DE-IDENTIFIED DEPOSITION OF PULMONARY & CRITICAL CARE PHYSICIAN

1

2 SUPREME COURT OF THE STATE OF NEW YORK

3 COUNTY OF NASSAU
----------X

4

as Parents and Natural

5 Guardians of , an infant
under the age of fourteen years,

6

Plaintiffs,

7

-against-

8

, M.D.,

9 , , M.D., ,
M.D., M.D., , M.D.,

10

Defendants.

11

----------X

12

13 Mineola, New York

14 October 17,
10:11 a.m.

15

16

17 EXAMINATION BEFORE TRIAL of a Non-Party

18 Witness, , M.D.

TOMMER REPORTING, INC.
192 Lexington Avenue
Suite 802
New York, New York 10016
(212) 684-2448

A P P E A R A N C E S:

THE LAW OFFICES OF GERALD M. OGINSKI
Attorneys for Plaintiffs
150 Great Neck Road, Suite 304
Great Neck, New York 11021

& , ESQS.
Attorneys for Defendant
, M.D.

BY: , ESQ.

, LLP
Attorneys for Defendants
, , M.D., , M.D., , M.D., , M.D.

BY: , ESQ.

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

It is hereby stipulated and agreed by and between the counsel for the respective parties hereto that all rights provided by the C.P.L.R., including the right to object to any question, except as to form, or to move to strike any testimony at this examination, are reserved, and, in addition, the failure to object to any question or to move to strike any testimony at this examination shall not be a bar or waiver to doing so at, and is reserved for, the trial of this action;

It is further stipulated and agreed by and between counsel for the respective parties hereto that this examination may be sworn to by the witness being examined before a Notary Public other than the Notary Public before whom this examination was begun, but the failure to do so, or to return the original of this examination to counsel, shall not be deemed a

waiver of the rights provided by Rules 3116 and 3117 of the C.P.L.R., and shall be controlled thereby.

It is further stipulated and agreed by and between counsel for the respective parties hereto that this examination may be utilized for all purposes as provided by the C.P.L.R.;

It is further stipulated and agreed by and between counsel for the respective parties hereto that the filing and certification of the original of this examination shall be and the same are hereby waived;

It is further stipulated and agreed by and between counsel for the respective parties hereto that a copy of the within examination

shall be furnished to counsel representing the witness testifying without charge.

, M. D.,

called as a witness, having been first duly sworn, was examined and

testified as follows:

EXAMINATION BY

MR. OGINSKI:

Q State your name for the record, please.

A , M.D.

Q Your address, please?

A , ,

.

MR. OGINSKI: Please mark this as Plaintiffs' 1.

(Whereupon, the Doctor's curriculum vitae was received and marked as Plaintiffs' Exhibit 1 for identification, as of this date.)

Q Good morning, Doctor?

A Morning.

Q Do you currently work for the ?

A Yes, I do.

Q What in what capacity?

, M.D.

A I'm a fellow in the Pediatric ICU.

Q What year fellowship are you?

A I'm currently in my third year.

Q Is this your final year for this fellowship program?

A Yes.

Q In the year what was your position at ?

A I was a first-year Pediatric ICU fellow.

Q Your attorney has provided us with a copy of your CV, have you reviewed that?

A Yes.

Q Is that accurate as of today?

A Yes.

Q We've had it marked as Plaintiffs' 1 for identification.

MR. : We have the original record here, which was previously marked on July 29th as Plaintiffs' Exhibit 1 for identification.

MR. OGINSKI: I'm only talking about her CV.

, M.D.

MR. : I know, but in addition we have that here.

MR. OGINSKI: Fine.

Q Did you review 's hospital record in preparation for today's deposition?

A Yes.

Q Did you review any notes separate and apart from what's contained in those records regarding this deposition?

A No.

Q Did you review any deposition testimony given by anyone in this case up to the present time?

A No.

Q Did you speak with Dr. concerning this deposition?

A No.

Q Did you speak with Dr. concerning this deposition?

A No.

Q Have you spoken with either Dr. or Dr. about the testimony that they have given in this case?

, M.D.

A No.

Q I'd like you to turn, please, to your first note in the hospital's chart, which appears on the paginated Page 8 on the bottom right, and the date on your note appears to be August 21, ?

MR. : We have it.

Q At that time were you a first-year fellow in the PICU?

