

MICHAEL R. REED  
UNITED STATES DISTRICT COURT  
DISTRICT OF MINNESOTA

In re Bair Hugger Forced  
Air Warming Products  
Liability Litigation,

MDL No. 14-2666 (JNE/FLN)

VIDEOTAPED DEPOSITION OF  
MICHAEL R. REED

London, United Kingdom

Taken December 4th, 2016 By Rose Kay

Job No. 115951

MICHAEL R. REED

## APPEARANCES:

THE EXAMINER  
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MICHAEL R. REED

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MICHAEL R. REED

Sunday, December 4, 2016

THE VIDEOTAPED DEPOSITION OF MICHAEL R. REED

is taken on this 4th day of December 2016,  
at Faegre Baker Daniels, LLP, 7 Pilgrim Street,  
London EC4V 6LB, United Kingdom,  
commencing at 12:30 p.m.

THE VIDEOGRAPHER: We are on the record in the deposition of  
Michael Reed, in the matter of Bair Hugger Forced Air  
Warming Products Liability Litigation; in the High Court  
of Justice, Queen's Bench Division, job number 15-2666  
(JNE/FLN).

The deposition is being held at Faegre Baker  
Daniels, 7 Pilgrim Street, London, U.K. on December 4,  
2016. The time is half past 12.

My name is Gerlando Scaffidi. I am the legal video  
specialist from TSG Reporting, Inc, headquartered at 747  
Third Avenue, New York. The court reporter is Rose Kay,  
also in association with TSG Reporting.

Would counsel please introduce themselves and the  
parties they represent?

MR. GORDON: Corey Gordon, on behalf of the defendants 3M  
and Arizant in the U.S. proceedings.

MR. ASSAAD: Gabriel Assaad, on behalf of the plaintiffs.

MICHAEL R. REED

MS. ZIMMERMAN: Genevieve Zimmerman, on behalf of the  
plaintiffs.

MR. HOLL-ALLEN: Jonathan Holl-Allen, counsel for Mr. Reed.

MS. OKONEDO: Ediri Okonedo, solicitor for Mr. Reed.

THE EXAMINER: Allen Dyer. I am the court appointed  
examiner.

Mr. Reed, could you repeat after me?

MR. MICHAEL R. REED.

having been sworn.

testified as follows:

THE EXAMINER: Could we have your full names and your  
professional address?

A. Mike -- Michael Richard Reed. I work for Northumbria  
Healthcare, which is in Northumberland, U.K.

THE EXAMINER: Thank you. Yes, Mr. Gordon.

EXAMINATION BY MR. GORDON:

Q. Good afternoon, Mr. Reed; and I understand by now that  
Mr. is the appropriate title for a senior physician in  
the U.K.

A. It's an exam. That's all.

Q. It's really hard, because in the U.S. to call  
a physician Mr. would be a real insult; so I am  
adapting, but it is a challenge.

You are an orthopaedic surgeon; is that correct?

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A. Yes.

Q. When did you become a consultant orthopaedic surgeon?

A. I think 13 years ago. That sort of order.

Q. Approximately --

A. 2004, I think. 2003, 2004.

Q. And how long was your period of what we would call  
residency?

A. Okay. So we do it slightly differently in the U.K., the  
residency thing. But we do a junior residency, which is  
about four years; and then a senior residency, which is  
just in orthopaedics, which is another six years.

I took a year off of my six years, because I did  
research, which is sort of recognized by a lot of that.

Q. So you would have left medical school some time in, like  
1994?

A. Yes. So we leave medical school at 23. So we don't do  
anything generally before medical school over here.

Q. All right. And since you -- well, strike that.

Where did you do your junior residency and your  
senior residency?

A. So junior residency, I did in the North East; and then  
I did two years of research in Sheffield. And then  
I did the rest of the time in the North East on the  
senior training program. And then I did a year in New

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Zealand or eight -- no, 15 months in New Zealand, doing  
joint replacement essentially in ... and I came back.

Q. What do you mean by the North East, for whose of us who  
are not familiar with it?

A. So the North East of England, which is -- we border onto  
Scotland, if that helps. So we are just at the very top  
of England, on the East Coast.

Q. Is that where Northumbria is now?

A. Yes.

Q. Okay. And is it the Northumbria Hospital Trusts; is  
that ...?

A. Yes, so Northumbria Healthcare NHS Foundation Trust.

Q. Explain what the trust is?

A. So the trust is an organization of hospitals which have  
the same management structure and the same financial  
mechanism, if you like; the same employment structure.

So my hospital, my trust has, I think, a total of 11  
or 12 hospitals, of which some will be community  
hospitals and some will be more like hospitals with  
operating theaters, and some will be trauma hospitals,  
or just one now, one trauma hospital out of all of that.

Q. How many of those hospitals do you perform surgery in?

A. Now, three.

Q. Let's start with now. Three?

<p style="text-align: right;">Page 10</p> <p>1                   MICHAEL R. REED</p> <p>2       A. Yes.</p> <p>3       Q. What are they? How are they identified?</p> <p>4       A. So one is called the Northumbria Hospital. It is the</p> <p>5           new one. One is called Hexham General Hospital. And</p> <p>6           one is called Wansbeck Hospital.</p> <p>7       THE EXAMINER: Sorry?</p> <p>8       A. Wansbeck.</p> <p>9       THE EXAMINER: Wansbeck.</p> <p>10      A. Yes.</p> <p>11      BY MR. GORDON:</p> <p>12      Q. How new is the Northumbria one?</p> <p>13      A. It opened in June last year, so that must be almost 18</p> <p>14           months.</p> <p>15      Q. And prior to that, were you practicing just at Hexham</p> <p>16           and Wansbeck, or did you replace something with</p> <p>17           Northumbria?</p> <p>18      A. So immediately prior to that, I was operating just in</p> <p>19           those two. But I have done some operations in North</p> <p>20           Tyneside Hospital, which is another one of our hospitals</p> <p>21           in North Shields.</p> <p>22      Q. How long have you been affiliated with the Northumbria</p> <p>23           Trusts?</p> <p>24      A. So I have been a consultant the whole time I have been</p> <p>25           with Northumbria, although I did do some training there</p>	<p style="text-align: right;">Page 11</p> <p>1                   MICHAEL R. REED</p> <p>2       as well. So I think it's about 2004 since I was</p> <p>3       appointed, 2003. And I have been at Northumbria since</p> <p>4       then.</p> <p>5       Q. And do you have any additional administrative</p> <p>6           responsibilities or titles, with respect to overall</p> <p>7           orthopaedic surgery?</p> <p>8       A. So I am head of training currently.</p> <p>9       Q. For orthopaedics?</p> <p>10      A. For the North East, for orthopaedics; so 67 orthopaedic</p> <p>11           trainees. So I am currently head of quality for</p> <p>12           Northumbria, although I am stepping down. My wife is</p> <p>13           ill, so I am stepping down from that.</p> <p>14           What other jobs do I have? I am Chair of the</p> <p>15           Education Committee for the Orthopaedics Association,</p> <p>16           British Orthopaedic Association.</p> <p>17      Q. Do you currently serve on any NHS committees?</p> <p>18      A. Well, I am on the NICE committee, so that's one of our</p> <p>19           guidelines generators. Well, it is our guidelines</p> <p>20           generator, if you like.</p> <p>21      Q. What does NICE stand for?</p> <p>22      A. So the National Institute for Health and Care</p> <p>23           Excellence. And I am on a committee currently for</p> <p>24           venous thromboprophylaxis.</p> <p>25      THE EXAMINER: You'd better repeat that last word.</p>
<p style="text-align: right;">Page 12</p> <p>1                   MICHAEL R. REED</p> <p>2       A. Yes, Thromboprophylaxis. So this is stopping clots in</p> <p>3           the legs, essentially, that go to the lungs.</p> <p>4           And I am on the NICE guidance committee for avoiding</p> <p>5           hypothermia in theater. And I have previously served on</p> <p>6           them, doing a quality standard for avoiding surgical</p> <p>7           site infection. And I did the evidence update for NICE</p> <p>8           on surgical site infection prevention.</p> <p>9       BY MR. GORDON:</p> <p>10      Q. All right. Let's go backwards.</p> <p>11           When did you do that evidence update on avoiding</p> <p>12           surgical site infections?</p> <p>13      A. I would estimate 2013.</p> <p>14      Q. And when did you serve on the committee for avoiding --</p> <p>15           for providing guidance for avoiding hypothermia?</p> <p>16      A. That is currently running, so it runs for maybe a year.</p> <p>17           You have several meetings, you look at all the evidence;</p> <p>18           so that's currently in process, if you like.</p> <p>19      Q. Is this the first time you have served on that</p> <p>20           committee?</p> <p>21      A. Yes.</p> <p>22      Q. Okay.</p> <p>23      A. So what happens is they update the guidance every few</p> <p>24           years. So when they are updating it, there are several</p> <p>25           meetings and you review lots of evidence and then it</p>	<p style="text-align: right;">Page 13</p> <p>1                   MICHAEL R. REED</p> <p>2       stops. The guidance comes out, and then maybe in five</p> <p>3       years time they will do it again and it might be</p> <p>4       a different committee next time.</p> <p>5       Q. Okay. And the venous thromboprophylaxis committee, is</p> <p>6           it the same thing, about a year?</p> <p>7       A. Same thing. And it's, I think, slightly more advanced</p> <p>8           than the other one, down that road. They are running</p> <p>9           parallel, but they are not related.</p> <p>10      Q. The reason I am asking is: for some reason, I thought</p> <p>11           you had some responsibilities with NICE, going back</p> <p>12           several years.</p> <p>13      A. So the surgical site infection prevention update was</p> <p>14           2013, I think. And the quality standard was about the</p> <p>15           same time, maybe 2014, something like that; but that</p> <p>16           sort of order. I don't think I have done anything with</p> <p>17           NICE before that.</p> <p>18      Q. Okay.</p> <p>19           I apologize in advance for having thrust in front of</p> <p>20           you four volumes of material. We have pre-marked them,</p> <p>21           the volumes 1 through 4 as exhibits 1 through 4.</p> <p>22           These are documents that were provided to you</p> <p>23           a couple of weeks ago, under the High Court's</p> <p>24           requirements.</p> <p>25      MR. ASSAAD: I would like to make an objection at this time,</p>

<p style="text-align: right;">Page 14</p> <p>1           MICHAEL R. REED</p> <p>2           just for the record, for the court.</p> <p>3           THE EXAMINER: It is not an objection, I don't think. It is</p> <p>4           something that you want to put on the record.</p> <p>5           MR. ASSAAD: Well, I have an objection as well. First of</p> <p>6           all, I am going to have an objection to globally</p> <p>7           offering these exhibits as 1 through 4; because as we</p> <p>8           have realized, within each binder, there's multiple</p> <p>9           exhibits, multiple different documents and he has not</p> <p>10          laid any foundation for whether or not they are</p> <p>11          authentic documents. And to just globally limit it as 1</p> <p>12          through 4, it is not commonly done in the United States</p> <p>13          and I don't think it is done either under English law in</p> <p>14          trial, to take a whole stock of miscellaneous documents</p> <p>15          and exhibits and maybe mark it as one big exhibit.</p> <p>16          Second, I also object to the use of any of these</p> <p>17          documents, because we received these documents only</p> <p>18          a few days before; we received 1,700 pages two days</p> <p>19          before the date of this deposition, which I think is</p> <p>20          untimely and goes against the spirit of the sealed</p> <p>21          order.</p> <p>22          THE EXAMINER: Does it not go against the words of the</p> <p>23          sealed order?</p> <p>24          MR. ASSAAD: Well --</p> <p>25          MR. GORDON: It does not.</p>	<p style="text-align: right;">Page 15</p> <p>1           MICHAEL R. REED</p> <p>2           MR. ASSAAD: It does not go against the words. But, you</p> <p>3           know, as we have realized, the sealed order was created</p> <p>4           and written by defense counsel for now --</p> <p>5           THE EXAMINER: Okay. You have put your objection on the</p> <p>6           record.</p> <p>7           MR. ASSAAD: I do object. For the purposes of going</p> <p>8           forward, it is going to be very difficult, unless you</p> <p>9           identify each document being used and what the exhibit</p> <p>10          number is for the U.S. court.</p> <p>11          It is also improper, unless you want to go through</p> <p>12          every single page in exhibits 1 through 4. And whether</p> <p>13          or not he lays the foundation for each document, and</p> <p>14          whether or not it is authentic, I think each document</p> <p>15          that's within the binders should be labeled as</p> <p>16          a different exhibit for ease of use going forward in</p> <p>17          this deposition, as -- so the court in the United States</p> <p>18          could rule on the admissibility of each and every</p> <p>19          document.</p> <p>20          MR. GORDON: Counsel, as we have done in the last two</p> <p>21          depositions, I am identifying, by the specific</p> <p>22          pagination within each of these group of exhibits, those</p> <p>23          documents that I am examining the witness on and that is</p> <p>24          the evidence -- the documents that I am offering.</p> <p>25          And if the court finds foundation lacking for any</p>
<p style="text-align: right;">Page 16</p> <p>1           MICHAEL R. REED</p> <p>2           particular subset of this, that I specifically enumerate</p> <p>3           and identify, then so be it. And to the extent that</p> <p>4           I have adequately identified the specific pages and only</p> <p>5           those specific pages, that's what we are offering.</p> <p>6           These binders correspond to the documents that we</p> <p>7           have provided to Mr. Reed and to the other deponents,</p> <p>8           pursuant to the requirements of the London High Court.</p> <p>9           So for ease of review and going through the</p> <p>10          materials in the manner that they were provided to the</p> <p>11          witnesses and marking them as group exhibits and</p> <p>12          identifying by specific pagination.</p> <p>13          THE EXAMINER: Okay. Have you put on the record -- and this</p> <p>14          was the question. Have you put on the record</p> <p>15          an objection to lack of foundation for all of these</p> <p>16          documents?</p> <p>17          MR. ASSAAD: I have a lack of foundation, a lack of --</p> <p>18          THE EXAMINER: So you don't have to repeat it.</p> <p>19          MR. ASSAAD: But I have one more thing. I just want to say</p> <p>20          that in accordance with the sealed order, it also refers</p> <p>21          to the Federal Rules of Evidence and the rules of being</p> <p>22          at trial. And this is -- we are supposed to conduct</p> <p>23          this deposition as being a trial before the English</p> <p>24          courts, as well as the U.S. courts, and this is not how</p> <p>25          we identify documents by showing 1,700 pages without</p>	<p style="text-align: right;">Page 17</p> <p>1           MICHAEL R. REED</p> <p>2           establishing authenticity or foundation.</p> <p>3           THE EXAMINER: Okay. Carry on.</p> <p>4           MR. HOLL-ALLEN: Sir, may I just say this. For the purposes</p> <p>5           of the record, the order states --</p> <p>6           THE EXAMINER: Hang on. Let me just get my copy. Yes.</p> <p>7           Paragraph?</p> <p>8           MR. HOLL-ALLEN: Subparagraph (f):</p> <p>9           "The documents in relation to which Mike Reed is to</p> <p>10          be questioned by either the defendants or the plaintiffs</p> <p>11          shall be provided to him in a tabbed and paginated</p> <p>12          bundle at least 14 days before the date listed in</p> <p>13          paragraph (b) above."</p> <p>14          And I, in the interests of my client, am bound to</p> <p>15          put on the record this: that a specific inquiry was made</p> <p>16          by me before the Senior Master as to the likely volume</p> <p>17          of the material, and the indication was that it would be</p> <p>18          one or perhaps two Lever Arch files, and I acknowledge</p> <p>19          that the defendants have not produced anything greater</p> <p>20          than that in relation to any of the other effective</p> <p>21          witnesses. But certainly the volume of material that</p> <p>22          Mr. Reed has been served with is significantly in excess</p> <p>23          of what we were led to believe.</p> <p>24          THE EXAMINER: Well, it grows from time to time. That's one</p> <p>25          of those things.</p>

<p style="text-align: right;">Page 18</p> <p>1           MICHAEL R. REED</p> <p>2           I think the order is perhaps a bit mean, when it</p> <p>3           provides for him to get them 14 days before and not the</p> <p>4           other parties, but there we are. That is a matter of</p> <p>5           hindsight. Gabriel should have been ordered to get them</p> <p>6           14 days in advance. I have sympathy for Mr. Reed.</p> <p>7           There are a number of files.</p> <p>8           Anyway, let's get on with the real event.</p> <p>9           MR. ASSAAD: Can I have a ruling to identify documents and</p> <p>10          the foundation, because --</p> <p>11          THE EXAMINER: You have put it on the record for the U.S.</p> <p>12          court. I really think that spending time identifying</p> <p>13          each document as an exhibit is unnecessary. You have</p> <p>14          put it on the record. You can say that this was -- you</p> <p>15          see, we don't have a procedure like this in England. So</p> <p>16          there's no trial procedure you can follow and rely on in</p> <p>17          this country. You are restricted to the new -- the</p> <p>18          federal rules, because we don't do it this way.</p> <p>19          MR. ASSAAD: Well, I have a standing order for --</p> <p>20          THE EXAMINER: Fair enough. We have a procedure by which</p> <p>21          all documents are presumed to be authentic unless</p> <p>22          someone challenges them specifically. And by the time</p> <p>23          we get to trial, we can have a trial bundle agreed by</p> <p>24          everyone.</p> <p>25          MR. ASSAAD: But each document is labeled as different</p>	<p style="text-align: right;">Page 19</p> <p>1           MICHAEL R. REED</p> <p>2           exhibit numbers.</p> <p>3           THE EXAMINER: We don't have exhibit numbers.</p> <p>4           MR. ASSAAD: Well, whatever number. In the United States,</p> <p>5           that is the way it is done.</p> <p>6           THE EXAMINER: I understand. But you have put your</p> <p>7           objection on the record for the U.S. court.</p> <p>8           MR. ASSAAD: Fair enough.</p> <p>9           MR. GORDON: I bet you wish you had gone to law school, huh?</p> <p>10          A. I didn't get 14 days either, but we will press on.</p> <p>11          BY MR. GORDON:</p> <p>12          Q. If you take exhibit 1, which is volume 1. It is in</p> <p>13          front of you.</p> <p>14          (Exhibit Reed 1 marked for identification.)</p> <p>15          THE EXAMINER: He needs to have enough space at least to</p> <p>16          have each file open before him.</p> <p>17          BY MR. GORDON:</p> <p>18          Q. If you could turn to page 505.</p> <p>19          MR. HOLL-ALLEN: Volume 1?</p> <p>20          MR. GORDON: Volume 1. Page ...</p> <p>21          A. I don't have a 505 in volume 1.</p> <p>22          MR. GORDON: The pagination is in the lower right hand</p> <p>23          corner.</p> <p>24          THE EXAMINER: Not on mine. So you'd better tell me which</p> <p>25          tab number.</p>
<p style="text-align: right;">Page 20</p> <p>1           MICHAEL R. REED</p> <p>2           MR. GORDON: They are not paginated?</p> <p>3           MR. HOLL-ALLEN: Volume 1 only goes to ...</p> <p>4           A. 300 and something.</p> <p>5           MR. HOLL-ALLEN: 387.</p> <p>6           MR. GORDON: I apologize. Volume 2.</p> <p>7           (Exhibit Reed 2 marked for identification.)</p> <p>8           THE EXAMINER: I have an unpaginated version.</p> <p>9           MR. HOLL-ALLEN: Just for the avoidance of any doubt, there</p> <p>10          are five files.</p> <p>11          THE EXAMINER: Five?</p> <p>12          MR. HOLL-ALLEN: Four of them are the -- what we understand</p> <p>13          to be the defendants' documents, and they are</p> <p>14          continuously paginated throughout those four files.</p> <p>15          THE EXAMINER: Not mine. Not mine.</p> <p>16          MR. HOLL-ALLEN: Not yours? I am sorry to hear that. The</p> <p>17          fifth file is the plaintiffs' documents and those are</p> <p>18          not -- those are tabbed, but not paginated.</p> <p>19          THE EXAMINER: Well, I don't have that either.</p> <p>20          MR. GORDON: These are paginated.</p> <p>21          THE EXAMINER: It's all right.</p> <p>22          MR. GORDON: These are.</p> <p>23          THE EXAMINER: I can cope. Just tell me where they are.</p> <p>24          MR. GORDON: Where did these come from?</p> <p>25          THE EXAMINER: No idea.</p>	<p style="text-align: right;">Page 21</p> <p>1           MICHAEL R. REED</p> <p>2           MR. GORDON: Here is 1 and 3.</p> <p>3           MR. ASSAAD: These are our 4 to ...</p> <p>4           MR. GORDON: Are those paginated?</p> <p>5           A. There's numbers on them.</p> <p>6           MR. HOLL-ALLEN: These are paginated. It is a complete set,</p> <p>7           I think.</p> <p>8           MR. GORDON: Why don't we switch that out.</p> <p>9           (Off the record remarks.)</p> <p>10          A. What page are we on, sorry?</p> <p>11          MR. GORDON: 505.</p> <p>12          THE EXAMINER: 505, yes.</p> <p>13          BY MR. GORDON:</p> <p>14          Q. And I specifically want to ask you about the document</p> <p>15          that runs from 505 to 510.</p> <p>16          Could you tell us what that -- this particular</p> <p>17          document is?</p> <p>18          A. So this is a paper which looks at the forced air warming</p> <p>19          machines, if you like, and the potential for them to</p> <p>20          have bacteria build-up within them; and also to have,</p> <p>21          sort of, emissions of particles out of the -- out of the</p> <p>22          hose at the end.</p> <p>23          Q. And are you the first listed author in this one?</p> <p>24          A. I am, yes.</p> <p>25          Q. And when was this published?</p>

<p style="text-align: right;">Page 22</p> <p>1 MICHAEL R. REED</p> <p>2 A. August 2013.</p> <p>3 Q. Okay. So with your permission, I am going to refer to</p> <p>4 this particular study as "Reed 2013".</p> <p>5 A. Okay.</p> <p>6 Q. Now --</p> <p>7 THE EXAMINER: What does it mean, that you are the first</p> <p>8 named author on this one?</p> <p>9 A. So it means various things, actually. So the very</p> <p>10 traditional route is that the junior author, if you</p> <p>11 like, goes first.</p> <p>12 THE EXAMINER: That is what we have heard to date.</p> <p>13 A. Yes. And the senior author would go last. In this</p> <p>14 particular instance, I went first because I was keen to</p> <p>15 get this to, if you like, an orthopaedic community, to</p> <p>16 get the message to the orthopaedic community. So that's</p> <p>17 the basis of me going first on it.</p> <p>18 THE EXAMINER: And what is the AANA Journal?</p> <p>19 A. It is a nursing journal, I think. I think it's</p> <p>20 anesthesia ...</p> <p>21 THE EXAMINER: It is in the area of anesthesia and nursing?</p> <p>22 A. Yes. That's my recollection.</p> <p>23 THE EXAMINER: Okay. Yes.</p> <p>24 BY MR. GORDON:</p> <p>25 Q. If you could turn to pages 533 through 538.</p>	<p style="text-align: right;">Page 23</p> <p>1 MICHAEL R. REED</p> <p>2 And if you could just briefly identify what this is?</p> <p>3 A. So this is a paper which I am a sort of middle author,</p> <p>4 if you like, and it's a paper that looks at the</p> <p>5 disturbance of laminar flow with forced air warming</p> <p>6 during a simulated knee replacement.</p> <p>7 Q. And when was this published?</p> <p>8 A. This was published in -- actually, I can't read that on</p> <p>9 the copy. I think 2013.</p> <p>10 MR. HOLL-ALLEN: I see --</p> <p>11 THE EXAMINER: August 2013, at the top of page 534.</p> <p>12 MR. HOLL-ALLEN: Accepted for publication, April 16, 2012,</p> <p>13 I see at the bottom of 533, copyright 2013.</p> <p>14 BY MR. GORDON:</p> <p>15 Q. And the first author on this is Belani, sir?</p> <p>16 A. Yes.</p> <p>17 Q. Again with your permission, I will refer to this study</p> <p>18 as "Belani 2013"; okay?</p> <p>19 A. Okay.</p> <p>20 Q. Then I would like you to turn to pages 540 through 547.</p> <p>21 And again, I will ask you to briefly identify this?</p> <p>22 A. Okay, so this is a paper which looks at two things. One</p> <p>23 is the disturbance of laminar flow using forced air</p> <p>24 warming in a sort of experimental set-up, and it also</p> <p>25 has some clinical data. I would like to discuss the</p>
<p style="text-align: right;">Page 24</p> <p>1 MICHAEL R. REED</p> <p>2 clinical data with you actually. I am sure we are going</p> <p>3 to do that, anyway.</p> <p>4 Q. I can assure you, your wish will be granted.</p> <p>5 A. Yes, but there is something specific I want to bring to</p> <p>6 your attention. So when we get there, I will bring that</p> <p>7 to you.</p> <p>8 Q. Okay. When -- strike that.</p> <p>9 The first author on this is Paul McGovern?</p> <p>10 A. Yes.</p> <p>11 Q. And you are the last author?</p> <p>12 A. Yes.</p> <p>13 Q. And by convention, that makes you the senior author?</p> <p>14 A. In this stance, yes.</p> <p>15 Q. When was this published?</p> <p>16 A. I think 2011.</p> <p>17 Q. So I will again, with your permission, refer to this</p> <p>18 study as "McGovern 2011" and I will probably spend the</p> <p>19 lion's share of my examination on this study.</p> <p>20 So you said you looked at two things; the</p> <p>21 disturbance and then some clinical data.</p> <p>22 Did you do both things essentially simultaneously or</p> <p>23 around the same time, or was one done first and the</p> <p>24 other done with some separation of time in between?</p> <p>25 A. So my recollection is that the sort of experiment, if</p>	<p style="text-align: right;">Page 25</p> <p>1 MICHAEL R. REED</p> <p>2 you like, the mocked-up experiment was done in the</p> <p>3 summer of 2010, which would be sort of in the middle,</p> <p>4 almost in that transition phase of when we were moving</p> <p>5 between the clinical -- you know, the two different</p> <p>6 clinical types of warming.</p> <p>7 Q. And the clinical part of it was done later; is that</p> <p>8 correct?</p> <p>9 A. No. So it sort of straddles it, I think is how I would</p> <p>10 describe it. Because my recollection is that, looking</p> <p>11 at the timings, the theater experiment with the warming,</p> <p>12 et cetera, was done, I think in May of that year, which</p> <p>13 would be 2010.</p> <p>14 Q. When the McGovern study was initially conceived, did you</p> <p>15 initially plan on doing the two different components?</p> <p>16 A. No, I don't think we did.</p> <p>17 Q. What was the one you initially planned to do?</p> <p>18 A. Well, you know, the theater-based, lab-based one, if you</p> <p>19 like, of those two, would be the one that we</p> <p>20 specifically set out. The other one was more</p> <p>21 opportunistic.</p> <p>22 Q. Okay. And so the one that was, sort of, the progenitor</p> <p>23 of this study was the airflow disruption component; is</p> <p>24 that right?</p> <p>25 A. Yes.</p>

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Q. Okay.

How did you come to be interested in that subject?

A. Okay. So I have been trying to recollect the exact order of events; but I am pretty sure I saw a video, which I am sure will be used in some of the evidence, which was smoke coming out of the bottom of a draped theater which was being shown around by Augustine, and I think that was in 2009, perhaps at one of the orthopaedic meetings.

I then heard David Leaper, who I think is another one of your witnesses, speaking at a conference in 2009. And following that, I contacted him by e-mail, actually, and we had an e-mail discussion about his anxiety about the fact that laminar flow was potentially disrupted by forced air.

And then --

THE EXAMINER: Was that the topic of his talk that you heard?

A. I did make some notes on it. I am actually not sure it was. There must have been something in it, in all honesty, because I did e-mail him and the conversation went that way. I have got that e-mail. But there must have been something in his talk that set me off with that discussion.

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And so -- and he at that point, I think, was a consultant for Augustine.

BY MR. GORDON:

Q. Are you talking about Professor David Leaper?

A. Yes. And in late 2009, we did an experiment in our theater, which was comparing forced air warming with conductive fabric warming, which was the Augustine product.

Q. Also known as the Hot Dog?

A. The Hot Dog. And that involved getting a -- essentially sucking air in, onto culture plates, to see whether there was an increased bacteria load in the theater.

And we did that with a microbiologist. There was a minor celebrity microbiologist who was a bit of a TV personality at that time who came up and did that with us, and they went off and cultured the air, if you like, that sucked onto these plates.

Q. What --

A. So --

Q. What were the results of that?

A. So what that showed was that there was no difference in contamination, whether you use forced air warming or not.

Q. Who financed that study?

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A. So that was financed by Augustine. He gave our department £5,000 for that.

Q. How did you connect with Dr. Augustine for that financing? In other words, did he come to you, did you go to him? Was there some other ...?

A. Yes, I am not even sure I had met him, but it was through David Leaper. David Leaper essentially arranged that. But I know the money was coming from Augustine. I don't think I had met him at that point.

Q. Okay.

So Professor Leaper arranged for funding from Augustine for you to do a microbiological study?

A. Yes. And David Leaper came as well and we did it on a weekend in theater.

Q. I have to ask. How does a microbiologist become a TV celebrity?

A. So my recollection is, it was something about the sort of -- where bacteria grow and everything. She wasn't a celebrity for that long actually, but she was a slightly colorful character and she was good for TV, I think.

Q. Was this done at one specific hospital?

A. Yes.

Q. Which one?

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A. Wansbeck.

Q. Okay. Is Wansbeck your primary hospital or was it back then?

A. Yes.

Q. Is it still today?

A. It is much more gray now, but it's where my office is.

But I am not sure I operate any more there than I do anywhere else.

Q. Back in that 2009 timeframe, that would have been where you did more surgeries?

A. Yes.

Q. Did -- at that time period in 2009, did Northumbria Hospital Trust have its own microbiology staff?

A. Yes.

Q. Did you involve any of them in this project?

A. No. I think they probably wouldn't have been too keen because, you know, these things involve costs and hassle for the lab techs. So they are not too keen on doing ad hoc experiments like that in the microbiology department.

Q. So the people involved in this were you, Professor Leaper, this -- the celebrity microbiologist; and anyone else?

A. Yes. There would be one or two trainees, of which



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I can't actually recollect who they were.

Q. Do you recall if Paul McGovern was involved in this project?

A. Yes, I think he probably was. He was actually. He was definitely involved, because subsequently he submitted the abstract.

THE EXAMINER: Because?

A. Because he submitted the paper. So when you do the work, you send it to a meeting and hopefully someone listens.

BY MR. GORDON:

Q. Did you send it to --

A. The Hip Society.

Q. The British Hip Society?

A. Yes.

Q. As a -- for a publication or a presentation or for something else? We have learned that there are different ways of presenting research.

A. Yes, so it would have been for a presentation. So you stand up for ten minutes and you tell everyone about your paper. And I think there's a sort of downgraded category which is a poster, so that's just -- you get to stand next to a laminated sheet about what you did.

Q. So this was submitted to the British Hip Society as

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a proposed presentation, presumably to a meeting of the British Hip Society?

A. Yes, so 200 or 300 people, probably. Hip surgeons go to that meeting.

Q. And Dr. McGovern was the primary author of this presentation?

A. Yes, I think so.

Q. Was Augustine, as the funder, notified of the results of this -- of your test?

A. So I don't know about officially. I would be surprised if he didn't know. I mean, that paper, it wasn't accepted by the Hip Society, because it didn't -- negative papers unfortunately don't tend to get a lot of air time.

Q. Let's -- I want to make sure that, when the U.S. jury hears this, they understand what you mean by that. What -- in science medical research, what does a negative paper mean?

A. So what we are saying there is that that paper showed there was no difference between the two warming methods. There was no bacterial contamination between the two that we could ascertain; based on what we did.

Q. So -- and what would a positive paper mean?

A. Where one is better than the other.

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Q. So in your experience, a paper that shows a difference is more likely to be accepted for publication or presentation or posters or something; is that basically what you are saying?

A. I think that's true, yes. Well, that's definitely true. That's well known.

Q. Did you or anyone connected with this research attempt to submit the results of this study to any other forum or journal or anything else?

A. So it may have been submitted to other meetings. I wouldn't necessarily know. Sometimes trainees do submit things; particularly when they have been submitted once, they do submit them to other places. But it wasn't presented, I am pretty sure, anywhere in the end, because it was -- if it was submitted elsewhere, it was rejected.

Q. So would Dr. McGovern have been the person --

A. Yes.

Q. -- doing that? So he is the best person to ask?

A. Exactly.

Q. We will get to do that later this week.

When you actually did this study and found out that there was no difference in bacteria, did that have any impact on how you viewed the issue of disruption of --

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potential disruption of airflow?

A. So certainly it had an impact, because you have to look at it and say: well, okay, there's no difference. But we had seen, you know, the videos of the -- of air moving from outside of the, you know, essentially the Augustine smoke videos which I am sure you have seen, which show that air is mobilized out -- from the floor, for instance, up into the theater.

So I mean, yes, it's reassuring. And you know, the abstract is pitched as such. But I didn't -- it didn't put it to bed for me, if that's the question.

Q. So after you had done this microbiology study, Dr. Leaper and Dr. McGovern, or Professor Leaper -- or Mr. Leaper, I think. I get the term --

A. He is a Dr. again actually. A bit more confusing, but ...

Q. Okay. If I call you guys "Dr.", please, this is no disrespect. It is just my default position; it is my default salutation of respect.

