

A. Two years.

Q. Is that typical? Or do they range?

A. Well, typically, it's one year. Some can be -- if it's combined fellowship with research, it can be as short as six months. But most are one to two years.

Q. How would you describe your experience at Johns Hopkins, in terms of hands-on training?

A. It's a very hands-on program. We did a lot of surgery. We did a lot of complex surgery. It was a great exposure to the types of things that we do in neurosurgery, especially some of the most difficult and challenging procedures. And because of the range of pathologies that we treated, it was a very, very hands-on experience. That was a great place to train.

Q. Is that different than what you observed at Semmes Murphey?

A. It was different. At Semmes Murphey, it was -- because it was a very -- a lot of minimally-invasive surgeries -- minimally-invasive surgery, usually, it's a one-person surgery, for the most part. So it's fairly-small incisions, small instruments, and things like that.

So the hands-on-ness of the procedures, it was different than what I'd been accustom to as a trainee. Even though I was an observer, it was different than what I was accustom to in my training.

Q. Okay. So it sounds like at Seemes Murphey, since they focus on minimally-invasive surgeries, there's only room for one cook in the kitchen; is that correct?

A. For a lot of minimally-invasive cases, yes, ma'am.

Q. The way I'm imagining, you would have Dr. Foley or some other senior surgeon, fellowship director, doing the surgery and the students would be watching.

A. For the most part, yes, ma'am.

Q. Okay. Did you ever observe any students actually -- or trainees actually -- doing surgeries there?

A. So, the hands-on experience of the trainees -- again, in my experience -- was very limited.

Q. Okay. Would you be comfortable with that type of limited exposure to surgery?

A. I think with minimally-invasive surgery it's a challenge, one, because it is a very, very steep learning curve. Especially on the steep end of that curve, the complication rate is higher than for open -- traditional open surgery.

So I think, at least for me, it would be a more difficult environment to learn and to learn the types of things that I do.

Q. Okay. You'd agree that it's important for a surgeon or surgeon in training to actually put the reps in, to get his hands dirty, so to speak, instead of just

watching?

A. I think that's critically important. Yes, ma'am.

Q. Okay. Critically important. Let's assume that a student was accepted into a twelve-month fellowship and they spent six of those twelve months in a lab not doing surgery.

Would you think that would be a sufficient amount of time in surgery, just in general?

A. Again, I would say there's no one that's normal, per se', or that one size fits all. It would definitely be very limited experience for six months versus the typical amount -- the typical year that most folks get.

Q. Okay. It sounds like, in your opinion, it's important for a student to actually do instead of just watch.

A. Yes. Especially as you progress through your residency. That's part of the reason why residency training is so long, in that actually doing -- there's only so much you can learn by watching.

At a point, you actually have to get your hands dirty, as you alluded to. Especially as you're getting ready to walk out the door and do this on your own, because the safety net is no longer there.

Q. Okay. And whenever you're putting the reps in as a student, you're learning judgment. Is that true?

A. That's one of the things. You're learning

judgment continually. Do you really learn judgment?

Your judgment is being assessed and tweaked, as you're progressing through your training program.

Q. Your judgment, your ability to properly judge risk, for instance, is being refined as you practice.

A. Yes, ma'am.

Q. Okay. So let's go back to the student that I posed to you, doing a twelve-month fellowship at an observership like Semmes Murphey and they spend half of that time in a lab not doing surgery. Let's say, after they got their Certificate of Completion, they take another year and-a-half off of surgery.

Would you expect, in general, that surgeon to be prepared to do surgery on his or her own?

A. I think I'd be very worried for that individual, as they embarked on their own practice, with that sort of limited experience. Especially at the tail end of your training, which is really some of the most critical training that you get. Because that's where you have the most experience with decision-making and the most hands-on experience and kind of the critical years of your development, per se'.

So, that would be very worrisome.

Q. When a fellowship gives a student a Certificate of Completion, what are they saying about that student?

A. Well, I know for -- as a fellowship director at Duke's neuro spine program, you're -- essentially, you're attesting to that person being safe and sound to go treat and take care of patients on their own.

Q. Okay. Can you think of a reason as to why a fellowship would give a student a Certificate of Completion, even though they didn't put the reps in and they didn't have the skill set necessary to be safe?

A. That would be difficult to know, for certain. It would be -- again, at a training program, it's one of the most difficult things that we deal with, in us trying to assess someone's safety before they leave our nest. And when someone is on the fence or someone is kind of marginal, it's even more difficult.

So, you know, I would say, in my experience, if someone hasn't put in the reps and hasn't kind of gotten over that bar of safety for the public, then you can't sign their Certificate. At least, in my experience.

Why someone would do that in the opposite circumstance, again, it's hard to say for certain why they would.

Q. You and I talked about fellowships and how --

A. Yes, ma'am.

Q. -- a fellowship director and I guess other faculty, they select the trainees; is that correct?

A. Yes, ma'am.

Q. And they invest in the trainees?

A. Yes, ma'am.

Q. And do they have, you know -- with that investment, do they have any incentive to make sure they make it, they graduate?

A. In a sense. And this is something that we discuss at times, why suboptimal trainees are able to kind of make it through and folks turn a blind eye.

Part of that is, as faculty, you're admitting your failure. Because you're admitting that someone you selected, that you anointed as worthy, that you were wrong.

The group of folks that -- you know, doctors don't like to be told that they're wrong or like to admit that they're wrong. I think it's somewhat of that -- that a failure of a trainee, although it sometime falls squarely on that individual's shoulders, is admitting that you also made a mistake.

Q. So, I mean, a student or a trainee, it's up to them to actually put in the reps and to go do surgery, right?

A. Yes, ma'am.

Q. But whether or not to sign that Certificate of Completion, that's up to the fellowship director.

A. The fellowship in the training program. Yes, ma'am.

Q. They can say no.

A. Yes, ma'am.

Q. Do you think Dr. Duntsch was poorly-trained, based on your review of these surgeries?

A. Well, I would say -- again, I don't know what the denominator is, how many cases this was out of.

But, for the number of catastrophic injuries that occurred over a very short period of time, it would be hard-pressed to imagine that those qualities didn't show themselves during training.