When the three of you and anyone else -- microbiologists did this study, was there a discussion amongst any of you, after the negative results came out from the British Hip Society that it was not interested in a presentation that: maybe we should look at

<p style="text-align: right;">Page 34</p> <p>1                   MICHAEL R. REED</p> <p>2           something else, some other aspect of this?</p> <p>3   MR. ASSAAD: Objection to form.</p> <p>4   THE EXAMINER: You may answer.</p> <p>5   A. Well, I think we did go on. With that particular group,</p> <p>6           and the microbiologists, we did not take it any further.</p> <p>7           But we did go on quite separately, it must have been</p> <p>8           seven or eight months later, to do the experiment we</p> <p>9           talked about before, in the -- but it wasn't related as</p> <p>10          such.</p> <p>11   THE EXAMINER: Which experiment was that?</p> <p>12   A. That was the one that's in this McGovern et al paper.</p> <p>13          That's the one that was in the theater, in the middle of</p> <p>14          2010.</p> <p>15   THE EXAMINER: Okay.</p> <p>16   A. But it was -- yes. I mean, that was then, at that</p> <p>17          point, unfunded. I was already asking -- well, I had</p> <p>18          asked in 2009 for a randomized trial to be funded by</p> <p>19          Augustine, but that wasn't forthcoming.</p> <p>20   BY MR. GORDON:</p> <p>21   Q. How would you have communicated it to Augustine?</p> <p>22   A. Through David Leaper.</p> <p>23   Q. What was the reason you were told that Augustine wasn't</p> <p>24          going to fund a randomized trial?</p> <p>25   A. I think I wasn't particularly told that. I think I was</p>	<p style="text-align: right;">Page 35</p> <p>1                   MICHAEL R. REED</p> <p>2           told that we would start with the smaller stuff, like</p> <p>3           the sort of bacteria one that we just talked about. And</p> <p>4           then that was negative.</p> <p>5   MR. ASSAAD: I will make an objection to the last question</p> <p>6           as hearsay.</p> <p>7   THE EXAMINER: You may answer.</p> <p>8   A. Sorry, what was the question again; sorry?</p> <p>9   BY MR. GORDON:</p> <p>10   Q. I forgot too.</p> <p>11   A. Okay. We have all forgotten.</p> <p>12   Q. I am just trying to understand the sequence. So --</p> <p>13          well, let's step back for a second.</p> <p>14          What's a randomized trial?</p> <p>15   A. Okay. So a randomized trial is when you essentially --</p> <p>16          you design the experiments, so things happen at random,</p> <p>17          so they are not being driven by anything else. So then</p> <p>18          you can decide ultimately what the effect -- what the</p> <p>19          effect of that is, and then you can ascribe it to</p> <p>20          a particular thing.</p> <p>21          So these, in fact, are randomized trials, these</p> <p>22          experiments in the operating theaters, because you are</p> <p>23          essentially doing things at random and then you are</p> <p>24          measuring the effect of that and you will come to the</p> <p>25          conclusion that one thing is better than the other.</p>
<p style="text-align: right;">Page 36</p> <p>1                   MICHAEL R. REED</p> <p>2           But what I was asking Augustine for was a randomized</p> <p>3           clinical trial, where you essentially take a patient and</p> <p>4           you -- before you do the operation, you assign them at</p> <p>5           random to having forced air warming or an alternative,</p> <p>6           and then you measure what happens to those patients.</p> <p>7   Q. In the hierarchy of research, where does a randomized</p> <p>8          clinical trial fall?</p> <p>9   A. So a randomized clinical trial falls almost at the top.</p> <p>10          So the very best level of evidence is when you get</p> <p>11          multiple randomized trials and you see the effect of</p> <p>12          them; better analysis of randomized trials. But</p> <p>13          a randomized trial, you know, a large well constructed</p> <p>14          randomized trial would be a very good level of evidence.</p> <p>15   Q. Are they costly?</p> <p>16   A. Yes. I would have thought a trial to look at this</p> <p>17          particular thing would be probably 1.5, £2 million to</p> <p>18          do.</p> <p>19   Q. Is that typical for a randomized clinical trial?</p> <p>20   A. Of that sort of scale, I mean, you would need lots and</p> <p>21          lots of patients. So yes, that would be pretty typical.</p> <p>22          It would be cheaper in the U.K. than it would be in the</p> <p>23          U.S.</p> <p>24   Q. Why would you need -- I will strike that.</p> <p>25          Was there something about this, where you would need</p>	<p style="text-align: right;">Page 37</p> <p>1                   MICHAEL R. REED</p> <p>2           more patients than other kinds of randomized trials, or</p> <p>3           just that -- that's the nature of the beast; you need</p> <p>4           lots of patients?</p> <p>5   A. It is because infection is relatively unusual. You need</p> <p>6          to have lots of patients to show the effect of different</p> <p>7          intervention. So an infection that occurred in half the</p> <p>8          patients, you wouldn't need many patients to show that</p> <p>9          one treatment was significantly better than the others.</p> <p>10   Q. And when you say "infection" and "usual", are you</p> <p>11          speaking specifically in joint arthroplasty?</p> <p>12   A. Yes.</p> <p>13   Q. Had you ever done any estimate of the number of patients</p> <p>14          who would have to be involved, to have a valid</p> <p>15          randomized clinical trial that would look at the issue</p> <p>16          of the impact of warming modality on joint infections?</p> <p>17   MR. ASSAAD: Objection. I am going to object that this is</p> <p>18          outside the scope of the subject areas on the list of</p> <p>19          the sealed order. Unless he is discussing about the</p> <p>20          stuff that he's done in the past in respect to his own</p> <p>21          studies, if he has ever done that kind of analysis. But</p> <p>22          a reference to a hypothetical and future study, I don't</p> <p>23          think that is part of the sealed order about calculating</p> <p>24          sample sizes. And if counsel would wish to point to</p> <p>25          a certain area, I would be happy to review it, but</p>

<p style="text-align: right;">Page 38</p> <p>1                   MICHAEL R. REED</p> <p>2           I have not seen it in the order.</p> <p>3   A. Do you want me to answer or ...?</p> <p>4   MR. ASSAAD: Hold on.</p> <p>5   A. Hold on.</p> <p>6   THE EXAMINER: Mr. Gordon?</p> <p>7   MR. GORDON: Yes?</p> <p>8   THE EXAMINER: Well, do you accept that objection or do you</p> <p>9       say it is within the scope?</p> <p>10   MR. GORDON: No. It's -- we are trying to get his</p> <p>11       background and his involvement in the development of</p> <p>12       these studies. And he sought funding from Augustine for</p> <p>13       a randomized clinical trial. He was denied it.</p> <p>14   THE EXAMINER: Yes.</p> <p>15   MR. GORDON: And I am trying to find out what, if any,</p> <p>16       additional steps he took to gain funding and to --</p> <p>17       I will let the matter drop.</p> <p>18   THE EXAMINER: I don't think your question had anything to</p> <p>19       do with that at all. If you had restricted to that,</p> <p>20       then I don't suppose there would be an objection. So</p> <p>21       shall we treat that question as withdrawn and go to --</p> <p>22       something which goes to: what steps he did take to</p> <p>23       secure funding?</p> <p>24   BY MR. GORDON:</p> <p>25   Q. Sure. When Augustine said "no", was that the end of</p>	<p style="text-align: right;">Page 39</p> <p>1                   MICHAEL R. REED</p> <p>2           your interest in a randomized clinical trial on this</p> <p>3           issue?</p> <p>4   A. No. I think -- I don't think we got to specific numbers</p> <p>5       with Augustine or even a specific cost, but it was like</p> <p>6       an expression of interest, I would say.</p> <p>7       So yes, over the years, I have done quite a few</p> <p>8       trials now, looking at infections at the end point and</p> <p>9       it depends on what -- as well as how rare the outcome</p> <p>10       is, like infection, it's also --</p> <p>11   MR. ASSAAD: Objection. He's answered the same initial</p> <p>12       question as before. This is going into something that</p> <p>13       he has done in the past -- the studies that are the</p> <p>14       subject matter of this case, the subject of his work.</p> <p>15   MR. GORDON: I am guessing that even in England, it's</p> <p>16       considered improper to interrupt a witness in the middle</p> <p>17       of an answer.</p> <p>18   THE EXAMINER: Well, if this question shouldn't have been</p> <p>19       asked, then he is entitled to ...</p> <p>20       The schedule B does seem to be, apart from a few</p> <p>21       items at the top about useful knowledge of the</p> <p>22       patient-warming device and factors that influence</p> <p>23       infection control practices, restricted to specific</p> <p>24       studies; not studies that weren't done or funded. It's</p> <p>25       studies that have been produced.</p>
<p style="text-align: right;">Page 40</p> <p>1                   MICHAEL R. REED</p> <p>2   MR. GORDON: It also -- and this was a vigorous point of</p> <p>3       discussion. It relates to the relationship with funding</p> <p>4       sources and the fact of Augustine and Augustine</p> <p>5       companies.</p> <p>6   THE EXAMINER: Where is that? Unless I am missing a page,</p> <p>7       which I am not.</p> <p>8   MR. ASSAAD: Just for the record, I assume that we could all</p> <p>9       rely on the draft order that's been submitted to the</p> <p>10       Senior Master, as the current live ...?</p> <p>11   THE EXAMINER: I assume schedule B has not been touched?</p> <p>12   MR. HOLL-ALLEN: Schedule B has not been touched. And in</p> <p>13       fact, the order that was sent to the Master on Friday</p> <p>14       was made by the Master. So it is not a draft.</p> <p>15   THE EXAMINER: No, no, no, but we have to rely on the</p> <p>16       previous version.</p> <p>17   MR. HOLL-ALLEN: Yes, indeed. So if I can intervene at this</p> <p>18       point. It is correct that if one turns, for example, to</p> <p>19       the second page of schedule B, within the scope of this</p> <p>20       deposition are communications or any potential</p> <p>21       communications with Dr. Augustine, Augustine Temperature</p> <p>22       Management and the like.</p> <p>23   THE EXAMINER: About the studies?</p> <p>24   MR. HOLL-ALLEN: Well, that was the point that I was moving</p> <p>25       on to make. Every paragraph is qualified in that way.</p>	<p style="text-align: right;">Page 41</p> <p>1                   MICHAEL R. REED</p> <p>2   THE EXAMINER: Well, I assume that was part of your</p> <p>3       objections you were taking at the time the order was</p> <p>4       made, to tie it down to specific published studies.</p> <p>5   MR. HOLL-ALLEN: And to be fair to the defendants, the way</p> <p>6       in that respect, in which they were putting it.</p> <p>7   THE EXAMINER: Okay.</p> <p>8   MR. HOLL-ALLEN: As I understood it.</p> <p>9   THE EXAMINER: So Mr. Gordon, can we stick to the studies</p> <p>10       that were done, rather than the studies that were not</p> <p>11       done?</p> <p>12   MR. GORDON: Actually, no. With all due respect, and I can</p> <p>13       get to the documents where Mr. Reed is pushing the issue</p> <p>14       of a randomized clinical trial, e-mails back and forth</p> <p>15       with Dr. Augustine, with Mr. Albrecht, about: the better</p> <p>16       way to go would be a randomized clinical trial. We will</p> <p>17       get to those.</p> <p>18   THE EXAMINER: But that is not within the scope of the</p> <p>19       schedule B.</p> <p>20   MR. GORDON: With all due respect, sir, it is, because --</p> <p>21   THE EXAMINER: Where?</p> <p>22   MR. GORDON: It relates to the communications, relating to</p> <p>23       these studies; the ones that were published.</p> <p>24   THE EXAMINER: Yes. Well, I don't understand how</p> <p>25       communications about unpublished studies relates to</p>

<p style="text-align: right;">Page 42</p> <p>1                   MICHAEL R. REED</p> <p>2           communications about published studies.</p> <p>3   MR. GORDON: The communications about published studies</p> <p>4           relate to criticisms of the published studies and the</p> <p>5           way to respond to and address those criticisms and why</p> <p>6           things were or were not done on a particular --</p> <p>7   THE EXAMINER: Let's look at the e-mails.</p> <p>8   MR. GORDON: That is what we are --</p> <p>9   THE EXAMINER: Let's get to the e-mails. I am not persuaded</p> <p>10           at the moment. If you show me relevant e-mails, I may</p> <p>11           be persuaded.</p> <p>12   MR. GORDON: I will get to it, but you know --</p> <p>13   THE EXAMINER: No, I am not going to allow this type of</p> <p>14           questioning to continue, unless you lay a basis with</p> <p>15           proper e-mail references to this witness. I am simply</p> <p>16           not going to allow it to continue.</p> <p>17   MR. GORDON: That is fine. I appreciate that Mr. Reed is</p> <p>18           kind of cutting to the chase and getting things out,</p> <p>19           that I will get to eventually. So I will stick to the</p> <p>20           documents. I apologize. This is going to take a little</p> <p>21           bit longer this way.</p> <p>22   BY MR. GORDON:</p> <p>23   Q. Let's go to the McGovern paper, and I want to focus on</p> <p>24           the second part of the study, the comparison or the --</p> <p>25           what you described as the clinical component.</p>	<p style="text-align: right;">Page 43</p> <p>1                   MICHAEL R. REED</p> <p>2           A. Yes. I would like to speak to you about that.</p> <p>3   THE EXAMINER: Well, let's get to it first, where it is; so</p> <p>4           that those of us who are not familiar with this document</p> <p>5           can identify it.</p> <p>6   A. So 540.</p> <p>7   THE EXAMINER: Yes, I have got that. Where in the document</p> <p>8           are you talking about?</p> <p>9   MR. GORDON: I think the discussion begins on page 543 and</p> <p>10           it kind of intertwines a little bit, but --</p> <p>11   THE EXAMINER: Can I suggest, Mr. Reed, that you allow Mr.</p> <p>12           Gordon to ask his questions and answer them and then</p> <p>13           before we leave this document, you can make any point</p> <p>14           you wish to make about it, unless you think it is</p> <p>15           essential for you to lay down your marker before you</p> <p>16           answer questions about it.</p> <p>17   A. I would prefer to do that, if that is okay.</p> <p>18   THE EXAMINER: Fine. Do it that way.</p> <p>19   A. So when I was reading this documentation yesterday and</p> <p>20           going through e-mails, it's clear to me that some of the</p> <p>21           data on the clinical side of the paper is wrong,</p> <p>22           slightly wrong. It doesn't affect the conclusion of the</p> <p>23           paper and there's still a significant difference. But</p> <p>24           there is, in fact, one more infection in each group.</p> <p>25           Now, this was e-mailed to Mark Albrecht and he did</p>
<p style="text-align: right;">Page 44</p> <p>1                   MICHAEL R. REED</p> <p>2           reply to it and, in fact, it's in your documents; the</p> <p>3           e-mail correspondence. And he says he will put it into</p> <p>4           the main paper and, in fact, he then says he has put it</p> <p>5           in the main paper, but unfortunately it's slightly old</p> <p>6           data that is in the main paper. It does not affect the</p> <p>7           conclusion in any way, but nevertheless it is not the</p> <p>8           latest data they have got in there, and I don't know why</p> <p>9           that is.</p> <p>10   THE EXAMINER: If Mr. Gordon points you to that specific</p> <p>11           section, then you can identify it for us.</p> <p>12   A. I will ...</p> <p>13   BY MR. GORDON:</p> <p>14   Q. I am sure we will get to those details.</p> <p>15           Just broadly speaking, the clinical component of it</p> <p>16           was a retrospective observation analysis of infection</p> <p>17           data; is that correct?</p> <p>18   A. So I mean, the data is collected prospectively. So it</p> <p>19           is not that we look back. It is collected live. So it</p> <p>20           is prospective in that sense, but I would say it is</p> <p>21           opportunistic, because we had made the change and then</p> <p>22           we looked to see what happened. The data is</p> <p>23           prospective.</p> <p>24   Q. Was the data being collected -- were the data being</p> <p>25           collected for purposes of doing this study?</p>	<p style="text-align: right;">Page 45</p> <p>1                   MICHAEL R. REED</p> <p>2           A. No. We collect data routinely and we have</p> <p>3           a surveillance team, so that is essentially nursing</p> <p>4           staff, of which I think we had three at that time, whose</p> <p>5           job it is purely to look at infection rates, if you</p> <p>6           like.</p> <p>7   Q. Okay. So just again, in broadbrush terms. You had and</p> <p>8           have a body of infection data and what this study did</p> <p>9           was to look back at a particular time period; is that</p> <p>10           correct?</p> <p>11   A. Well, we collect --</p> <p>12   MR. ASSAAD: Objection, misstates the prior testimony.</p> <p>13   THE EXAMINER: You may answer.</p> <p>14   A. We collect the data as we go, if you like, and we have</p> <p>15           done since probably, I think, 2007/2008.</p> <p>16   BY MR. GORDON:</p> <p>17   Q. What is the reference on page 533 to --</p> <p>18   THE EXAMINER: 543?</p> <p>19   BY MR. GORDON:</p> <p>20   Q. 543, thank you. For demographic information on relevant</p> <p>21           risk factors for surgical site infections, SSI,</p> <p>22           collected for primary hip and knee replacement</p> <p>23           procedures performed at our hospitals -- hospital during</p> <p>24           a 2.5-year period starting 1st July, 2008?</p> <p>25   MR. ASSAAD: Where are you reading? I am sorry.</p>

<p style="text-align: right;">Page 46</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: At the top of --</p> <p>3 MR. GORDON: At the beginning of the text on page --</p> <p>4 MR. ASSAAD: Oh, thank you.</p> <p>5 THE EXAMINER: Sorry, what was the question arising out of</p> <p>6 that?</p> <p>7 BY MR. GORDON:</p> <p>8 Q. What does that refer to?</p> <p>9 A. Well, that's essentially the data that we collect on</p> <p>10 patients as they come in and have a joint replacement.</p> <p>11 Q. Did you just start collecting that data on 1st July,</p> <p>12 2008?</p> <p>13 A. I think that's probably about right, yes. That's when</p> <p>14 we went to full-time surveillance. We didn't have</p> <p>15 a surveillance team. We had part-time surveillance. So</p> <p>16 in England, there's the -- the NHS law is that you have</p> <p>17 to submit the one quarter every year, one operation</p> <p>18 infection rates. And we moved to full-time surveillance</p> <p>19 in that time. So we had a complete handle on infection</p> <p>20 rates from that point.</p> <p>21 Q. And at the end of that 2.5-year period, did you stop</p> <p>22 collecting data?</p> <p>23 A. No. We still collect data.</p> <p>24 Q. The 2.5-year period is the -- would be the time period</p> <p>25 of the McGovern paper; right? That's -- it's just</p>	<p style="text-align: right;">Page 47</p> <p>1 MICHAEL R. REED</p> <p>2 a finding that what -- the book-ends of the study?</p> <p>3 A. Yes.</p> <p>4 Q. Okay.</p> <p>5 So when you -- at the start date of 1st July, 2008,</p> <p>6 patients were being warmed with the Bair Hugger; is that</p> <p>7 correct?</p> <p>8 A. Yes.</p> <p>9 Q. And at some point, you transitioned over from warming</p> <p>10 patients with the Bair Hugger to warming them with the</p> <p>11 Hot Dog; is that correct?</p> <p>12 A. Yes.</p> <p>13 Q. And at some point, you were fully transitioned and only</p> <p>14 had -- were only using the Hot Dog?</p> <p>15 A. Yes.</p> <p>16 Q. Is that correct?</p> <p>17 A. Yes.</p> <p>18 Q. So there were really three periods in that 2.5 years.</p> <p>19 The first period being Bair Hugger only; the second</p> <p>20 period being transition; and the third period being</p> <p>21 Hot Dog; is that correct?</p> <p>22 A. Yes.</p> <p>23 Q. What was the period of Hot Dog only use?</p> <p>24 A. So that's in the paper. It's from -- it was something</p> <p>25 like June till -- until the end of December.</p>
<p style="text-align: right;">Page 48</p> <p>1 MICHAEL R. REED</p> <p>2 Q. Of ...?</p> <p>3 THE EXAMINER: Where is this?</p> <p>4 A. So this is page 546. And it's the chart which has been</p> <p>5 written on.</p> <p>6 THE EXAMINER: Oh, I see.</p> <p>7 BY MR. GORDON:</p> <p>8 Q. So June to December 2010?</p> <p>9 A. Yes, I think it's June.</p> <p>10 MS. ZIMMERMAN: What page was this?</p> <p>11 MR. HOLL-ALLEN: 546. This is the table ...</p> <p>12 BY MR. GORDON:</p> <p>13 Q. Would that be seven months?</p> <p>14 A. It feels about right. Six or seven months.</p> <p>15 MR. ASSAAD: There's markings on this page. Did you</p> <p>16 mark ...</p> <p>17 THE EXAMINER: I am a bit confused to where the proper lines</p> <p>18 are, in the light of all these ...</p> <p>19 So you used the Bair Hugger from July 2008 to</p> <p>20 March -- February/March 2010?</p> <p>21 A. No. So the -- what's the best way to explain this</p> <p>22 chart? So if you can try and ignore the scribbles.</p> <p>23 THE EXAMINER: Yes, I am trying to.</p> <p>24 MR. HOLL-ALLEN: Sir, I am sorry to interrupt. In the</p> <p>25 plaintiffs' file, there is a clean copy of the same</p>	<p style="text-align: right;">Page 49</p> <p>1 MICHAEL R. REED</p> <p>2 document.</p> <p>3 THE EXAMINER: Thank you. I don't have the plaintiffs'</p> <p>4 file.</p> <p>5 MR. ASSAAD: And I would prefer to use that, because it</p> <p>6 seems that this document was used during the Albrecht</p> <p>7 deposition that was taken in October(?) 2016 and I had</p> <p>8 to have -- these markings could influence the witness's</p> <p>9 testimony today. So I would rather have a clean copy.</p> <p>10 THE EXAMINER: That is another reason. The principal reason</p> <p>11 is that it's virtually impossible to understand, with</p> <p>12 all these markings on it.</p> <p>13 MR. HOLL-ALLEN: Would you like to use my copy, sir?</p> <p>14 THE EXAMINER: No, it is more important that you have it</p> <p>15 than I do.</p> <p>16 BY MR. GORDON:</p> <p>17 Q. Well, let's skip that chart. If you go back to</p> <p>18 page 543 --</p> <p>19 MR. ASSAAD: Are you moving on to the ...</p> <p>20 MR. GORDON: No, that was the ...</p> <p>21 THE EXAMINER: Which one of these is ...?</p> <p>22 A. I think --</p> <p>23 BY MR. GORDON:</p> <p>24 Q. Under "Joint infection data", there is a reference to:</p> <p>25 a transition of warming -- forced air warming to</p>

<p style="text-align: right;">Page 50</p> <p>1                   MICHAEL R. REED</p> <p>2           conductive fabric was made in all pre-selected</p> <p>3           orthopaedic theaters starting on 1st March, 2010, and</p> <p>4           ending on 1st June, 2010.</p> <p>5   A. Yes.</p> <p>6   Q. So that the transition period would be March, April, May</p> <p>7           of 2010; correct?</p> <p>8   A. Yes.</p> <p>9   Q. So that would be three months?</p> <p>10   A. Yes, that looks right.</p> <p>11   THE EXAMINER: So prior to March 1st, 2010 it was</p> <p>12           Bair Hugger. And after 1st June, it was Hot Dog.</p> <p>13   A. Yes.</p> <p>14   THE EXAMINER: Thank you.</p> <p>15   BY MR. GORDON:</p> <p>16   Q. So the Bair Hugger only period was July --</p> <p>17   A. July 2008.</p> <p>18   Q. July 2008 to the end of February 2010?</p> <p>19   A. Yes.</p> <p>20   Q. And --</p> <p>21   A. Yes.</p> <p>22   Q. And after those three months, there was use of both</p> <p>23           Hot Dog and Bair Hugger.</p> <p>24   A. (Nods.)</p> <p>25   Q. Is that right? You have to say "yes" or "no".</p>	<p style="text-align: right;">Page 51</p> <p>1                   MICHAEL R. REED</p> <p>2   A. Oh sorry, yes.</p> <p>3   Q. That is all right. And the last seven months of the</p> <p>4           period you looked at, it was Hot Dog only; is that</p> <p>5           right?</p> <p>6   A. So is it seven months or six?</p> <p>7   Q. June, July, August, September, October, November,</p> <p>8           December.</p> <p>9   MR. HOLL-ALLEN: Seven.</p> <p>10   A. Seven. There you go.</p> <p>11   BY MR. GORDON:</p> <p>12   Q. So the Bair Hugger only period was 20 months; is that</p> <p>13           right?</p> <p>14   A. Well, it was that time, certainly. That feels right.</p> <p>15   THE EXAMINER: 20 months.</p> <p>16   BY MR. GORDON:</p> <p>17   Q. How -- were the data that you looked at collected at</p> <p>18           more than one hospital?</p> <p>19   A. No.</p> <p>20   Q. Which hospital were these data from?</p> <p>21   A. Wansbeck Hospital.</p> <p>22   Q. Do you recall how you initially gathered the data for</p> <p>23           analysis?</p> <p>24   A. So the data is gathered by a team of nurses,</p> <p>25           surveillance nurses. That's their job. That's what</p>
<p style="text-align: right;">Page 52</p> <p>1                   MICHAEL R. REED</p> <p>2           they do. That's all they do.</p> <p>3   Q. I was being a little bit more ministerial in my</p> <p>4           question. If you go to the file cabinet and pull it</p> <p>5           out, is it computerized data, is it ...?</p> <p>6   A. Ah, so I asked them to -- I mean, the way this works is</p> <p>7           that we have a report which is produced, of which</p> <p>8           there's some in here actually, which is all the various</p> <p>9           operations that are done, the risk factors those</p> <p>10           patients have and then the outcomes they have; which is</p> <p>11           generated by the hospital systems.</p> <p>12           But infection is a difficult one. You can't rely on</p> <p>13           computers to sort of diagnose that, or you can't rely on</p> <p>14           coding. So it's a specific -- you need a specific team.</p> <p>15           So they have got that and then they have added their</p> <p>16           call on whether there is an infection or not, to that.</p> <p>17   Q. Let me ask you to take a look in volume 3, at pages 788</p> <p>18           through 1081.</p> <p>19           (Exhibit Reed 3 marked for identification.)</p> <p>20   MR. ASSAAD: 7 ...?</p> <p>21   BY MR. GORDON:</p> <p>22   Q. 788 through 1081.</p> <p>23           Does that look familiar to you?</p> <p>24   A. Yes.</p> <p>25   Q. Is that the form of the data on infections that you</p>	<p style="text-align: right;">Page 53</p> <p>1                   MICHAEL R. REED</p> <p>2           would have pulled and provided to your co-authors?</p> <p>3   A. Yes.</p> <p>4   Q. Who did the actual data analysis?</p> <p>5   A. For this paper, Mark Albrecht.</p> <p>6   Q. So were these data, pages 788 through 1081, provided by</p> <p>7           you to Mr. Albrecht?</p> <p>8   MR. ASSAAD: Objection, lack of foundation.</p> <p>9   THE EXAMINER: You may answer.</p> <p>10   A. I expect so. I don't remember that, but I imagine</p> <p>11           I did. There was nothing on here that would -- you</p> <p>12           know, there is no data governance issues with this. So</p> <p>13           I think, I am almost certain I would have provided it.</p> <p>14   THE EXAMINER: Well, it starts on 1st October, 2007,</p> <p>15           according to page 788.</p> <p>16   A. Yes. I mean, he wouldn't have analyzed that; but this</p> <p>17           data goes back, in fact, to 2002.</p> <p>18   MR. ASSAAD: I would just like a clarification for my</p> <p>19           objection. I am uncertain whether or not this witness</p> <p>20           is saying that this is exactly what he gave or used,</p> <p>21           or whether he says it looks like it, but he is not</p> <p>22           clear. I just want a clarification.</p> <p>23   THE EXAMINER: Which is it, Mr. Reed?</p> <p>24   A. In all honesty, it looks like it. I don't know if it is</p> <p>25           what I gave. But I don't know where he would have got</p>

<p style="text-align: right;">Page 54</p> <p>1                   MICHAEL R. REED</p> <p>2               it, if it wasn't from me.</p> <p>3   MR. ASSAAD: Do you know whether or not it is accurate?</p> <p>4   A. I don't know.</p> <p>5   MR. ASSAAD: All right. Objection, lack of foundation</p> <p>6               with any questions regarding this -- this spreadsheet,</p> <p>7               without authenticity or proof that it is accurate -- an</p> <p>8               accurate picture of the data that Mr. Reed may have</p> <p>9               used --</p> <p>10   THE EXAMINER: We have your objection. Yes, Mr. Gordon.</p> <p>11   MR. GORDON: Now I know why you have those paginated ones.</p> <p>12               That was my set.</p> <p>13   THE EXAMINER: No, they came from ...</p> <p>14   MR. GORDON: The two that I ...</p> <p>15   THE EXAMINER: You can have it back.</p> <p>16               (Off the record remarks.)</p> <p>17   BY MR. GORDON:</p> <p>18   Q. On exhibit 10 -- actually, strike that.</p> <p>19               In volume 3, exhibit 3, the data spreadsheet from</p> <p>20               788 to 1081; under column B, "Site", there are a series</p> <p>21               of two letters. Do you know what those letters stand</p> <p>22               for?</p> <p>23   A. So this is the -- the hospitals that are performing</p> <p>24               joint replacements. So "HX" would be Hexham. "NT"</p> <p>25               would be North Tyneside. And WG would be Wansbeck.</p>	<p style="text-align: right;">Page 55</p> <p>1                   MICHAEL R. REED</p> <p>2   Q. So these are the data for all three of those hospitals</p> <p>3               for the time period --</p> <p>4   A. It looks like that, yes.</p> <p>5   Q. I think if you turn to page 1082 and 1083, this is</p> <p>6               a document -- we can tell by the Bates numbers, let's</p> <p>7               say Augustine 0005490 and 5491. This was sequentially</p> <p>8               accompanying the spreadsheets that were produced,</p> <p>9               pursuant to the subpoena to Dr. Augustine, produced by</p> <p>10              Dr. Augustine.</p> <p>11              Does pages 1082 through 1083 look familiar to you?</p> <p>12   MR. ASSAAD: Objection to the -- objection, assumes facts</p> <p>13              not in evidence. Another objection as to speculation.</p> <p>14   THE EXAMINER: You can answer.</p> <p>15   A. Yes. It looks familiar to me.</p> <p>16   BY MR. GORDON:</p> <p>17   Q. There is a reference to a Mike Reed database. Do you</p> <p>18              know what that maybe refers to?</p> <p>19   A. Well, this is the explanatory table, if you like, for</p> <p>20              all of those dots and dashes that we have just been</p> <p>21              looking at.</p> <p>22   Q. Are you talking about pages 788 through 1081; is that</p> <p>23              right?</p> <p>24   A. Yes.</p> <p>25   Q. So what columns in the large spreadsheet tell us when</p>
<p style="text-align: right;">Page 56</p> <p>1                   MICHAEL R. REED</p> <p>2               a given patient has had an infection?</p> <p>3   MR. ASSAAD: Objection, lack of foundation. I would like to</p> <p>4               have a standing objection with regards to the</p> <p>5               foundation. Is that acceptable?</p> <p>6   THE EXAMINER: Yes.</p> <p>7   MR. ASSAAD: So this document --</p> <p>8   THE EXAMINER: You have your objection on the record. It</p> <p>9               applies to the whole document. I understand.</p> <p>10   MR. ASSAAD: Well, and every question. I don't want to</p> <p>11              waive any objections.</p> <p>12   THE EXAMINER: No. Sorry, repeat the question, Mr. Gordon?</p> <p>13              Which column is in the ...</p> <p>14   BY MR. GORDON:</p> <p>15   Q. In the 788 through 1081 that we looked at, do we find</p> <p>16              an indication that there has been an infection?</p> <p>17   A. So as I said before, there's -- this database is looking</p> <p>18              at the -- where it was done, the complications and the</p> <p>19              co-morbidities.</p> <p>20              This database is then given to the surgical site</p> <p>21              infection surveillance team and then they populate it</p> <p>22              with a field at the end. This is what they have done in</p> <p>23              this -- certainly some of these cases.</p> <p>24              So it is an additional field. Like I said, it is</p> <p>25              not collected by computer. It is done by an actual</p>	<p style="text-align: right;">Page 57</p> <p>1                   MICHAEL R. REED</p> <p>2               surveillance team whose job it is just to do that. So</p> <p>3               it is not from hospital episode statistics, which is</p> <p>4               where this has come from.</p> <p>5   THE EXAMINER: This is a record of all hip and knee</p> <p>6               operations, is it?</p> <p>7   A. Yes, yes.</p> <p>8   THE EXAMINER: Where do we find an identification of which</p> <p>9               ones resulted in an infection; which column?</p> <p>10   A. I am not sure it is on this. It might be on this.</p> <p>11   MR. GORDON: On the --</p> <p>12   A. There are some. If you look at page 1051, it's --</p> <p>13              unfortunately it is not very helpful, because it's</p> <p>14              printed out across many, many pages.</p> <p>15   THE EXAMINER: Yes, I understand that.</p> <p>16   A. But if you see in cell 4602 --</p> <p>17   THE EXAMINER: 1051.</p> <p>18   A. There is one identified there and the bugs are next to</p> <p>19              it.</p> <p>20   MR. GORDON: So since this is an Excel spreadsheet, it is --</p> <p>21              rather than having it over half the length of the table,</p> <p>22              it is printed on multiple pages. But if we look back</p> <p>23              for the identifier 4602 --</p> <p>24   THE EXAMINER: If you look back at what?</p> <p>25   BY MR. GORDON:</p>

<p style="text-align: right;">Page 58</p> <p>1 MICHAEL R. REED</p> <p>2 Q. On page 1047, 4602, that coding would indicate that this</p> <p>3 was something that was done at Wansbeck General; is that</p> <p>4 right?</p> <p>5 MR. ASSAAD: Objection, leading.</p> <p>6 A. Sorry, what page are you on; sorry?</p> <p>7 MR. GORDON: 1047.</p> <p>8 A. What was the cell number?</p> <p>9 BY MR. GORDON:</p> <p>10 Q. Let's track 460 to -- all the way through; and I won't</p> <p>11 ask a leading question.</p> <p>12 What hospital was 4602 performed at?</p> <p>13 A. Well, it's a little tricky to tell, given they are</p> <p>14 all -- running from the sheets. But 4602? I can't</p> <p>15 really see it, with the quality of this print.</p> <p>16 Q. On 1047 you can't, under column B?</p> <p>17 A. Yes. On 4602, I can't identify it. 4602. Yes, I think</p> <p>18 I can read it here. It was Wansbeck General. Patient</p> <p>19 aged 76. Is that right?</p> <p>20 Q. And what type of procedure was it?</p> <p>21 A. A hip replacement.</p> <p>22 Q. What was the date of the surgery?</p> <p>23 A. The --</p> <p>24 THE EXAMINER: Is yours a very poor copy? Because mine is</p> <p>25 quite clear.</p>	<p style="text-align: right;">Page 59</p> <p>1 MICHAEL R. REED</p> <p>2 A. I am struggling to focus, unfortunately, with the light</p> <p>3 in my eyes. It is very small. I probably need to wear</p> <p>4 glasses. 15 September, 2010, I would say.</p> <p>5 BY MR. GORDON:</p> <p>6 Q. And when -- if we go back to the page that I pointed</p> <p>7 out, 1051, under 4602, under the column "BF", what does</p> <p>8 that tell us?</p> <p>9 A. What page are you on now?</p> <p>10 Q. 1051.</p> <p>11 A. On 4602, it says: "infection Staph Epidermis".</p> <p>12 Q. Is there a date indicated there?</p> <p>13 A. Yes. It looks like -- sorry, I can't really focus.</p> <p>14 THE EXAMINER: 3rd October.</p> <p>15 A. 3rd October, 2010.</p> <p>16 BY MR. GORDON:</p> <p>17 Q. And what does that date refer to?</p> <p>18 A. I suspect -- I don't know. Probably the diagnosis date.</p> <p>19 Q. What was the -- in the McGovern study, what was the time</p> <p>20 period of surveillance that you included? In other</p> <p>21 words, how long after the surgery was an infection one</p> <p>22 that got counted in your study?</p> <p>23 A. 60 days.</p> <p>24 Q. So if the surgery -- if 4602 was performed on</p> <p>25 15th September, 2010 and diagnosed on 3rd October, 2010,</p>
<p style="text-align: right;">Page 60</p> <p>1 MICHAEL R. REED</p> <p>2 would that have been included or excluded in your count?</p> <p>3 A. When was the surgery done, sorry?</p> <p>4 Q. It was done on 15th September, 2010.</p> <p>5 A. It would be included.</p> <p>6 Q. Okay. And what is staph epidermis?</p> <p>7 MR. HOLL-ALLEN: Epidermis.</p> <p>8 A. So yes, it is a bacteria. It is a fairly common sort of</p> <p>9 infection in a joint replacement.</p> <p>10 BY MR. GORDON:</p> <p>11 Q. How was that column, the "BG" column populated? Is it</p> <p>12 before or after this has been reviewed by the</p> <p>13 surveillance team?</p> <p>14 A. Well, they populate it.</p> <p>15 Q. Okay.</p> <p>16 A. They populate it.</p> <p>17 Q. So if there's a "yes" and a date and a bacteria</p> <p>18 indicated, does that indicate that that has already been</p> <p>19 identified and confirmed by the surveillance process?</p> <p>20 A. Yes. I mean, that's -- they have written it. The only</p> <p>21 caveat, I would say, is that some people will be</p> <p>22 ultimately removed if they are hip replacements for</p> <p>23 trauma. That is the only caveat, I would say, but ...</p> <p>24 THE EXAMINER: If there is ...?</p> <p>25 A. If it is a hip replacement that has been done for</p>	<p style="text-align: right;">Page 61</p> <p>1 MICHAEL R. REED</p> <p>2 trauma. So if they have fallen and broken their hip,</p> <p>3 then they fall in a different classification system</p> <p>4 because they are much higher risk. So generally they</p> <p>5 have got their own surveillance. We do still measure</p> <p>6 them, but they don't fall into planned joint replacement</p> <p>7 territory.</p> <p>8 BY MR. GORDON:</p> <p>9 Q. It appears at 1060, there is a category under "AZ" that</p> <p>10 describes the -- whether it is trauma or non-trauma?</p> <p>11 MR. ASSAAD: What page?</p> <p>12 MR. GORDON: 1060.</p> <p>13 MR. ASSAAD: 1060.</p> <p>14 A. I am not sure that would be a reliable way of saying</p> <p>15 whether it was trauma or not. It seems to me, that's</p> <p>16 the way the hospital is paid. And it's -- I think, do</p> <p>17 you have DRGs in the States? But it's essentially --</p> <p>18 it's the way they are paid. I wouldn't necessarily rely</p> <p>19 on saying that's trauma or not.</p> <p>20 THE EXAMINER: Well, every one on the page, I think, apart</p> <p>21 from one, refers to a non-trauma category. Is that</p> <p>22 a fairly accurate indication?</p> <p>23 A. I mean, it might be. But I think there are sometimes</p> <p>24 operations that fall into different groups, because</p> <p>25 that's a very wide group.</p>



<p style="text-align: right;">Page 62</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: Okay.</p> <p>3 A. I mean, there is an enormous amount of operations that</p> <p>4 fall into those groups. You are probably right, but</p> <p>5 I don't -- I think a coder wouldn't rely on that to say</p> <p>6 whether it was trauma or not.</p> <p>7 BY MR. GORDON:</p> <p>8 Q. When you initially saw a printout of data for use in the</p> <p>9 McGovern study, did you limit it to non-trauma, hip and</p> <p>10 knee surgeries?</p> <p>11 MR. ASSAAD: Objection, misstates the prior testimony. Lack</p> <p>12 of foundation. He never stated he saw a printout.</p> <p>13 THE EXAMINER: You can answer.</p> <p>14 A. So normally, the patients you get on here are elective.</p> <p>15 So there will be some that come on, that are not</p> <p>16 elective, and then they will be removed by the</p> <p>17 surveillance team and put -- not actually removed, but</p> <p>18 put into a different category of joint replacement.</p> <p>19 BY MR. GORDON:</p> <p>20 Q. When you compiled the data for the McGovern study, did</p> <p>21 you in any way try to separate the trauma and the</p> <p>22 non-trauma patients?</p> <p>23 MR. ASSAAD: Objection, misstates the prior testimony.</p> <p>24 THE EXAMINER: You may answer.</p> <p>25 A. I mean, we definitely attempted to do that, because this</p>	<p style="text-align: right;">Page 63</p> <p>1 MICHAEL R. REED</p> <p>2 database is meant to be just planned cases, just</p> <p>3 elective cases.</p> <p>4 BY MR. GORDON:</p> <p>5 Q. Okay. And by --</p> <p>6 A. But we do know that other ones get in through coding and</p> <p>7 then they will be taken out in the sort of data cleaning</p> <p>8 process.</p> <p>9 Q. By this database, you mean the 788 through 1050 -- 1081?</p> <p>10 A. So you know, before we would publish, if you like, on</p> <p>11 infection rates, then we would go through it, we would</p> <p>12 check every case is as -- you know, every case, whether</p> <p>13 the infection is trauma or not. You might by chance end</p> <p>14 up pulling one out, you might not. I am not aware</p> <p>15 whether we did with this study.</p> <p>16 Q. Okay. The data here, on 788 through 1081, as Mr. Dyer</p> <p>17 pointed out, began on 1st October, 2007. What was your</p> <p>18 reasoning for commencing the Bair Hugger only period on</p> <p>19 1st July, 2008?</p> <p>20 A. So my recollection is that we got a full-time</p> <p>21 surveillance team at that point. So as I said,</p> <p>22 previously in the U.K. you only have to do a quarter.</p> <p>23 Actually, you can choose which operation you do. So you</p> <p>24 might not have full-time surveillance prior to that.</p> <p>25 THE EXAMINER: So one operation, one quartile, per annum?</p>
<p style="text-align: right;">Page 64</p> <p>1 MICHAEL R. REED</p> <p>2 A. Correct. That's the national standard. But we have</p> <p>3 moved to doing every operation full-time; and that's why</p> <p>4 we have got that reliable data. So there would be big</p> <p>5 gaps in the period. If you looked at 2006, you might</p> <p>6 only have a quarter of the year populated, which would</p> <p>7 be very unreliable data.</p> <p>8 THE EXAMINER: Yes.</p> <p>9 BY MR. GORDON:</p> <p>10 Q. So I really want to drill down on the timing; and that</p> <p>11 is critical. I am going to ask you to take a look at</p> <p>12 volume 2, pages 487 through 490.</p> <p>13 A. Okay.</p> <p>14 Q. Have you seen this before?</p> <p>15 A. I saw it yesterday.</p> <p>16 Q. Is that the first time you saw it?</p> <p>17 A. I'm not sure.</p> <p>18 MR. ASSAAD: I am going to object for lack of foundation for</p> <p>19 any questions being asked, if he hasn't established</p> <p>20 foundation. He has written this document -- the</p> <p>21 authorship of this document --</p> <p>22 THE EXAMINER: You have made your objection. Keep</p> <p>23 objections short.</p> <p>24 MR. ASSAAD: Well, I need to put all the objections for the</p> <p>25 U.S. court.</p>	<p style="text-align: right;">Page 65</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: I know.</p> <p>3 MR. GORDON: They are all preserved.</p> <p>4 THE EXAMINER: I am familiar with how U.S. attorneys --</p> <p>5 MR. ASSAAD: They are --</p> <p>6 MR. GORDON: The only objection is: waives form or</p> <p>7 foundation.</p> <p>8 MR. ASSAAD: I am only doing it for trial --</p> <p>9 BY MR. GORDON:</p> <p>10 Q. Do you know who Julie Gillson is?</p> <p>11 A. Yes. Julie Gillson was one of our matrons.</p> <p>12 Q. What is a matron?</p> <p>13 A. So it is a senior nurse, essentially.</p> <p>14 Q. Was she one of the SSI surveillance nurses?</p> <p>15 A. No. So Julie is a matron, so the senior nurse within</p> <p>16 surgery, if you like. Gail Lowdon leads the surgical</p> <p>17 site infection surveillance team.</p> <p>18 Q. And if you look at the front page of this document. At</p> <p>19 page 71, the very last paragraph, it says during --</p> <p>20 THE EXAMINER: Where are you?</p> <p>21 BY MR. GORDON:</p> <p>22 Q. Page 71. Oh, I am sorry.</p> <p>23 THE EXAMINER: 487.</p> <p>24 MR. GORDON: 487, thank you. Page 487, the last full</p> <p>25 paragraph on the page:</p>

<p style="text-align: right;">Page 66</p> <p>1 MICHAEL R. REED</p> <p>2 "During the last two quarters of 2008/2009,</p> <p>3 Northumbria Healthcare NHS Foundation Trust was</p> <p>4 reporting SSI rates in the combined total of surgeries</p> <p>5 in the THR/TKR and repair neck of femur between</p> <p>6 3.5 percent and 5.7 percent and was regularly receiving</p> <p>7 letters from the HPA informing the trust of its high</p> <p>8 outlier status for SSI."</p> <p>9 First of all, did I read that correctly?</p> <p>10 A. Yes.</p> <p>11 MR. ASSAAD: Objection. Move to strike for hearsay.</p> <p>12 BY MR. GORDON:</p> <p>13 Q. Did --</p> <p>14 THE EXAMINER: (Overspeaking.) ... moving on to</p> <p>15 a question --</p> <p>16 MR. ASSAAD: He can't read evidence in, without establishing</p> <p>17 a foundation. I am saying this is hearsay. He is</p> <p>18 reading someone else's words into the record. He is</p> <p>19 basically advocating this point. Objection for hearsay.</p> <p>20 BY MR. GORDON:</p> <p>21 Q. Do you recall there being a period of time when the</p> <p>22 Northumbria Healthcare Trust was getting letters from</p> <p>23 the HPA about SSI rates?</p> <p>24 A. Yes.</p> <p>25 Q. And what were those -- first of all, what is the HPA?</p>	<p style="text-align: right;">Page 67</p> <p>1 MICHAEL R. REED</p> <p>2 A. So the HPA is the Health Protection Agency and they are</p> <p>3 the group that collate the national database, based on</p> <p>4 people collecting it locally. So Gail Lowdon who leads</p> <p>5 our surgical site infection surveillance team, a member</p> <p>6 of her team will be uploading that information</p> <p>7 nationally, if you like, to the Health Protection</p> <p>8 Agency.</p> <p>9 The issue with that is that not every trust puts in</p> <p>10 the data as we have established; and the infection rates</p> <p>11 that they quote are very low and, in fact, they have --</p> <p>12 I mean, the government advisers on infection have</p> <p>13 publicly written to say that their quotes -- they quote</p> <p>14 very low infection rates, unrealistically low, because</p> <p>15 the surveillance system is poor in many trusts?</p> <p>16 THE EXAMINER: Do you have a recollection of these letters</p> <p>17 being received?</p> <p>18 A. Yes.</p> <p>19 THE EXAMINER: Okay.</p> <p>20 BY MR. GORDON:</p> <p>21 Q. And what did Northumbria do in response to those</p> <p>22 letters?</p> <p>23 A. So I mean, we have done lots of things, as I think has</p> <p>24 become clear. We have made loads of changes over</p> <p>25 a period, a sustained period, to try and reduce the</p>
<p style="text-align: right;">Page 68</p> <p>1 MICHAEL R. REED</p> <p>2 infection rates.</p> <p>3 Q. Was there any type of a committee or a working group</p> <p>4 formed?</p> <p>5 A. Yes. So there was a surgical site infection prevention</p> <p>6 committee, which I chair.</p> <p>7 Q. And when was that formed?</p> <p>8 A. It may actually even be on here. About 2008, maybe even</p> <p>9 2007. That sort of timescale.</p> <p>10 Q. And that's your independent recollection?</p> <p>11 A. Yes.</p> <p>12 Q. So the reason I say that is that on page 548, it says</p> <p>13 that the multiple -- a multi-disciplinary team formed</p> <p>14 the trust SSI group and the first meeting took place in</p> <p>15 December 2008.</p> <p>16 A. There you go then.</p> <p>17 Q. Well, if you --</p> <p>18 THE EXAMINER: What is the --</p> <p>19 BY MR. GORDON:</p> <p>20 Q. If your recollection is different than what is here --</p> <p>21 A. Yes, I think that feels right and she would know. What</p> <p>22 I would say is that we may have been doing stuff before</p> <p>23 that, before we did a formal meeting, but it would not</p> <p>24 have been long before that.</p> <p>25 Q. And there is a reference in the next paragraph to:</p>	<p style="text-align: right;">Page 69</p> <p>1 MICHAEL R. REED</p> <p>2 "The first action point of this meeting was to place</p> <p>3 a successful bid to appoint two full-time SSI nurses on</p> <p>4 a 12-month secondment."</p> <p>5 MR. ASSAAD: Objection, hearsay.</p> <p>6 BY MR. GORDON:</p> <p>7 Q. And my question is: was there -- were there full-time</p> <p>8 SSI nurses prior to whenever this multi-disciplinary</p> <p>9 group first met?</p> <p>10 A. Yes, so the -- the surveillance was done -- I mean, we</p> <p>11 should probably go back one step.</p> <p>12 So we were named in the paper, based on the 2007</p> <p>13 data, as having a high infection rate. And after that,</p> <p>14 we went to full-time surveillance, some time probably in</p> <p>15 early 2008, but we didn't have the business case and</p> <p>16 people -- and people formally appointed to those rules.</p> <p>17 They were being done, I think, by infection control,</p> <p>18 rather than by a surveillance team. Same methodology.</p> <p>19 MR. ASSAAD: I am going to object again to those line of</p> <p>20 questions. It is not part of the subject matter of the</p> <p>21 sealed order. It has nothing to do with the studies</p> <p>22 that he has been performing, that it has been limited</p> <p>23 to -- by the Senior Master.</p> <p>24 THE EXAMINER: He is still in the --</p> <p>25 MR. ASSAAD: I mean, we -- well, it really isn't. It is</p>

<p style="text-align: right;">Page 70</p> <p>1 MICHAEL R. REED</p> <p>2 dealing with what these two people wrote, regarding</p> <p>3 infection control that they set up a committee to do</p> <p>4 a bunch of stuff, that has nothing to do with the</p> <p>5 McGovern study, the Belani study or any of the other</p> <p>6 studies.</p> <p>7 THE EXAMINER: Well, at the moment, it seems to me that it</p> <p>8 relates to the McGovern study.</p> <p>9 MR. ASSAAD: How does it relate --</p> <p>10 MR. GORDON: It relates exclusively to the McGovern study</p> <p>11 and it is the category of the infection control</p> <p>12 procedures.</p> <p>13 MR. ASSAAD: Procedures, but not how they set it up, who is</p> <p>14 on the committee, what the history is --</p> <p>15 MR. GORDON: Well, your objection is noted, Gabriel. Let's</p> <p>16 start this game playing.</p> <p>17 THE EXAMINER: Let's proceed.</p> <p>18 MR. ASSAAD: Stop what?</p> <p>19 MR. GORDON: Game playing.</p> <p>20 MR. ASSAAD: Okay. Don't accuse me of playing games, sir.</p> <p>21 THE EXAMINER: Let's get on with the questions.</p> <p>22 BY MR. GORDON:</p> <p>23 Q. Mr. Reed, if you turn on to page 421 of the same ...</p> <p>24 THE EXAMINER: Where are we?</p> <p>25 BY MR. GORDON:</p>	<p style="text-align: right;">Page 71</p> <p>1 MICHAEL R. REED</p> <p>2 Q. 421. Can you identify the people in that?</p> <p>3 A. So the lady in red is a nurse and the lady in black is</p> <p>4 the surgical site infection coordinator, if you like.</p> <p>5 I am in that photo. And the other guy is -- I couldn't</p> <p>6 tell you his name, but he was from one of the companies.</p> <p>7 Q. Do you know what he is holding?</p> <p>8 A. Yes. Some -- it is like an award for reducing infection</p> <p>9 rates.</p> <p>10 Q. And the award from whom to who?</p> <p>11 THE EXAMINER: I must say, I do not think this is assisting</p> <p>12 our progress very much, studying this photograph.</p> <p>13 MR. GORDON: No, I agree.</p> <p>14 THE EXAMINER: Let's get back to the paper.</p> <p>15 MR. GORDON: Again, I keep getting diverted. I want to get</p> <p>16 the timeline of the infection control changes. That is</p> <p>17 the sole interest I have --</p> <p>18 THE EXAMINER: How does looking at this photograph advance</p> <p>19 that?</p> <p>20 MR. GORDON: We are going to get foundation objections up</p> <p>21 the wazoo about everything else, all -- piece by piece.</p> <p>22 BY MR. GORDON:</p> <p>23 Q. Mr. Reed, in this photograph, what's behind you, behind</p> <p>24 them, on the wall?</p> <p>25 A. Well, it is a timeline of the changes we have made.</p>
<p style="text-align: right;">Page 72</p> <p>1 MICHAEL R. REED</p> <p>2 I think it is the same one that's in the paper you just</p> <p>3 showed here.</p> <p>4 Q. Now, if you would turn to page 436. This document</p> <p>5 actually goes from 436 up to 457 -- excuse me, 451.</p> <p>6 It's a copy of a July 2012 operating theater journal.</p> <p>7 Are you familiar with that publication?</p> <p>8 A. Yes, probably, yes.</p> <p>9 Q. And if you turn to page 446 --</p> <p>10 MR. ASSAAD: Objection, lack of established foundation for</p> <p>11 use of this document in questioning the witness.</p> <p>12 BY MR. GORDON:</p> <p>13 Q. Is that you in that picture?</p> <p>14 A. I think it is the same picture.</p> <p>15 Q. Okay. And do you recall seeing this publication?</p> <p>16 A. I saw it yesterday. I may have seen it at the time.</p> <p>17 I don't -- I don't remember it. I remember the</p> <p>18 photograph being taken, I think.</p> <p>19 Q. Do you remember receiving an HAI Watchdog Award in 2011?</p> <p>20 A. Yes. I think that's what he's got in his hand.</p> <p>21 Q. Do you remember being interviewed by anybody about that</p> <p>22 award?</p> <p>23 A. Not explicitly, but it's -- it's not unlikely.</p> <p>24 Q. How did the award come to be awarded to Northumbria?</p> <p>25 Did it come out of the blue? Did somebody apply for it?</p>	<p style="text-align: right;">Page 73</p> <p>1 MICHAEL R. REED</p> <p>2 MR. ASSAAD: Objection. How is this award within the scope</p> <p>3 of the McGovern paper?</p> <p>4 THE EXAMINER: I don't understand, I confess, Mr. Gordon,</p> <p>5 how what you have been doing for the last ten minutes</p> <p>6 assists us with accurate dates at all.</p> <p>7 MR. GORDON: Because I want to get back to the chart with</p> <p>8 the dates, but I have got these --</p> <p>9 THE EXAMINER: Where do you get a date that assists from</p> <p>10 this page?</p> <p>11 BY MR. GORDON:</p> <p>12 Q. Well, let me ask you, Mr. Reed. Did you submit</p> <p>13 an application for an award, an HAI Watchdog Award for</p> <p>14 success for reducing infections?</p> <p>15 MR. ASSAAD: Same objection.</p> <p>16 A. So I may have done. It would have been me or the</p> <p>17 nursing staff that did it, I imagine. I mean, we</p> <p>18 applied for lots of awards over the years. That would</p> <p>19 be not unusual.</p> <p>20 BY MR. GORDON:</p> <p>21 Q. Would you have expected that application to have</p> <p>22 said: the only thing we did to reduce infections was to</p> <p>23 change from forced air warming to the Hot Dog?</p> <p>24 MR. ASSAAD: Objection, calls for speculation. Lack of</p> <p>25 foundation.</p>

<p style="text-align: right;">Page 74</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: Do you remember what you included in the</p> <p>3 application for the award?</p> <p>4 A. I don't remember. I don't actually make any</p> <p>5 application, but I may have done.</p> <p>6 THE EXAMINER: Well, you may have done anything. We are</p> <p>7 dealing with probabilities, rather than what may have</p> <p>8 happened.</p> <p>9 A. Yes. Well, it would have been made by me or by</p> <p>10 Gail Lowdon, I imagine. Would we have said --</p> <p>11 MR. ASSAAD: I would like a ruling. I don't think he should</p> <p>12 answer that question, if he doesn't recall --</p> <p>13 THE EXAMINER: No, fine. No, I am ruling that he does not</p> <p>14 need to answer that question.</p> <p>15 BY MR. GORDON:</p> <p>16 Q. Was the only thing that you -- you won the award for,</p> <p>17 was for changing the warming modalities, or were there</p> <p>18 other infection control things that you did in the --</p> <p>19 MR. ASSAAD: Objection, outside the scope.</p> <p>20 THE EXAMINER: Let's get back to the documents, rather than</p> <p>21 the award.</p> <p>22 MR. ASSAAD: Ask him not to answer that question.</p> <p>23 THE EXAMINER: That has no part within schedule B.</p> <p>24 BY MR. GORDON:</p> <p>25 Q. Did you change -- I will direct your attention to</p>	<p style="text-align: right;">Page 75</p> <p>1 MICHAEL R. REED</p> <p>2 page 425.</p> <p>3 MR. ASSAAD: Sorry, what page?</p> <p>4 MR. GORDON: The document is 425 through 431.</p> <p>5 A. Yes, I have got that, yes.</p> <p>6 BY MR. GORDON:</p> <p>7 Q. And specifically page 427. Again, it says "Mike Reed as</p> <p>8 a consultant orthopaedic surgeon." Do you see that?</p> <p>9 A. (Nods.)</p> <p>10 Q. Is this something you recall ever seeing before?</p> <p>11 A. Well, I definitely saw it yesterday. I don't recall if</p> <p>12 I have seen this before or not. It's obviously written</p> <p>13 about me, rather than by me. Whether I would have</p> <p>14 given -- been given the opportunity to sign it off,</p> <p>15 I don't know.</p> <p>16 Q. Well, do you recall being interviewed by the Clinical</p> <p>17 Services Journal?</p> <p>18 A. I don't think this was an interview. I think this</p> <p>19 was -- this is based upon a presentation, I think,</p> <p>20 rather than an interview.</p> <p>21 Q. Okay.</p> <p>22 A. I could be wrong, but that was my impression yesterday.</p> <p>23 Q. Well, let's turn to page 453. The document goes from</p> <p>24 453 through 457. Do you recognize that?</p> <p>25 A. Yes.</p>
<p style="text-align: right;">Page 76</p> <p>1 MICHAEL R. REED</p> <p>2 Q. Okay.</p> <p>3 THE EXAMINER: What is the JTO? Journal of Trauma and</p> <p>4 Orthopaedics?</p> <p>5 A. Yes.</p> <p>6 BY MR. GORDON:</p> <p>7 Q. You were one of the authors of this?</p> <p>8 A. Yes.</p> <p>9 Q. If you turn to page 454.</p> <p>10 MR. ASSAAD: Just for the record: when you use these</p> <p>11 documents, can you identify the Bates number, the title</p> <p>12 of the document and establish foundation before asking</p> <p>13 questions? Page number and title, so we know for the</p> <p>14 record, so the record is clear and clean?</p> <p>15 BY MR. GORDON:</p> <p>16 Q. On page 454 in that box, that column, what are those --</p> <p>17 under "Management", what are each of those items</p> <p>18 contended to be?</p> <p>19 A. So essentially there's risk factors for infection, so</p> <p>20 this is identifying certain patient groups that are more</p> <p>21 likely to get infections; so patients who are obese,</p> <p>22 patients who smoke.</p> <p>23 Q. Let's focus on the second --</p> <p>24 A. And then perioperative factors. These are things maybe</p> <p>25 that you can influence, as opposed to not.</p>	<p style="text-align: right;">Page 77</p> <p>1 MICHAEL R. REED</p> <p>2 Q. And you describe this as a summary table of common</p> <p>3 prevention tactics; is that right?</p> <p>4 A. Yes.</p> <p>5 Q. And towards the bottom, you say you maintain</p> <p>6 normothermia as one of the prevention tactics; right?</p> <p>7 A. Yes, I think that's right, one of the ... yes.</p> <p>8 Q. And your skin prep, you say you use an alcohol pre-wash,</p> <p>9 followed by a 2 percent chlorhexidine-alcohol scrub; is</p> <p>10 that right?</p> <p>11 A. Whereabouts is that? Yes, okay. Well, that's what we</p> <p>12 said.</p> <p>13 MR. ASSAAD: I am going to object to the --</p> <p>14 A. Actually, we said -- or betadine actually, so --</p> <p>15 MR. GORDON: Okay.</p> <p>16 MR. ASSAAD: Lack of foundation to his --</p> <p>17 THE EXAMINER: Did you say lack of foundation? That is</p> <p>18 fine. That is the standard objection made by U.S.</p> <p>19 attorneys.</p> <p>20 MR. ASSAAD: Okay. Well --</p> <p>21 THE EXAMINER: They don't go on and explain the basis for</p> <p>22 it, in my experience.</p> <p>23 MR. ASSAAD: In depositions, no. But I say the --</p> <p>24 THE EXAMINER: This is a deposition.</p> <p>25 MR. ASSAAD: To be raised at trial.</p>

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BY MR. GORDON:

Q. Did there come a time when you switched the skin prep that you used at Wansbeck?

A. Yes. It is on the timeline somewhere.

Q. What did you switch from and what did you switch to?

A. So we would have switched from a variety of things. It is surgeon preference. To -- I think we switched maybe at the end of 2010, the very end of 2010.

Q. Do you recall there being a period of time that the laminar air system at Wansbeck required repair?

A. Yes.

Q. What was wrong with it?

A. Well, this was -- it wasn't in all theaters, but in particular theaters, essentially it wasn't functioning properly.

Q. How did you come to learn that?

A. We had a guy come and assess it, an expert.

Q. Was -- had you noticed some problem or was this a routine assessment?

A. So I mean, I think as we made clear, we were trying to reduce the infection rates. We made a number of changes. We made -- you know, we were looking everywhere we could, trying to get a marginal gain on reducing infection rates. And that's the basis for

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getting them all checked.

Q. Were any of the procedures in the Bair Hugger only period performed in the operating room that needed repair of the laminar airflow system?

A. In truth, I am not sure when those dates are. It might be on the timeline; is it?

Q. Did you have any hand in preparing the timeline?

THE EXAMINER: I am sorry. I missed the question.

BY MR. GORDON:

Q. You --

THE EXAMINER: I just did not hear it.

A. Did I have a hand in preparing the timeline?

THE EXAMINER: Right.

A. Certainly over the years I have.

BY MR. GORDON:

Q. There's no way you can read the one in that -- in the article. So I took the liberty, for my sake, if you have -- of printing out a larger version of it.

THE EXAMINER: How does this relate to the studies that we are concerned with?

MR. ASSAAD: I agree.

THE EXAMINER: I have not been able to have a copy that I can read.

MR. GORDON: I understand that. I am going to pass you

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a copy that you can read.

MR. ASSAAD: Can I have a copy that I can read?

THE EXAMINER: If other counsel in the room could have a copy of it, so that they can read.

MR. GORDON: Well, they are younger. They can probably read that one.

MR. ASSAAD: I want the same copy that you are giving him.

MR. GORDON: Okay. Well, I don't have it.

THE EXAMINER: My question is: how does this relate to any of the studies with which -- to which this witness's evidence is confined?

MR. GORDON: Mr. Dyer, with all due respect, this is a --

THE EXAMINER: No, it is a simple question.

MR. GORDON: Yes. And if you -- the timeframe that the Bair Hugger only was compared to the Hot Dog only, and resulting in a 74 percent reductions in infections, happens to coincide with a whole bunch of other infection control practices.

THE EXAMINER: Why don't you put that to the witness?

MR. GORDON: That is what I am trying to get to.

THE EXAMINER: Dear God, we must have been trying to do it for about an hour now.

MR. GORDON: Well, I am sorry I don't have the exquisite skills to go right to the point.

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THE EXAMINER: Well, then, get right to the point --

BY MR. GORDON:

Q. Is this the timeline you have been referring to, Mr. Reed? And we will mark this separately as, I guess, exhibit 5. So we will put copies in the record. (Exhibit Reed 5 marked for identification.)

MR. ASSAAD: We have --

THE EXAMINER: I am sure you do.

A. Yes. I mean, I am sure this was produced in my department. I am not sure when or how up to date it is. I can't verify it. But I imagine it's correct there or thereabouts.

MR. ASSAAD: Can we mark this as an exhibit, since we have produced this?

THE EXAMINER: I think Mr. Gordon --

MR. GORDON: I just said we will mark it as an exhibit.

MR. ASSAAD: I am going to object to whatever exhibit this is, based on the lack of foundation. The witness has just said he didn't create it.

BY MR. GORDON:

Q. Just to clarify, and I think the record is clear. But did you -- were you involved in the creation of the timeline?

A. I definitely have been involved in the creation of the

<p style="text-align: right;">Page 82</p> <p>1 MICHAEL R. REED</p> <p>2 timeline over the years. It is a live document; that is</p> <p>3 what I would say. So it's not fire and forget. It is</p> <p>4 kind of updated as we go. So this is quite -- probably</p> <p>5 quite a recent one.</p> <p>6 Q. But maybe not the most recent one?</p> <p>7 A. Yes.</p> <p>8 MR. ASSAAD: Leading.</p> <p>9 BY MR. GORDON:</p> <p>10 Q. Was there a switch in your hospital's -- in the</p> <p>11 antibiotic use for hip and knee replacement surgeries,</p> <p>12 where you switched from cefuroxime to gentamicin?</p> <p>13 A. Yes, so this is obviously made clear in the paper that</p> <p>14 we wrote, with -- you know, this is based on caveats and</p> <p>15 this is all in the paper that we wrote.</p> <p>16 THE EXAMINER: Which paper are you referring to?</p> <p>17 A. The McGovern paper.</p> <p>18 THE EXAMINER: Right, okay.</p> <p>19 A. The one that has got the clinical data, if you like.</p> <p>20 These riders are clear in the paper that we have --</p> <p>21 THE EXAMINER: Some of us haven't had the opportunity to</p> <p>22 look at the paper before today at any time; so that is</p> <p>23 why, Mr. Gordon, your route is somewhat unclear to me.</p> <p>24 So you are saying the paper contains caveats as to</p> <p>25 other matters that have changed during the period?</p>	<p style="text-align: right;">Page 83</p> <p>1 MICHAEL R. REED</p> <p>2 A. Yes.</p> <p>3 THE EXAMINER: Thank you.</p> <p>4 BY MR. GORDON:</p> <p>5 Q. Is it correct that the cefuroxime was switched to</p> <p>6 gentamicin in August 2007; is that correct?</p> <p>7 A. The dates that are in the paper -- actually, that isn't</p> <p>8 in the paper. That's beyond -- that's well beyond it.</p> <p>9 That is before the paper. Yes, so that feels right.</p> <p>10 Q. And is there any reference in the McGovern paper to the</p> <p>11 hospital having switched from cefuroxime to gentamicin</p> <p>12 in 2007?</p> <p>13 A. I don't think so, but it's before the -- it's well</p> <p>14 before the time period, isn't it?</p> <p>15 Q. Well, there is a reference in the paper to switching</p> <p>16 from gentamicin only to the lower dose of gentamicin and</p> <p>17 adding teicoplanin?</p> <p>18 A. Mm-hm, which was in the time period of the paper, of</p> <p>19 the ...</p> <p>20 Q. Well, the switch from cefuroxime to gentamicin, that</p> <p>21 occurred before you started the Bair Hugger only period</p> <p>22 that you were looking at; right?</p> <p>23 A. Yes.</p> <p>24 Q. So what -- and the gentamicin reduction and addition of</p> <p>25 teicoplanin, is it correct that that occurred in the</p>
<p style="text-align: right;">Page 84</p> <p>1 MICHAEL R. REED</p> <p>2 beginning of March 2009?</p> <p>3 A. The data in the paper, if you've got the paper there in</p> <p>4 front of you, then that will be right.</p> <p>5 Q. Okay.</p> <p>6 THE EXAMINER: Just remind me where the McGovern paper is?</p> <p>7 MR. HOLL-ALLEN: 540.</p> <p>8 THE EXAMINER: Thank you.</p> <p>9 MR. HOLL-ALLEN: There are details of the changes in the</p> <p>10 antibiotic regime at 543, reflected in the column ...</p> <p>11 MR. GORDON: Thank you.</p> <p>12 BY MR. GORDON:</p> <p>13 Q. So when did the switch from gentamicin only to</p> <p>14 gentamicin plus teicoplanin take place?</p> <p>15 A. So from July 2008 to February 2009, a single dose of</p> <p>16 gentamicin was given, 4.5 milligrams per kilogram.</p> <p>17 In March 2009, this was changed to teicoplanin,</p> <p>18 400 milligrams, and gentamicin, 3 milligrams per</p> <p>19 kilogram. And then I go on to talk about the gentamicin</p> <p>20 and the cement.</p> <p>21 THE EXAMINER: The gentamicin, briefly, is ...?</p> <p>22 A. It is an antibiotic which is effective against many of</p> <p>23 the bacteria that cause infections.</p> <p>24 BY MR. GORDON:</p> <p>25 Q. And in fact, though, you have said it should not be used</p>	<p style="text-align: right;">Page 85</p> <p>1 MICHAEL R. REED</p> <p>2 as a prophylactic -- by itself as a prophylactic</p> <p>3 antibiotic in hip and knee arthroplasties; correct?</p> <p>4 A. So the main reason for our switch, in fact, was renal</p> <p>5 failure; because it is a high dose of gentamicin that we</p> <p>6 were having to give, 4.5 milligrams per kilogram. And</p> <p>7 that was, we felt, damaging a proportion of our</p> <p>8 patients. So we switched to gentamicin because we had</p> <p>9 to move -- we had to stop using cefuroxime. That</p> <p>10 became, if you like, almost illegal in the U.K., to</p> <p>11 use --</p> <p>12 THE EXAMINER: To use?</p> <p>13 A. The cefuroxime change in 2007 was driven by the NHS, the</p> <p>14 big NHS, if you like, and it's because it has</p> <p>15 an association with Clostridium difficile infection. So</p> <p>16 the big NHS --</p> <p>17 THE EXAMINER: I think that is a terminology that is</p> <p>18 familiar in this country, but not necessarily to the</p> <p>19 U.S. attorneys. Could you repeat that?</p> <p>20 A. So it is a diarrhoeal infection which is associated with</p> <p>21 antibiotic use. And there is a big government campaign</p> <p>22 to reduce Clostridium difficile rates, a bit like MRSA</p> <p>23 maybe in the United States. So the executives of the</p> <p>24 trust are charged with reducing rates of Clostridium</p> <p>25 difficile. One of the ways of doing that would be to</p>

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 2 stop using cefuroxime in the hospital. So that's what  
 3 happened to us back in 2007.  
 4 THE EXAMINER: So that came from above?  
 5 A. It was driven from above.  
 6 THE EXAMINER: But your change to a gentamicin mix, what  
 7 came from active patient experience?  
 8 A. Yes. So there was two things. We -- we have written  
 9 a paper on this, which is probably somewhere in there.  
 10 But that, from memory, showed an increase in infection  
 11 rates and an increase in renal failure rates; and  
 12 a significant reduction in Clostridium difficile,  
 13 reduced by three patients.  
 14 BY MR. GORDON:  
 15 Q. Are you talking about the switch from cefuroxime to  
 16 gentamicin; it reduced the Clostridium difficile, but  
 17 you had an increase in infection and ...?  
 18 A. Yes, I don't know -- I genuinely don't know, but I am  
 19 sure you have got the paper, whether we had an increase  
 20 in infection, but I am sure it was in that direction.  
 21 It wasn't significant.  
 22 Q. Take a look at pages 527 through 531.  
 23 And it is in the abstract, the findings. Can you  
 24 just summarize them?  
 25 MR. ASSAAD: Objection. I just want to be clear. Based on

1 MICHAEL R. REED  
 2 Q. That RTT for proven infection; what does that mean?  
 3 A. Return to theater for proven infection increased.  
 4 Q. And what did it go from and to?  
 5 A. Well, 0.66 to 1.52.  
 6 Q. So it went from 0.66 percent infection to 1.52 percent  
 7 infection when you switched from cefuroxime to  
 8 gentamicin by itself; am I reading that right?  
 9 A. Yes.  
 10 Q. And that switch occurred prior to the start of the  
 11 Bair Hugger only period; is that right?  
 12 A. That switch occurred, yes; the switch from cefuroxime to  
 13 gentamicin, yes. The switch beyond that occurred in --  
 14 as we have said in the paper, occurred during the Bair  
 15 Hugger period.  
 16 Q. And, well, the switch occurred, I thought you -- at the  
 17 end of -- you were using gentamicin only up until  
 18 February 28, 2009; is that right?  
 19 A. Well again, that's in the McGovern paper, when we  
 20 changed. There is detail on that.  
 21 Q. And if you start at the McGovern -- the Bair Hugger only  
 22 period in the McGovern, on 1st July, 2008, that would  
 23 mean July, August, September, October, November,  
 24 December 2008, February and March of 2009?  
 25 THE EXAMINER: No, January and February, I think.

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 2 Mr. Jonathan's objection earlier on about using  
 3 documents that are not part of the scope of this, you  
 4 know -- the scope of this sealed order. Are we saying  
 5 he is allowed to go to other documents by the --  
 6 THE EXAMINER: Well, yes, because he is -- as I understand  
 7 it, because I have not had the opportunity to read the  
 8 McGovern paper, so I don't know what its conclusions  
 9 are. But as I understand it, Mr. Gordon is seeking to  
 10 establish other operative factors during the relevant  
 11 period. Do I have that right, Mr. Gordon?  
 12 MR. GORDON: Yes.  
 13 MR. ASSAAD: I just want to be clear, based on what Mr.  
 14 Holl-Allen was saying earlier about other documents.  
 15 THE EXAMINER: If Mr. Holl-Allen will point us to  
 16 a different one.  
 17 MR. HOLL-ALLEN: It was --  
 18 A. So in summary, there was what would be said to be  
 19 an insignificant fall in Clostridium difficile rates,  
 20 although very close to significance. But there was  
 21 an increase in pneumonia, which -- cefuroxime probably  
 22 protects the chest; that's why that happened. Renal  
 23 failure, which required critical care admission and  
 24 return to theater, and return to theater for infection.  
 25 BY MR. GORDON:

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 2 BY MR. GORDON:  
 3 Q. What did I say?  
 4 THE EXAMINER: It started -- it ended on 1st March.  
 5 BY MR. GORDON:  
 6 Q. January and February. I will do that again.  
 7 July, August, September, October, November,  
 8 December, 2008. January 2009, February 2009; eight  
 9 months.  
 10 For eight months of the Hot Dog only period, the  
 11 only antibiotic that was being given to patients was  
 12 gentamicin; correct?  
 13 A. Yes. That sounds plausible.  
 14 Q. And --  
 15 A. That's written in the paper.  
 16 Q. Once you switched to a combination of gentamicin and  
 17 teicoplanin, were there any further changes to the  
 18 antibiotic regimen through the remainder of the study  
 19 period?  
 20 A. So we changed from gentamicin to gent/teic. That was  
 21 the change we made.  
 22 Q. And that remained the same through the remainder of the  
 23 balance of the study period; is that right?  
 24 A. Yes. It is the same today.  
 25 Q. Yes. Was there -- wasn't there a point in time after

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the study period, where you actually lowered the gentamicin further or increased the teicoplanin a little ...? It doesn't matter. I am not going to --

A. I don't think so.

Q. Obviously that is beyond -- that is beyond the scope, I think.

A. It's 3 milligrams per kilogram that we used. That's what we've always used, I think.

Q. Okay. During the seven months of the Hot Dog only period, what antibiotic regimen was used?

A. Gent/teic.

Q. So all of the Hot Dog patients, Hot Dog only patients, had the combination of gentamicin and teicoplanin; is that correct?

A. Mm-hm.

Q. And for eight months of the 20 months of the Bair Hugger only period, Bair Hugger only patients had only gentamicin; right?