So it would be hard to imagine that those same errors or mistakes and errors in judgment didn't also arise during training earlier in education and whatnot.

Q. What could happen if a fellowship fails to recommend a former student for privileges?

A. So, if a hospital were to contact, say, me, as a fellowship director or a former faculty of a student, and I will not sign off on their privileges or sign off on them only in a qualified manner, it would be difficult or challenging for them to get privileges.

They still could, with additional hurdles, I'm sure, that the program may make them -- the hospital may make them jump through. But it would be very difficult for that to occur.

Q. Could that student sue the school or the

fellowship?

A. I would say, probably, it has happened. It wouldn't be unheard of, for something like that to happen.

Q. I guess that's what I'm trying to get at is, why would a fellowship recommend privileges to a student that they know didn't -- they know or believe they're not safe for surgery?

Would they have any legal incentive to endorse them? Or is it just a matter of loyalty to the student?

A. Again, in each circumstance, I would say it may vary. But I would say probably a bit of both.

There's always -- you know, as we are training individuals, as ironic as it is, even a poorly-performing trainee, it's fairly difficult to fire them. And there's a lot of paperwork that has to be done in order to kick them out of the program, per se'.

So, you know, whether the concern for legal ramifications would play a role, I would say it is something that does come up in faculty discussions, when discussing problematic or more general trainees.

Q. Now, we talked earlier about, I guess, the lack of self-awareness in surgeons.

I'm not saying all surgeons lack self-awareness. But you've noted that that's pretty common, for them to lack self-awareness. And, because of that, we need checks and

balances.

A. Yes, ma'am.

Q. Because we can't just rely on surgeons to be self-aware of their shortcomings and their mistakes. We need other people on the outside to watch and criticize them; is that correct?

A. Or praise.

Q. Or praise.

A. Criticize or praise. Yes, ma'am.

Q. Okay. Do you think surgeons should be self-regulating?

Or do you believe that these external checks and balances are important and essential to safe surgeries?

A. I think it should be both. I think there's -- you know, no one knows better the quality of care provided than someone that does that themselves.

However, you also have to do that in an objective manner that doesn't tie any personal feelings towards an individual or any competitive feelings about someone that may be kind of impacting your financial bottom line because the patients are going to them instead of you.

So I think it should be both. But I think, within the surgical community, we could do better in terms of policing ourselves. So, as a result of that, it falls to a lot of external regulatory bodies to police the quality of care

that we provide.

Q. Such as the Texas Medical Board, for instance.

A. Yes, ma'am.

Q. I mean, they're the body that gives doctors their license to actually do what you do, right? At least here in Texas.

A. Yes, ma'am.

Q. And the checks and balances begin in medical school and in these fellowships, right?

A. Yes, ma'am.

Q. We hope that the school and training programs aren't gonna, you know, give someone a Certificate of Completion unless they're safe. That's the hope.

A. That's the hope.

Q. Is that correct?

A. Yes, ma'am.

Q. What happens if that check fails? What could happen?

A. Then you've essentially unleashed someone that's unsafe onto the world.

Q. Can you tell the jury, what is the National Practitioner Databank?

A. It's -- I'm not sure what government body it falls under, but it's a databank of any adverse actions against a physician or any, say, medical/legal settlements.

Anything like that regarding a practicing clinician is reported to this databank, and it's kept online so that you can -- different states and different credentialing bodies can review that and get a sense of the history of the person's care; or at least, in one respect, the care that they provided to the patients they've taken care of.

Q. Okay. Because these hospitals aren't expected just to rely on what the surgeon himself says about his performance.

A. Yes, ma'am.

Q. Okay. What kind of information do you think is important to be reported in this databank?

A. Again, from what I understand, any adverse actions against your privileges. Any adverse actions against your licenses that you hold. And any settlements that -- medical/legal settlements -- you were involved in, in any capacity, are reported there.

Q. Okay. Because the whole point of this databank is to, I guess, make transparent what someone may want to hide -- what a surgeon may want to hide about his past.

A. I think it's to make it available for everyone, everywhere, as much as you can. Again, those are objective things. But to have it in a central location where any state can access it, and things like that.

Q. And, as you said, surgeons sometimes aren't very

critical of themselves. It's important to have an objective body evaluating your performance.

A. Yes, ma'am.

Q. Now, if a hospital decides to tell a surgeon "you're not going to do surgery at our hospital anymore" but we're not going to put that in writing, we're not going to make it formal, is that something that they would have to report to the National Practitioner Databank?

A. So, again, from what I understand, if there's an adverse action taken against your privileges, whether it be limiting what you can do or revoking your hospital privileges or credentials, that has to be reported to the State Board, as well as the National Practitioner Databank.

Q. So there would have to be a formal revocation of your privileges or a formal adverse action?

A. From what I understand, yes, there would have to be some action taken in order for it to be reported.

Q. Is there a reason why a hospital would want to avoid making an adverse action formal?

A. I think it can fall into two categories of why it might happen. Again, it's hard to know in any specific circumstance.

But sometimes it's the feeling that you're -- quote, unquote -- "ruining someone's career and their livelihood, what they do for a living".

Some of it is the concern for litigation. That's part of the fear that the hospitals and their legal team has, in those instances. Yes, ma'am.

Q. Okay. So a hospital may -- in order to avoid a potential lawsuit from a physician, they may opt to not make their adverse action formal?

A. Yes, ma'am. That would be one reason to do that.

Q. Okay. Do you think a hospital, if they do a peer review, they should make the findings available to the physician in question?

A. That would be ideal. Yes, ma'am.

Q. And why do you think that?

A. If you're doing a peer review, it's obviously some question regarding quality of care. Some are very benign things and some are more egregious.

But, for the education and the advancement of that individual having resolution and some sort of outcome would be beneficial, whether it be good or bad. I think knowing what that outcome was would be very beneficial.