A. I mean, I am not sure about the exact dataset in evidence, but certainly there was a period when -- during that Bair Hugger phase, if you like, where one group was on the antibiotic gent, and one was on gent/teic. That is in the paper.

Q. Right. And there were 12 months of the Bair Hugger only

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period where the Bair Hugger patients were receiving the same antibiotic regimen as the Hot Dog only patients were; correct?

A. Sorry, say that again?

THE EXAMINER: What period was that?

BY MR. GORDON:

Q. From March 1st, 2009 until the end of the Bair Hugger only period. That was the same gentamicin and teicoplanin that continued on into the Hot Dog period?

A. That feels right, yes.

Q. So it's only the -- the first eight months of the Hot Dog only period, where there was a different antibiotic regimen?

A. Do you mean the Bair Hugger only period?

Q. I mean the Bair Hugger only period, yes.

A. Well, again, I would need a bit more time to work out exactly how many months. But you're right, in principle, in that there was a period in the Bair Hugger group when you are on the gentamicin and a period when you are on the gent/teic.

THE EXAMINER: Is that right? As I understand it, the change to gent/teic occurred right at the end of the Bair Hugger only period, but at the beginning of the transition period.

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MR. GORDON: No, I think it is a year on.

MR. HOLL-ALLEN: Yes. The transition period was beginning in 2010.

THE EXAMINER: Oh sorry, I apologize. I'll withdraw that. Sorry, that explains my confusion.

BY MR. GORDON:

Q. In addition to the change in the antibiotics you also changed the venous thromboprophylaxis regimen; right?

A. (Nods.)

Q. You need to say "yes" or "no", just to ...

A. Yes, yes.

Q. What was that change?

A. So again, I wouldn't be able to cite dates for you, but we went for a period on rivaroxaban, which again is in the McGovern paper. We have put the dates in there. And yes, we had an increase in our return to theater rates when we were using that, and we published that.

Q. And what happened? Did you continue with the rivaroxaban or change to something else?

A. Yes, we changed to tinzaparin; something else, yes.

Q. What were you using before you changed to rivaroxaban?

A. Heparin, I think. I am not entirely sure.

Q. I don't want to -- I am not trying to test your memory. If you go back to the paper on page 540 through 547 --

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if you --

THE EXAMINER: You have got about five minutes left on the tape.

BY MR. GORDON:

Q. Let's see if we can at least pin down the thromboprophylaxis change.

We have the -- before you switched to rivaroxaban, you were using tinzaparin; right?

A. Yes.

Q. You switched to rivaroxaban for a seven month period; right?

A. Yes, that feels right.

Q. And then went back to tinzaparin; right?

A. Yes.

Q. What were the months that you switched from tinzaparin to rivaroxaban?

A. Well, I think as you said, August 2009 to February 2010. That's when we were on rivaroxaban.

Q. So that would be August, September, October, November, December of 2009. January, February 2010. Seven months of rivaroxaban; is that right?

A. Yes.

Q. And those seven months occurred solely in the Bair Hugger only period; right?



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A. It may be six months, but yes.

Q. And you switched from tinzaparin to rivaroxaban, why?

THE EXAMINER: Sorry, are you asking about the first switch?

MR. GORDON: Yes, the first switch.

THE EXAMINER: Okay.

A. I am not sure why we switched. I mean, I think it's -- it's an oral treatment, so you can have a tablet, rather than injections. So there's an advantage for the patients and maybe for compliance. That would be the rationale, if you like, for switching.

BY MR. GORDON:

Q. And regardless of the rationale for switching to rivaroxaban, you switched back after six or seven months, because of all the complications with rivaroxaban; right?

A. Because they were bleeding essentially, yes.

Q. And returning to theater; correct?

A. Yes.

Q. And --

THE EXAMINER: Rectal bleeding?

A. No, just bleeding from the wound.

THE EXAMINER: Oh right.

A. Well, and bleeding into the wound specifically. So they were getting what we call hematomas. So collections of

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blood that just continued to leak and cause trouble.

THE EXAMINER: So after six or seven months, it would have been sufficient to justify a change back; that must have been a fairly marked sequence of events?

A. Yes. I mean, well, we certainly -- we picked it up. And we weren't the first. In fact, subsequently there were ten other trusts, and I think you have got that paper in there, that had that issue. And internationally as well, since then.

THE EXAMINER: Shall we change the tape?

MR. GORDON: Yes. Let's do that.

THE VIDEOGRAPHER: This is the end of tape number 1, in the deposition of Michael Reed. We are going off the record at 2:28.

(2:28 p.m.)

(Break taken.)

(2:37 p.m.)

THE VIDEOGRAPHER: This is the beginning of tape number 2, in the deposition of Michael Reed. We are going on the record at 2:37.

THE EXAMINER: Yes.

BY MR. GORDON:

Q. Mr. Reed, I am not sure where we were. What was the period of rivaroxaban; what were the months?

MICHAEL R. REED

A. So from August 2009 to February 2010, rivaroxaban was provided from Day 1 post-operatively.

Q. Was it at the beginning or at the end of February?

A. I couldn't tell you from here. I mean, we would have that somewhere.

Q. It says "in February", but ...

A. Sure, I appreciate that. Based on what I have got in front of me, I can't remember.

THE EXAMINER: "In February" suggests a change some time during the month, as opposed to at the beginning or at the end, doesn't it?

MR. GORDON: Well --

THE EXAMINER: Perhaps we can --

MR. GORDON: Let's look at another paper.

BY MR. GORDON:

Q. If you turn to page 521 through 525, that's -- is that the paper you were referring to earlier, where you were the co-author about the switch to rivaroxaban?

A. (Nods.)

Q. If you look on page 522, the first very full paragraph, it says:

"Group 2 had their primary operation between 1 August, 2009 and 28 February, 2010." Seven months.

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A. (Nods.)

Q. So would that be the rivaroxaban only period?

A. On the basis of what we have here, yes, I think it would, yes.

Q. Okay.

Well, I have been trying to track this now, over the chart. The Bair Hugger only period went from July 2008 to the end of February 2010. The transition period was March, April, May of 2010 and then the last seven months of 2010 was the Hot Dog only.

Now, in the comparison between Hot Dog and Bair Hugger, you didn't use the three months of the crossover; right?

A. Correct.

Q. Okay.

So the surgical site infection rate for the Bair Hugger only included eight months where you were using gentamicin only; right?

A. Okay.

Q. And it included seven months where you had switched from tinzaparin to rivaroxaban; right?

A. Okay.

Q. And those two periods actually didn't coincide. In other words, the switch -- the antibiotics switch to

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gentamicin plus teicoplanin had occurred prior to the rivaroxaban?

A. I will take your word for it. I am sure you have got the data -- you have got the advantage of having mapped it out. I can't think of ...

Q. Well, I'm more than happy -- if you want to see my scribble, or you can map out for itself.

A. I don't disagree with what you're saying. I'm sure you have got that ...

Q. Just those two factors, the antibiotic and the proper(?) thromboprophylaxis or the common(?) thromboprophylaxis. There were five months during the Bair Hugger period when the Bair Hugger patients had the same antibiotic regimen and thromboprophylaxis regimen, as in the seven months of the Hot Dog period; right? That being March of 2009 to the end of July 2009?

A. I cannot think that fast, I am afraid, but you are probably right.

Q. Well ...

A. So are you saying that there was a crossover when they had rivaroxaban and gentamicin; is that what you are saying?

Q. No, there wasn't; was there?

A. Well, I don't know. You have got the data there.

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Q. We spent a lot of time on this. The gentamicin only period, for Bair Hugger, was from July 2008 to the end of February 2009; but the rivaroxaban switch did not start until August 2009 and ended in February of 2010, and there was no overlap.

A. Okay.

Q. So there are two discrete periods; right?

A. Right. Sounds fair.

Q. But both those discrete periods occurred in the Bair Hugger period?

A. Yes.

Q. But there was five months in the middle essentially of the Bair Hugger only period, when the Bair Hugger patients were getting the same antibiotics and the same thromboprophylaxis as the Hot Dog only patients got?

MR. ASSAAD: Objection, leading.

A. Was there? Weren't they on different antibiotics?

BY MR. GORDON:

Q. Okay. What antibiotics were the Bair Hugger patients on in March to July 2009?

A. I am going to have to go back to the paper. We could just map this out and ...

Q. Well, how about -- why don't you map it out. So that's your conclusions. Yes.

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A. Do you want me to borrow your sheet where you have written it all out or ... just in the interests of time?

Q. Well, I would love to, but I know I am going to get an objection.

THE EXAMINER: Well, if we had clean copies of the chart on page 546, which I understand are in the plaintiffs' bundle, it would make everyone's life much easier, wouldn't it?

MR. GORDON: Right, but I am getting huge objections on foundation for that, so I --

MR. ASSAAD: I have no objection if you want to use my copy.

THE EXAMINER: He can't object to a document that they have included in their bundle.

MR. ASSAAD: And I would never make an objection.

A. Do you want me to go to that?

MR. ASSAAD: We have a clean copy in our --

MR. GORDON: Oh, I see what you are saying. Oh yes. I don't have an objection to that.

MR. HOLL-ALLEN: Do you want to take my page?

A. Thank you.

MR. HOLL-ALLEN: I am supplying the witness with page 1543 of the McGovern article, which corresponds with page 546 in the marked copy.

THE EXAMINER: Okay. And what is it, Mr. Gordon, you want

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him to mark on it?

MR. GORDON: I guess we will have to mark this as a separate exhibit, if he is writing on it. So this could be exhibit 6.

(Exhibit Reed 6 marked for identification)

BY MR. GORDON:

Q. If you could just draw the line, draw a line indicating when the -- you switched from gentamicin to gentamicin plus teicoplanin.

A. Just excuse me. I am just going to draw the rivaroxaban because I have got the page, to save us time.

Q. Perfect.

A. And then the next one was the gentamicin switch.

Q. Yes.

A. The McGovern paper. Could you give me a page for that? Just give me the ...

MR. ASSAAD: So 543, I think is the information; the left hand column.

A. 543.

MR. GORDON: Yes.

A. Actually, I can just copy it off here.

THE EXAMINER: This is what he was being asked to do, as I understand it, as well.

MR. GORDON: I think page 543 does give the --

<p style="text-align: right;">Page 102</p> <p>1                   MICHAEL R. REED</p> <p>2       THE EXAMINER: What are you looking for, Mr. Reed?</p> <p>3       MR. GORDON: The antibiotic switch dates.</p> <p>4       A. The antibiotic switch dates. So --</p> <p>5       BY MR. GORDON:</p> <p>6       Q. In the middle of that first paragraph?</p> <p>7       A. So in February 2009, they switched.</p> <p>8       Q. Well, it looks like it says that in March 2009, this was</p> <p>9               changed to teicoplanin 4 milligrams and gentamicin</p> <p>10              3 milligrams per kilogram.</p> <p>11       A. Yes, okay. My chart looks like that. Is that what you</p> <p>12             are expecting?</p> <p>13       Q. Yes. And you -- based on what you have done now, is</p> <p>14             there a period of time in the Bair Hugger only time</p> <p>15             period, when the Bair Hugger patients were receiving the</p> <p>16             same antibiotics and the same thromboprophylaxis as the</p> <p>17             Hot Dog patients?</p> <p>18       A. Yes.</p> <p>19       Q. What was that period?</p> <p>20       A. Well, it's from February 2009 till July 2009.</p> <p>21       Q. Five months?</p> <p>22       A. So it was March, April -- no, it wasn't. It was</p> <p>23             February, March, April, May, June. Five months.</p> <p>24       Q. Okay. So if you had compared the SSI rate for that five</p> <p>25             month period, in the middle of the Hot Dog only period,</p>	<p style="text-align: right;">Page 103</p> <p>1                   MICHAEL R. REED</p> <p>2             to the seven month Hot Dog -- excuse me. Did I say</p> <p>3             Hot Dog?</p> <p>4             If you had compared the five months in the Bair</p> <p>5             Hugger only period, when the same antibiotic and</p> <p>6             thromboprophylaxis regimens were used, to the seven</p> <p>7             months of the Hot Dog period, then you would have</p> <p>8             eliminated the possibility that the differences you were</p> <p>9             seeing could have been influenced either by the</p> <p>10            antibiotics or the thromboprophylaxis; correct?</p> <p>11       MR. ASSAAD: Objection, lack of foundation, misstates the</p> <p>12             prior testimony. Assumes facts not in evidence.</p> <p>13       THE EXAMINER: You may answer.</p> <p>14       A. It would be a pretty small series to compare, but you</p> <p>15             could compare them, yes.</p> <p>16       BY MR. GORDON:</p> <p>17       Q. In your rivaroxaban study, what was the period of time</p> <p>18             of the series that you compared?</p> <p>19       A. Could you tell me that?</p> <p>20             So ...</p> <p>21       Q. It looks to me like it was six months versus seven</p> <p>22             months.</p> <p>23       A. Okay. Bearing in mind there is a different end point he</p> <p>24             is looking for. He is not looking for infection as</p> <p>25             an end point.</p>
<p style="text-align: right;">Page 104</p> <p>1                   MICHAEL R. REED</p> <p>2       Q. Did you assess infection in the rivaroxaban study?</p> <p>3       A. We did, I think, assess infection.</p> <p>4       Q. And --</p> <p>5       A. My recollection is: there was no difference in the</p> <p>6             infection rates.</p> <p>7       Q. Let's take a look at that. That is an important point.</p> <p>8             521 through 525?</p> <p>9       A. There was no significant ...</p> <p>10       THE EXAMINER: Where are we looking now?</p> <p>11       MR. GORDON: The rivaroxaban study.</p> <p>12       THE EXAMINER: Which is page what?</p> <p>13       MR. GORDON: 521 through 525.</p> <p>14       BY MR. GORDON:</p> <p>15       Q. If you look at 523, the very last paragraph on that</p> <p>16             page, where it says:</p> <p>17             "Our rate of infection increased from 1 percent to</p> <p>18             2.5 percent, following RBC ... following the</p> <p>19             introduction of rivaroxaban and infection rate of</p> <p>20             1 percent is similar to that reported in the literature</p> <p>21             following hip and knee replacements."</p> <p>22             Did I read that correctly?</p> <p>23       A. Yes.</p> <p>24       Q. And the six month period that you compared the</p> <p>25             rivaroxaban to -- or the six month tinzaparin period</p>	<p style="text-align: right;">Page 105</p> <p>1                   MICHAEL R. REED</p> <p>2             where you found a 1 percent infection rate, that you</p> <p>3             said was similar to that reported in the literature</p> <p>4             following hip and knee replacement, that six month</p> <p>5             period in your rivaroxaban study coincides with five of</p> <p>6             the six months of the Bair Hugger only period, where the</p> <p>7             antibiotics and the thromboprophylaxis was the same.</p> <p>8             There is one month difference; right?</p> <p>9       MR. ASSAAD: Objection, lack of foundation. Misstates the</p> <p>10            document.</p> <p>11       THE EXAMINER: Is that correct?</p> <p>12       A. Could you repeat that for me? I am sorry. I am not</p> <p>13             picking up on exactly what you are saying there, so ...</p> <p>14       BY MR. GORDON:</p> <p>15       Q. The period of time that you -- in your rivaroxaban</p> <p>16             study.</p> <p>17       A. Yes.</p> <p>18       MR. ASSAAD: Which one are you referring to? Because</p> <p>19             there's two.</p> <p>20       MR. GORDON: 521 through, whatever, 525.</p> <p>21       BY MR. GORDON:</p> <p>22       Q. Actually, page 521.</p> <p>23             "Between February 2009 and February 2010, all</p> <p>24             patients who underwent(?) THR/TKR in our hospital ..."</p> <p>25             And there you were using a 30 day period instead of</p>

<p style="text-align: right;">Page 106</p> <p>1                   MICHAEL R. REED</p> <p>2           60 days for follow-up; right?</p> <p>3   A. Okay. If that's what it says, yes.</p> <p>4   Q. So the first six months of the rivaroxaban comparator</p> <p>5       was tinzaparin only; and that was February 1st, through</p> <p>6       the end of July 2009; right?</p> <p>7   A. Yes.</p> <p>8   Q. And that coincides with five of the six months of that</p> <p>9       period of Bair Hugger, when the same antibiotic regimen</p> <p>10       and thromboprophylaxis regimen was being used?</p> <p>11   A. Yes.</p> <p>12   Q. As in the Hot Dog only period.</p> <p>13       So in that six month timeframe in your rivaroxaban</p> <p>14       study, you found a 1 percent infection rate. In the</p> <p>15       next seven months of rivaroxaban, which was also during</p> <p>16       the Bair Hugger only period, the infection rate jumped</p> <p>17       to 2.5 percent and then you went back to tinzaparin;</p> <p>18       right?</p> <p>19   A. Yes. So what is clear in the rivaroxaban paper is that</p> <p>20       there is no significant difference in infection rates.</p> <p>21       I think that was what it showed. It wasn't far off</p> <p>22       significance, I will give you that; but if you -- we</p> <p>23       couldn't link rivaroxaban to infection.</p> <p>24   Q. Who did the statistical analysis for your rivaroxaban</p> <p>25       paper?</p>	<p style="text-align: right;">Page 107</p> <p>1                   MICHAEL R. REED</p> <p>2   THE EXAMINER: "For your"; which ...?</p> <p>3   MR. GORDON: The rivaroxaban paper.</p> <p>4   MR. ASSAAD: There's two of them. Can we be clear which one</p> <p>5       we are talking about?</p> <p>6   MR. GORDON: The one we are looking at. The one from page</p> <p>7       521 to page 52 -- whatever. You can ask him about</p> <p>8       another paper later.</p> <p>9   MR. ASSAAD: You have a paper right after that, sir. That</p> <p>10       is the same thing.</p> <p>11   THE EXAMINER: We are on 521 to 525. We will stay on there</p> <p>12       until we move.</p> <p>13   A. I don't know. I was not lead author on that. I don't</p> <p>14       know.</p> <p>15   BY MR. GORDON:</p> <p>16   Q. Okay. And when you say it is not statistically</p> <p>17       significant, the jump from 1 percent to 2.5 percent, it</p> <p>18       had a P value of 0. -- 0.102. So you are saying that</p> <p>19       didn't meet the test for statistical significance.</p> <p>20   A. Yes. So it doesn't meet, if you like, the sort of</p> <p>21       accepted test; although in reality, it is a continuum,</p> <p>22       I accept that. So ...</p> <p>23   Q. And from a clinical standpoint, jumping from 1 percent</p> <p>24       to 2.5 percent --</p> <p>25   A. Sure.</p>
<p style="text-align: right;">Page 108</p> <p>1                   MICHAEL R. REED</p> <p>2   Q. -- in a short period of time like that was sufficiently</p> <p>3       concerning that you switched back?</p> <p>4   A. Yes, that's --</p> <p>5   MR. ASSAAD: Objection, leading.</p> <p>6   A. That's why we put it in the paper. That's why we</p> <p>7       referred to it in the McGovern paper.</p> <p>8   BY MR. GORDON:</p> <p>9   Q. Okay. And the 1 percent timeframe, 1 percent infection</p> <p>10       rate, covers that five month window in the middle of the</p> <p>11       Bair Hugger period, that you could compare apples to</p> <p>12       apples, at least with respect to thromboprophylaxis and</p> <p>13       antibiotics; correct?</p> <p>14   MR. ASSAAD: Objection, leading.</p> <p>15   A. I think, yes. I think on the basis of what you are</p> <p>16       saying, that is a reasonable thing. The groups are very</p> <p>17       small, then. You can't -- it is easier to compare a big</p> <p>18       group to a small group than it is a small group to</p> <p>19       a small group, when you are looking at the significance</p> <p>20       of testing.</p> <p>21   BY MR. GORDON:</p> <p>22   Q. Well, it would be even bigger to compare a big group to</p> <p>23       a big group; right?</p> <p>24   A. Yes.</p> <p>25   Q. Was there a period of time when you adopted some sort of</p>	<p style="text-align: right;">Page 109</p> <p>1                   MICHAEL R. REED</p> <p>2       a color coding system in the OR, in terms of what people</p> <p>3       wore?</p> <p>4   A. Yes.</p> <p>5   Q. What was that? What was the purpose of that?</p> <p>6   A. So we -- essentially when you are in theater, you wear</p> <p>7       purple, what we would call scrubs, so the sort of</p> <p>8       pajamas. When you are out of theater, you wear blue.</p> <p>9       And it's just a way of making sure that people don't go</p> <p>10       out of theater and contaminate people on the ward and</p> <p>11       vice versa.</p> <p>12   Q. Was there --</p> <p>13   THE EXAMINER: Are there changing facilities before you</p> <p>14       leave the operating theater area?</p> <p>15   A. Yes.</p> <p>16   BY MR. GORDON:</p> <p>17   Q. Was there some change in the footwear that occurred?</p> <p>18   A. Yes. So we made lots of changes, as we have detailed</p> <p>19       here.</p> <p>20   Q. When you say "As we have detailed", are you talking</p> <p>21       about the McGovern paper?</p> <p>22   A. So you mean, there's presentations in here. There's</p> <p>23       papers we have written on it and ...</p> <p>24   Q. And the reason I am asking about the McGovern paper is</p> <p>25       that you say on page 546:</p>

<p style="text-align: right;">Page 110</p> <p>1           MICHAEL R. REED</p> <p>2           "This study does not establish a causal basis for</p> <p>3           this association. Although the demographics were</p> <p>4           similar between the patient groups in terms of risk</p> <p>5           factors for infection, the data are observational and</p> <p>6           may be confounded by other infection control measures</p> <p>7           instituted by the hospital. For example ..."</p> <p>8           THE EXAMINER: Where are we?</p> <p>9           MR. GORDON: Page 546.</p> <p>10          THE EXAMINER: Yes, but where?</p> <p>11          BY MR. GORDON:</p> <p>12          Q. On the left hand side, the first full paragraph that</p> <p>13          begins:</p> <p>14                "This study does not establish a causal basis ..."</p> <p>15                But you say:</p> <p>16                "For example, changes were made to the antibiotic</p> <p>17                and thromboprophylaxis protocols used during the study,</p> <p>18                although no infection control changes were made</p> <p>19                after February 2010."</p> <p>20                And my -- I am emphasizing the words "For example".</p> <p>21                You've got thromboprophylaxis and antibiotics specified</p> <p>22                in here.</p> <p>23                But my question is: are there -- did I miss it or</p> <p>24                are there any other places within there, where you</p> <p>25                actually -- within the McGovern paper, where you talk</p>	<p style="text-align: right;">Page 111</p> <p>1           MICHAEL R. REED</p> <p>2           about what other changes had occurred or when?</p> <p>3           A. So we did -- we obviously listed that there were</p> <p>4           changes, so we chose two specific ones, because they are</p> <p>5           the ones really with the evidence base or the concern</p> <p>6           around them.</p> <p>7           So to turn that on its head, if I was to say, you</p> <p>8           know: we changed the color of theater blues in the</p> <p>9           article here on infection, they would say: well, where</p> <p>10          is the evidence for that, that influence? And you</p> <p>11          wouldn't find a reference for that either.</p> <p>12          So a lot of the things we have done are on the basis</p> <p>13          of common sense, rather than evidence that it will help</p> <p>14          infection. I would accept that.</p> <p>15          Q. Did you change the dressings?</p> <p>16          A. That's -- at one point we changed the dressings, yes.</p> <p>17          Q. From what to what?</p> <p>18          A. So I am struggling to think if we had a policy before we</p> <p>19          changed, in terms of -- I think it was probably certain</p> <p>20          preference. But after we changed, it was to something</p> <p>21          called Aquacel Surgical.</p> <p>22          Q. Is that the same thing as Jubilee?</p> <p>23          A. Jubilee, yes. Jubilee is --</p> <p>24          Q. The hospital?</p> <p>25          A. The hospital that invented it. The Golden Jubilee.</p>
<p style="text-align: right;">Page 112</p> <p>1           MICHAEL R. REED</p> <p>2           Q. Was there any evidence to support switching to the</p> <p>3           Jubilee dressing?</p> <p>4           A. So they had evidence.</p> <p>5           THE EXAMINER: "They" being?</p> <p>6           A. The Golden Jubilee had done a small trial on it.</p> <p>7           BY MR. GORDON:</p> <p>8           Q. The hospital in Glasgow?</p> <p>9           A. Yes.</p> <p>10          Q. What did their trial demonstrate?</p> <p>11          A. So they looked at a variety of outcome measures, but the</p> <p>12          ones I remember were blister rates. So you can</p> <p>13          sometimes get blistering around a wound. And they were</p> <p>14          reduced with that dressing, and infection rates were</p> <p>15          reduced. I can't remember whether that was superficial</p> <p>16          and deep or whether it was just deep. But there was</p> <p>17          a -- there was an effect.</p> <p>18          Q. And when did you switch to the Jubilee dressing?</p> <p>19          A. It's probably on the timeline, I think.</p> <p>20                Would you care to point it out, to speed me up?</p> <p>21                There is a lot on here.</p> <p>22          Q. If I am reading correctly, it is the October 2009.</p> <p>23          THE EXAMINER: Right at the bottom left hand side, at the</p> <p>24          bottom, in the yellow box.</p> <p>25          A. Okay. So ...</p>	<p style="text-align: right;">Page 113</p> <p>1           MICHAEL R. REED</p> <p>2           THE EXAMINER: Well, that's audit.</p> <p>3           A. Yes, it's audit. I am not quite sure what that means.</p> <p>4           It may well have changed well ahead of that. There is</p> <p>5           another wound dressing audit you see underway, I think,</p> <p>6           at the beginning of 2008.</p> <p>7           THE EXAMINER: I see, yes.</p> <p>8           A. So I couldn't say with any certainty when we changed,</p> <p>9           but it was a pretty early change, I think, that we made.</p> <p>10          BY MR. GORDON:</p> <p>11          Q. Would it have been before or after the audit?</p> <p>12          A. Well --</p> <p>13          THE EXAMINER: You can't audit something you are not using.</p> <p>14          A. No, so I mean, I think -- I am struggling to know</p> <p>15          whether in quarter 1 2009 we introduced it or whether it</p> <p>16          was before that. I don't know.</p> <p>17          BY MR. GORDON:</p> <p>18          Q. Okay. But it was before --</p> <p>19          A. It probably is written somewhere in your documents.</p> <p>20          Q. It was before the switch to Hot Dog; right?</p> <p>21          A. I mean, my recollection is that it was, but I couldn't</p> <p>22          say with any certainty.</p> <p>23          Q. Did there come a point in time when, at Wansbeck, you</p> <p>24          started screening hip and knee patients for methicillin</p> <p>25          resistant staphylococcus aureus, MRSA?</p>

<p style="text-align: right;">Page 114</p> <p>1                   MICHAEL R. REED</p> <p>2       A. No. We have always done that, but I think you are</p> <p>3           alluding to sensitive staph aureus.</p> <p>4       Q. That was my next question. So you have always done the</p> <p>5           first screening?</p> <p>6       A. Yes, I can't remember when we didn't.</p> <p>7       Q. But my next question -- yes. So did there come a time</p> <p>8           when you -- was there a time when you had not been</p> <p>9           screening for methicillin susceptible staphylococcus</p> <p>10           aureus, and you started screening for that?</p> <p>11       A. So that was in early 2010, I think we started screening</p> <p>12           for that.</p> <p>13       Q. And was it just screening, or did somebody who had --</p> <p>14           did you take some action?</p> <p>15       A. So we would decolonize patients to -- essentially what</p> <p>16           you are trying to do is to reduce the load of this</p> <p>17           particular bug in someone's nose or on their hands or</p> <p>18           whatever.</p> <p>19       Q. So some of the Bair Hugger only patients would have not</p> <p>20           had the benefit of MSSA screening; some of them would</p> <p>21           have? Either way -- did you say February 2010?</p> <p>22       A. I think it was January, but ...</p> <p>23       Q. Okay. So at the very end of the Bair Hugger only</p> <p>24           period?</p> <p>25       A. Yes.</p>	<p style="text-align: right;">Page 115</p> <p>1                   MICHAEL R. REED</p> <p>2       Q. So if you were the Bair Hugger -- some of the</p> <p>3           Bair Hugger patients at the very end would have had MRSA</p> <p>4           screening and all of the Hot Dog only patients had the</p> <p>5           benefit of MSSA screening?</p> <p>6       A. That is due. But what I would say is that there is no</p> <p>7           evidence that it reduces infection rates in this group;</p> <p>8           certainly at this point. That may not be the case now,</p> <p>9           six years down the line. But yes, it was introduced</p> <p>10           with that intention.</p> <p>11       Q. Did there come a point in time when you instituted</p> <p>12           pre-warming of patients for hip and knee ...?</p> <p>13       A. Yes.</p> <p>14       Q. When was that?</p> <p>15       A. It will probably be on the timeline.</p> <p>16       THE EXAMINER: What does it mean?</p> <p>17       A. So essentially, if you warm someone up before their</p> <p>18           operation, then they are less likely to get cold during</p> <p>19           their operation. If you are less likely to get cold</p> <p>20           during the operation, then it reduces your complications</p> <p>21           of bleeding, heart attacks and perhaps infection.</p> <p>22       BY MR. GORDON:</p> <p>23       Q. Well, had you seen any studies before you implemented</p> <p>24           the pre-warming, to address that specific issue; does it</p> <p>25           have any impact on infection?</p>
<p style="text-align: right;">Page 116</p> <p>1                   MICHAEL R. REED</p> <p>2       A. So it does have an impact on infection. But I think</p> <p>3           what's less certain is whether it has an impact on</p> <p>4           infection if you warm them in theater as well. So</p> <p>5           isolated pre-warming has an impact on infection.</p> <p>6           In fact, David Leaper, who you are going to meet,</p> <p>7           published that in a very good large study. But my</p> <p>8           recollection is that those patients weren't warmed</p> <p>9           during surgery.</p> <p>10       Q. Are you talking about the Melling paper from 2001?</p> <p>11       A. Yes.</p> <p>12       Q. Was there a study closer in time, so when you switched</p> <p>13           to pre-warming that you had seen ...?</p> <p>14       A. So I have certainly seen a study that shows that if you</p> <p>15           pre-warm people, they are less likely to get cold, so</p> <p>16           that's like a proxy. So I have certainly had that in</p> <p>17           some of my presentations.</p> <p>18       Q. Have you ever indicated that in your presentations, that</p> <p>19           you read the New England Journal and found some article</p> <p>20           about a significant reduction in infection rates by</p> <p>21           adding pre-warming, and then you decided to do that as</p> <p>22           part of your routine procedures?</p> <p>23       MR. ASSAAD: Objection, leading.</p> <p>24       A. That was David Leaper; David Leaper's study, I think.</p> <p>25           I think that was in the Lancet, actually, David Leaper's</p>	<p style="text-align: right;">Page 117</p> <p>1                   MICHAEL R. REED</p> <p>2           study. Is pre-warming in the New England Journal of</p> <p>3           Medicine? I am not aware of that.</p> <p>4       BY MR. GORDON:</p> <p>5       Q. Okay. I am not going to take time going into too many</p> <p>6           more ...</p> <p>7       A. There is now good evidence evolving, but it is coming</p> <p>8           into practice as a definite now, compulsory. This is</p> <p>9           six years down the line.</p> <p>10       Q. When did you start pre-warming patients?</p> <p>11       A. It is probably on the timeline. Can you point that out</p> <p>12           for me?</p> <p>13       Q. I think it is probably the second quarter of 2010.</p> <p>14       A. Okay. It is likely to be correct if it is on here.</p> <p>15       THE EXAMINER: Yes, it is part of the entry in the yellow</p> <p>16           box.</p> <p>17       BY MR. GORDON:</p> <p>18       Q. The yellow box up on the top bit.</p> <p>19       A. Yes, I am not sure that the Lancet study -- and I am</p> <p>20           genuinely not sure. But I think that is not based on</p> <p>21           the people who are warmed during the operation as well.</p> <p>22           I think in David's study, they were only pre-warmed.</p> <p>23       Q. The 2001 Melling --</p> <p>24       A. Yes.</p> <p>25       THE EXAMINER: So in your hospital, as from June 2010 they</p>

<p style="text-align: right;">Page 118</p> <p>1                   MICHAEL R. REED</p> <p>2           were both pre-warmed and warmed during the operation?</p> <p>3   A. Yes, yes. And the major benefit of that would be</p> <p>4       reducing bleeding, reducing anxiety, reducing pain</p> <p>5       perhaps as well, reducing transfusion rates. It has</p> <p>6       a lot of advantages. It does not relate specifically to</p> <p>7       infection and I am not sure that warming and pre-warming</p> <p>8       together reduce infection rates. Either is probably</p> <p>9       fine.</p> <p>10   BY MR. GORDON:</p> <p>11   Q. Now, at some point you switched to chlorhexidine as</p> <p>12       a skin prep; is that right?</p> <p>13   A. (Nods.)</p> <p>14   Q. When was that?</p> <p>15   A. In my recollection, late 2010, right at the end of</p> <p>16       the -- I will save you some time. Right at the end of</p> <p>17       the -- actually, I can't remember which period it was.</p> <p>18   THE EXAMINER: Look at the little red box for Q4/2010.</p> <p>19   A. Okay, there you go, right. At the end of 2010. So --</p> <p>20       yes.</p> <p>21   BY MR. GORDON:</p> <p>22   Q. Did there come a point in time when you instituted</p> <p>23       a root cause analysis of infections?</p> <p>24   A. Yes. I think that was pretty early on, actually.</p> <p>25   Q. Like the first quarter of 2009?</p>	<p style="text-align: right;">Page 119</p> <p>1                   MICHAEL R. REED</p> <p>2   A. Yes, or even before that, I suspect, actually.</p> <p>3   THE EXAMINER: It says "underway", which is not exactly very</p> <p>4       precise.</p> <p>5   BY MR. GORDON:</p> <p>6   Q. I just want to cut to the chase. Would you agree that</p> <p>7       there were -- that there was, first of all, a serious</p> <p>8       problem with infections in the knee and joint area, in</p> <p>9       the late 2008/early 2009 timeframe?</p> <p>10   MR. ASSAAD: Objection to form, argumentative.</p> <p>11   THE EXAMINER: You may answer.</p> <p>12   A. So I mean, I would definitely agree, we were trying to</p> <p>13       reduce our infection rates. And it's a devastating</p> <p>14       complication and we were trying to reduce them. And you</p> <p>15       know, I think as we have made very, very clear publicly,</p> <p>16       we have tried lots of things to reduce it.</p> <p>17   BY MR. GORDON:</p> <p>18   Q. And over a period of time, you implemented a whole</p> <p>19       variety of infection control procedures?</p> <p>20   A. Yes.</p> <p>21   Q. And it wasn't just switching from Hot Dog -- or from</p> <p>22       Bair Hugger to Hot Dog; right?</p> <p>23   A. So in the time period that we have put in the paper,</p> <p>24       I don't think there's anything significant that we</p> <p>25       haven't mentioned in the paper, which is the gentamicin</p>
<p style="text-align: right;">Page 120</p> <p>1                   MICHAEL R. REED</p> <p>2       and the rivaroxaban, in terms of -- in terms of</p> <p>3       affecting infection rates.</p> <p>4       You know, there are other things like MSSA screening</p> <p>5       which was introduced.</p> <p>6       But at the time of this paper and still, there is no</p> <p>7       evidence to say that it reduces infection rates, staph</p> <p>8       aureus infection rates in joint replacement patients.</p> <p>9       Now, we are doing a piece of work now that does</p> <p>10       actually, I think, show that. But that is not in the</p> <p>11       literature at all, even six years down the line.</p> <p>12   Q. Just looking at the timeline and the picture of you</p> <p>13       standing in front of that thing, the graph that starts</p> <p>14       out very high and goes down very quickly. Was that</p> <p>15       reflective of what was happening to the SSI rates?</p> <p>16   A. So I mean, this chart is the SSI rates, but it is not --</p> <p>17       you need to understand, it is not the Wansbeck primary</p> <p>18       joint replacement infection rates. This is --</p> <p>19   Q. The whole system?</p> <p>20   A. -- the conglomerate of superficial and deep revision,</p> <p>21       hip fracture patients, hemiarthroplasties, DHSs, and it</p> <p>22       is a large group. And the value of that is that you can</p> <p>23       make a change and hopefully track the advantage of that.</p> <p>24   Q. There came a point in time when you stopped using one</p> <p>25       particular operating theater; correct?</p>	<p style="text-align: right;">Page 121</p> <p>1                   MICHAEL R. REED</p> <p>2   A. Yes.</p> <p>3   Q. Why was that?</p> <p>4   A. That was, I think here.</p> <p>5   Q. I think it was a little later in time.</p> <p>6   A. The laminar flow repaired in Wansbeck. Is that the one</p> <p>7       you ...</p> <p>8   Q. And that was when? That was -- it is kind of hard to</p> <p>9       tell from the timeline, other than that it was --</p> <p>10   A. That was quarter 3/2008. Quarter -- at the start of</p> <p>11       quarter 3.</p> <p>12   Q. Now, I --</p> <p>13   A. To June 2008.</p> <p>14   Q. From memory, I think it is in the orange box on the far</p> <p>15       right.</p> <p>16   A. Okay.</p> <p>17   Q. After the --</p> <p>18   THE EXAMINER: That is Q4 of 2013, theater 2, WGH, closed to</p> <p>19       all TKH joint replacements.</p> <p>20   A. Yes, so there was a brief period. That is not actually</p> <p>21       my theater, but there was a brief period that it was</p> <p>22       closed.</p> <p>23   BY MR. GORDON:</p> <p>24   Q. Okay. It was not a permanent closure? I don't want to</p> <p>25       talk about that, then.</p>

<p style="text-align: right;">Page 122</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: Before we go on, the air conditioning,</p> <p>3 whatever you have done --</p> <p>4 MR. HOLL-ALLEN: Have I made it worse?</p> <p>5 THE EXAMINER: I heard it behind me cease to come out of the</p> <p>6 vents.</p> <p>7 (Off the record remarks.)</p> <p>8 THE VIDEOGRAPHER: Going off the record at ten past 3.</p> <p>9 (3:11 p.m.)</p> <p>10 (Break taken.)</p> <p>11 (3:11 p.m.)</p> <p>12 THE VIDEOGRAPHER: Back on the record at 3:11.</p> <p>13 THE EXAMINER: So you want to go to volume 4 now?</p> <p>14 BY MR. GORDON:</p> <p>15 Q. Yes, please. Can I direct your attention to page 1584?</p> <p>16 (Exhibit Reed 4 marked for identification.)</p> <p>17 Q. It is actually a full e-mail chain. The full e-mail</p> <p>18 chain goes from 1584 to 1589.</p> <p>19 A. Okay.</p> <p>20 Q. Got it? And the bottom half of that page, 1584, is that</p> <p>21 an e-mail from you to Mark Albrecht and Paul McGovern?</p> <p>22 A. Yes.</p> <p>23 Q. And is this -- it concerns what ultimately became the</p> <p>24 published McGovern paper; right?</p> <p>25 A. I would have to read that, but it sounds likely. Yes,</p>	<p style="text-align: right;">Page 123</p> <p>1 MICHAEL R. REED</p> <p>2 that would be right.</p> <p>3 Q. If you look at the second full paragraph under your</p> <p>4 comments, could you just read that one? It starts with</p> <p>5 "the infection reduction data".</p> <p>6 A. So I have said:</p> <p>7 "The infection reduction data has been given too</p> <p>8 much prominence. Whilst the data is real and can be</p> <p>9 used in the discussion, it is potentially controlled by</p> <p>10 many factors and I am not prepared to imply that this is</p> <p>11 solely a forced air warming effect. We have made lots</p> <p>12 of interventions -- it could be any, although I agree it</p> <p>13 could largely be a forced air warming effect."</p> <p>14 Q. By whom was the infection reduction data being given too</p> <p>15 much prominence?</p> <p>16 A. Well, I think I am referring to the first draft, which</p> <p>17 I think was done by Mark Albrecht.</p> <p>18 Q. And based on the e-mail at the top of that, after a --</p> <p>19 a week after you sent that e-mail about infection</p> <p>20 reduction data being given too much prominence, Albrecht</p> <p>21 sent back to you and Paul McGovern, with a carbon copy</p> <p>22 to Scott Augustine and Christopher Nachtsheim, what he</p> <p>23 describes as the first official rough draft of the</p> <p>24 paper. Do you know what that means?</p> <p>25 A. Well, it is a rough draft of the paper, yes.</p>
<p style="text-align: right;">Page 124</p> <p>1 MICHAEL R. REED</p> <p>2 Q. Was Mark Albrecht the primary writer of the paper?</p> <p>3 A. He had the first go at this paper and I think many other</p> <p>4 papers.</p> <p>5 Q. Do you know why Scott Augustine was copied on this?</p> <p>6 A. I think he was on the payroll at that time. Mark -- in</p> <p>7 fact, he's got an Augustine e-mail address.</p> <p>8 THE EXAMINER: So over the page at 1585, when he wrote to</p> <p>9 you on 22 December, saying:</p> <p>10 "I've started getting serious about getting your</p> <p>11 manuscript done."</p> <p>12 What does that mean, as you understood it?</p> <p>13 A. I think he was going to do a draft of the paper.</p> <p>14 THE EXAMINER: So he actually did the initial first draft?</p> <p>15 A. Yes; I am 90 percent sure he did that.</p> <p>16 THE EXAMINER: Okay.</p> <p>17 BY MR. GORDON:</p> <p>18 Q. If I could now move you to 1601 through 1607; another</p> <p>19 e-mail chain.</p> <p>20 It looks like this is a few days later than the one</p> <p>21 we just looked at. In particular, I want to draw your</p> <p>22 attention to page 1602, where you say -- at the top,</p> <p>23 where you say:</p> <p>24 "Mark, the paper reads well and (until the reviewers</p> <p>25 complain!) I am happy to include both the spinal data</p>	<p style="text-align: right;">Page 125</p> <p>1 MICHAEL R. REED</p> <p>2 and the infection plots. Could you have a read through</p> <p>3 and I would be very grateful if you could address</p> <p>4 comments and add references. I will also need a new</p> <p>5 deep infection chart drawing up and stats when I have up</p> <p>6 to date data. Same message but a couple of infections</p> <p>7 under CFW with many more numbers of primaries. It makes</p> <p>8 the data much more credible with the same message."</p> <p>9 What did you mean by that?</p> <p>10 A. Well, it's just a longer follow-up in the forced air</p> <p>11 warming group.</p> <p>12 Q. What was the reference to making it more credible?</p> <p>13 A. Well, the more patients you have in it, the more</p> <p>14 credible it is. I mean, that's what that ...</p> <p>15 THE EXAMINER: What does the sentence:</p> <p>16 "Same message but a couple of infections under CFW</p> <p>17 with many more numbers of primaries."</p> <p>18 What does that mean?</p> <p>19 A. It means we have had infections under forced air</p> <p>20 warming -- sorry, under conductive fabric warming. So</p> <p>21 I was more or less telling him that it wasn't going to</p> <p>22 be data that he would particularly love, but</p> <p>23 nevertheless it probably still shows an advantage. That</p> <p>24 was my view at that point. So we had had more</p> <p>25 infections.</p>



<p style="text-align: right;">Page 126</p> <p>1                   MICHAEL R. REED</p> <p>2       THE EXAMINER: As many more numbers of primaries?</p> <p>3       A. So that means that the -- so essentially, "primaries"</p> <p>4           means the primary joint replacement. So we had done --</p> <p>5       THE EXAMINER: Primary?</p> <p>6       A. Primary joint replacement. So we had done lots of</p> <p>7           operations. We had two more infections. So that's --</p> <p>8           compared to the data we had seen before, I think it's</p> <p>9           presumably saying ...</p> <p>10      BY MR. GORDON:</p> <p>11      Q. If you could turn to page 718 through 739.</p> <p>12      THE EXAMINER: What is this, sorry?</p> <p>13      MR. GORDON: I think that goes back to volume 2.</p> <p>14      THE EXAMINER: 718?</p> <p>15      MR. GORDON: 718 through 739.</p> <p>16      A. Okay.</p> <p>17      BY MR. GORDON:</p> <p>18      Q. And on the cover page of 718, it shows as authors: Mike</p> <p>19           Reed, Mark Albrecht, Oliver Kimberger, Mark Litchy and</p> <p>20           David Leaper.</p> <p>21           Do you know what this is?</p> <p>22      A. So I think this is an early version of the -- of Reed</p> <p>23           et al, as you call it.</p> <p>24      Q. The one that we find at page 505 through 510, are the</p> <p>25           authors Reed, Kimberger, McGovern and Albrecht?</p>	<p style="text-align: right;">Page 127</p> <p>1                   MICHAEL R. REED</p> <p>2       A. I think so. To be clear, I have not -- I think that</p> <p>3           probably -- yes, that will be this paper, sent in</p> <p>4           Vienna.</p> <p>5       THE EXAMINER: So this is what you would call Reed 2013?</p> <p>6       MR. GORDON: Yes.</p> <p>7       BY MR. GORDON:</p> <p>8       Q. So what was David Leaper's involvement in that paper?</p> <p>9       A. So I don't know, is the truth of it. My recollection of</p> <p>10           this, when I was going through this last week, is that</p> <p>11           he was on early versions of this paper, but he wasn't on</p> <p>12           the final version.</p> <p>13      Q. You don't know why?</p> <p>14      A. I don't know why. He would be the best person to tell</p> <p>15           you. I can speculate, but that would be speculative.</p> <p>16      THE EXAMINER: No.</p> <p>17      BY MR. GORDON:</p> <p>18      Q. Okay. If you could turn to pages 741 through 754. On</p> <p>19           page 741, it identifies authors of this paper as Leaper,</p> <p>20           Reed, Wim -- W-I-M -- Amsterdam and Mark Albrecht. Do</p> <p>21           you have any idea what this is?</p> <p>22      A. I don't have any recollection of this, I am afraid.</p> <p>23           I don't know whether I should, but ...</p> <p>24      Q. Do you have any idea who "Wim" refers to?</p> <p>25      A. No.</p>
<p style="text-align: right;">Page 128</p> <p>1                   MICHAEL R. REED</p> <p>2       Q. Okay. One more.</p> <p>3       A. This paper was never published, as far as I am aware.</p> <p>4       Q. Did you participate in writing it?</p> <p>5       A. I don't think so.</p> <p>6       Q. Are you even aware that -- strike that.</p> <p>7           Was it the practice for somebody else to author</p> <p>8           something with your name on it and then ask you to sign</p> <p>9           on as an author?</p> <p>10      A. No. I mean, the involvement, if you like, of the</p> <p>11           clinicians was to have a clinical context to the data.</p> <p>12           So in the paper that I eventually -- the Reed et al, you</p> <p>13           know, my involvement was really to put some -- add some</p> <p>14           weight to it, essentially, and that's the reason that</p> <p>15           I was on that.</p> <p>16           I think my recollection of that particular paper was</p> <p>17           that it was pretty well written. I think that -- just</p> <p>18           let me get this clear in my ...</p> <p>19           The Reed paper, I actually put quite a lot of time</p> <p>20           into. Is there a copy of that?</p> <p>21      MR. HOLL-ALLEN: 505, I think we said.</p> <p>22      THE EXAMINER: 505.</p> <p>23      A. Was it in here as well?</p> <p>24      MR. HOLL-ALLEN: Yes, it is in the same volume, 505. Ah no,</p> <p>25           sorry. That is the plaintiffs' bundle. You want</p>	<p style="text-align: right;">Page 129</p> <p>1                   MICHAEL R. REED</p> <p>2           volume 2.</p> <p>3       A. I think, isn't it in here as well?</p> <p>4       MR. HOLL-ALLEN: It may be.</p> <p>5       A. I was just going for an easier ...</p> <p>6           So the forced air warming evaluation and intake</p> <p>7           filtration actually, I put quite a lot of work into, in</p> <p>8           terms of the paper, because it took quite a lot of</p> <p>9           understanding. I don't know if you read that paper. It</p> <p>10           is a complicated paper.</p> <p>11      THE EXAMINER: That is why it is well written. I have not</p> <p>12           read it, because I was not given the task.</p> <p>13      A. So I had quite a lot of input into that, albeit after</p> <p>14           the experiments were done. But the concept there of</p> <p>15           filters and the likes took quite a lot of understanding</p> <p>16           for me.</p> <p>17      BY MR. GORDON:</p> <p>18      Q. The experiments were done in Minnesota; right?</p> <p>19      A. That one was done in, I think, Minnesota and in Vienna.</p> <p>20           So there were two aspects to that study.</p> <p>21      Q. If I could have you turn to page 1479 now. It is</p> <p>22           an e-mail chain, 1479 to 1480. I want to ask you</p> <p>23           about --</p> <p>24      MR. ASSAAD: On exhibit 3?</p> <p>25      MR. GORDON: It is in exhibit 4, actually. Sorry.</p>

<p style="text-align: right;">Page 130</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: 1479?</p> <p>3 MR. GORDON: Yes.</p> <p>4 BY MR. GORDON:</p> <p>5 Q. What I want to direct your attention to is the top of</p> <p>6 1479 and just really -- it doesn't show you as being</p> <p>7 copied on it, so I just really want to ask you if you</p> <p>8 are aware of any discussion about the line:</p> <p>9 "Ok, Scott, that leaves you with a decision to</p> <p>10 make."</p> <p>11 MR. ASSAAD: Objection.</p> <p>12 BY MR. GORDON:</p> <p>13 Q. "Pick 1 of 3 options.</p> <p>14 "1) We ask Mike Reed to take lead on this abstract</p> <p>15 also."</p> <p>16 MR. ASSAAD: I am going to make an objection before you</p> <p>17 enter it into the record. Something -- you failed to</p> <p>18 establish foundation. He is not even on the e-mail.</p> <p>19 You are just testifying here. This is not proper.</p> <p>20 MR. GORDON: Gabriel, are you going to be okay with me</p> <p>21 interrupting you in the middle of a question?</p> <p>22 THE EXAMINER: Carry on, Mr. Gordon.</p> <p>23 MR. ASSAAD: If I am reading an e-mail from somebody else,</p> <p>24 feel free.</p> <p>25 THE EXAMINER: He has ...</p>	<p style="text-align: right;">Page 131</p> <p>1 MICHAEL R. REED</p> <p>2 MR. ASSAAD: He does not. He is not copied on it.</p> <p>3 THE EXAMINER: It does not matter.</p> <p>4 MR. ASSAAD: It does matter.</p> <p>5 THE EXAMINER: What rules ...</p> <p>6 MR. ASSAAD: The Federal Rules of Evidence.</p> <p>7 THE EXAMINER: All right. You make your objection.</p> <p>8 MR. ASSAAD: That is what I am doing.</p> <p>9 THE EXAMINER: Carry on.</p> <p>10 BY MR. GORDON:</p> <p>11 Q. I will go back. The line I am asking back:</p> <p>12 "Ok, Scott, that leaves you with a decision to make.</p> <p>13 Pick 1 of 3 options:</p> <p>14 "1) We ask Mike Reed to take lead on this abstract</p> <p>15 also (maybe preferred choice).</p> <p>16 "2) We ask Bob Gauthier to take lead on this.</p> <p>17 "3) You take the lead author role (I also like this</p> <p>18 option equally to #1)."</p> <p>19 Have you ever seen this before?</p> <p>20 A. No.</p> <p>21 Q. Were you privy to any discussions with Mark Albrecht or</p> <p>22 Scott Augustine about Scott Augustine deciding who was</p> <p>23 going to be asked to be --</p> <p>24 A. No.</p> <p>25 Q. -- an author of the paper?</p>
<p style="text-align: right;">Page 132</p> <p>1 MICHAEL R. REED</p> <p>2 A. No.</p> <p>3 THE EXAMINER: Were you asked to take the lead on this</p> <p>4 abstract?</p> <p>5 A. I am not entirely clear what this refers to, to be</p> <p>6 honest. It could be almost anything, in terms of</p> <p>7 papers. There's no attachment.</p> <p>8 THE EXAMINER: Well, it is. It is a forced air warming</p> <p>9 abstract document.</p> <p>10 A. Have we got that?</p> <p>11 THE EXAMINER: I don't know where the document ...</p> <p>12 MR. GORDON: Well, when I find it, I will circle back to</p> <p>13 this.</p> <p>14 THE EXAMINER: Okay.</p> <p>15 MR. GORDON: You see the crud and bug. Just put that into</p> <p>16 the back of your head. We will come back to that.</p> <p>17 BY MR. GORDON:</p> <p>18 Q. Since we are in this volume, I just want to deal with</p> <p>19 one small thing and get it done with.</p> <p>20 If you look at 1494 through 1505 -- correction, 1492</p> <p>21 through 1505.</p> <p>22 And at the beginning of this, there's an e-mail</p> <p>23 chain and then an attached draft of a presentation.</p> <p>24 Is this at all familiar to you?</p> <p>25 A. I mean, I have certainly read it in the last couple of</p>	<p style="text-align: right;">Page 133</p> <p>1 MICHAEL R. REED</p> <p>2 weeks; and I have probably read it at the time I was</p> <p>3 copied in. It is my e-mail address.</p> <p>4 Q. You know, I apologize. I lumped together in that, the</p> <p>5 e-mail and the attachment. The e-mail chain just goes</p> <p>6 from 1492 to 1498; and then 1500 to 1505 is the attached</p> <p>7 draft. That's what I'm talking ...</p> <p>8 Oh, I am sorry. Before we leave that e-mail chain.</p> <p>9 If you look at 1496, please. In the middle of the</p> <p>10 page, there is an e-mail from Mark Albrecht to</p> <p>11 Paul McGovern with a carbon copy to Mike Reed,</p> <p>12 Scott Augustine, Brent Augustine and "Nach001" and the</p> <p>13 text of that is:</p> <p>14 "Much better Paul. You did a good job of hiding the</p> <p>15 'agenda' and making this look much more impartial. I'll</p> <p>16 give you an updated infection graph and summary</p> <p>17 tomorrow."</p> <p>18 What was your understanding of what "agenda" Mark</p> <p>19 was praising Paul for doing a good job of hiding?</p> <p>20 MR. ASSAAD: Objection. Calls for speculation.</p> <p>21 THE EXAMINER: Did you have an understanding?</p> <p>22 A. I can speculate, I can speculate on it.</p> <p>23 THE EXAMINER: No.</p> <p>24 A. I mean, I wasn't --</p> <p>25 MR. ASSAAD: We don't want you to speculate.</p>

<p style="text-align: right;">Page 134</p> <p>1                   MICHAEL R. REED</p> <p>2       A. -- engaging in that conversation, so I would be</p> <p>3       speculating.</p> <p>4       BY MR. GORDON:</p> <p>5       Q. So as you sit here today, you don't remember any</p> <p>6       discussion of an agenda that you wanted to hide, with</p> <p>7       this presentation that you and Dr. McGovern gave?</p> <p>8       A. No, I don't think -- I am speculating, but I don't think</p> <p>9       the agenda is referring to Paul McGovern.</p> <p>10      Q. Okay. One other question before we leave the e-mails.</p> <p>11      At the very bottom of 1496, Brent Augustine sends</p> <p>12      an e-mail to Mark, CCed to others, but he specifically</p> <p>13      says:</p> <p>14          "Dr. Reed, it was nice to see you in San Diego. The</p> <p>15          research was extremely well received by those that saw</p> <p>16          it."</p> <p>17          Do you know what that was referring to?</p> <p>18      A. Just let me check the date. So -- sorry, which page are</p> <p>19      you on?</p> <p>20      Q. 1496.</p> <p>21      A. So -- well, I mean, I had been to San Diego once. It</p> <p>22      was for the American Academy of Orthopaedic Surgeons.</p> <p>23      It must have been there. Did I present there?</p> <p>24      Probably.</p> <p>25      Q. Do you recall what you presented?</p>	<p style="text-align: right;">Page 135</p> <p>1                   MICHAEL R. REED</p> <p>2       A. No. I could find out, probably. As far as I am aware,</p> <p>3       it wasn't on anything related to this.</p> <p>4       Q. Okay. That was going to be my question.</p> <p>5          Did you ever speak at a conference on anything</p> <p>6       related to forced air warming where Scott Augustine or</p> <p>7       his company helped you with travel costs or lodging</p> <p>8       costs?</p> <p>9       A. Me? No.</p> <p>10      Q. Someone else?</p> <p>11      A. Well, Paul McGovern, I think, went to Minneapolis and my</p> <p>12      recollection was that I advised him to get receipts and</p> <p>13      just get them reimbursed and not to take anything</p> <p>14      financial. That's my recollection of it.</p> <p>15      Q. Okay.</p> <p>16          Now, I want to flip to 1500 through 1505. It is</p> <p>17          titled "Outline of BHS presentation". And if you look</p> <p>18          at the comment boxes on the right, on that first page,</p> <p>19          1500, the very first comment is:</p> <p>20          "Comment: MRR1."</p> <p>21      A. Mm-hm.</p> <p>22      Q. Who is MRR1?</p> <p>23      A. Very likely to be me, I would say.</p> <p>24      Q. And you -- this outline indicates that the presenters of</p> <p>25      this BHS presentation are Paul McGovern and Mike Reed.</p>
<p style="text-align: right;">Page 136</p> <p>1                   MICHAEL R. REED</p> <p>2       Was there ever such a presentation?</p> <p>3       A. Yes. So I think this is a presentation at the Hip</p> <p>4       Society, which was in Bournemouth or the south of</p> <p>5       England somewhere, in about -- well, it was the meeting</p> <p>6       in probably 2011, 2012, something like that. It was the</p> <p>7       same meeting that we got declined the other -- the</p> <p>8       original piece of research we did. That was declined at</p> <p>9       this meeting. This one was accepted.</p> <p>10      Q. Okay.</p> <p>11          This presentation doesn't reference that negative</p> <p>12          microbiology study, does it?</p> <p>13      A. Correct, that was declined. So the two separate --</p> <p>14      I mean, he may well have put lots of papers in. I think</p> <p>15      at that particular meeting, I personally and my team had</p> <p>16      loads and loads of papers in. That -- so the first one</p> <p>17      wasn't accepted. This one was accepted. So he gave</p> <p>18      this presentation.</p> <p>19      Q. If you drop down to the bottom comment on page 1500,</p> <p>20      "M3". First of all, do you know who the "M" comments</p> <p>21      are coming from?</p> <p>22      A. I am speculating, but it's probably Mark --</p> <p>23      MR. ASSAAD: Objection.</p> <p>24      A. Well, I don't know, no, is the answer.</p> <p>25      THE EXAMINER: I don't quite understand these commented</p>	<p style="text-align: right;">Page 137</p> <p>1                   MICHAEL R. REED</p> <p>2       boxes. "MRR1", you say, is you?</p> <p>3       A. I think it is my first comment.</p> <p>4       THE EXAMINER: But "M2", which continues the sequence, is</p> <p>5       obviously from someone else, because it says "I agree</p> <p>6       with Mike".</p> <p>7       A. Yes.</p> <p>8       MS. ZIMMERMAN: Just the ...</p> <p>9       THE EXAMINER: No, I don't think it is M1, because it is</p> <p>10      that person's first comment.</p> <p>11      MR. GORDON: There might have been an M1 that, you know, he</p> <p>12      deleted before it got sent.</p> <p>13      MR. ASSAAD: No, because there is MR5 after M4.</p> <p>14      MR. GORDON: I have seen, I ...</p> <p>15      THE EXAMINER: I saw this the other day and I was very</p> <p>16      confused by it.</p> <p>17      BY MR. GORDON:</p> <p>18      Q. Looking at comment "M3" where it says:</p> <p>19          "I suggest you add this as an additional slide to</p> <p>20          focus the direction of where you are going in the</p> <p>21          broader context, that you are only looking at one</p> <p>22          potential factor among many possible ['many' or 'may</p> <p>23          possible'] culprits. This makes it look impartial and</p> <p>24          hides our agenda, so to speak..."</p> <p>25      MR. ASSAAD: Objection, hearsay.</p>

<p style="text-align: right;">Page 138</p> <p>1                   MICHAEL R. REED</p> <p>2       BY MR. GORDON:</p> <p>3       Q. Do you recall any discussion with Mr. Albrecht about the</p> <p>4           need to make this presentation that you were and</p> <p>5           Dr. McGovern about to give --</p> <p>6       MR. ASSAAD: Objection. Sorry.</p> <p>7       MR. GORDON: Gabriel, let me finish.</p> <p>8       MR. ASSAAD: I thought you were done. You had a question --</p> <p>9       THE EXAMINER: Okay, let him finish.</p> <p>10      MR. ASSAAD: I thought he had finished.</p> <p>11      A. Just to be clear, that is not my comment, M3.</p> <p>12      BY MR. GORDON:</p> <p>13      Q. I understand, I understand. I am just wondering: when</p> <p>14           you saw the back and forth on these comments, did you</p> <p>15           even read that one?</p> <p>16      A. I probably haven't -- I mean, I have probably read this</p> <p>17           once and commented. And he's made comments after I've</p> <p>18           read it, because I don't -- well, is there any of his</p> <p>19           things that I have commented on? I suspect he's</p> <p>20           commented after me.</p> <p>21      MR. ASSAAD: I would like to make an objection to the last</p> <p>22           question. It assumes facts not in evidence. You said</p> <p>23           this was Albrecht's comment and that has not been</p> <p>24           established.</p> <p>25      MR. GORDON: That is what Mr. Albrecht testified to, so</p>	<p style="text-align: right;">Page 139</p> <p>1                   MICHAEL R. REED</p> <p>2           I consider that a fact established in evidence already.</p> <p>3       MR. ASSAAD: That is not --</p> <p>4       MR. HOLL-ALLEN: May I intervene to say this. Mr. Gordon</p> <p>5           said a moment ago to the witness:</p> <p>6           "When you saw the back and forth in relation to</p> <p>7           these comments."</p> <p>8           With respect, I don't know whether it has been</p> <p>9           established that at the time, Mr. Reed saw the back and</p> <p>10          forth in relation to these comments; in the sense that</p> <p>11          it seems to me to be perfectly plausible that he made</p> <p>12          comments, and then M made comments which he did not</p> <p>13          subsequently see.</p> <p>14          So it seems to me that there has to be a better</p> <p>15          foundation for the questions, and an assumption is being</p> <p>16          made about a factual issue which has not been accepted.</p> <p>17      THE EXAMINER: So we would have to see an MRR response to</p> <p>18          an M comment.</p> <p>19      MR. HOLL-ALLEN: I think we would, or the witness would have</p> <p>20          to accept that he had seen the M comments at the time;</p> <p>21          and I don't believe that he has accepted that.</p> <p>22      BY MR. GORDON:</p> <p>23      Q. If you turn to page 1501. At the very bottom, there is</p> <p>24          a comment, MRR8:</p> <p>25           "Are there any pictures of this in use with models?"</p>
<p style="text-align: right;">Page 140</p> <p>1                   MICHAEL R. REED</p> <p>2           Ideally an attractive one."</p> <p>3           Comment, M9:</p> <p>4           "I know the exact picture Mike wants ... I'll get it</p> <p>5           to you."</p> <p>6           Comment, MRR10:</p> <p>7           "Need to mention the improved efficiency. Watts</p> <p>8           spend etc. Mark will have figures in comparison to</p> <p>9           FAW."</p> <p>10          Does that refresh your recollection as to whether</p> <p>11          you only made comments once and did not review any</p> <p>12          responsive comments?</p> <p>13      THE EXAMINER: No, I am sorry, Mr. Gordon. That does not</p> <p>14          work.</p> <p>15      A. No, I don't think so. No, that is a separate --</p> <p>16      THE EXAMINER: If you look at the dotted line, it is clear</p> <p>17          that M9 responds to MRR8, but MRR10 is a separate</p> <p>18          comment. It is not responsive to M9.</p> <p>19      MR. GORDON: Right. But it is sequentially current.</p> <p>20      THE EXAMINER: Well, that is -- it is in the document.</p> <p>21      MR. GORDON: It is not sequentially referring to his first</p> <p>22          comment. Comment MRR10 does not respond sequentially to</p> <p>23          MRR8. In other words, they weren't done at the same</p> <p>24          time. I am not going to belabor the point. It is --</p> <p>25      THE EXAMINER: They may have been done a minute later,</p>	<p style="text-align: right;">Page 141</p> <p>1                   MICHAEL R. REED</p> <p>2           I don't know, but ...</p> <p>3      A. I think the way track changes works is to -- they have</p> <p>4          all got different numbers. Every comment has got</p> <p>5          a different number. That doesn't mean that I have</p> <p>6          seen -- there is nothing in here that makes me think</p> <p>7          I have seen the conversation. I have seen it once,</p> <p>8          I suspect. It would be unlikely that I would do it</p> <p>9          twice, to be honest.</p> <p>10      BY MR. GORDON:</p> <p>11      Q. So when you commented, MRR6:</p> <p>12          "I'm tempted to say the driver for this was the need</p> <p>13          to verify the smoke DVD produced by Augustine ... remind</p> <p>14          them that this DVD was posted to all orthosurgeons in</p> <p>15          U.K. last year (assuming that is correct)."</p> <p>16          So the comment, M7:</p> <p>17          "I'd be careful here. That might imply a strong</p> <p>18          corporate agenda behind these activities and raise</p> <p>19          questions as to the credibility of the results."</p> <p>20          You never saw that response?</p> <p>21      A. I don't think so. I mean, I couldn't honestly say I saw</p> <p>22          it. It would be unlikely that I would review a trainee</p> <p>23          presentation twice, before going. But it's possible</p> <p>24          I did.</p> <p>25      Q. Okay.</p>

<p style="text-align: right;">Page 142</p> <p>1 MICHAEL R. REED</p> <p>2 If you turn to the final page. I'm sorry, 1505. It</p> <p>3 is your comment, MRR20, I want to ask you about. It</p> <p>4 is -- at the bottom, there's somebody saying:</p> <p>5 "Notes -- for discussion, or to fit into main body."</p> <p>6 And one of them is:</p> <p>7 "Mention infection data from Northumbria."</p> <p>8 And the dash line goes over to your comment, MRR20:</p> <p>9 "Suggest you hold this as the very last slide -- one</p> <p>10 that is placed after your thank you slide at the end.</p> <p>11 If you are lucky you can steer a question into exposing</p> <p>12 it. Normally work a treat and can be introduced with</p> <p>13 'I thought you might ask that...'"</p> <p>14 What did you mean by that?</p> <p>15 A. So when you give your presentation, you have essentially</p> <p>16 being accepted to give a presentation on a particular</p> <p>17 topic. And that was on the -- from my recollection,</p> <p>18 that was on the difference between forced air warming</p> <p>19 and conductive fabric warming that we did on the</p> <p>20 experimental -- on the experimental sort of one in</p> <p>21 theater.</p> <p>22 But a common question after that sort of thing</p> <p>23 is: how does this apply to clinical practice? That</p> <p>24 would be the next question.</p> <p>25 So you can't really present on it in your main</p>	<p style="text-align: right;">Page 143</p> <p>1 MICHAEL R. REED</p> <p>2 presentation, because that's not what they have given</p> <p>3 you permission to do. But if then someone in the</p> <p>4 audience asks, that's when you can show, you know,</p> <p>5 a relevant slide.</p> <p>6 And that's something that I will do fairly</p> <p>7 routinely, is to try and anticipate a question that</p> <p>8 I think will be -- that will be asked, and then you can</p> <p>9 answer it. Rather than with a sort of a bumbling</p> <p>10 statement, you can actually have something to show.</p> <p>11 THE EXAMINER: So the slide is on the screen?</p> <p>12 A. Yes.</p> <p>13 THE EXAMINER: And you are hoping that someone is going to</p> <p>14 say: "I want to ask questions about that"?</p> <p>15 A. Yes and I might hold two or three slides that I might</p> <p>16 get asked and so my thank you slide is up and someone</p> <p>17 asks me. I say: "Well, I thought you might ask. I have</p> <p>18 got a slide on that." And just -- it is a fairly common</p> <p>19 practice.</p> <p>20 BY MR. GORDON:</p> <p>21 Q. Why didn't you want to have the issue of the infection</p> <p>22 data presented during the --</p> <p>23 A. Because the abstract that had been accepted was not</p> <p>24 a clinical paper. It was a specific experiment. That's</p> <p>25 what the -- you know, if they accept that, you can't</p>
<p style="text-align: right;">Page 144</p> <p>1 MICHAEL R. REED</p> <p>2 really go with something else. You need to go with what</p> <p>3 they have accepted and present that. It would be --</p> <p>4 because otherwise you could just turn up with anything</p> <p>5 and say anything in your slot.</p> <p>6 Q. Had you submitted the infection data part of the study?</p> <p>7 A. I think that was too early at that point. That was,</p> <p>8 I think -- I forget when this was, but this was probably</p> <p>9 2010. So there might have been a hint towards some data</p> <p>10 at that point.</p> <p>11 Q. Okay.</p> <p>12 If you turn now to the e-mail chain, 1529 through</p> <p>13 1535. The top page, 1529, is an August 20, 2010 e-mail</p> <p>14 from Mark Albrecht to you and Paul McGovern, with a CC</p> <p>15 to Nachtsheim, Gauthier and Scott Augustine.</p> <p>16 Do you recall seeing this before?</p> <p>17 A. I saw it the other day, but I am sure I did receive it</p> <p>18 at the time.</p> <p>19 Q. Yes.</p> <p>20 At the bottom, he says that:</p> <p>21 "Bob is more than happy to assume the lead</p> <p>22 authorship role and verify the fidelity of our research</p> <p>23 (he has seen it first hand). Further, I'm sure Chris</p> <p>24 will also vouch for that since we brought him over to</p> <p>25 take a look at it too. If we take the burden off of</p>	<p style="text-align: right;">Page 145</p> <p>1 MICHAEL R. REED</p> <p>2 both of you as being lead authors, would you be</p> <p>3 comfortable with submitting the current publication as</p> <p>4 is with a role as secondary authors? The only reason</p> <p>5 I ask is that I've got a backlog of these things to get</p> <p>6 in that are just sitting here -- without any clue as to</p> <p>7 when the bubble generator will clear customs. I'd like</p> <p>8 to target an anesthesiology journal with this article</p> <p>9 anyways, so Bob is a natural choice for lead author."</p> <p>10 What does that refer to?</p> <p>11 A. So --</p> <p>12 MR. ASSAAD: Objection, calls for speculation.</p> <p>13 A. I am just trying to think about the timeline, 2010.</p> <p>14 That -- I am speculating, and I know that's not</p> <p>15 allowed, but ...</p> <p>16 THE EXAMINER: No, thank you.</p> <p>17 A. Okay, fine.</p> <p>18 THE EXAMINER: See if you can reword the question, Mr.</p> <p>19 Gordon.</p> <p>20 BY MR. GORDON:</p> <p>21 Q. Okay.</p> <p>22 Was there -- we have probably talked about this</p> <p>23 earlier -- some study that had been done in Minnesota</p> <p>24 that you didn't actually see?</p> <p>25 A. The Belani study, yes.</p>