Q. And let's say the outcome was not favorable for the doctor.

A. Yes, ma'am.

Q. Would it be important for that doctor to know that, so that he could become aware of his shortcomings?

A. Absolutely. I think that would be very important

to know.

Q. Let's assume we have a hospital that tells a doctor "you're not going to do surgery here anymore and we have grave concerns about your ability" and they allow that doctor to voluntarily resign privileges. And then they give him a letter that he can use to get privileges at another hospital, that says nothing about any poor outcomes that he had or any restrictions the hospital placed on him. Basically, the letter says he's fine.

A. Uh-huh.

Q. What do you think about that?

A. I would be very disappointed and worried by that.

Q. Why is that?

A. Essentially, that would be akin to just kicking the can down the road: it's not my problem anymore. Especially if it rises to the level of grave concerns. I don't know. I think it's -- I don't know the proper way to phrase it. That would be very, very worrisome.

Again, if you have grave concerns about the safety of patients, because they're not in your hospital anymore, doesn't mean those same concerns don't still exist.

Q. Physicians should be concerned about the safety of other patients, at other hospitals --

A. Yes, ma'am.

Q. -- if their decisions have an impact on their

safety.

A. Yes, ma'am.

Q. If a hospital provided such a letter under those circumstances, do you think they have any level of responsibility in what that surgeon does at a new hospital?

A. I would -- I don't know the best way to phrase it, but it would be enabling the continuance of what was going on already, elsewhere.

Q. And that's something you've mentioned to me before; that in order for a dangerous surgeon to continue practicing, that requires enabling.

A. I think, in order for this to happen, it would require a complete system failure. And I think that's kind of my opinion on all of this: it's a failure on multiple fronts. One individual can't do this alone.

Q. And I've been talking in hypotheticals but, to be specific, you're aware of the -- of Dr. Duntsch's situation?

A. Yes, ma'am.

Q. And the six surgeries that we have in front of us, and what Baylor did or didn't do.

A. Uh-huh.

Q. And what his -- Semmes Murphey did or didn't do and what Texas Medical Board did or didn't do.

I mean, would you say that this is a failure of the system to protect the public?

A. The only way that this happens is that the entire system fails the patients.

Again, there are multiple things that have to occur in order for us to be here, for me to be sitting here, and it's not just this one thing. Again, it's a complete system failure. All the checks and balances go out of the window. I don't know what better way to say it.

Q. If those checks and balances did what they were supposed to do, is it your opinion that Ms. Efurd, whose surgery was on July 25th, 2012, she may have had a better outcome, because Dr. Duntsch wouldn't be doing her surgery?

A. Yes, ma'am.

Q. We're talking about system failures and checks and balances.

Dallas Medical Center is the hospital that Dr. Duntsch went to after Baylor. And you're aware of that, right?

A. Yes, ma'am.

Q. And he met with the CEO, and he disclosed to her that he had a bad outcome at Baylor and that he voluntarily resigned his privileges.

Would you consider those -- that information to be red flags?

A. Absolutely. Yes, ma'am.

Q. And what would you do about that, if you are considering giving privileges to a surgeon?

A. At a minimum, rethink that. At the least, do some additional background checking and kind of fact finding as to what happened and the totality of the events that were referred to.

Q. You wouldn't just give that person temporary privileges and hope for the best?

A. No, ma'am.

Q. That would be irresponsible.

A. I would consider it very suboptimal. "Irresponsible" is one way to put it. Yes, ma'am.

Q. That would be dangerous for the patients.

A. Yes, ma'am.

Q. Now, let's say you're considering a surgeon. You know he's had a bad outcome and he voluntarily resigned privileges at a major hospital in the metroplex.

Would you give him temporary privileges, even though you don't have the complete information from his former hospital, with regard to any peer review that took place?

A. No, ma'am. Definitely not without restriction.

Q. And why is that?

A. Because you don't know how safe or unsafe the individual is until you've had a chance to do your due diligence and complete vetting of the individual and the background. It would be impractical to do that.

Q. Why would a hospital give temporary privileges to

a doctor, under these circumstances that I just described?

A. I guess, one would speculate that it would be that they wanted the person operating and filling beds at their hospital.

Q. When a doctor operates at a hospital, is he making money for the hospital?

A. Yes, ma'am.

Q. Neurosurgery is lucrative?

A. It's a very lucrative discipline for hospitals. Yes, ma'am.

Q. Would a hospital be afraid of alienating that new doctor?

A. Yes. Especially in a competitive environment as it is here in Dallas/Fort Worth. There's a lot of hospitals competing for surgeons and their attention and their patients.

So, yes, there would definitely be the concern of alienating the individual and him or her taking their patients down the road to a different facility.

Q. One of the possible conditions that a hospital could place on a surgeon is to require a more experienced, skilled surgeon supervise their surgeries; is that correct?

A. Yes, ma'am.

Q. It's not unheard of?

A. No, ma'am.

Q. Is it possible that a hospital would not opt for that safeguard, because they don't want to alienate that particular surgeon?

A. I think that would definitely be a concern, the surgeon feeling insulted or alienated.

Q. What kind of responsibility do you think fellow surgeons have in regulating each other?

You see something that you think is dangerous, what do you think you are required to do?

A. Oh, I think, ethically, raise the concerns to the powers that be, you know, locally. Depending on the level of concern, even kind of directly reaching out to the Medical Board.

Q. And the Medical Board, you know they're -- let's pretend like they're getting complaints from well-respected doctors, saying, "We have a doctor here that's dangerous. I don't even know if he graduated from medical school."

Should the Texas Medical Board just sit on their hands and hope for the best? Or should they act quickly?

A. I would hope -- especially in a field like neurosurgery, where the potential harm that we can bring to patients is, you know, as we see, catastrophic, that you would act quickly.

Q. Because, again, without the license, without Texas Medical Board's approval, a doctor like Dr. Duntsch can't

operate.