<p style="text-align: right;">Page 146</p> <p>1                   MICHAEL R. REED</p> <p>2       Q. Okay, so that refers to the Belani study. And the</p> <p>3           co-authors on that were Albrecht, McGovern, you and</p> <p>4           Nachtsheim; right?</p> <p>5       A. Yes.</p> <p>6       MS. ZIMMERMAN: And that binder is going behind tab 4.</p> <p>7       A. Yes.</p> <p>8           Do you want me to comment or ...?</p> <p>9       BY MR. GORDON:</p> <p>10      Q. Go ahead.</p> <p>11      A. I am not sure, in honesty, whether this e-mail refers to</p> <p>12           this paper. I don't know how you have linked that. It</p> <p>13           may be so. If you could help me out, that would be</p> <p>14           good.</p> <p>15      Q. No. I know that I can't help you any more than that.</p> <p>16           If you don't know, you don't know.</p> <p>17           But if you turn to page 1532 in the e-mail chain --</p> <p>18           no, in that one. There appears, at the top, an e-mail</p> <p>19           from Robert Gauthier to Mark Albrecht, Mike Reed,</p> <p>20           Paul McGovern, CCed to Nachtsheim, Gauthier and</p> <p>21           Scott Augustine. It says:</p> <p>22           "Mike and Paul. As Mark mentioned, I have worked</p> <p>23           closely with these guys."</p> <p>24           I am not going to read the whole thing, but do you</p> <p>25           recall seeing that?</p>	<p style="text-align: right;">Page 147</p> <p>1                   MICHAEL R. REED</p> <p>2       A. Well, I recall reading the whole transcript yesterday,</p> <p>3           which was interesting.</p> <p>4       Q. What was interesting about it?</p> <p>5       A. Well, it looked as if the e-mail text had been authored</p> <p>6           by my recollection and here was -- by Albrecht, or by</p> <p>7           somebody else.</p> <p>8       Q. In your experience, was that unusual for Mr. Albrecht to</p> <p>9           ghost write, if you will, communications on behalf of</p> <p>10           other people?</p> <p>11      A. I never saw him write any communications. Well,</p> <p>12           obviously -- I mean, I have just seen this now and that</p> <p>13           was to me; so it obviously happened. But I wouldn't be</p> <p>14           aware of that happening, no.</p> <p>15      Q. Was there ever a time he drafted a letter to the editor</p> <p>16           for your signature, concerning criticisms of flaws in</p> <p>17           the McGovern study?</p> <p>18      A. Yes. So I mean, like the papers, he would tend to do</p> <p>19           the first draft and he did draft a letter which</p> <p>20           actually, I think ultimately I didn't send. But he did</p> <p>21           draft a letter.</p> <p>22      THE EXAMINER: And that was criticizing ...?</p> <p>23      A. My recollection is that it was a letter commenting on</p> <p>24           a paper criticizing my paper.</p> <p>25      THE EXAMINER: Right.</p>
<p style="text-align: right;">Page 148</p> <p>1                   MICHAEL R. REED</p> <p>2       A. I think.</p> <p>3       BY MR. GORDON:</p> <p>4       Q. Why did you decide not to send it?</p> <p>5       A. I think there was a couple of reasons.</p> <p>6           One initially was that I was concerned that it was</p> <p>7           double publishing the same data, which is kind of</p> <p>8           frowned upon. That was my main concern.</p> <p>9           As time went on, there was more data I could have</p> <p>10           put in it and a sort of extended follow-up, but it was</p> <p>11           a particularly busy time of year.</p> <p>12           In fact, I was doing a lecture tour in the States</p> <p>13           that summer and by the time I came back, that was never</p> <p>14           being pushed. I don't know if Albrecht was no longer</p> <p>15           working for Augustine or something had happened, but</p> <p>16           I was pushed -- not pushed, but I was reminded</p> <p>17           constantly to do it, and then the reminding stopped and</p> <p>18           I never got round to it.</p> <p>19      Q. I am going to flip to the e-mail chain that goes from</p> <p>20           1519 to 1522.</p> <p>21           And at the bottom of the first page, 1519, there is</p> <p>22           an e-mail from you to Mark Albrecht with a CC to</p> <p>23           McGovern, Nachtsheim, Scott Augustine -- two S.</p> <p>24           Augustines -- T. Neils. You go on:</p> <p>25           "Thanks Mark, very impressive. The transfusion data</p>	<p style="text-align: right;">Page 149</p> <p>1                   MICHAEL R. REED</p> <p>2           is unreliable, I'm afraid -- it just shows errors we are</p> <p>3           making in coding/billing. It is actually about</p> <p>4           10 percent. I can get the reliable data but it would</p> <p>5           take quite a lot of work. Likewise I can get ASA grade</p> <p>6           but possibly BMI by pulling the charts/notes. I suggest</p> <p>7           we don't do that as I don't have the resource -- what do</p> <p>8           others feel?"</p> <p>9           What are you referring to there?</p> <p>10      A. So do you remember, we started today with that big long</p> <p>11           spreadsheet that has codes collected by professional</p> <p>12           coders on what happened to the patient? So you can</p> <p>13           reliably get data on whether they either had a heart</p> <p>14           attack or whether they had a chest infection. But we</p> <p>15           know that the transfusion box on that, even though we</p> <p>16           collect the data, we know it's unreliable.</p> <p>17           So the best way of getting that data is to go to the</p> <p>18           transfusion lab and cross reference with their data. So</p> <p>19           I could get it, but actually it would be quite a lot of</p> <p>20           work and insofar as our paper was concerned, not of much</p> <p>21           relevance.</p> <p>22           So that is the transfusion data.</p> <p>23           Likewise, for ASA grades, anyone know what the ASA</p> <p>24           is?</p> <p>25      Q. Why don't you explain what that is?</p>

<p style="text-align: right;">Page 150</p> <p>1 MICHAEL R. REED</p> <p>2 A. So the American Society of Anesthesiologists. It is</p> <p>3 their grading system, which essentially is a grading</p> <p>4 system to see how healthy you are. So ASA grade 1 is</p> <p>5 very healthy and ASA grade 5 is very unhealthy. So we</p> <p>6 do have that data. It is collected, but it is not</p> <p>7 collected electronically. So I would have to go back to</p> <p>8 each patient's notes, which would be several hundred</p> <p>9 sets of notes.</p> <p>10 THE EXAMINER: It would be a massive job.</p> <p>11 A. A massive job. So for the value it was going to give</p> <p>12 us ...</p> <p>13 So I suggested, I think, perhaps in this</p> <p>14 conversation, that we do something called Charlson</p> <p>15 scoring.</p> <p>16 BY MR. GORDON:</p> <p>17 Q. If you turn to 1521 at the bottom.</p> <p>18 THE EXAMINER: How is it this gentleman can print out these</p> <p>19 e-mails running in date order, as opposed to reverse</p> <p>20 date order?</p> <p>21 (Off the record remarks.)</p> <p>22 BY MR. GORDON:</p> <p>23 Q. "Mark, I agree hypo and hyperthyroidism and COPD would</p> <p>24 be useful but only if the list was more complete.</p> <p>25 I think it would highlight the fact that we don't have</p>	<p style="text-align: right;">Page 151</p> <p>1 MICHAEL R. REED</p> <p>2 ASA data, obesity and transfusion. We should leave</p> <p>3 out."</p> <p>4 Why -- what is the reference there to highlighting</p> <p>5 the fact that: "We don't have ASA data, obesity and</p> <p>6 transfusion"?</p> <p>7 A. Well, if we did not have it in the dataset, we would</p> <p>8 have to go and look for it. So it would be a big piece</p> <p>9 of work, so I was not keen to embark on that. You might</p> <p>10 embark on that if the reviewers really wanted it. If</p> <p>11 they are saying: "We will publish your paper if you get</p> <p>12 that", then it would be worth pulling 1,000 sets of</p> <p>13 notes or whatever.</p> <p>14 But for the benefit, it probably wasn't worth it.</p> <p>15 Now, what I have suggested is that we did have</p> <p>16 robust data on those three things; hypo, hyperthyroidism</p> <p>17 and COPD. But in itself, if you put that in, people</p> <p>18 would say: "Why are you collecting that and not other</p> <p>19 things that are more obviously linked, like ASA, obesity</p> <p>20 and transfusion?" So it would just alert the reviewers</p> <p>21 to the fact that we haven't got that data.</p> <p>22 Q. I recognize that it was a whimsical statement, but what</p> <p>23 did you mean by:</p> <p>24 "It is fair to say my assassin may be funded by</p> <p>25 Bayer or Arizant!"</p>
<p style="text-align: right;">Page 152</p> <p>1 MICHAEL R. REED</p> <p>2 A. Because both of those companies -- so Bayer make</p> <p>3 rivaroxaban. Well, we know what Arizant made. So you</p> <p>4 know, it was clear to me that they wouldn't like what</p> <p>5 I was saying.</p> <p>6 Q. Okay. Maybe I do need to be more specific. What was</p> <p>7 the concern with respect to Bayer?</p> <p>8 A. Because we published our paper on rivaroxaban. Do you</p> <p>9 remember, the one we discussed at length earlier,</p> <p>10 about --</p> <p>11 Q. Okay.</p> <p>12 A. -- the return to theater rates?</p> <p>13 THE EXAMINER: That was the --</p> <p>14 MR. GORDON: Separately.</p> <p>15 THE EXAMINER: That was the short period for which you used</p> <p>16 it.</p> <p>17 A. Yes. And also we wrote a paper about ten other</p> <p>18 hospitals, which we have not discussed today, I think it</p> <p>19 is in the package, showing the same effect. So --</p> <p>20 THE EXAMINER: What is Charlson scoring?</p> <p>21 A. So the Charlson score is a predictor of likelihood to</p> <p>22 die, essentially. So it looks at a variety of measures</p> <p>23 like: have you got heart disease, have you got lung</p> <p>24 disease, have you got HIV? All of these things. And it</p> <p>25 produces a scoring system for your chance of dying. So</p>	<p style="text-align: right;">Page 153</p> <p>1 MICHAEL R. REED</p> <p>2 it is useful -- if your paper is, for instance, on</p> <p>3 mortality, then it is useful to be able to grade the</p> <p>4 patient's Charlson score, so you can compare big groups</p> <p>5 of patients.</p> <p>6 And we can do that from the spreadsheet, you know,</p> <p>7 that exhaustive spreadsheet we had before. I can turn</p> <p>8 that into a Charlson score for any individual patient,</p> <p>9 so you risk assess them.</p> <p>10 BY MR. GORDON:</p> <p>11 Q. Do you currently use the Hot Dog?</p> <p>12 A. No, I don't, actually.</p> <p>13 Q. When did you stop using the Hot Dog?</p> <p>14 A. In -- certainly earlier on this year.</p> <p>15 Q. What do you use now?</p> <p>16 A. So we are currently undergoing an evaluation of</p> <p>17 different systems.</p> <p>18 So in the last six months -- well, certainly this</p> <p>19 year, I have used the Hot Dog. But we had some</p> <p>20 difficulties with them beginning to bubble and sort of</p> <p>21 melt; "melt" is an overexaggeration, but they began to</p> <p>22 bubble along the seams and we were anxious that the</p> <p>23 patient was going to get injured. So we stopped using</p> <p>24 them, we pulled them.</p> <p>25 And we are currently trialing different conductive</p>

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fabric systems, different companies; and sometimes used forced air warming if there was nothing else available.

Q. Which forced air warming system do you use, if there is nothing else available?

A. Bair Hugger.

Q. Have you yourself used Bair Hugger in the last six months?

A. Yes.

Q. How about the other surgeons at Northumbria? Have any of them used Bair Hugger in the last six months?

THE EXAMINER: Do you know --

A. Yes.

THE EXAMINER: -- what other surgeons use?

A. They will have used Bair Hugger and they will have used conductive fabric, because we are doing -- we are sort of evaluating different systems and we haven't always got conductive fabric available. So yes. There are some surgeons I know who are refusing to use

Bair Hugger, but I am not one of them.

BY MR. GORDON:

Q. I think we need to go back to volume 1, which is exhibit 1.

(Off the record remarks.)

Q. Mr. Dyer, I think you might have my volume 1.

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THE EXAMINER: Volume 1?

MR. GORDON: Yes. Is there an extra volume 1 over there?

MR. ASSAAD: Mr. Videographer, what is the current time?

The current time, for the record?

THE VIDEOGRAPHER: We have been on the record for three hours and 21 minutes.

MR. ASSAAD: Thank you.

MR. GORDON: How much of that time was Mr. Assaad spending making his speaking objections? You don't have to answer that.

MR. HOLL-ALLEN: Does anyone want this folder, volume 1?

THE EXAMINER: If someone can tell me which tab and which internal Bates stamp, I am perfectly happy.

MR. GORDON: I am actually winding up pretty quickly, but I guess I didn't understand the order to say three and a half hours, regardless of how much time the plaintiffs consume with --

THE EXAMINER: Three and a half hours is what you get. I do not notice that there have been an excess of interventions which would have -- in that time. Believe me, I have heard much longer interventions, with much more frequency.

Which tab are we going to?

MR. GORDON: I will start with -- it is under tab 5, but it

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is page 371.

THE EXAMINER: Yes, but what is the internal Albrecht reference?

MR. GORDON: I am sorry?

THE EXAMINER: What is the internal Albrecht reference? The Bates stamp?

MR. GORDON: Oh, 0018360.

Did you not have a paginated one? Because there is another ...

THE EXAMINER: Oh, there is one here.

MR. GORDON: That is all I am using.

THE EXAMINER: So page number now, 3 ...

MS. OKONEDO: 371.

THE EXAMINER: Thank you.

MR. GORDON: Page 371.

A. Ah, 371.

BY MR. GORDON:

Q. Yes, yes. Sorry.

A. Oh, sorry.

THE EXAMINER: This is a back to front order.

MR. GORDON: Sorry?

THE EXAMINER: This is a back to front order.

BY MR. GORDON:

Q. It is an exchange of e-mails with you and Scott

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Augustine and Brent Augustine, Paul McGovern. It is really just one line I want to ask you about, at the very bottom. You said:

"I don't have a great appetite for writing to the editor, though. I think there is probably enough background concern, so it is reaching people's consciousness. What we need here is an RCT."

First of all, do you know what letter to the editor that refers to?

A. I think it's probably the letter which we discussed ten minutes ago, that Mark Albrecht had started and drafted.

Q. What did you mean by: "There is probably enough background concern, so it is reaching people's consciousness"?

A. I think people were talking about it. People --

Q. What is "it"? What were people talking about?

A. I think people accept that it affects laminar flow. I think it is much more contentious, whether it affects infection rates. I think it is pretty accepted that forced air warming will affect your laminar flow, because of the way it affects air movements and the heat. It is very fragile.

Q. And then the last line:

"What we need here is an RCT."



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What is that a reference to?

A. So this goes back to the thing I have been saying since 2009. We had a randomized control trial. We needed a big trial to show if there is a difference between forced air warming and conductive fabric warming, in terms of infection rates.

Q. Are you aware of any such trial, either underway or planned?

A. So there is a planned trial, which I am a principal investigator for, which means that I am not leading it; but I am, if you like, on the grant and I am on the team that are hopefully going to run the trial.

Q. How were you recruited to be part of that?

A. So the chief investigator has, I think, probably seen me show the videos of how it disrupts laminar flow or something similar, at least. He -- he is not an orthopaedic surgeon. He is an infectious disease consultant.

Q. That is Professor Scarborough?

A. Yes, I think so.

THE EXAMINER: Professor?

A. Scarborough. Dr., I think.

BY MR. GORDON:

Q. Scarborough. I am sorry. He asked you to be part of

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the research team?

A. I think -- I can't remember. Well, I suppose he did, because I haven't led it. He has come to me. I would be a reasonably natural person to come to, because we do a lot of randomized trials and I have clearly got an interest in this.

Q. And what is the randomized trial going to be comparing?

A. So it's a pilot study, which means it is a study where we are trying to gain information to see what we would have to do for a big trial. But it's randomizing patients with a hip fracture, who are having a hemiarthroplasty with a very high rate of infection. So if you break your hip in your 70s and 80s, then you have a much higher rate of infection. So we've chosen that group deliberately. Because of the high infection rate, you need smaller numbers.

THE EXAMINER: That is in trauma situations specifically?

A. In trauma.

BY MR. GORDON:

Q. What is the intervention that you're going to be examining?

A. Conductive fabric warming versus forced air warming.

Q. And the end point is?

A. Infection.

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Q. So when you talked about an RCT, is that --

A. That is the Holy Grail.

Q. That is the Holy Grail. Who is funding this?

A. 3M. Well actually, 3M and a charity. But 3M are certainly funding the pilot.

THE EXAMINER: A U.S. charity or a U.K. charity?

A. Are we ...?

THE EXAMINER: A U.S. charity or a U.K. charity?

A. Oh, a U.K. charity. It is something like the Infection Prevention Society or something like that. It is on my CV somewhere.

BY MR. GORDON:

Q. And this study that 3M is funding, that's similar to what you had wanted to do earlier and Augustine declined to fund; is that right?

A. Yes.

MR. GORDON: Thank you. I have nothing further.

THE EXAMINER: Right. Let's go off the record briefly.

THE VIDEOGRAPHER: Going off the record at 4:06.  
(4:07 p.m.)

(Break taken.)

(4:17 p.m.)

THE VIDEOGRAPHER: Back on the record at 4:17.

EXAMINATION BY MR. ASSAAD:

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Q. Mr. Reed, my name is Gabriel Assaad and I am one of the attorneys that represent hundreds of plaintiffs in the United States litigation with respect to Bair Hugger.

We have never met before; correct?

A. Correct.

Q. Have you met any attorneys that are representing plaintiffs in the United States with respect to this litigation?

A. I am not sure I understand the wording, but I haven't met any attorneys from the United States if that makes it easy.

Q. Have you met any attorneys that are representing the plaintiffs or the claimants with respect to this litigation?

A. No.

Q. Have you met with any attorneys that are representing 3M or Arizant with respect to this litigation?

THE EXAMINER: Before today?

BY MR. ASSAAD:

Q. Before today.

A. No.

Q. Have you been in contact with anyone from 3M regarding this litigation?

A. So I do randomized trials; that is one of the things

<p style="text-align: right;">Page 162</p> <p>1                   MICHAEL R. REED</p> <p>2       I do. And I am doing a randomized trial on a 3M</p> <p>3       product, which is completely unrelated to this. And</p> <p>4       they did contact me six months ago, essentially just</p> <p>5       agreeing that this was -- they were nothing to do with</p> <p>6       each other. And -- but it clearly was on their radar</p> <p>7       that this was going on. But apart from that, they</p> <p>8       wanted to hire me to do one of their studies on</p> <p>9       something completely different.</p> <p>10      Q. And that would be the Crebbs(?); is that correct?</p> <p>11      A. Yes.</p> <p>12      Q. During those conversations or those meetings with 3M,</p> <p>13      did you have any substantive conversations about your</p> <p>14      viewpoint regarding this litigation or the substantive</p> <p>15      parts of this litigation?</p> <p>16      MR. GORDON: Object to the form of the question.</p> <p>17      THE EXAMINER: You may answer.</p> <p>18      A. No, I don't think I did.</p> <p>19      BY MR. ASSAAD:</p> <p>20      Q. Now, before we get into the substance -- I am going to</p> <p>21      start off with the background, but I just want to go</p> <p>22      over a few ground rules, just so we are clear.</p> <p>23             I am going to ask you numerous questions. If you do</p> <p>24      not understand my question, please let me know. Fair</p> <p>25      enough?</p>	<p style="text-align: right;">Page 163</p> <p>1                   MICHAEL R. REED</p> <p>2       A. Yes.</p> <p>3       Q. If you answer the question, we will assume that you</p> <p>4       understood the question I asked; fair?</p> <p>5       A. Okay.</p> <p>6       Q. And any time you want to take a break, please let me</p> <p>7       know. This is not an endurance contest, so please speak</p> <p>8       up.</p> <p>9             And I'd ask you, as you have heard before, please do</p> <p>10      not speculate or guess to any questions. If you don't</p> <p>11      know the answer, it is okay to say "I do not know";</p> <p>12      fair?</p> <p>13      A. Okay.</p> <p>14      Q. And also try to be verbal with a "yes" or "no", so the</p> <p>15      court reporter can take a clear record. So she can't</p> <p>16      take down you nodding your head; okay?</p> <p>17      A. Okay.</p> <p>18      THE EXAMINER: And if it is possible, because Mr. Gordon may</p> <p>19      want to put an objection on the record, pause for</p> <p>20      a moment before you start your answer to the question.</p> <p>21      I know it is very difficult.</p> <p>22      A. Okay.</p> <p>23      BY MR. ASSAAD:</p> <p>24      Q. I would like to mark this as exhibit number 7, please.</p> <p>25      THE EXAMINER: This is?</p>
<p style="text-align: right;">Page 164</p> <p>1                   MICHAEL R. REED</p> <p>2       MR. ASSAAD: The CV.</p> <p>3             (Exhibit Reed 7 marked for identification)</p> <p>4       BY MR. ASSAAD:</p> <p>5       Q. Mr. Reed, can you please describe what has been marked</p> <p>6       as exhibit number 7?</p> <p>7       A. It is my curriculum vitae.</p> <p>8       Q. Why was this prepared?</p> <p>9       A. About two weeks ago.</p> <p>10      Q. And it is dated November 21st, 2016. Is that when it</p> <p>11      was prepared?</p> <p>12      A. Yes. That feels about right.</p> <p>13      Q. Is this the most up to date version of your CV?</p> <p>14      A. Yes.</p> <p>15      Q. Is there anything in this CV that is not included, with</p> <p>16      regard to your education, training, background,</p> <p>17      employment?</p> <p>18      A. I don't think there is anything major excluded that I am</p> <p>19      aware of. Everything big, I have put in.</p> <p>20      THE EXAMINER: Was it prepared in response to the order in</p> <p>21      this case, or do you have one which you keep running all</p> <p>22      the time?</p> <p>23      A. Yes, I have one that I update when needed.</p> <p>24      BY MR. ASSAAD:</p> <p>25      Q. On page 2, it has an index of your publications. Do you</p>	<p style="text-align: right;">Page 165</p> <p>1                   MICHAEL R. REED</p> <p>2       see that?</p> <p>3       A. Yes.</p> <p>4       Q. And unfortunately, as I've got a PDF copy, I could not</p> <p>5       click here. Where is the link going? Is it going to</p> <p>6       PubMed?</p> <p>7       A. Google Scholar.</p> <p>8       Q. Google Scholar, okay.</p> <p>9             And I, in fact, printed off a copy of the Google</p> <p>10      Scholar and I have approximately 214 publications that</p> <p>11      you have been part of; does that sound correct?</p> <p>12      A. In terms of Google Scholar, yes, probably.</p> <p>13      Q. Are there more than 214?</p> <p>14      A. No. But Google Scholar is very inclusive. So there</p> <p>15      will be abstracts. So for instance, if you present at</p> <p>16      a meeting, like the Hip Society one, then it may well</p> <p>17      get onto Google Scholar when it wouldn't get onto</p> <p>18      PubMed.</p> <p>19      Q. Okay. So they might not all be peer reviewed articles?</p> <p>20      A. Yes.</p> <p>21      THE EXAMINER: I am a little lost. PubMed?</p> <p>22      A. So PubMed -- so PubMed is a website where you can look</p> <p>23      for papers that have been peer reviewed, if you like; so</p> <p>24      they are in a journal and they are peer reviewed.</p> <p>25      Whereas Google Scholar has a wider net and they will</p>

<p style="text-align: right;">Page 166</p> <p>1                   MICHAEL R. REED</p> <p>2           pick up maybe so-called abstracts from meetings, so just</p> <p>3           short pieces of work that are not necessarily peer</p> <p>4           reviewed.</p> <p>5   THE EXAMINER: So Google Scholar is produced as a result of</p> <p>6           searches by someone else?</p> <p>7   A. Yes, by --</p> <p>8   THE EXAMINER: PubMed, do you post information to it, or is</p> <p>9           there some sort of search?</p> <p>10   A. So I think Google Scholar searches the whole internet</p> <p>11           for your name. PubMed will only go to journals that are</p> <p>12           peer reviewed and search their databases.</p> <p>13   THE EXAMINER: Fine, thank you.</p> <p>14   A. So probably I have 130, 140 on PubMed, I would think.</p> <p>15   BY MR. ASSAAD:</p> <p>16   Q. And according to Google Scholar, it is my understanding</p> <p>17           that your peer reviewed articles have been cited over</p> <p>18           2,700 times; does that sound about right?</p> <p>19   A. I have never looked, but it does tell you. So that's --</p> <p>20           you are probably right.</p> <p>21   Q. Now, I just want to go briefly to your educational</p> <p>22           background.</p> <p>23           If you could start from the beginning, just so we</p> <p>24           have a clear picture of -- a chronological picture of</p> <p>25           your background, starting with your education, through</p>	<p style="text-align: right;">Page 167</p> <p>1                   MICHAEL R. REED</p> <p>2           your training, through your employment.</p> <p>3           So let's start with your education. Could you just</p> <p>4           go briefly through your education?</p> <p>5   THE EXAMINER: Which level; starting at which level?</p> <p>6   BY MR. ASSAAD:</p> <p>7   Q. The level right after what we would call high school.</p> <p>8   A. Okay.</p> <p>9   THE EXAMINER: From 18?</p> <p>10   MR. ASSAAD: Yes.</p> <p>11   THE EXAMINER: From 18 on.</p> <p>12   A. Right. So I went to Newcastle University to do</p> <p>13           medicine. They give you two degrees for that in our</p> <p>14           country, MBBS. And then I did some training, further</p> <p>15           training in the North East.</p> <p>16   BY MR. ASSAAD:</p> <p>17   Q. I don't mean to interrupt you. Could you just provide</p> <p>18           dates, so we have a chronological picture of when you</p> <p>19           started your training and finished?</p> <p>20   A. Right, okay. I have got my CV, so this helps. In 1992</p> <p>21           I started training, having qualified as a doctor. And</p> <p>22           then I, two years later --</p> <p>23   THE EXAMINER: Training as a surgeon?</p> <p>24   A. Yes, training as a surgeon. But the first few years is</p> <p>25           quite general.</p>
<p style="text-align: right;">Page 168</p> <p>1                   MICHAEL R. REED</p> <p>2           And then I sat my first surgical exams in 1994.</p> <p>3           I did the second part of my surgical exams in 1996.</p> <p>4           I then joined a specialist training scheme in trauma</p> <p>5           and orthopaedics, having first completed two years of</p> <p>6           orthopaedic research in Sheffield. So I did six -- in</p> <p>7           fact, five years on the training scheme in trauma and</p> <p>8           orthopaedics in the North East.</p> <p>9           Then I went on a fellowship to New Zealand and did</p> <p>10           a specialist joint replacement and revision and</p> <p>11           infection fellowship; and then did some trauma training</p> <p>12           in New Zealand as well on a fellowship.</p> <p>13           And then just before I went to New Zealand, I sat my</p> <p>14           sort of consultant exams, I would say; maybe the</p> <p>15           equivalent of your boards, in 2002.</p> <p>16           And then I have been a consultant since 2002. It</p> <p>17           looks like I was awarded a fellowship of the English</p> <p>18           College of Surgeons without examination a couple</p> <p>19           of years ago. So you -- in your early career, you tend</p> <p>20           to have to sit an exam to get in. And then later on, if</p> <p>21           they like you, then they will let you into a different</p> <p>22           college without having to sit the exam. So that's what</p> <p>23           that is.</p> <p>24   BY MR. ASSAAD:</p> <p>25   Q. Okay. And so FRCS is the equivalent of maybe the U.S.</p>	<p style="text-align: right;">Page 169</p> <p>1                   MICHAEL R. REED</p> <p>2           boards; correct?</p> <p>3   A. I would say FRCS trauma and orthopaedics is equivalent</p> <p>4           to the U.S. boards.</p> <p>5   Q. Okay.</p> <p>6   A. So FRCS part 1 and 2 are maybe more junior surgeons. It</p> <p>7           takes a very long time in the U.K. to train as</p> <p>8           an orthopaedic surgeon, compared to the U.S.</p> <p>9   Q. And to take your FRCS exam for trauma and orthopaedics,</p> <p>10           do you have to have a certain qualification like so many</p> <p>11           surgeries or so much experience?</p> <p>12   A. Yes, you do.</p> <p>13   Q. Can you please describe to the ladies and gentlemen of</p> <p>14           the jury and the judge what qualifications and</p> <p>15           experience is required to sit for the FRCS for trauma</p> <p>16           and orthopaedics?</p> <p>17   A. Right. So the -- there are rules around that, which are</p> <p>18           soft rules. But to finish as an orthopaedic surgeon,</p> <p>19           you have to have your trauma and orthopaedic FRCS exam</p> <p>20           and then you have to have done so many types of surgery.</p> <p>21           So you need to have had so many cases in your logbook,</p> <p>22           et cetera, et cetera.</p> <p>23           So actually, when I went through, it was not as</p> <p>24           regulated. It is now very regulated.</p> <p>25   Q. Right. And then you have -- I think you have mentioned</p>

<p style="text-align: right;">Page 170</p> <p>1 MICHAEL R. REED</p> <p>2 it, but FRCS England awarded ad eundem, in England. Is</p> <p>3 that without an exam?</p> <p>4 A. Yes.</p> <p>5 Q. And is that a special recognition when you get admitted</p> <p>6 or get qualified for FRCS England without an exam?</p> <p>7 A. I -- in a way, I would say it was. That was how it was</p> <p>8 sold to me.</p> <p>9 THE EXAMINER: So these previous --</p> <p>10 A. They still make you pay.</p> <p>11 THE EXAMINER: These previous FRCSs, were they not English?</p> <p>12 A. So they are the College of Surgeons of Edinburgh. So</p> <p>13 there are several surgical colleges, all of which you</p> <p>14 can join; they are all of equal ranks, so --</p> <p>15 THE EXAMINER: So you were Scots qualified until 2014?</p> <p>16 A. Yes, and I am still Scots qualified. I am now doubly,</p> <p>17 if you like, if you want to call it a qualification.</p> <p>18 BY MR. ASSAAD:</p> <p>19 Q. For us that are not around here: what does that mean,</p> <p>20 "Scots qualified", as ...?</p> <p>21 THE EXAMINER: Edinburgh.</p> <p>22 A. So we have -- there are several colleges of surgeons.</p> <p>23 So there is the College of Surgeons of Ireland, one of</p> <p>24 Edinburgh, one of England, and I think the Glasgow one</p> <p>25 is physicians and surgeons. It is quite confusing.</p>	<p style="text-align: right;">Page 171</p> <p>1 MICHAEL R. REED</p> <p>2 But you have to be -- by law, you have to be</p> <p>3 a fellow of one of them, in order to -- because it is by</p> <p>4 exam and you have to pass your exam. And all the exams</p> <p>5 are actually the same exam. They have all joined up and</p> <p>6 do the same exam. And then you just -- one college will</p> <p>7 hold your -- take your money, essentially.</p> <p>8 BY MR. ASSAAD</p> <p>9 Q. It doesn't limit where you can practice; correct?</p> <p>10 A. Correct. I mean, trauma and orthopaedics is where</p> <p>11 I practice. But yes, I can operate right across the</p> <p>12 breadth of trauma and orthopaedics, based on that</p> <p>13 qualification.</p> <p>14 Q. I meant the geographical region as well. It does not</p> <p>15 limit the geographical region?</p> <p>16 A. No, so that is completely universal. So I can take that</p> <p>17 to New Zealand.</p> <p>18 THE EXAMINER: I was going to say: Edinburgh and Glasgow are</p> <p>19 in Scotland, if you don't know, so that is why</p> <p>20 I referred to it as "Scots qualified".</p> <p>21 BY MR. ASSAAD:</p> <p>22 Q. Now, after you -- following 2002, you said that is when</p> <p>23 you became a consultant?</p> <p>24 A. Yes.</p> <p>25 Q. And --</p>
<p style="text-align: right;">Page 172</p> <p>1 MICHAEL R. REED</p> <p>2 A. Maybe 2003, I think I became a consultant.</p> <p>3 Q. And before that, what would your title have been before</p> <p>4 a consultant?</p> <p>5 A. A specialist registrar, I think we were called.</p> <p>6 Q. And what is the difference between a special registrar</p> <p>7 and a consultant?</p> <p>8 A. So as a specialist registrar, you are still working</p> <p>9 under the governance of a consultant; whereas once you</p> <p>10 are a consultant, you are an independent practitioner,</p> <p>11 albeit within the constraints of the health service and</p> <p>12 its given governance structures. But I am an autonomous</p> <p>13 practitioner.</p> <p>14 Q. Okay. So if we had to relate it to -- are you familiar</p> <p>15 with the United States system, with a -- with the</p> <p>16 trainee, the residency, and then there's also</p> <p>17 an attending at a university hospital?</p> <p>18 A. Yes, so it would be an attending position. If I have</p> <p>19 now -- I think that's what you would call it. And the</p> <p>20 resident would be the specialist registrar. The</p> <p>21 difference is that your residency is very short, whereas</p> <p>22 ours is very, very long in comparison.</p> <p>23 Q. Understandable.</p> <p>24 And as a consultant, do you train specialist</p> <p>25 registrars?</p>	<p style="text-align: right;">Page 173</p> <p>1 MICHAEL R. REED</p> <p>2 A. Yes.</p> <p>3 Q. And do you currently train?</p> <p>4 A. Yes; and I am currently training program director, so</p> <p>5 I am head of training in the North East. So that's 67</p> <p>6 trainees that are, if you like, under my auspices.</p> <p>7 Q. And those 67 trainees are trainees for trauma and</p> <p>8 orthopaedics?</p> <p>9 A. Yes.</p> <p>10 Q. You said "program director". Are those individuals that</p> <p>11 are in the hierarchy below you, but assist you in</p> <p>12 training those 67?</p> <p>13 A. Yes, so there are people -- I wouldn't say they are</p> <p>14 below me, but there are people, attending surgeons of</p> <p>15 equal rank who will generally train one individual each,</p> <p>16 if you like; that sort of make-up.</p> <p>17 So we have got a wide body of attending surgeons who</p> <p>18 train specialist registrars in my region and I am head</p> <p>19 of training. I would not say I am in charge of them.</p> <p>20 I think they have made that pretty clear, that I wasn't.</p> <p>21 Q. And those program directors are also consultants;</p> <p>22 correct?</p> <p>23 A. Yes. So I am a program director and I am a consultant,</p> <p>24 yes.</p> <p>25 Q. Okay.</p>

<p style="text-align: right;">Page 174</p> <p>1                   MICHAEL R. REED</p> <p>2           Are you a member of any national organizations, in</p> <p>3           respect to trauma and orthopaedic surgery?</p> <p>4           A. Yes. So I am a fellow of the British Orthopaedic</p> <p>5           Association and the -- I am a member of the British Hip</p> <p>6           Society as well.</p> <p>7           Q. Are you a member of any international organizations?</p> <p>8           A. Not from memory.</p> <p>9           Q. Just out of curiosity. I remember you mentioned during</p> <p>10          Mr. Gordon's questioning to you that you gave</p> <p>11          a presentation to the American Academy of Orthopaedic</p> <p>12          Surgeons in San Diego; is that correct?</p> <p>13          A. Yes, it sounds like it's correct. I can't remember --</p> <p>14          I actually can't remember what it was. But I did say</p> <p>15          I gave one. I did go to that meeting for sure. I don't</p> <p>16          remember what presentation it is. I give a very -- I do</p> <p>17          a huge amount of presentations.</p> <p>18          Q. And have you given many presentations -- or have you</p> <p>19          given any other presentations in the United States?</p> <p>20          A. So in 2012, I represented Britain in a traveling</p> <p>21          fellowship of orthopaedic surgeons; so there was four</p> <p>22          surgeons from Britain selected to tour round the United</p> <p>23          States, giving talks.</p> <p>24          Q. Do you know Dr. Parvizi?</p> <p>25          A. Yes.</p>	<p style="text-align: right;">Page 175</p> <p>1                   MICHAEL R. REED</p> <p>2           Q. Do you know him personally?</p> <p>3           A. Yes.</p> <p>4           Q. Were you part of the consensus that was formed among the</p> <p>5           orthopaedic surgeons internationally?</p> <p>6           A. I was not part of the last one, but I am part of the one</p> <p>7           that is coming up.</p> <p>8           Q. And you know the consensus I am speaking about?</p> <p>9           A. Yes, the peri-prosthetic joint infection consensus, yes.</p> <p>10          THE EXAMINER: Sorry, can you repeat that?</p> <p>11          A. Okay. So there's probably now -- I think in 2013, there</p> <p>12          was a meeting held in the United States to agree on risk</p> <p>13          factors for peri-prosthetic infection; so infection of</p> <p>14          a joint replacement. And in fact, I didn't go to the</p> <p>15          consensus meeting but I did contribute to it, actually</p> <p>16          on theater and laminar flow. Maybe even on forced air</p> <p>17          warming. But certainly on laminar flow.</p> <p>18          So I wrote some of the text for it, which I think</p> <p>19          they subsequently voted on in the big meeting. And that</p> <p>20          meeting is coming round again, and I will be going --</p> <p>21          I think it is next year or the year after.</p> <p>22          BY MR. ASSAAD:</p> <p>23          Q. We are talking about work group 4, correct, dealing with</p> <p>24          particles and laminar flow and forced air warming?</p> <p>25          A. Sounds correct.</p>
<p style="text-align: right;">Page 176</p> <p>1                   MICHAEL R. REED</p> <p>2           Q. I think you cited two before in some of your articles?</p> <p>3           A. Right, yes. I did provide some text for it. I don't</p> <p>4           genuinely know how far that got.</p> <p>5           THE EXAMINER: It is a consensus document, is it?</p> <p>6           A. Yes. So it is -- it is a sort of highly publicized</p> <p>7           consensus document of, if you like, world experts,</p> <p>8           mainly U.S. focused, but still there's a few U.K. people</p> <p>9           that go.</p> <p>10          BY MR. ASSAAD:</p> <p>11          Q. And have you seen the consensus, the final version of</p> <p>12          it, the one that was prepared in 2013?</p> <p>13          A. Yes, I have seen it.</p> <p>14          Q. And do you understand that 3M was a sponsor of the</p> <p>15          consensus?</p> <p>16          A. I hadn't realized that, but ...</p> <p>17          Q. And it's -- based on your CV, you have received awards</p> <p>18          in the event; correct?</p> <p>19          A. I have received awards.</p> <p>20          Q. Yes.</p> <p>21          A. Yes, I suppose I have. I am trying to think what.</p> <p>22          THE EXAMINER: Where are they listed?</p> <p>23          MR. ASSAAD: It might not be on his CV. I know we talked</p> <p>24          about it, but I thought I saw it on his CV.</p> <p>25          BY MR. ASSAAD:</p>	<p style="text-align: right;">Page 177</p> <p>1                   MICHAEL R. REED</p> <p>2           Q. Well, I don't see it on your CV, but have you received</p> <p>3           any awards in orthopaedic surgery?</p> <p>4           A. I received the Program Director of the Year Award last</p> <p>5           year. So that's the national award for theoretically</p> <p>6           the best program director in that job we just talked</p> <p>7           about, of training the trainees.</p> <p>8           I can't remember any others. You will have to</p> <p>9           prompt me.</p> <p>10          Q. All right. And I can tell you, you have had</p> <p>11          publications, such as peer reviewed articles. You have</p> <p>12          done presentations, book chapters and you have been</p> <p>13          a reviewer for publications and given lectures; correct?</p> <p>14          A. Yes.</p> <p>15          Q. All on orthopaedic surgery; correct?</p> <p>16          A. Yes.</p> <p>17          Q. And did any of them have to do with peri-prosthetic</p> <p>18          joint infections?</p> <p>19          A. Quite a large number of book chapters and papers would</p> <p>20          relate to that.</p> <p>21          Q. Just so we are on the same definition. Is there</p> <p>22          a difference between a wound infection in your mind and</p> <p>23          a peri-prosthetic joint infection?</p> <p>24          A. I mean, I think a wound infection is a more general term</p> <p>25          that can refer to someone that's had surgery generally</p>

<p style="text-align: right;">Page 178</p> <p>1 MICHAEL R. REED</p> <p>2 and has got an infection; whereas a peri-prosthetic</p> <p>3 joint infection, we will call it "PJI" maybe, PJI, is</p> <p>4 specific to when you have an implant in place, a hip</p> <p>5 replacement, for instance.</p> <p>6 Q. Like, for example, the McGovern study which we discussed</p> <p>7 a lot today, or you discussed a lot today. That dealt</p> <p>8 with PJIs; correct?</p> <p>9 A. Correct.</p> <p>10 Q. Not superficial wound infections; correct?</p> <p>11 A. Correct, yes.</p> <p>12 Q. And that is a big difference to treat a superficial</p> <p>13 wound infection, as compared to a PJI; correct?</p> <p>14 A. Yes. I mean, it is a world apart.</p> <p>15 Q. And we talked about peer review. And just in your own</p> <p>16 words, would you agree -- or strike that.</p> <p>17 Would you agree that the peer review process is</p> <p>18 a rigorous process?</p> <p>19 A. Yes.</p> <p>20 Q. And based on my review of your -- of the literature that</p> <p>21 was on Google Scholar, it is my understanding that you</p> <p>22 have done research on methods to reduce peri-prosthetic</p> <p>23 joint infections?</p> <p>24 A. Yes.</p> <p>25 Q. And you have done research on operating theater methods</p>	<p style="text-align: right;">Page 179</p> <p>1 MICHAEL R. REED</p> <p>2 to reduce peri-prosthetic joint infections?</p> <p>3 A. Yes.</p> <p>4 Q. And you have actually done research on draping methods</p> <p>5 to reduce peri-prosthetic joint infections?</p> <p>6 A. On what methods?</p> <p>7 Q. Draping methods?</p> <p>8 A. Draping methods. Certainly gowning methods, yes.</p> <p>9 THE EXAMINER: That is slightly different?</p> <p>10 A. Well, draping I think is what you put on a patient;</p> <p>11 whereas gowning is what you put on yourself.</p> <p>12 THE EXAMINER: Quite.</p> <p>13 A. But yes.</p> <p>14 BY MR. ASSAAD:</p> <p>15 Q. You have also done research on prophylactic antibiotics</p> <p>16 to reduce PJIs; correct?</p> <p>17 A. Correct.</p> <p>18 Q. You have done research on thrombo-prophylactics to</p> <p>19 reduce PJIs; correct?</p> <p>20 A. I am not sure about to reduce it, but its impact on,</p> <p>21 yes.</p> <p>22 Q. And going back, because I am not sure if we have</p> <p>23 discussed this, or if you discussed it in the direct.</p> <p>24 Just for the ladies and gentlemen of the jury back</p> <p>25 home, what is peer review and why is it important?</p>
<p style="text-align: right;">Page 180</p> <p>1 MICHAEL R. REED</p> <p>2 A. So peer review is when you send an article that you have</p> <p>3 written. You send it to the journal and they will send</p> <p>4 it, normally anonymously, to several people who will --</p> <p>5 who are also experts in that area, who will read it and</p> <p>6 decide. Normally they will decide that it's not good</p> <p>7 enough for publication. If they -- if they like it,</p> <p>8 then they will generally send it back for changes,</p> <p>9 suggestions. And very, very rarely, they will take it</p> <p>10 first, first hit. So it is important obviously; it is</p> <p>11 a quality indicator. It is a quality measure.</p> <p>12 Q. Quality control for an article?</p> <p>13 A. Yes.</p> <p>14 Q. Reaching the -- your other colleagues in the field;</p> <p>15 correct?</p> <p>16 A. Yes.</p> <p>17 Q. Do you follow any certain -- or do you subscribe to any</p> <p>18 certain peer review journals?</p> <p>19 A. So I subscribe to the Bone and Joint Journal, and have</p> <p>20 access to a large number of journals through my</p> <p>21 university network and the hospital network.</p> <p>22 Q. And you said you were a reviewer for some of those</p> <p>23 journals?</p> <p>24 A. I am a reviewer for, in the last year, the Bone and</p> <p>25 Joint Journal. Yes, I think I review for probably three</p>	<p style="text-align: right;">Page 181</p> <p>1 MICHAEL R. REED</p> <p>2 or four journals. Certainly in the last three or four</p> <p>3 years, I've reviewed for three or four journals.</p> <p>4 Q. Would it be fair or accurate to state that you devoted</p> <p>5 most of your research to PJIs?</p> <p>6 A. Certainly to joint replacement. I would say a large</p> <p>7 amount is PJI. I do also do other things on outcomes,</p> <p>8 but yes, largely -- quite a large body of work would be</p> <p>9 prosthetic joint infections.</p> <p>10 Q. And the purpose of that is you are trying to make joint</p> <p>11 replacements safer for the patient?</p> <p>12 A. Yes.</p> <p>13 Q. Because safety is paramount to any methods you ascribe</p> <p>14 to, with respect to the patient; correct?</p> <p>15 A. Yes.</p> <p>16 Q. And you would expect that safety should be paramount to</p> <p>17 a medical device manufacturer that markets and sells</p> <p>18 devices to your hospital; correct?</p> <p>19 A. Yes.</p> <p>20 Q. And PJI is a serious complication and can be</p> <p>21 catastrophic; correct?</p> <p>22 A. Yes.</p> <p>23 Q. You can have multiple surgeries?</p> <p>24 A. Yes.</p> <p>25 Q. You mentioned before, amputations?</p>

<p style="text-align: right;">Page 182</p> <p>1 MICHAEL R. REED</p> <p>2 A. Rarely, but to get to that point, there is a huge number</p> <p>3 of surgeries normally as well.</p> <p>4 Q. And potentially it could cause death?</p> <p>5 A. Yes. Well, it does cause death. I mean, there is</p> <p>6 a definite association with mortality. It reduces your</p> <p>7 life span.</p> <p>8 Q. Do you consider yourself an expert in peri-prosthetic</p> <p>9 joint infections?</p> <p>10 A. Well, in, you know, the view that I have been invited to</p> <p>11 the international consensus perhaps, and I do speak</p> <p>12 frequently on it at meetings. I spoke yesterday in</p> <p>13 Manchester on it. So yes, I speak quite frequently on</p> <p>14 it.</p> <p>15 THE EXAMINER: And my understanding is that it is not that</p> <p>16 there is a significant percentage or proportion of</p> <p>17 infections in this surgery. It is because of the</p> <p>18 severity of the cost to --</p> <p>19 A. Exactly. So it is the severity of the complication</p> <p>20 which is just game changing for most patients. It is</p> <p>21 a terrible, terrible complication.</p> <p>22 BY MR. ASSAAD:</p> <p>23 Q. And do you consider yourself an expert with respect to</p> <p>24 the causation of peri-prosthetic joint infections?</p> <p>25 A. I think "expert" is maybe for someone else to judge, but</p>	<p style="text-align: right;">Page 183</p> <p>1 MICHAEL R. REED</p> <p>2 I do know a lot about it and I have spent a lot of time</p> <p>3 researching it.</p> <p>4 MR. ASSAAD: We need to go off the record, because of the</p> <p>5 change of CD.</p> <p>6 THE VIDEOGRAPHER: This is the end of tape number 2 in the</p> <p>7 deposition of Michael Reed. Going off the record at</p> <p>8 4:44.</p> <p>9 (4:44 pm)</p> <p>10 (Break taken.)</p> <p>11 (4:49 pm)</p> <p>12 THE VIDEOGRAPHER: This is the beginning of tape number 3 in</p> <p>13 the deposition of Michael Reed. Going on the record at</p> <p>14 4:48.</p> <p>15 BY MR. ASSAAD:</p> <p>16 Q. Mr. Reed, we can agree that you need a bacteria to cause</p> <p>17 a peri-prosthetic joint infection; correct?</p> <p>18 A. Yes.</p> <p>19 Q. And we can agree that because of the implant, you need</p> <p>20 very few bacteria to cause a peri-prosthetic joint</p> <p>21 infection; correct?</p> <p>22 A. Correct.</p> <p>23 Q. Contrary to a wound infection, where you might need</p> <p>24 millions; correct?</p> <p>25 A. So if you don't have an implant in situ, then you can</p>
<p style="text-align: right;">Page 184</p> <p>1 MICHAEL R. REED</p> <p>2 have many, many more bacteria on the wound without</p> <p>3 getting an infection. So yes, it is much more important</p> <p>4 when you have got an implant.</p> <p>5 Q. So an implant is highly susceptible to a bacteria and</p> <p>6 the cause of a peri-prosthetic joint infection mainly</p> <p>7 because of biofilm; correct?</p> <p>8 A. Yes, so biofilm is a slime that the bacteria produce</p> <p>9 that protect it from antibiotics and other mechanisms</p> <p>10 the body might have to rid the infection. So yes, it is</p> <p>11 very -- it is driven by biofilm, we think, the</p> <p>12 difficulties in getting rid of the infection.</p> <p>13 Q. And you would agree with me that as a result -- strike</p> <p>14 that.</p> <p>15 You would agree with me that most, if not all of the</p> <p>16 peri-prosthetic joint infections occur when bacteria</p> <p>17 gets to the implant during the perioperative period;</p> <p>18 correct?</p> <p>19 A. I am not sure we know that. That's -- but that is sort</p> <p>20 of an accepted philosophy. But I don't think we know</p> <p>21 that for sure, in actual fact. But that is the dogma.</p> <p>22 THE EXAMINER: You referred to the peri ...?</p> <p>23 BY MR. ASSAAD:</p> <p>24 Q. Peri, during the surgery.</p> <p>25 THE EXAMINER: I see, during the operation.</p>	<p style="text-align: right;">Page 185</p> <p>1 MICHAEL R. REED</p> <p>2 BY MR. ASSAAD:</p> <p>3 Q. When you say that is the accepted philosophy, that is</p> <p>4 the main consensus among most orthopaedic surgeons;</p> <p>5 correct?</p> <p>6 A. Yes.</p> <p>7 Q. And because of the biofilm, it is very difficult to</p> <p>8 treat these peri-prosthetic joint infections through</p> <p>9 medication; correct, such as antibiotics?</p> <p>10 A. Yes. Essentially you can't get rid of an infection with</p> <p>11 antibiotics alone.</p> <p>12 Q. Because there is no vascularity to the joint?</p> <p>13 A. Yes, because -- because bacteria and biofilm become very</p> <p>14 protected by the slime, and so you need about a thousand</p> <p>15 times the dose of the antibiotic for it to work, and you</p> <p>16 can't deliver that much antibiotic to the patient.</p> <p>17 Q. Have you heard of the term "chain of infection"?</p> <p>18 A. Can you -- can you rephrase that?</p> <p>19 Q. Yes, I can actually. Basically, for an infection to</p> <p>20 occur, you have to have an infectious agent,</p> <p>21 a reservoir, a portal of exit, a mode of transportation,</p> <p>22 a portal of entry and a susceptible host. Have you</p> <p>23 heard that described before?</p> <p>24 A. Yes.</p> <p>25 Q. And for example, so with respect to the infectious</p>

<p style="text-align: right;">Page 186</p> <p>1                   MICHAEL R. REED</p> <p>2           agent, that would be bacteria; correct?</p> <p>3           A. Yes.</p> <p>4           Q. And the reservoir in the operating room, that could be</p> <p>5           the patient; correct?</p> <p>6           A. Yes.</p> <p>7           Q. It could be the surgeon?</p> <p>8           A. Yes.</p> <p>9           Q. It could be the assistant?</p> <p>10          A. Yes.</p> <p>11          Q. It could be the scrub nurse?</p> <p>12          A. Yes.</p> <p>13          Q. It could be the Bair Hugger?</p> <p>14          A. Yes.</p> <p>15          THE EXAMINER: It is just the source of the infection.</p> <p>16          MR. ASSAAD: Yes.</p> <p>17          THE EXAMINER: It could be hundreds of things probably.</p> <p>18          MR. ASSAAD: The most likely things I am talking about,</p> <p>19          actually.</p> <p>20          THE EXAMINER: Right.</p> <p>21          BY MR. ASSAAD:</p> <p>22          Q. And you would agree with me that the mode of transit --</p> <p>23          the transmission of the bacteria in the operating room</p> <p>24          would be particles; correct?</p> <p>25          A. Yes, I think that would be fair.</p>	<p style="text-align: right;">Page 187</p> <p>1                   MICHAEL R. REED</p> <p>2           Q. Such as skin squames; correct?</p> <p>3           A. (Nods.)</p> <p>4           Q. You have to say "yes".</p> <p>5           A. Yes.</p> <p>6           Q. Or another name for it might be "fomites"; correct?</p> <p>7           A. Yes, I don't think we have a definite understanding of</p> <p>8           actually where the infection comes from. But these are</p> <p>9           the commonly accepted things.</p> <p>10          THE EXAMINER: What about if you had a dirty instrument?</p> <p>11          Would that involve particles or not?</p> <p>12          A. Well, I mean, there would be -- in particle form,</p> <p>13          I guess on the instrument; but yes, you could certainly</p> <p>14          spread infection by instruments that haven't been</p> <p>15          sterilized and that does happen from time to time.</p> <p>16          BY MR. ASSAAD:</p> <p>17          Q. But that wouldn't meet the standard of care; correct?</p> <p>18          A. Correct.</p> <p>19          Q. The standard of care would have sterile conditions;</p> <p>20          correct?</p> <p>21          A. Yes.</p> <p>22          Q. Now, with respect to a peri-prosthetic joint infection</p> <p>23          to reveal itself, that might take a couple of years;</p> <p>24          correct?</p> <p>25          A. It can take that long. It is relatively rare, but it</p>
<p style="text-align: right;">Page 188</p> <p>1                   MICHAEL R. REED</p> <p>2           can.</p> <p>3           Q. And that's because of the biofilm; correct?</p> <p>4           A. Well, I think it's because some bacteria are slow</p> <p>5           growing, that you can get infections that last that</p> <p>6           long. But what sustains them is the biofilm. That's</p> <p>7           what -- that's what allows them to continue to grow and</p> <p>8           become problematic, is that with being in biofilm, they</p> <p>9           are not able to be treated by antibiotics or by the host</p> <p>10          defenses. That is why they can take so long.</p> <p>11          Q. In your practice, have you ever had a patient come in</p> <p>12          that had a peri-prosthetic joint infection that had the</p> <p>13          primary surgery done more than six months?</p> <p>14          A. Yes.</p> <p>15          Q. More than a year?</p> <p>16          A. Yes.</p> <p>17          Q. More than two years?</p> <p>18          A. Yes.</p> <p>19          Q. How long?</p> <p>20          A. Well, people can present at any point with an infected</p> <p>21          joint replacement.</p> <p>22          THE EXAMINER: I think he was asking: what was the longest</p> <p>23          period between primary and return?</p> <p>24          BY MR. ASSAAD:</p> <p>25          Q. If you know. If you don't know, it's ...</p>	<p style="text-align: right;">Page 189</p> <p>1                   MICHAEL R. REED</p> <p>2           A. Well, I have certainly seen plenty of people that had</p> <p>3           a joint replacement 15 years ago that come in with</p> <p>4           an infection. But then the question is whether it was</p> <p>5           caused during the primary operation or not, or whether</p> <p>6           it is a new infection which has gone through the</p> <p>7           bloodstream. But yes, it can present at any time, but</p> <p>8           it commonly presents early, in the first few months.</p> <p>9           Q. Okay.</p> <p>10          THE EXAMINER: Is there an alternative to removal of the</p> <p>11          implant and replacement?</p> <p>12          A. So there's various criteria that you might use to make</p> <p>13          decisions. But one operation you can do is to open up</p> <p>14          the wound and literally scrub it and clean it and cut</p> <p>15          away all the affected tissue. The idea is to try to get</p> <p>16          rid of the biofilm, and then give them antibiotics which</p> <p>17          hopefully are targeted on the bacteria.</p> <p>18          And in a proportion of cases, perhaps 60 percent of</p> <p>19          cases, you might be able to make that the only extra</p> <p>20          operation. But many patients will go on to having</p> <p>21          further very significant surgery to remove the implant.</p> <p>22          THE EXAMINER: So if you try that route and it doesn't work,</p> <p>23          the patient is faced with at least four operations;</p> <p>24          a third to remove the implant and a fourth to replace,</p> <p>25          and a fifth implant?</p>



<p style="text-align: right;">Page 190</p> <p>1                   MICHAEL R. REED</p> <p>2       A. Yes, at least, yes.</p> <p>3       THE EXAMINER: I hope my hips remain in one piece.</p> <p>4       BY MR. ASSAAD:</p> <p>5       Q. In your practice, you have had patients that may have</p> <p>6           had more than five or six surgeries to remove</p> <p>7           an infection; correct?</p> <p>8       A. Yes.</p> <p>9       Q. Though it is uncommon, it is not rare to have that many</p> <p>10           surgeries?</p> <p>11       A. It is not rare. I think my record is about 14 or 15</p> <p>12           operations.</p> <p>13       Q. Now, we're going to get into discussing your</p> <p>14           publications that we have discussed before, and I am</p> <p>15           going to ask you many questions. And if you give</p> <p>16           an opinion, I am not asking for an expert -- but just if</p> <p>17           you give an opinion, I want to make sure that it is</p> <p>18           within a reasonable degree of medical probability,</p> <p>19           similar to a medical diagnosis. I don't want you to</p> <p>20           guess or anything. Is that fair?</p> <p>21       A. So, just so I am clear. Are you saying that if it is</p> <p>22           more than 50 percent, you want me to say "yes", or more</p> <p>23           than 20 percent?</p> <p>24       Q. For example, you were asked questions like: does, for</p> <p>25           example, MSSA screening reduce infections? And you</p>	<p style="text-align: right;">Page 191</p> <p>1                   MICHAEL R. REED</p> <p>2       said: well, there is no evidence. When you give that</p> <p>3       opinion, I want that to be with a reasonable degree of</p> <p>4       medical probability.</p> <p>5           The reason I am asking that is because under our</p> <p>6       Federal Rules of Evidence, without having that limit as</p> <p>7       a standard, it would be inadmissible in court. So it is</p> <p>8       greater than 50 percent; fair enough?</p> <p>9       A. Okay.</p> <p>10       Q. And if you can't make that opinion, if you are unsure,</p> <p>11           please let me know and we don't have to -- you don't</p> <p>12           have to answer the question. Fair enough?</p> <p>13       A. Yes. And just so I am clear: are you talking about now</p> <p>14           or in 2010 or '11?</p> <p>15       THE EXAMINER: You are not here to give opinion evidence</p> <p>16           today. You are here to give evidence about the facts</p> <p>17           and matters surrounding the production of these papers.</p> <p>18       A. So my answers relate to what we knew in 2010 or '11?</p> <p>19       BY MR. ASSAAD:</p> <p>20       Q. Or whatever period the article was.</p> <p>21       A. Okay.</p> <p>22       Q. Fair enough?</p> <p>23       A. Yes.</p> <p>24       Q. Now, part of the McGovern study dealt with disruption of</p> <p>25           the unidirectional airflow; correct?</p>
<p style="text-align: right;">Page 192</p> <p>1                   MICHAEL R. REED</p> <p>2       A. Yes.</p> <p>3       Q. Are you familiar with the Legg studies?</p> <p>4       A. Somewhat familiar.</p> <p>5       Q. Do you know Andrew Legg?</p> <p>6       A. I have met him.</p> <p>7       Q. Do you know Mr. Hamer?</p> <p>8       A. Yes, I do.</p> <p>9       Q. Have you had any discussions with them about their</p> <p>10           studies?</p> <p>11       A. We have definitely discussed it in the past. We haven't</p> <p>12           discussed it in any detail recently, in the last</p> <p>13           probably three or four years. I don't think we have</p> <p>14           discussed it.</p> <p>15       Q. But you are aware that their studies showed an increase</p> <p>16           in particle count on the surgical site; correct?</p> <p>17       A. Yes.</p> <p>18       Q. And I think in some of your articles, you cite those</p> <p>19           studies; correct?</p> <p>20       A. (Nods.)</p> <p>21       Q. Is that correct?</p> <p>22       A. Yes.</p> <p>23       Q. And would you agree with me that the longer the surgery</p> <p>24           exposure, there's more -- there is likely more exposure</p> <p>25           to particles?</p>	<p style="text-align: right;">Page 193</p> <p>1                   MICHAEL R. REED</p> <p>2       A. So the longer the operation, the higher the infection</p> <p>3       rate. That is accepted. We don't know quite why that</p> <p>4       is and whether that is linked to obesity.</p> <p>5           But yes, in broad terms, if your wound is open and</p> <p>6       that's when the particles get into it, then clearly</p> <p>7       there will be a temporal link between the wound being</p> <p>8       open for a length of time and an infection.</p> <p>9       THE EXAMINER: What sort of -- if there can be an average</p> <p>10           hip replacement operation, what sort of time are we</p> <p>11           talking about?</p> <p>12       A. For a slim patient, probably an hour, an hour and</p> <p>13           a quarter, something like that.</p> <p>14       THE EXAMINER: And with an obese patient, it increases?</p> <p>15       A. Yes.</p> <p>16       BY MR. ASSAAD:</p> <p>17       Q. And speaking about patients themselves, the patient is</p> <p>18           a susceptible host, right, to the infection; correct?</p> <p>19       A. Yes, yes.</p> <p>20       Q. And some hosts, some patients have more difficulty</p> <p>21           fighting off infections than others; correct?</p> <p>22       A. Yes.</p> <p>23       Q. Obese patients or underweight patients have more</p> <p>24           difficulty fighting off bacteria; correct?</p> <p>25       A. Yes.</p>

<p style="text-align: right;">Page 194</p> <p>1 MICHAEL R. REED</p> <p>2 Q. Perhaps smokers?</p> <p>3 A. Yes. I mean, I would say definitely smokers, if you</p> <p>4 base it on the RCTs.</p> <p>5 Q. Diabetics. In one of your papers, you cited to a study</p> <p>6 that showed there was no difference in PJIs in people</p> <p>7 with type 1 or type 2 diabetes; is that correct?</p> <p>8 A. Yes, so in our own series we have not actually found</p> <p>9 a link with diabetes and infection. But most series</p> <p>10 would show a link.</p> <p>11 Q. And with all these co-morbidities that we are</p> <p>12 discussing, at the end of the day, you still need the</p> <p>13 bacteria to enter into the host to cause the infection;</p> <p>14 correct?</p> <p>15 A. Yes.</p> <p>16 Q. Okay. Smoking does not cause bacteria to get into the</p> <p>17 implant; correct?</p> <p>18 A. Correct.</p> <p>19 Q. So does --</p> <p>20 MR. HOLL-ALLEN: Forgive me for interrupting. It does seem</p> <p>21 to me that we are getting into the area of opinion</p> <p>22 evidence which is not clearly related to the individual</p> <p>23 studies. I question whether these issues are within the</p> <p>24 scope of the defined studies or whether the answers to</p> <p>25 these questions are required in order to understand the</p>	<p style="text-align: right;">Page 195</p> <p>1 MICHAEL R. REED</p> <p>2 studies.</p> <p>3 MR. ASSAAD: If you look at my tab 7, which is one of the</p> <p>4 studies that I have -- which he has authored. It talks</p> <p>5 about obesity, diabetes, smoking.</p> <p>6 THE EXAMINER: Yes, but just because he has authored</p> <p>7 an article on that topic, it does not necessarily bring</p> <p>8 it into the scope.</p> <p>9 MR. ASSAAD: Okay.</p> <p>10 THE EXAMINER: Hang on, hang on. That is not necessarily</p> <p>11 an end of the matter.</p> <p>12 MR. HOLL-ALLEN: Sir, the order, as with the orders in the</p> <p>13 other cases, identifies certain specified other studies.</p> <p>14 This is paragraph 25.</p> <p>15 THE EXAMINER: Yes, it does refer at 4 and 5 to factors that</p> <p>16 influence infections in general orthopaedic surgery and</p> <p>17 5, infections and general practices. I think that we</p> <p>18 are in the area of factors that influence infection.</p> <p>19 Does smoking influence infection? It does seem to me</p> <p>20 a proper question. I -- you have put a marker down.</p> <p>21 MR. HOLL-ALLEN: And may I very briefly, because I don't</p> <p>22 want to hold up matters, say that I specifically</p> <p>23 objected to paragraph 4 in front of the hearing before</p> <p>24 the Senior Master; and the Master let it in, in part on</p> <p>25 the understanding that it might well include matters of</p>
<p style="text-align: right;">Page 196</p> <p>1 MICHAEL R. REED</p> <p>2 opinion evidence, but that was a matter that could be</p> <p>3 taken up at the time of the deposition.</p> <p>4 So I have registered my concerns.</p> <p>5 THE EXAMINER: You have. I am sure Mr. Assaad has heard and</p> <p>6 I am sure he will --</p> <p>7 MR. ASSAAD: I am --</p> <p>8 THE EXAMINER: -- restrict himself to paragraph 4 of the</p> <p>9 schedule B.</p> <p>10 MR. ASSAAD: I will, and ...</p> <p>11 BY MR. ASSAAD:</p> <p>12 Q. You are familiar with the Belani study; correct?</p> <p>13 A. Yes.</p> <p>14 Q. And you are an author in the Belani study; correct?</p> <p>15 A. Yes.</p> <p>16 Q. With respect to the McGovern study, that just dealt with</p> <p>17 the primary, total knee and total hip arthroplasty;</p> <p>18 right?</p> <p>19 A. McGovern was hip and spine. Belani was knee. That's my</p> <p>20 recollection.</p> <p>21 THE EXAMINER: Where is the Belani?</p> <p>22 MR. ASSAAD: Tab number 1.</p> <p>23 THE EXAMINER: I don't have ...</p> <p>24 MR. ASSAAD: I am sorry, McGovern.</p> <p>25 THE EXAMINER: McGovern?</p>	<p style="text-align: right;">Page 197</p> <p>1 MICHAEL R. REED</p> <p>2 MR. ASSAAD: Yes.</p> <p>3 BY MR. ASSAAD:</p> <p>4 Q. We could keep that in there, but just for the record,</p> <p>5 I would like to mark tab 1, exhibit number 8. If you</p> <p>6 would like to put a sticker on the McGovern study in</p> <p>7 tab number 1?</p> <p>8 THE EXAMINER: It is already exhibited.</p> <p>9 A. This is the McGovern study, not the Belani study.</p> <p>10 MR. ASSAAD: That is in a different case or a different</p> <p>11 deposition. I am going to mark it in this deposition</p> <p>12 for the court, so I can ...</p> <p>13 A. This is McGovern?</p> <p>14 MR. ASSAAD: Yes.</p> <p>15 (Exhibit Reed 8 marked for identification.)</p> <p>16 THE EXAMINER: She is marking the one in your file.</p> <p>17 MR. ASSAAD: Yes.</p> <p>18 BY MR. ASSAAD:</p> <p>19 Q. If you look at Reed 5 at the bottom, there is a graph at</p> <p>20 the top of the page, table 1.</p> <p>21 The data that was provided is here(?); is that</p> <p>22 correct?</p> <p>23 A. Yes. Sorry, I thought you were referring to the</p> <p>24 lab-based study in this paper, as opposed to the</p> <p>25 clinical study.</p>

<p style="text-align: right;">Page 198</p> <p>1                   MICHAEL R. REED</p> <p>2       Q. I am sorry?</p> <p>3       A. I thought when you were referring to the lab-based</p> <p>4           study -- because in the McGovern paper the lab-based</p> <p>5           study, if you like, the one not involving patients, was</p> <p>6           on -- was on hips.</p> <p>7       Q. Sure, the airflow or the bubble tests.</p> <p>8       A. Yes, those tests. But the clinical paper, you are quite</p> <p>9           correct, is on both.</p> <p>10      Q. And if you don't understand my question or you are</p> <p>11          getting confused, let me know. We will try to be on the</p> <p>12          same page, because I want to have a clear record here.</p> <p>13      A. Yes.</p> <p>14      Q. And those surgeries that had been dealt with: primary,</p> <p>15          total knee and total hip arthroplasty?</p> <p>16      A. Yes.</p> <p>17      Q. Which is less time for surgery than revision; correct?</p> <p>18      A. Correct.</p> <p>19      Q. Revision surgeries have higher infection rates; correct?</p> <p>20      A. Correct.</p> <p>21      Q. In some of your articles, you have also referred to the</p> <p>22          Sessler study. Are you familiar with the Sessler study?</p> <p>23      A. Yes. So --</p> <p>24      THE EXAMINER: How is that spelt?</p> <p>25      MR. ASSAAD: S-E-S-S-L-E-R.</p>	<p style="text-align: right;">Page 199</p> <p>1                   MICHAEL R. REED</p> <p>2       A. You will need to tell me which Sessler study, because he</p> <p>3           has been --</p> <p>4       MR. ASSAAD: The Sessler Olmsted 2011 study.</p> <p>5       A. What is the title of the paper?</p> <p>6       Q. 2011?</p> <p>7       THE EXAMINER: No, the title.</p> <p>8       BY MR. ASSAAD:</p> <p>9       Q. Oh, the title.</p> <p>10      A. He has been fairly prolific over the years.</p> <p>11      Q. Do you know Dr. Sessler personally?</p> <p>12      A. I don't.</p> <p>13      Q. Do you --</p> <p>14      A. I know -- I know he has done some studies for Arizant.</p> <p>15          I don't know him.</p> <p>16      Q. It is titled:</p> <p>17          "Forced-air warming does not worsen air quality in</p> <p>18          laminar flow operating rooms."</p> <p>19          Do you know that study?</p> <p>20      A. I am not very familiar with it, I am afraid. Have you</p> <p>21          got it here?</p> <p>22      Q. I don't think I -- since your name was not on it,</p> <p>23          I didn't ... you have cited two, but I can give you</p> <p>24          a blank copy.</p> <p>25      A. Sure.</p>
<p style="text-align: right;">Page 200</p> <p>1                   MICHAEL R. REED</p> <p>2       Q. If you -- going back to ...</p> <p>3           I want to turn to tab number 13.</p> <p>4       THE EXAMINER: I ...</p> <p>5       MR. ASSAAD: You are not going to have this one.</p> <p>6       THE EXAMINER: Not even what you sent me electronically?</p> <p>7       MR. ASSAAD: Oh, electronically, yes. It would be page</p> <p>8           number -- I would like to mark this as exhibit 9.</p> <p>9           (Exhibit Reed 9 marked for identification.)</p> <p>10      BY MR. ASSAAD:</p> <p>11      Q. If you go to the second page.</p> <p>12      THE EXAMINER: So the index is a blank document. The other</p> <p>13          says that the -- oh, the document. Yes, sorry.</p> <p>14          Where are we going?</p> <p>15      MR. ASSAAD: The second page. Do you know what page it is</p> <p>16          on? I gave you an index. It is Reed 116.</p> <p>17      BY MR. ASSAAD:</p> <p>18      Q. Have you seen this e-mail before?</p> <p>19      A. I saw it in this -- this week or two.</p> <p>20      Q. This is an e-mail dated March 8, 2012.</p> <p>21      A. Yes.</p> <p>22      Q. Oh I am sorry, December 2nd, 2011, from you to --</p> <p>23      A. Yes, I do remember sending it, yes.</p> <p>24      Q. Can you please describe this e-mail?</p> <p>25      A. Right. I wish it was a bigger font. So my recollection</p>	<p style="text-align: right;">Page 201</p> <p>1                   MICHAEL R. REED</p> <p>2           is that this was an inquiry that I had from a center in</p> <p>3           the U.S. I think actually in Minneapolis. And they are</p> <p>4           asking about a study we have done and I am providing</p> <p>5           them with some updates. I think I have taken the</p> <p>6           trouble to put my disclosures in and where it's been</p> <p>7           presented. And I have offered to put them in touch with</p> <p>8           Mark Albrecht, who could come and demonstrate the issue,</p> <p>9           which I think would probably be fairly easy to</p> <p>10          demonstrate in a theater.</p> <p>11      Q. And were you in Minneapolis at any point in time during</p> <p>12          this period?</p> <p>13      A. So I was in Minneapolis in 2012, so maybe in, I think,</p> <p>14          May 2012.</p> <p>15      THE EXAMINER: Look at the last sentence of your e-mail.</p> <p>16      A. There you go. June 2012. That was when I mentioned</p> <p>17          I was doing a lecture tour of the States and I knew it</p> <p>18          was going through their town in June, by the look of it.</p> <p>19      BY MR. ASSAAD:</p> <p>20      Q. Okay. And you are aware that this e-mail was forwarded</p> <p>21          on to 3M?</p> <p>22      A. I wasn't aware of that until yesterday.</p> <p>23      Q. Okay. At any point in time, when 3M was made aware,</p> <p>24          I guess they were made aware in March 13, 2012, did you</p> <p>25          ever get a phone call or any type of e-mail from 3M</p>