A. Yes, ma'am.

Q. You've obviously reviewed the records belonging to Ms. Efurd and the other patients that we've talked about.

Do you think there are less obvious ways that Dr. Duntsch could have hurt these people, if he really wanted to hurt them?

A. As a clinician, there are multiple ways that you can injure a patient that aren't as obvious as doing it in an operating room, in front of half a dozen people.

Q. So if a doctor's desire is to hurt a patient, he could do so in a more less obvious way than performing bad surgeries?

A. Yes, ma'am.

Q. All the areas that you have seen -- let me clarify: Seen in Dr. Duntsch's surgeries, are these errors that a surgeon could make, even if he wasn't under the influence of drugs or alcohol?

A. There are all -- the injuries and the errors that I saw were all reported outcomes or known risks or outcomes or adverse outcomes associated with the procedures that were performed. So they've all occurred before elsewhere and been reported in the literature.

Q. Okay. So they're not unique to a -- quote/unquote -- "apparent surgeon"?

A. No, ma'am.

Q. Now, let's talk about some signs that tell you that a doctor's concerned about his patients.

Would one of those signs be that he goes to the ICU with the patient, if she's had a bad outcome?

A. Yes, ma'am. That could be.

Q. Would another sign be that he tries to fix a surgery that he's previously done?

A. That can be the case. Yes, ma'am.

Q. I guess doctors, would you say, they are not the most emotionally-expressive group of people that you have known?

A. I would say surgeons typically tend not to be.

Q. Surgeons.

A. Again, everyone reacts to things differently. At least externally, regarding their -- you know, I guess the external evidence of what's going on internally with them.

Q. Now, you came to Texas about a year and-a-half ago?

A. Yes, ma'am.

Q. Okay. Can you tell the jury about the process that you went through to get your license here.

A. So, what did I have to do to get my license here? You, of course, fill out an application. And then they ask for additional verification of things.

Any states where you have licenses, you have to give them permission to get your -- not necessarily your record, but any information that they have on you.

The hospitals where you've had credentials, they get information on you as well, regarding your care of patients there. They verify your training.

So, they go back to -- for neurosurgery, your neurosurgery training program. You know, verify that you completed your training satisfactorily and your fellowships, and things like that.

What else do they do? I think they take blood. It seems like it. A lot of hoops that you have to jump through, before they finally grant you your license.

Q. Based on your understanding, is the rigorous process you went through new?

Or has that been a long-standing procedure that new doctors must follow to come into Texas?

A. So, when I was looking at the position here, and once I decided to accept the position, a couple of my colleagues forewarned me that the medical board had become a bit more scrutinizing of -- particularly neurosurgeons coming in, because of something that had happened. And I was unaware of what had happened. But I am now aware of what had happened.

(NO OMISSIONS)

And so there was a great deal more scrutiny and probing and questioning of any and all things. At least -- again, I have no reference point. But my colleagues that were here said it was much more onerous now than it had been in years past.

Q. And that's because of Dr. Duntsch's situation?

A. That's what I was -- what was told to me be my colleagues here. Yes, ma'am.

Q. Based on that, would you agree that the Texas Medical Board decided to increase their scrutiny because they realized they failed when it came to Dr. Duntsch?

A. My reading of the reaction is that there was some sort of self-reflection and a feeling that there could have been more done at the board level to have prevented this from occurring.

So part of that is, those of us in neurosurgery, or fields that are similar to this, are gonna undergo a great deal more scrutiny. It's fine. Because the potential to harm patients is high. So they're doing a little bit more probing now, from what I understand.

Q. So if they probed Dr. Duntsch when he came to Texas, the way they probed you, it's possible he wouldn't be sitting here today.

A. Again, from what I have seen -- I can't say for certain, but it would be hard to imagine that his license

would have been granted.

Q. One thing I forgot to ask you about, Doctor, was a role that distraction and stress can have in a surgery.

What's the ideal setting for surgery -- for neurosurgery?

A. A nice, controlled environment, with very few unexpected variables and occurrences.

Q. So a chaotic operating room, that's not what you want?

A. That would be suboptimal.

Q. Suboptimal.

A. Yes, ma'am.

Q. Is a chaotic operating room even more suboptimal for an inexperienced and poorly-trained surgeon?

A. It would be an additional barrier to providing appropriate care.

Q. Is it more likely that that particular surgeon would make a mistake, if he felt stressed out and distracted, in a chaotic operating room?

A. In my experience, yes, ma'am.

Q. Doctor, we previously admitted these in a hearing outside the presence of the jury.

Defendant's Exhibit 1, which is your CV, correct?

A. Yes, ma'am.

Q. And then Defendant's Exhibit 2, which is what?

A. It's the American College of Surgeons Expert Witness Affirmation.

Q. Okay.

MRS. LEHMANN: Permission to publish?

THE COURT: Yes, ma'am.

THE WITNESS: That's an old CV, by the way.

Q. (By Mrs. Lehmann) Is there something that you wanted to add to it, Doctor?

A. I know it's old, because it's before I finished my MBA. So it's not on there.

Q. You have an MBA now?

A. Yes, ma'am.

MRS. LEHMANN: I'll pass the witness.

MISS SHUGHART: Thank you, Your Honor.

CROSS EXAMINATION

BY MISS SHUGHART:

Q. Dr. Bagley --

A. Yes, ma'am.

Q. -- we've heard a lot about the Texas Medical Board and hospitals and the University of Tennessee.

You're not saying the Defendant doesn't have some culpability for what happened to these patients, are you?

A. Oh, absolutely not.

Q. Because he's the person who actually operated on them, right?

A. Yes, ma'am.

Q. I want to go back just a little bit. In medical school and residency and fellowships, that's a really long process, isn't it?

A. Yes, ma'am.

Q. And part of that is to make sure that everybody is well-trained, right?

A. That is the goal of that. Yes, ma'am.

Q. Okay. I mean, doctors spend years working under other doctors, observing them and operating with them; isn't that right?