<p style="text-align: right;">Page 202</p> <p>1                   MICHAEL R. REED</p> <p>2           saying: "Hey, we want to know more about the data that</p> <p>3           you have obtained in the McGovern study"?</p> <p>4   A. No.</p> <p>5   Q. And you talk about more data on 400 more patients,</p> <p>6           around 400 more patients; correct?</p> <p>7   A. Yes.</p> <p>8   Q. And you -- and if you look at your e-mail, you write:</p> <p>9           "You will see the effect is present for knees (0.6</p> <p>10          vv 1.6%) as well as hips (1.3 vv 5.5%). The effect has</p> <p>11          been sustained."</p> <p>12          What did you mean by "The effect has been</p> <p>13          sustained".</p> <p>14   THE EXAMINER: Sorry, where is that?</p> <p>15   A. So it just meant that we continued to see low rates of</p> <p>16          infection.</p> <p>17   BY MR. ASSAAD:</p> <p>18   Q. For the Hot Dog?</p> <p>19   A. Yes. Well, yes.</p> <p>20   Q. Okay. Or the conductive warming device which was the</p> <p>21          Hot Dog; right?</p> <p>22   A. Yes.</p> <p>23   Q. So even after you published the McGovern study, you</p> <p>24          continued to obtain data to see whether the effect could</p> <p>25          be sustained; correct?</p>	<p style="text-align: right;">Page 203</p> <p>1                   MICHAEL R. REED</p> <p>2   A. Yes.</p> <p>3   Q. And at any time, did you run the statistical analysis</p> <p>4          regarding that data?</p> <p>5   A. Yes. Well, yes, I did.</p> <p>6   Q. Okay. Did you get the same -- a P value that still</p> <p>7          showed that the results were significant?</p> <p>8   A. So my recollection is that the P value at that point was</p> <p>9          very significant. I think it is somewhere in this</p> <p>10          documentation.</p> <p>11   Q. If you look at it, in the following tab, 14. Reed 118.</p> <p>12   A. Yes. So I haven't seen this before, although it was</p> <p>13          interesting as an analysis. But ...</p> <p>14   Q. Okay. Can we mark this as exhibit number 10?</p> <p>15   THE EXAMINER: "This" being?</p> <p>16   MR. ASSAAD: Reed 118.</p> <p>17   THE EXAMINER: Just that page?</p> <p>18   MR. ASSAAD: Yes.</p> <p>19          (Exhibit Reed 10 marked for identification.)</p> <p>20   BY MR. ASSAAD:</p> <p>21   Q. Why do you say this was very interesting?</p> <p>22   A. Well, it is the first time I have seen this, in</p> <p>23          different centers, being collated, if you like. So it</p> <p>24          was interesting that on the face of it, at least, they</p> <p>25          have had a similar experience. But of course, what you</p>
<p style="text-align: right;">Page 204</p> <p>1                   MICHAEL R. REED</p> <p>2           don't have here is peer review. But on the face of it,</p> <p>3           it looks, you know, like an impressive reduction.</p> <p>4   Q. There was discussion with respect to -- during the</p> <p>5          direct examination, about the change in antibiotics</p> <p>6          during the study period, with respect to forced air</p> <p>7          warming and the conductive fabric device. Do you recall</p> <p>8          that testimony, that discussion?</p> <p>9   A. Yes.</p> <p>10   Q. Were you aware that Mr. Albrecht ran the numbers to</p> <p>11          determine the differences in the reduction rate between</p> <p>12          the different antibiotic protocols?</p> <p>13   A. Only when I read this, you know, in the last couple of</p> <p>14          weeks.</p> <p>15   Q. Were you aware that there was no statistical difference</p> <p>16          between antibiotic protocol 1 and protocol 2?</p> <p>17   A. Not prior to the last couple of weeks.</p> <p>18   Q. If that's true, would you agree with me that the change</p> <p>19          in antibiotic protocol had no statistical significance</p> <p>20          in the infection rates in the McGovern study?</p> <p>21   A. So on the face -- on the basis that you have only got</p> <p>22          those two things involved, the antibiotics -- one</p> <p>23          antibiotic versus another, then this appears to show</p> <p>24          that.</p> <p>25   Q. And if that statement is true, you would agree with me</p>	<p style="text-align: right;">Page 205</p> <p>1                   MICHAEL R. REED</p> <p>2           that the change in antibiotic protocol would not be</p> <p>3           considered a confounding factor in the McGovern study?</p> <p>4   MR. GORDON: Object to the form of the question.</p> <p>5   THE EXAMINER: This is getting perilously close to asking</p> <p>6          him to give his opinion.</p> <p>7   MR. ASSAAD: In the McGovern study, he spent much time</p> <p>8          showing --</p> <p>9   THE EXAMINER: I know he did, but you are now introducing</p> <p>10          an additional factor which is something which has only</p> <p>11          come to his attention recently.</p> <p>12   MR. ASSAAD: Fair enough.</p> <p>13   THE EXAMINER: And asking him how, in his opinion, it</p> <p>14          affects matters, which I think is teetering on the edge.</p> <p>15   A. So on the basis of the information we have got in front</p> <p>16          of us, it looks as if there wasn't a difference between</p> <p>17          the two antibiotic regimes. I haven't had the ability</p> <p>18          to sort of look at this in detail. It is not my work;</p> <p>19          but clearly it's done about my work.</p> <p>20   MR. ASSAAD: I am not going to go any further with you,</p> <p>21          then, with respect to that question, then.</p> <p>22   BY MR. ASSAAD:</p> <p>23   Q. But you agree with me that the change in antibiotics</p> <p>24          does not add any sort of contamination to the sterile</p> <p>25          field; correct?</p>

<p style="text-align: right;">Page 206</p> <p>1 MICHAEL R. REED</p> <p>2 MR. GORDON: Object to the form of the question.</p> <p>3 A. Yes. You wouldn't expect the antibiotic choice to</p> <p>4 contaminate the operative field.</p> <p>5 BY MR. ASSAAD:</p> <p>6 Q. There is nothing about changing the antibiotics that</p> <p>7 would increase the bacteria in the sterile field during</p> <p>8 the operation?</p> <p>9 A. No.</p> <p>10 Q. Now, based on your McGovern study, you agree that at the</p> <p>11 time, your opinion, based on the McGovern study, was</p> <p>12 that convection currents from the forced air warming</p> <p>13 device, the Bair Hugger here in this situation, had</p> <p>14 an effect on the unidirectional airflow in the operating</p> <p>15 room; correct?</p> <p>16 A. Yes.</p> <p>17 Q. And in fact, the correlation -- or the convection</p> <p>18 currents added particles or showed that there was air</p> <p>19 coming from underneath the operating room table into the</p> <p>20 surgical site; correct?</p> <p>21 A. Yes.</p> <p>22 Q. Did you see any bubbles going in the operating room,</p> <p>23 where the back table would be or the implant is, and the</p> <p>24 instruments?</p> <p>25 A. I can't honestly recollect whether rogue bubbles would</p>	<p style="text-align: right;">Page 207</p> <p>1 MICHAEL R. REED</p> <p>2 have gone -- our back table would always be within the</p> <p>3 laminar flow. I don't know how things are done in the</p> <p>4 U.S. But -- I don't know. Probably --</p> <p>5 Q. Is your back table close to the surgeon or -- or close</p> <p>6 to the scrub nurse or ...?</p> <p>7 A. Yes. So everything is within this 2.4 meter squared</p> <p>8 canopy. We are pretty strict on that.</p> <p>9 Q. So at the time, you didn't formulate an opinion on</p> <p>10 whether or not the disruption in the airflow caused by</p> <p>11 the Bair Hugger could contaminate the sterile</p> <p>12 instruments or the sterile implant?</p> <p>13 A. So I can't confirm or refute that. It might be</p> <p>14 something to ask Paul McGovern who was in the room more</p> <p>15 frequently.</p> <p>16 Q. What is a colony forming unit?</p> <p>17 THE EXAMINER: A ...?</p> <p>18 BY MR. ASSAAD:</p> <p>19 Q. A colony forming unit, a CFU.</p> <p>20 A. So this is -- yes, this essentially is a bacteria which</p> <p>21 goes on to cause an infection.</p> <p>22 Q. So viable bacteria; correct?</p> <p>23 A. Yes.</p> <p>24 Q. Is there a correlation between particles and CFUs?</p> <p>25 A. We certainly can't have any colony forming units without</p>
<p style="text-align: right;">Page 208</p> <p>1 MICHAEL R. REED</p> <p>2 any particles. We think that lots of particles are</p> <p>3 bacteria. In fact, there is, I think, published work on</p> <p>4 them, on how many particles will carry bacteria.</p> <p>5 I think it's in the region of 10 percent, but it's --</p> <p>6 that's my recollection of the literature.</p> <p>7 Q. Do you agree with me that airborne contaminants are the</p> <p>8 largest single contributor to infection; correct?</p> <p>9 A. Yes, I think that's true. That's certainly what most</p> <p>10 orthopaedic surgeons would believe.</p> <p>11 Q. And you would agree with me that a person would shed</p> <p>12 1 billion skin cells daily?</p> <p>13 A. That's what the literature says.</p> <p>14 Q. That's what it would be --</p> <p>15 A. Yes.</p> <p>16 Q. And you just testified that 10 percent of those other</p> <p>17 particles would be carrying colony forming units;</p> <p>18 correct?</p> <p>19 A. Correct. That is what the literature tells us.</p> <p>20 Q. So as the colony forming units -- or the particles</p> <p>21 increase, it would be safe to assume that the amount of</p> <p>22 bacteria would increase?</p> <p>23 A. Yes.</p> <p>24 Q. So would you agree that the Bair Hugger, based on your</p> <p>25 research in the McGovern study and the Belani study,</p>	<p style="text-align: right;">Page 209</p> <p>1 MICHAEL R. REED</p> <p>2 increases particle counts?</p> <p>3 THE EXAMINER: I don't think I want him to agree. I want</p> <p>4 him to answer whether that was a result of your</p> <p>5 research.</p> <p>6 A. So there are several studies that show -- that compare</p> <p>7 forced air warming with conductive fabric warming. Many</p> <p>8 of these are on the table today. And yes, you will get</p> <p>9 more -- more contamination, if you like, from the sides</p> <p>10 if you are using forced air warming. I think there's</p> <p>11 numerous studies that show that.</p> <p>12 BY MR. ASSAAD:</p> <p>13 Q. And more contamination of particles would mean</p> <p>14 an increase of the bacteria in the surgical site;</p> <p>15 correct?</p> <p>16 A. That's --</p> <p>17 MR. GORDON: Object to form.</p> <p>18 A. One would assume so.</p> <p>19 BY MR. ASSAAD:</p> <p>20 Q. Well, if 10 percent of the particles -- you just</p> <p>21 testified, if you increase the particles by five or six</p> <p>22 times, you would have five or six times more bacteria?</p> <p>23 A. Correct. That's ...</p> <p>24 MR. GORDON: Object to the form of the question.</p> <p>25 BY MR. ASSAAD:</p>

<p style="text-align: right;">Page 210</p> <p>1 MICHAEL R. REED</p> <p>2 Q. And would you agree with me that an increase of the</p> <p>3 bacteria in the surgical site would cause a greater</p> <p>4 chance of PJI by the susceptible host?</p> <p>5 MR. GORDON: Object to the form of the question.</p> <p>6 THE EXAMINER: What I really want to know is: was this as</p> <p>7 a result of the research they carried out, rather</p> <p>8 than -- when you ask him to agree with you, you are</p> <p>9 asking him in effect to express an personal opinion.</p> <p>10 It is just rewording the question to say: did your</p> <p>11 studies show that ...</p> <p>12 MR. ASSAAD: I would like to have back-ups, as</p> <p>13 a cross-examiner, of the document I am looking at.</p> <p>14 BY MR. ASSAAD:</p> <p>15 Q. Did any of your studies indicate that the increase in</p> <p>16 bacteria around the surgical site increases the</p> <p>17 likelihood of a peri-prosthetic joint infection by the</p> <p>18 susceptible host?</p> <p>19 A. So what we have shown is an association with, you know,</p> <p>20 what we did for a period of time and then we changed,</p> <p>21 and then we had a change in our infection rates; with</p> <p>22 the caveats that we had changes to our practice. Apart</p> <p>23 from that, as we have detailed and as we have put in the</p> <p>24 paper.</p> <p>25 Q. Besides -- and you have spent much time on the color</p>	<p style="text-align: right;">Page 211</p> <p>1 MICHAEL R. REED</p> <p>2 graph and we will go over it a little bit, maybe go over</p> <p>3 it.</p> <p>4 But is there anything in that graph or the changes</p> <p>5 in your practices that you could point to, that would</p> <p>6 cause increased particles into the surgical site,</p> <p>7 besides the forced air warming device?</p> <p>8 THE EXAMINER: Is this the one you mean?</p> <p>9 MR. ASSAAD: Yes.</p> <p>10 A. No, there wouldn't be anything else that you would be</p> <p>11 suspicious of.</p> <p>12 BY MR. ASSAAD:</p> <p>13 Q. And going back to the other issue of the McGovern</p> <p>14 article that counsel has raised today.</p> <p>15 Was the -- it was the xarelto issue with respect to</p> <p>16 changing the thrombo-prophylactics; correct? Do you</p> <p>17 recall doing a study which actually looked at the return</p> <p>18 to theater, in which you compared a low molecular weight</p> <p>19 heparin to xarelto and determined the infection rates?</p> <p>20 A. Yes. So that was led by a colleague of mine, but I was</p> <p>21 part of the group. And the primary outcome measure was</p> <p>22 return to theater, not infection. But it didn't</p> <p>23 actually show a significant difference in infection</p> <p>24 rates, but ...</p> <p>25 Q. Can you turn to tab 8?</p>
<p style="text-align: right;">Page 212</p> <p>1 MICHAEL R. REED</p> <p>2 A. Tab 8, yes.</p> <p>3 THE EXAMINER: Page?</p> <p>4 MR. ASSAAD: Page Reed 84. Let's mark that as exhibit</p> <p>5 number 11.</p> <p>6 THE EXAMINER: The page?</p> <p>7 MR. ASSAAD: No, the entire article. Reed 84 to Reed 99.</p> <p>8 (Exhibit Reed 11 marked for identification.)</p> <p>9 BY MR. ASSAAD:</p> <p>10 Q. Can you please describe this article? What are we</p> <p>11 looking at in exhibit 11?</p> <p>12 A. Right. Well, I will certainly describe what we did and</p> <p>13 then if you give me a minute, I will describe what we</p> <p>14 found, because there is a lot of detail in here with the</p> <p>15 various types of complication.</p> <p>16 Q. Just for the record, while we are looking at it, I am</p> <p>17 going to read the title, just so we have it clear for</p> <p>18 the ladies and gentlemen of the jury.</p> <p>19 A. So this title -- this paper is entitled:</p> <p>20 "Wound complications following rivaroxaban</p> <p>21 administration -- a multi-centre comparison with low</p> <p>22 molecular weight heparin for thromboprophylaxis in lower</p> <p>23 limb arthroplasty."</p> <p>24 So in basic terms, this is people that are having</p> <p>25 a hip or a knee replacement and does -- does giving</p>	<p style="text-align: right;">Page 213</p> <p>1 MICHAEL R. REED</p> <p>2 rivaroxaban or a low molecular weight result in more</p> <p>3 complications?</p> <p>4 Q. Now, I need to confess to you. When I pulled up this</p> <p>5 document, it was in production by Nachtsheim; but</p> <p>6 actually yesterday, I actually found the published</p> <p>7 version which was published in the Journal of Bone &amp;</p> <p>8 Joint Surgery in 2012; is that correct?</p> <p>9 A. Yes, I think it was published in the American journal,</p> <p>10 the American Bone &amp; Joint --</p> <p>11 Q. I would offer you to look at the published version, if</p> <p>12 you would like, unless there is any objection by your</p> <p>13 counsel.</p> <p>14 MR. HOLL-ALLEN: No.</p> <p>15 THE EXAMINER: This is not the published version?</p> <p>16 MR. ASSAAD: No, I found the published version.</p> <p>17 A. Is it the same? I don't know.</p> <p>18 BY MR. ASSAAD:</p> <p>19 Q. I believe it is. It has the same numbers.</p> <p>20 A. Thank you. Okay.</p> <p>21 Q. Let's mark this as exhibit 12, please.</p> <p>22 (Exhibit Reed 12 marked for identification.)</p> <p>23 THE EXAMINER: Are the two first named authors from your</p> <p>24 trust?</p> <p>25 A. They were at that time.</p>

<p style="text-align: right;">Page 214</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: They were at that time?</p> <p>3 A. Yes. So this -- briefly, this is a paper where we asked</p> <p>4 other hospitals around the country that had changed</p> <p>5 similarly to us, to get in touch; and then we analyzed</p> <p>6 their data remotely to see what the complications had</p> <p>7 been.</p> <p>8 BY MR. ASSAAD:</p> <p>9 Q. And xarelto does not increase increased particles or</p> <p>10 bacteria to the surgical site; correct?</p> <p>11 A. Correct.</p> <p>12 Q. I would like you to refer to page 1556.</p> <p>13 (Off the record remarks.)</p> <p>14 Q. Now, Mr. Reed, you would agree with me that if someone</p> <p>15 has a peri-prosthetic joint infection, they would have</p> <p>16 to be returned to the operating room; correct?</p> <p>17 A. Almost certainly. Very rarely not.</p> <p>18 Q. Okay. So if you look at this document, you have wound</p> <p>19 complications using xarelto, as compared to a low</p> <p>20 molecular weight heparin. And then you have, two below</p> <p>21 it, return to surgery from infection. Do you see that?</p> <p>22 A. Yes.</p> <p>23 Q. And do you agree with me that if we are looking at PJIs,</p> <p>24 we should be looking at the differences between xarelto</p> <p>25 and the low molecular weight heparin for returning to</p>	<p style="text-align: right;">Page 215</p> <p>1 MICHAEL R. REED</p> <p>2 surgery for infection; correct?</p> <p>3 A. Yes, correct. I just have the caveat that I don't know</p> <p>4 what timescale this looks at. But it is probably within</p> <p>5 30 days, which would be a reasonable thing to look at.</p> <p>6 (Off the record remarks.)</p> <p>7 Q. So would you agree with me that the change from the low</p> <p>8 molecular weight heparin in the McGovern study to</p> <p>9 xarelto in the return had no effect; it was not</p> <p>10 a confounding factor with respect to the infection</p> <p>11 rates?</p> <p>12 A. So based on this study of 12,000 patients, I would say</p> <p>13 there was no effect on return to surgery from infection.</p> <p>14 Q. So would you agree with me that based on this study,</p> <p>15 that you are an author of, that looking at the date of</p> <p>16 the McGovern paper, that now we can exclude xarelto as</p> <p>17 a confounding factor for infection rates?</p> <p>18 A. I think that's what this paper says.</p> <p>19 THE EXAMINER: Because you nevertheless thought it</p> <p>20 appropriate to refer to the change in the McGovern</p> <p>21 paper.</p> <p>22 A. Yes, because in our paper, there wasn't a significant</p> <p>23 difference in infection rates. But there was a signal;</p> <p>24 that was -- so that's why I put it in. It is safer to</p> <p>25 be upfront and fair about it.</p>
<p style="text-align: right;">Page 216</p> <p>1 MICHAEL R. REED</p> <p>2 BY MR. ASSAAD:</p> <p>3 Q. And we had a discussion today about the unidirectional</p> <p>4 airflow in the operating rooms; correct?</p> <p>5 A. Yes.</p> <p>6 Q. And you believe that it prevents -- using unidirectional</p> <p>7 flow prevents peri-prosthetic joint infections?</p> <p>8 A. Yes.</p> <p>9 Q. Because it reduces the particles in the operating room;</p> <p>10 correct?</p> <p>11 A. Yes.</p> <p>12 Q. There is an argument that has been made with respect to</p> <p>13 critiquing your McGovern article, that laminar flow</p> <p>14 actually increases peri-prosthetic joint infections.</p> <p>15 Have you heard that argument before, regarding your</p> <p>16 article?</p> <p>17 A. Yes.</p> <p>18 Q. And you are of the opinion that, in fact, that needs to</p> <p>19 be looked at, because you think the forced air warming</p> <p>20 has an effect on the laminar unidirectional airflow;</p> <p>21 correct?</p> <p>22 A. Yes. I think it may have an effect on that data.</p> <p>23 Q. And actually you have written about that in the book</p> <p>24 chapter published in 2016; correct?</p> <p>25 A. Yes, very likely.</p>	<p style="text-align: right;">Page 217</p> <p>1 MICHAEL R. REED</p> <p>2 Q. We have also discussed keeping patients warm during the</p> <p>3 preoperative and perioperative period; correct?</p> <p>4 A. Yes.</p> <p>5 Q. And you believe one or the other is fine; correct? Or</p> <p>6 I could have misunderstood you.</p> <p>7 A. Well, it's not -- you haven't misunderstood me, but</p> <p>8 I think in terms of where the evidence is, I think</p> <p>9 that's possibly where the evidence is; one or the other</p> <p>10 is fine. But I would say the best practice now is to do</p> <p>11 both. And in fact, the NICE guidance draft, which has</p> <p>12 just come out, will be to do pre-warming and warming</p> <p>13 during surgery.</p> <p>14 Q. But you agree that there's no evidence, scientific</p> <p>15 evidence, that indicates that keeping a patient warm</p> <p>16 during surgery and before surgery reduces</p> <p>17 peri-prosthetic joint infections?</p> <p>18 A. So do -- okay. So there's definitely evidence that in</p> <p>19 colorectal surgery, that keeping people warm reduces</p> <p>20 their infection rate. And there is evidence from</p> <p>21 David Leaper's study, who you are going to meet, that</p> <p>22 pre-warming patients reduces infection rates in their</p> <p>23 clean surgery. But that is not during the operation.</p> <p>24 That is before.</p> <p>25 I would say there isn't any evidence that doing</p>

<p style="text-align: right;">Page 218</p> <p>1 MICHAEL R. REED</p> <p>2 forced air warming during a joint replacement reduces</p> <p>3 the infection rates. I think that's the -- that's the</p> <p>4 purpose of the trial.</p> <p>5 Q. And the colorectal study you are referring to is the</p> <p>6 study back in 1996, that I think that counsel was</p> <p>7 indicating in the 1996 New England Journal of Medicine?</p> <p>8 A. It was in the New England Journal of Medicine, yes.</p> <p>9 Q. Were you aware that the patients -- the controls were</p> <p>10 actually cooled in those cases?</p> <p>11 A. I was aware of that and I think I put that in the Wood</p> <p>12 review article.</p> <p>13 Q. Okay. Are you aware that Dr. Sessler and Dr. Kurz</p> <p>14 currently believe that that data would not withstand the</p> <p>15 current research guidelines today?</p> <p>16 MR. GORDON: Object to the form of the question. Assumes</p> <p>17 facts not in evidence.</p> <p>18 A. So their own study, do you mean?</p> <p>19 BY MR. ASSAAD:</p> <p>20 Q. Yes.</p> <p>21 A. I wasn't aware of that.</p> <p>22 Q. By the way, going back to the McGovern study, which is</p> <p>23 exhibit number 8. There is an odds ratio. What is the</p> <p>24 odds ratio of 3-point -- what does that mean, 3.8 odds</p> <p>25 ratio?</p>	<p style="text-align: right;">Page 219</p> <p>1 MICHAEL R. REED</p> <p>2 THE EXAMINER: Where do I find that?</p> <p>3 MR. ASSAAD: Page number Reed 6.</p> <p>4 A. It is the risk of something happening, essentially.</p> <p>5 BY MR. ASSAAD:</p> <p>6 Q. Would it be according -- could it be linked to the</p> <p>7 relative risk?</p> <p>8 A. Yes.</p> <p>9 THE EXAMINER: 15 ...</p> <p>10 MR. ASSAAD: 42.</p> <p>11 BY MR. ASSAAD:</p> <p>12 Q. So based on your study in the McGovern, would it be fair</p> <p>13 to say that the relative risk of getting -- and based on</p> <p>14 the data, that the relative risk of getting</p> <p>15 a peri-prosthetic joint infection is 3.8 times greater</p> <p>16 using a Bair Hugger than using a conductive warming</p> <p>17 blanket, based on your study?</p> <p>18 A. Based on that paper, yes.</p> <p>19 THE EXAMINER: What was the figure you put to him?</p> <p>20 MR. ASSAAD: 3.8.</p> <p>21 BY MR. ASSAAD:</p> <p>22 Q. Now, going forward to -- let me go back.</p> <p>23 There came a time when you became part of the pilot</p> <p>24 study that -- it's called the "Reducing implant</p> <p>25 infection orthopaedics"; correct? The pilot study that</p>
<p style="text-align: right;">Page 220</p> <p>1 MICHAEL R. REED</p> <p>2 you were referring to?</p> <p>3 A. The RIIO study, is it?</p> <p>4 Q. The RIIO study, yes. The RIIO stands for "Reducing</p> <p>5 implant infection orthopaedics"; and that is under tab</p> <p>6 number 18. And let's make that exhibit 13.</p> <p>7 (Exhibit Reed 13 marked for identification.)</p> <p>8 Q. Have you seen this document before, this protocol?</p> <p>9 A. Yes.</p> <p>10 Q. And that is version 1.0, dated September 9, 2016;</p> <p>11 correct?</p> <p>12 A. Yes. I have to say, I am not sure I have seen this</p> <p>13 version of the document, but I have seen -- I have seen</p> <p>14 the protocol.</p> <p>15 Q. Do you know if there's more than one version?</p> <p>16 A. Well, there will be several iterations. I know it is</p> <p>17 down as version 1.0, but it's probably -- you know,</p> <p>18 these things evolve over several weeks or months of</p> <p>19 discussion normally.</p> <p>20 Q. Have you been part of authoring this pilot study?</p> <p>21 A. I have certainly been involved in the -- in the</p> <p>22 conference calls about how it's designed.</p> <p>23 Q. Were you aware that there was another 1.0 version</p> <p>24 dated July 5th, 2016?</p> <p>25 A. Well, I am sure. I mean, generally there will be lots</p>	<p style="text-align: right;">Page 221</p> <p>1 MICHAEL R. REED</p> <p>2 of versions of them.</p> <p>3 Q. If you go to exhibit number 4, binder 4. Not in mine.</p> <p>4 In the big gigantic binders over there.</p> <p>5 A. Okay.</p> <p>6 THE EXAMINER: Page?</p> <p>7 MR. ASSAAD: Page 1609.</p> <p>8 A. 1609, is it?</p> <p>9 BY MR. ASSAAD:</p> <p>10 Q. Yes.</p> <p>11 A. Okay.</p> <p>12 (Off the record remarks.)</p> <p>13 Q. Have you seen this document before?</p> <p>14 A. Well, I mean, I have definitely been involved in the</p> <p>15 evolution of this study.</p> <p>16 Q. Were you involved in this project, the pilot study,</p> <p>17 prior to July 5th, 2016?</p> <p>18 A. In terms of discussion about it, yes.</p> <p>19 Q. Okay.</p> <p>20 And at this time, the funder does not have 3M</p> <p>21 Healthcare as part of the funding. It has, like, three</p> <p>22 Xs there under "Funding" on page 1609; correct?</p> <p>23 A. Yes, correct. It is just the Healthcare Infection</p> <p>24 Society.</p> <p>25 Q. Do you know when 3M Healthcare decided to become</p>



<p style="text-align: right;">Page 222</p> <p>1                   MICHAEL R. REED</p> <p>2           involved in this pilot study?</p> <p>3   A. A little earlier than this; but I don't think they have</p> <p>4           signed contracts. I'm not aware they have signed</p> <p>5           contracts. So normally these things actually evolve</p> <p>6           over several months.</p> <p>7           So were they discussing it in July? I think there</p> <p>8           probably was an expression of interest and</p> <p>9           an understanding that 3M may fund it, I believe.</p> <p>10   Q. Do you know Dr. Mark Harper?</p> <p>11   A. Yes.</p> <p>12   Q. How do you know Dr. Mark Harper?</p> <p>13   A. Well, we sit on the NICE guidance committee together.</p> <p>14           I run an infection prevention meeting in the North,</p> <p>15           which he spoke at about a month ago. So I have met him</p> <p>16           a few -- well, I would say three times.</p> <p>17   Q. Do you know that he is on the 3M advisory panel,</p> <p>18           scientific advisory panel?</p> <p>19   A. No, I didn't know that.</p> <p>20   Q. Do you know he got paid by 3M?</p> <p>21   MR. GORDON: Object to the form of the question.</p> <p>22   A. No.</p> <p>23   THE EXAMINER: What for?</p> <p>24   BY MR. ASSAAD:</p> <p>25   Q. For his consulting.</p>	<p style="text-align: right;">Page 223</p> <p>1                   MICHAEL R. REED</p> <p>2   A. No. He may have been the link between 3M and the study,</p> <p>3           I suppose. He probably was.</p> <p>4   Q. I take it the null hypothesis in this study is that</p> <p>5           there is no difference between forced air warming and</p> <p>6           resistive fabric warming; correct?</p> <p>7   A. Yes.</p> <p>8   Q. What is the hypothesis?</p> <p>9   A. So we are just trying to tell if there is a difference</p> <p>10           between the two. And we will decide on numbers, based</p> <p>11           on the first 1,000 patients that we get in; it will give</p> <p>12           us a feel for the infection rates and then we will be</p> <p>13           aiming to show a difference or not between the two.</p> <p>14   Q. But what is the working hypothesis, though? There has</p> <p>15           to be a working hypothesis. Is one better than the</p> <p>16           other?</p> <p>17   A. I am not sure how the stats are structured, to be</p> <p>18           honest; whether it is an equivalent study or</p> <p>19           a superiority study.</p> <p>20   Q. I think it is a superiority study. So it has to ...</p> <p>21   A. Well, I imagine suggesting then that there is</p> <p>22           a difference, that forced air has a higher infection</p> <p>23           rate. But I can't remember the detail of that, I am</p> <p>24           afraid. Unfortunately it's not my study.</p> <p>25   Q. What is your involvement in the study going to be?</p>
<p style="text-align: right;">Page 224</p> <p>1                   MICHAEL R. REED</p> <p>2   A. So I have been involved in the design, if you like, of</p> <p>3           it; and I will be a recruiting center for it. Our trust</p> <p>4           will recruit patients, I think. That depends a little</p> <p>5           bit on whether my colleagues are willing to do it. But</p> <p>6           I mean, this is a study that I have been wanting to do</p> <p>7           for some time.</p> <p>8   Q. Since you published the McGovern study; correct?</p> <p>9   A. Since before that. 2009 is when I asked Scott Augustine</p> <p>10           to fund it. We didn't ask 3M at that point.</p> <p>11   Q. And how much is the study going to cost, approximately,</p> <p>12           this patient study? Is there an estimate?</p> <p>13   A. I think -- I have got the figure on my CV. So this is</p> <p>14           a pilot study, so it is not the whole study. But</p> <p>15           I think the -- I think 3M and the infection --</p> <p>16           Healthcare Infection Society are putting in, was it</p> <p>17           117,000 I saw on my CV?</p> <p>18   Q. Yes. And are you getting compensated for your time</p> <p>19           involved in this study?</p> <p>20   A. No.</p> <p>21   Q. Do you have a contact at 3M that you are dealing with,</p> <p>22           regarding this study?</p> <p>23   A. Regarding this study, no. I have got no involvement</p> <p>24           with 3M personally, with this study. I do have</p> <p>25           involvement with a different branch of 3M over my other</p>	<p style="text-align: right;">Page 225</p> <p>1                   MICHAEL R. REED</p> <p>2           randomized trial that I am doing.</p> <p>3   Q. Were you aware that other experts such as -- such as</p> <p>4           Dr. Sessler has also advised 3M over the years back?</p> <p>5   MR. GORDON: Object to the form of the question.</p> <p>6   BY MR. ASSAAD:</p> <p>7   Q. If you go to page ...</p> <p>8           Sorry.</p> <p>9           (Off the record remarks.)</p> <p>10   Q. Page Reed 172, 15 of 22 of the pilot. And this is the</p> <p>11           pilot study with your name on it; is that correct?</p> <p>12   A. Yes.</p> <p>13   Q. Okay.</p> <p>14           If you look at the fourth line down, under "Warming</p> <p>15           method and temperature monitoring" under 8. It says:</p> <p>16           "Both forced air warming and resistive fabric</p> <p>17           warming are established and licensed for use in the U.K.</p> <p>18           and are equally effective at preventing inadvertent</p> <p>19           perioperative hypothermia."</p> <p>20           Did I read that correctly?</p> <p>21   A. I can't see where you are reading it, but what you</p> <p>22           said --</p> <p>23   Q. Under "Warming method" --</p> <p>24   THE EXAMINER: Right down at the bottom of the page.</p> <p>25   BY MR. ASSAAD:</p>

1 MICHAEL R. REED  
 2 Q. The third line up from the bottom.  
 3 A. Yes. Yes.  
 4 "... are established and licensed for use in the  
 5 U.K. and are equally effective at preventing inadvertent  
 6 perioperative hypothermia."  
 7 Yes. I think that is a reasonable statement.  
 8 THE EXAMINER: So the primary function, they are equivalent.  
 9 A. In terms of warming, yes, I think that is a fair  
 10 summary. I think even that is debated, but yes.  
 11 BY MR. ASSAAD:  
 12 Q. Mr. Reed, you stand by your studies; correct?  
 13 A. Yes.  
 14 Q. And even though Mr. Albrecht and Dr. Augustine were  
 15 funding the studies involved, they did not influence the  
 16 data or the results that you have concluded; correct?  
 17 A. Yes. So just to be clear, there was no funding for any  
 18 of these studies apart from the very first one, which  
 19 was the one actually that didn't show any difference.  
 20 But yes, I do stand by them, yes.  
 21 MR. ASSAAD: All right. At this time, under the Federal  
 22 Rules of Evidence, I am going to offer him as an expert  
 23 and the stuff he has testified in, with respect to  
 24 orthopaedic surgery, peri-prosthetic joint infections  
 25 and the causation of peri-prosthetic joint infections.

1 MICHAEL R. REED  
 2 to agree with him, or whatever the exact words were,  
 3 I can't remember. But essentially that using forced air  
 4 warming was 3.8, and it increased the rate of infection  
 5 3.8 times over the other warming modality and you said  
 6 "based on that paper".  
 7 Two questions.  
 8 First of all, why in the paper did you say:  
 9 "This study does not establish a causal basis for  
 10 this association."  
 11 MR. ASSAAD: Objection to form.  
 12 THE EXAMINER: You may answer.  
 13 A. Because it doesn't. It doesn't establish causation, our  
 14 paper. The -- yes, okay.  
 15 BY MR. GORDON:  
 16 Q. So what did you -- when you said "based on that paper",  
 17 I mean, what was it that you were saying?  
 18 A. So as I said right at the start, right at the start of  
 19 the proceedings, I said I wanted to mention something  
 20 about that paper.  
 21 And -- in that we -- there was some very up to date  
 22 data which I thought was in it. It does not actually  
 23 change the material effect of the paper. You know, the  
 24 conclusions are still the same.  
 25 But that final data that we got in, for some reason,

1 MICHAEL R. REED  
 2 And after that, I have no further questions.  
 3 THE EXAMINER: I am sorry, you are going to have to say that  
 4 again.  
 5 MR. ASSAAD: I am offering him as an expert in the testimony  
 6 he has given to his studies, with respect to orthopaedic  
 7 surgery, general causation on peri-prosthetic joint  
 8 infections and general peri-prosthetic joint infections  
 9 under the Federal Rules of Evidence.  
 10 THE EXAMINER: I don't know what you mean by "offering him  
 11 as an expert". However, he is not here specifically  
 12 under the terms of the U.K. order to give expert  
 13 evidence, on the basis that both parties have their own  
 14 experts in the United States.  
 15 Now, if you want to try and change this into  
 16 something different in the U.S.A., that is a matter  
 17 between the parties and the judge but I want to make it  
 18 crystal clear that he has not been giving evidence today  
 19 in this room as an expert. Okay?  
 20 Now, Mr. Gordon, it seems to me on the timescale,  
 21 you have about 20 seconds left for re-examination.  
 22 MR. GORDON: I thought it was more like 40.  
 23 FURTHER EXAMINATION BY MR. GORDON:  
 24 Q. Mr. Reed, when counsel asked you about the McGovern  
 25 studies showing an odds ratio of 3.8, and he asked you

1 MICHAEL R. REED  
 2 did not get into the final paper. It might -- it did  
 3 change the odds ratios very slightly. That's the reason  
 4 that I mention it.  
 5 So it might not be 3.9. It was probably 3.8 or  
 6 something like that. But I think it is somewhere in  
 7 here. We could look it up.  
 8 Q. But regardless of whether it's 3.8 or 3.9 or ...  
 9 What does it mean that there is -- that the study  
 10 does not establish a causal basis?  
 11 MR. ASSAAD: Objection. I think his time is up.  
 12 THE EXAMINER: I think I will allow you to answer this  
 13 question and then that's it.  
 14 A. So what we have shown is association and not causation.  
 15 We made that pretty clear in the paper.  
 16 THE EXAMINER: Okay.  
 17 MR. GORDON: Thank you.  
 18 THE EXAMINER: Thank you very much.  
 19 MR. ASSAAD: Thank you.  
 20 THE EXAMINER: That concludes your examination, Mr. Reed.  
 21 Thank you very much indeed.  
 22 THE VIDEOGRAPHER: This is the end of the deposition of  
 23 Michael Reed. We are going off the record at 5:53.  
 24 (5:53 p.m.)  
 25 (Whereupon the deposition concluded.)

MICHAEL R. REED

## CERTIFICATE OF DEPONENT

I, MICHAEL R. REED, hereby certify that I have read the foregoing pages, numbered 1 through 232, of my deposition of testimony taken in these proceedings on Sunday, December 4, 2016, and, with the exception of the changes listed on the next page and/or corrections, if any, find them to be a true and accurate transcription thereof.

Signed: .....

Name: MICHAEL R. REED

Date: .....

MICHAEL R. REED

## CERTIFICATE OF COURT REPORTER

I, ROSE HELEN CLAIRE KAY, an Accredited LiveNote Reporter of London, England, hereby certify that the testimony of the witness MICHAEL R. REED in the foregoing transcript, numbered pages 1 through 232, taken on Sunday, December 4, 2016 was recorded by me in machine shorthand and was thereafter transcribed by me; and that the foregoing transcript is a true and accurate verbatim record of the said testimony.

I further certify that I am not a relative, employee, counsel or financially involved with any of the parties to the within cause, nor am I an employee or relative of any counsel for the parties, nor am I in any way interested in the outcome of the within cause.

Signed: .....

ROSE HELEN CLAIRE KAY

Dated: December 7, 2016

MICHAEL R. REED

## E R R A T A

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