A. Yes, ma'am.

Q. Okay. And to learn how to do it in your residency, you kind of start out watching other doctors do the surgeries and, slowly, they start giving you little things to do.

A. Yes, ma'am.

Q. And then, over time, you start doing them -- you know, you, as the training surgeon, actually start doing the surgeries and then somebody is observing you; is that right?

A. Your hands-on involvement becomes greater, as you progress through the program. And your involvement in the decision-making process, and things like that, increases as you advance.

Q. The purpose is, by the time you get to the end,

you've done surgeries and you know how to do them and the school can say, "You know how to do the surgeries. Go forth and operate." Isn't that right?

A. That's how it's supposed to work. Yes, ma'am.

Q. Okay. And through that time, the schools are set up to weed out the people who are not good surgeons. Right?

A. Theoretically, they should. Yes, ma'am.

Q. And you have to go through -- in your residency, you have to do multiple different -- surgery is one of the rotations, right?

A. So, in residency, surgery should be the only rotation. In medical school, surgery should be one of the rotations.

Q. Okay. So once you're in your residency, you're operating all the time, for years?

A. Yes, ma'am.

Q. And when you're operating, they're teaching you those basic things in surgery, like, what blood loss means, right?

A. Yes, ma'am.

Q. Okay. What an increased heart and pulse rate mean.

A. Yes, ma'am.

Q. All right. Those are very basic things you're learning as a young resident.

A. You should be. Yes, ma'am.

Q. By the time you become the chief resident or you get into a fellowship, you already know that basic stuff and you've had -- you've mastered those and you're moving into the really complex stuff, right?

A. Theoretically. Yes, ma'am.

Q. By the time you're in a neurosurgical fellowship, you're doing the complex spine surgeries. Wouldn't you agree?

A. That's how it should work. Yes, ma'am.

Q. And have you seen the Defendant's CV?

A. I believe a version of it.

Q. A version of it, somewhere in all those records that you have reviewed?

A. Yes, ma'am.

Q. I'm going to let you just have it here with you and ask you a few questions, in case you need to review it.

A. Yes, ma'am.

Q. University of Tennessee. That's a pretty good program, right?

A. It's a good neurosurgical program.

Q. And Dr. Foley, who the Defendant trained under, he is nationally-renowned for his minimally-invasive spine techniques, right?

A. Yes, ma'am.

Q. You went to train under him for that, right?
A. I went to learn specifically for minimally-invasive. Yes, ma'am.
Q. And there are lots and lots of surgeons who work under Dr. Foley, and they come out and they do a great job out in the world.
A. Absolutely.
Q. In fact, you have a doctor at your hospital: Dr. Howard Morgan. Do you know him?
A. Yes, ma'am.
Q. He was -- he went to the University of Tennessee and trained there, right?
A. Many, many moons ago.
Q. Okay. But he's a good surgeon. Would you agree?
A. Yes, ma'am, he is.
Q. He came out of the University of Tennessee.
A. Yes, ma'am.
Q. There are lots of good surgeons around the State of Texas and the United States that came out of the University of Tennessee program, and they're great surgeons.
A. Yes, ma'am.
Q. Now, in looking at the Defendant's CV, can you see that he has 17 years of medical training, from when he started medical school?
A. Is there a particular page that you're --

Q. Right here (indicating).
A. Yes, ma'am.
Q. When did he start medical school?
A. Started medical school in 1995.
Q. And does it say when he finished his fellowship?
A. Finished fellowship in 2010.
Q. So that's a lot of training, uh?
A. Yes, ma'am.
Q. What is the purpose of a fellowship?
A. A fellowship is to gain additional skills in a specific area. Sometimes, it's to compliment skills that you have gained throughout your general residency. Other times, it's to supplement skills that you didn't get during your training.
Q. Okay. So if somebody -- if a doctor has a minimally-invasive spine fellowship, presumably, they would be quite good at minimally-invasive spine --
A. Theoretically. Yes, ma'am.
Q. Okay. And when you look at the Defendant's resume', did you see that he graduated from school with honors?
A. Yes, ma'am.
Q. That he was summa cum laude.
A. Yes, ma'am.
Q. So he was pretty smart, did good in school, right?

A. Yes, ma'am.

Q. To get out of your residency in fellowship, you have to prove that you had so many hours in the operating room.

A. No, ma'am.

Q. No?

A. No.

Q. Okay. Then what is it that they are certifying that you have so many hours, when they certify?

A. So, there's no certification of hours. There are requirements that the neurosurgery board has for training programs.

Particularly, they look at the senior resident or the chief resident year, that they have to do so many cases in specific areas. It doesn't equate to any specific hours, or anything like that.

We have hour limitations regarding how many hours our residents nowadays work. They can't go above that. But there's no certain hours of doing any particular activity that's required.

Q. Have you spoken to Dr. Foley about the Defendant?

A. No, ma'am.

Q. Have you talked to him about how he trained the Defendant or how -- whether the Defendant was taught everything he was supposed to be taught?

A. No, ma'am.
Q. Do you think that Dr. Foley would put his reputation on the line, to let a bad surgeon out?
A. I would not anticipate that.
Q. Have you ever met with the Defendant personally and discussed his cases?
A. Here? No, ma'am.
Q. I mean, ever. Have you ever talked to the Defendant about the cases?
A. Other than when asked to review the case, I didn't know who he was from Adam.
Q. Okay. The six procedures -- well, the six patients and eight procedures -- ten -- nine procedures that are in front of the jury --
A. Yes, ma'am.
Q. -- would you agree that most of those are the regular, basic surgeries that neurosurgical fellows should know?
A. They would be fairly-straightforward procedures for someone that was a spine surgeon or a neurosurgical graduate.
Q. Okay. So if you're a spine surgeon, these are ones you should know how to do?
A. Yes, ma'am.
Q. And the complications that go along with them,

those are things you should know?

A. Yes, ma'am.

Q. Can you think of any reasons that a surgeon would get out of his schooling and everybody says that he's doing find and did okay and then, when he gets out, he starts doing poorly?

A. I would say -- obviously, people change as they progress in life. But I would probably say that the fact that folks felt that he was -- he or she was -- safe and adequately-trained was probably inaccurate, to begin with.

Q. Okay. Have you ever heard of doctors getting into drugs?

A. Yes, ma'am.

Q. Okay. Would you agree with me that that contributes -- that can contribute -- to the decline in their skills?

A. I'm extremely conservative on that issue. I don't even drink. So I'm probably not the best person to ask that. I don't drink, period. Alcohol, drugs, anything like that.

I can't imagine that that has any -- helps your skill set. But, again, its a negative impact. Drugs or alcohol, again, I can't say it would help.

Q. I mean, you've heard of surgeons who get into drugs and things go poorly, right?

A. Yes, ma'am.

Q. Now, the hospitals, when they hire a surgeon and they look at all their credentials and they do background checks and they get references, they have to decide to hire someone based on just the information they can find, right?

A. Yes, ma'am.

Q. Okay. And if a surgeon starts doing poorly in their surgeries, they may eventually find that information out. But they're probably not going to know that before the surgeon's operating at their hospital.

A. I guess, that would depend on the scenario. If it's happening in realtime, they may not know that. Depending on the timing and the events that transpired, that may or may not be accurate.

Q. Okay. Now, let's say a hospital hires a doctor and they have no idea that he's not any good. He's just out of his fellowship. He comes with a great resume', and he has recommendations from his professors at his universities.

A. Yes, ma'am.

Q. The hospital kind of has to rely on that information, right?

A. Yes, ma'am.

Q. And it's not until something starts going wrong that they start paying attention. They're like, "Oh, this guy, there's an issue here."

A. That would be usual. Yes, ma'am.

Q. Okay. I mean -- I guess what I'm trying to get at is, hospitals don't really get involved in that until after something has already gone wrong, like another surgery.

A. Yes or no. They obviously can't fix something -- you can't fix something that's broken, until you know that it's broken. But, in the same token -- especially with new graduates -- it's not uncommon to have a higher level of scrutiny, as they are kind of starting in their practice.

So, I don't know if that answers the question or not.

Q. Uh-huh. Okay. Now, what about the Texas Medical Board: They don't get -- they don't hear about doctors until after things have gone wrong either, right?

A. Yes, ma'am.

Q. Okay. And are you aware that the Defendant lied to Dallas Medical Center about why he left Baylor Hospital?

A. Regarding what? What do you mean?

Q. About why he left Baylor Hospital, why he's switching hospitals.

Are you aware that he lied about that?

A. Regarding specifically a conversation or something like that, no. Other than what was already referred to earlier.

Q. Okay. Do you think that if a hospital was lied to about why a physician voluntarily resigned, that that might

affect why they give him privileges?

A. It could. Yes, ma'am.

Q. Have you read all of the Defendant's operative reports in these cases?

A. Yes, ma'am, I believe so.

Q. And, in reading those operative reports, did he admit that he did anything wrong in any of those surgeries?

A. In the operative reports?

Q. Yes.

A. No.

Q. They sound like things went pretty well in all of those surgeries, right?

A. Yes, ma'am.

Q. Okay. Now, we were talking -- I guess, earlier, we were talking about minimally-invasive surgeries.

All of those surgeries are not minimally-invasive, right?

A. That's correct. Yes, ma'am.

Q. Let's talk about which ones are not. Mary Efurd, her last surgery, where things went horribly wrong, that is not minimally-invasive, right?

A. That one -- actually, I can't remember if it was minimally-invasive or not.

The fusion -- I can't remember if it was an MIS or open wound. The others were not MIS. Yeah, the others were not

MIS cases. That one, I can't remember specifically.

Q. Where would you be able to find that? Would that be in the operative report?

A. You would be able to glean it basically from the event or somewhat infer it from the instrumentations that was used. Sometimes, it's in the operative report. Other times, it's kind of woven throughout how the exposure was gained, and things like that.

Q. Okay. Now, of the other ones, were any of those minimally-invasive?

A. No, ma'am.

Q. Okay. So I guess if they're not minimally-invasive, they must be open.

A. Yes, ma'am.

Q. And that is exactly the type of surgery that residents are trained in.

A. Well, I would say residents nowadays, in most programs, are trained in both. But all residents should be trained in open techniques.

Q. Okay. So even before the Defendant took his minimally-invasive fellowship, he would have been doing open back surgeries?

A. Yes, ma'am.

Q. Okay. And those are the kind where he definitely would have been in there doing it himself, not just one

person watching through a microscope.

A. Well, I would anticipate he would have had a more hands-on role in those cases.

Q. Let's talk about Jerry Summers. Do you remember his case?

A. Can you show me the procedure, and I can tell you.

Q. His was the ACDF.

A. Yes, ma'am.

Q. And he became a quadraplegic.

A. Yes, ma'am.

Q. Okay. Are you aware that the Defendant was friends with that patient?

A. I'm aware of that, by some of the other information that was provided. But, yes, not based on those records.

Q. Surgeons aren't really supposed to operate on their family and friends, right?

A. It's considered -- I don't know if "a conflict of interest" is the wrong thing so say, to operate on a family member.

Depending on where you are, it's hard not to operate on friends. I've operated on employees that I would consider a friend, and things like that.

Q. Okay. When you have a patient who comes out of surgery and they're immediately complaining they cannot move

their arms or legs, that's a pretty good indication that something went wrong in the surgery, right?

A. Yes, ma'am.

Q. And you should take that patient back in immediately -- either back into surgery or get imaging immediately.

A. Yes, ma'am.

Q. You should not be wasting that time going into another surgery, on a different patient.

A. Under ideal circumstances, yes, ma'am.

Q. Okay. Do you know Dr. Michael O'Brien?

A. No, ma'am.

Q. Did you read his medical records on what his findings were in the surgery?

A. For the case on Mr. Summers?

Q. Yes.

A. Yes, ma'am.

Q. And what was it that he found was wrong with Jerry?

A. Other than the cord compression, the packing of some hemostatic material and also, I believe, a dura tear, if I'm not mistaken, as well.

Q. And on that case, are you aware that the Texas Medical Board found that he was in gross violation of any standard of care regarding Jerry Summers?

A. I would agree with that.
Q. Do you remember a patient Kellie Martin?
A. Yes, ma'am.
Q. Okay. She was the one where he went in from the back and had a retroperitoneal bleed.
A. Yes, ma'am.
Q. Now, that's generally kind of a typical surgery for a spine surgeon. Wouldn't you agree?
A. Yes, ma'am.
Q. Something they should be able to readily perform.
A. Yes, ma'am.
Q. And the retroperitoneal bleed, that is a well-known complication.
A. Yes, ma'am.
Q. Extremely rare, though.
A. Yes, ma'am.
Q. But during your training and your education and reading of the literature, it's very clear that that's something you should be watching out for.
A. Yes, ma'am.
Q. In fact, when you have a patient whose heart rate is going up and their blood pressure is going down, an anesthesiologist is complaining to you about that, first thing that comes to your mind should be "I've got bleeding".
A. In theory, yes. I've been around when it

happened -- not in one of my cases, but when I was doing my training. It's not as clear-cut as it may seem.

But, yes, with all of those variables, particular concern from the anesthesiologist, that should be what enters your mind as to a potential complication.

Q. And when you have those issues coming your way, you should immediately try and figure out what's causing them.

A. Yes, ma'am.

Q. And are you aware that the Texas Medical Board found that it was a violation of the standard of care on her case?

A. Again, I would agree with that.

Q. Let's talk about Floella Brown.

A. Yes, ma'am.

Q. She's the one where it was an ACDF, and she ended up having a stroke.

A. Yes, ma'am.

Q. When you operate on a cervical patient, are you generally supposed to leave a drain in?

A. There's not supposed to or not. You can, but not always.

Q. Why would you leave one in?

A. If you were concerned about bleeding.

Q. If you had a case where you had a lot of bleeding

during the surgery, is that the kind of case where you would leave a drain in?

A. I would, yes. But, again, some folks leave drains all the time. Some folks do it selectively.

Q. And you're aware that the Defendant did not leave a drain in Ms. Brown?

A. I can't say that particularly I was aware of that, one way or another.

Q. When you have a patient who, overnight, becomes obtunded and nonresponsive, is that something where it's important to act quickly?

A. Yes, ma'am.

Q. Should you wait seven hours or so to take care of her?

A. No, ma'am.

Q. Should you be going into another surgery while she's in that state, if nobody else can take care of her?

A. No, ma'am.

Q. And are you aware that the Texas Medical Board found that he was grossly incompetent in the execution of that surgery?

A. I would agree again with that. Yes, ma'am.

Q. Okay. Let me talk about Mary Efurd. On her case, do you also agree that the things that were done in that surgery were pretty egregious?

A. Absolutely.
Q. And the Texas Medical Board, do you know that they found it was grossly in violation of the standard of care?
A. Yes, ma'am.
Q. When you are learning how to operate on the spine, are you taught how to feel the difference between muscle and bone?
A. Yes, ma'am.
Q. I mean, that's something you can feel with your instruments and see with your eyes.
A. (Witness nods.)
Q. You reviewed more than just these six patients, right?
A. Yes, ma'am.
Q. How many did you review?
A. Again, I couldn't tell you an exact number. But 20-some-odd cases, probably.
Q. Out of those 20-some-odd cases, you know that a couple of them are okay; is that right?
A. Say that again.
Q. You know that a couple of those patients are doing fine.
A. Again, I have no long-term follow-up on any of the patients -- I guess, on the majority of the patients. So I can't say how most of the patients are or aren't doing,

other than the ones that I know expired as a result of the surgery.

Q. And of the records that you reviewed, would you agree that there is an unusually-high number of complications in those surgeries?

A. Absolutely.

Q. And many of them are extremely catastrophic.

A. Yes, ma'am.

Q. The Defendant tended to have high blood loss in his surgeries, right?

A. Again, EBL, I don't necessarily trust. But, definitely, there were cases where the amount of blood loss was beyond what would be typical for those patients.

Q. I mean, if patients are getting blood transfusions, then they've lost a lot of blood.

A. Typically. Yes, ma'am.

Q. And these types of surgeries, you're not usually preparing for a blood transfusion in them, are you?

A. Most of them don't -- yes. At least those six cases, the majority of those would be atypical to require a transfusion.

Q. Would you -- it's a pretty rare -- by "pretty" I mean extremely rare, for a neurosurgeon to hit the vertebral artery.

A. Yes, ma'am. It's a rare complication.

Q. It is kind of a once-in-a-lifetime event.

A. It is -- as a practicing neurosurgeon it's, hopefully, a never-in-a-lifetime event. But it's something that's been known to happen.

Again, I've been in the OR when it's happened down the hall, and things like that.

Q. And in your review of all the Defendant's records, you know that he likely hit the vertebral artery many times.

A. More than for the time period that was -- of cases that I reviewed, it was higher than acceptable.

Q. And he had a high rate of patients coming back after their surgeries complaining of new neurological problems.

A. Again, the rate, I can't say because I only reviewed specific records. But that was a lot of patients, for the time. But I don't know what the denominator is. I don't know how many patients it's out of.

Q. I mean, I'm just asking the questions out of the patients that you have reviewed.

A. Yes, ma'am. But I'm saying, in terms of just being technical, in terms of a rate, that means you've got to know out of how many. So that's why I kind of qualified that. But, yes, there were a number of patients.

Q. In reviewing the records, do you see that multiple patients had loose hardware left in them?

A. I can't necessarily recall that as a specific issue. There were a number of hardware issues in cases, yes.

Q. Okay. I mean, some of the hardware was malpositioned.

A. Uh-huh. Yes, ma'am.

Q. And some of those patients had to go see new doctors to have hardware removed, because it was left loose in them.

A. Whether or not it was left loose, again, that, I can't say. But there were loose hardware removed.

At the same token, a pseudo reversis (phonetic) or loosening of the hardware is something that does happen in cases, as a consequence downstream.

Q. I mean, if you have reviewed all of these medical records of these patients that the Defense gave you, it should include all of the records of the patients going to see their -- other doctors later. I mean, you saw those, right?

A. Again, I can't speak to whether the records I was given were in totality or not because, again, I only have what I have. So I don't know what the totality of the records are.

Q. Sure. But of the ones that you have, many of those were records from doctors after the patients have been

operated on by the Defendant.

A. Some of the records. Yes, ma'am.

Q. And those doctors put indications in there about how the patient was fairing afterwards.

A. Yes, ma'am.

Q. I mean, that's why they're seeing another doctor is because they're not doing well, right?

A. Yes, ma'am.

Q. And these complications that are happening in these surgeries, most of them are pretty rare, right?

A. Yes, ma'am.

Q. I mean, you said earlier that you have heard of all these complications; that they're known complications, but they're extremely rare.

A. Yes, ma'am.

Q. These things don't just happen all the time, on a regular basis.

A. Yes, ma'am.

Q. So it's highly unusual that a surgeon would have all of these extremely-rare complications in a very short period of time.

Wouldn't you agree?

A. Extremely. Yes, ma'am.

Q. And even a surgeon who wants to say they're poorly trained, when they -- when a patient is complaining of new

pain over and over and over again, multiple patients, you start to know that you're hurting people.

A. I would hope so. Yes, ma'am.

Q. The person who's responsible for doing all these things, is that the Defendant?

A. Yes, ma'am.

Q. And he operated on these people and did all of those horrific things to them.

A. He operated on the patients that had horrific outcomes with his patients. Yes, ma'am.

Q. And you're not here defending the things that he did in the surgery.

A. No. Again, I think the surgical technique that -- the surgeries that were performed were -- again, I don't know a politically-correct way to say it. But they were very, very poor.

Again, my whole summation of all of this is that, again, this is a complete and utter failure of the entire system of checks and balances for safety for patients, from start to finish.

Q. I think we would all agree with you on that.

A. Yes, ma'am.

Q. But, ultimately, the person who chooses to go in the operating room and keep operating, that's the Defendant, right?

A. Yes, ma'am.
Q. Even when he knows he's hurting people and killing people, he's the one choosing to go back into the operating room.
A. Well, I would hope that he would know that. But, yes, absolutely. You're choosing to continue to treat patients.
Q. And the surgeries that were done in these cases, they don't generally have a high mortality rate, do they?
A. No, ma'am.
Q. It's not like doing brain surgery on someone, where it's a bigger risk.
A. Yes, ma'am. These would be considered low-risk surgeries. Yes, ma'am.
Q. Are you being -- were you paid for your review of all these records?
A. I've charged, but I haven't been paid anything.
Q. But you're doing it based on the fact that, hopefully, the Court will pay you some day.
A. In a theoretical sense. Yes, ma'am.
Q. Theoretically.
A. Theoretically. Yes, ma'am.
Q. And you're testifying today under that presumption, too.
A. I'm testifying today, because I was asked to.

And, again, when I agreed to review the case, I didn't know what it was or the totality of all of it. But I'm here, because I gave my word that I would review and give my honest opinion of what I felt were the facts of it.

Q. And the Texas Medical Board -- earlier, you told us that they have in fact increased their scrutiny because of this case.

A. Again, I know that -- I assume that, based on my experience of going through the Board with getting my license, which was after all of these events and what my colleagues had relayed to me as the change in behavior. Yes, ma'am.

Q. I mean, I guess we can assume that the Texas Medical Board thought that what he did was so horrible that they needed to change the procedures that they had been doing for decades, to make 'em harder.

A. I would hope that every single entity involved have a very long period of self-reflection in this case.

Q. And you yourself have some experience with the Texas Medical Board.

A. Yes, ma'am.

Q. Okay. And they in fact found that you were below standard of care on two cases, and put you in a remedial plan for that.

A. So, that was -- so, in North Carolina, where I was

practicing at Duke, we're co-insured with the hospital. So when the hospital settles, if you're the attending physician, you are also tagged with that settlement.

There were two cases where the hospital chose to settle cases, and I was the attending physician for those patients. So the Medical Board -- also, as a change in posture, because of those settlements that the hospital made, they -- that's how the Texas Medical Board worded that. So I've never --

Q. And the plan that you signed with the Texas Medical Board, it had the actual findings that you failed to meet the standard of care in postoperative treatment of two patients.

A. That's what it says.

Q. That's what it says.

A. Yes, ma'am.

MISS SHUGHART: Pass the witness.

THE COURT: Ma'am, do you think you're likely to be more than a few minutes?

MRS. LEHMANN: Yes, Judge, I do.

THE COURT: Okay. Members of the Jury, it's been awhile. The reporter needs to kind of get her fingers relaxed a little bit. I do see the clock, like you can. I'm going to send you back to kind of stretch your legs. If you will be available in five minutes to come back, maybe we

can get this concluded.

Okay. Lawyers, I need to talk to you.

(Off-the-record discussion held at the bench.)

THE BAILIFF: All rise.

(Members of the Jury retire to the jury room.)

(Recess had.)

(Defendant present in the courtroom.)

THE COURT: Yes, sir. We're ready.

THE BAILIFF: All rise.

(Members of the Jury enter the courtroom.)

THE COURT: Have a seat. Welcome back, Members of the Jury.

Any further questions?

MRS. LEHMANN: No further questions for Dr. Bagley.

THE COURT: Okay. I note that the time of when we're supposed to adjourn is mighty close anyhow. If we were to hear further witnesses, we probably wouldn't get done by ten -- I mean, by four. It's already ten minutes of. I don't think we can do it in ten minutes.

As I mentioned to you informally, some of us lawyer types, we can hardly clear our throat in less than about a half hour. I'm about to send you on the way home.