A Yes.

Q Had you just completed your residency in June of ?

A Yes.

Q That was in general pediatrics, correct?

A Yes.

Q That was done at

?

A Yes.

Q The note that you wrote on August 21, that was the admission note for this patient into the Pediatric Intensive Care Unit, correct?

A Yes.

, M.D.

Q Was it customary for you as fellow to conduct a history, perform a physical and note your findings in the form of a note?

A Yes.

Q Is that what you did?

A Yes.

Q I'd like you to turn, please, to the second page of that admission note under

the plan and I'd like to you read that paragraph, please?

A "Continue CV respiration."

Q Let me interrupt you. If there are initials just tell me what that they represent?

A "Continuous cardiovascular respiratory monitoring. Start Nafcillin for a possible staphylococcus infection. Consider Vancomycin for possible drug resistant pneumococci. Infectious Disease approval not obtained. Observe for now. Continue Ceftriaxone. Chest x-ray in A.M."

Q You discussed all your findings with Dr. , correct?

A Yes.

Q When you wrote, "ID approval not

, M.D.

obtained," what did you mean?

A As protocol for the hospital, certain antibiotics before you can use them you need to discuss their use with Infectious Disease, and Vancomycin is one of them. For them to determine whether it is to be indicated or not you do have to discuss the case with them and the current antibiotics regimen in place, so that is why that particular sentence was made because we discussed the possible need for Vancomycin and they deemed it was not necessary.

Q When you say we discussed it, can you be specific as to who you were referring to?

A Infectious Disease attending or the fellow on service.

Q That would be a conversation that you had with either one of those physicians?

A Yes.

Q Do you have an independent memory of this patient separate and apart from your review of this chart?

A No.

, M.D.

Q Is there anything in your notes which indicates to you exactly who it was from the Infectious Disease service that you spoke to?

A No.

Q Is there any reason that you know of as you can sit here today determine why approval was not given for the use of Vancomycin?

A Because the antibiotics were deemed appropriate for her particular presentation.

Q You're referring to the Ceftriaxone and the Nafcillin?

A Yes.

Q Did they make any other recommendations to you about any other types of medication for the condition for which she was now admitted?

A Not that I recall.

Q When you spoke to someone from the Infectious Disease service, was it by telephone or in person?

A I don't remember. It could be either way.

, M.D.

Q At the time that you had a conversation with someone from ID, did that

person examine the child before coming to any conclusion about any questions you may have had?

A I do not recall, but it's not customary for them to go to the bedside.

MR. : Under these circumstances.

A Under these circumstances. If it's for antibiotic approval, they did not usually routinely examine the child.

Q You noted that Vancomycin was considered for possible drug resistant pneumococci. What suggested to you that this patient might have a drug resistant pneumococci?

A Just that she -- the fact that she was admitted to the unit with persistent symptoms.

Q Did you obtain a history from the parents as well?

A It is my custom to do that, but I do not recall.

, M.D.

Q From your note can you tell whether you spoke to Mrs. , Mr. or any other family member?

A I do not particularly recall.

Q Is there anything in your note to suggest who, if anyone, from the family you spoke to in obtaining the patient's history?

A No.

Q As part of your history and physical and making a note, would it be customary for you to review the patient's records for her admission for the days before entering the PICU?

A Yes.

Q Did you learn on August 21, ,

that the patient had been seen and evaluated by her pediatrician prior to being admitted to ?

A Yes.

Q What information did you learn about the treatment she received from her pediatrician?

A All that's just recorded in her history.

, M.D.

Q Which history are you referring to?

A The emergency room record and the admitting history on the pediatric floor.

Q In both of those histories did you learn that the patient had experienced any type of abdominal pain prior to her admission?

A At her presentation to the ER she had abdominal pain.

Q Did you learn from the prior history that's noted in the hospital record that whether she had been given any course of antibiotics by the pediatrician?

A As I recall just from looking at the history, I remember that she did not.

Q Do you know a physician named Dr. ?

A No.

Q Have you ever spoken with Dr. regarding ?

A No.

Q Did you review the patient's x-rays that were taken on admission or shortly after admission but before she was admitted to the PICU?

, M.D.

A Yes, at the time of her admission.

Q At that time did you observe that there was a total white out to a portion of her lungs?

A Yes.

Q What was the medical significance of that finding to you, if anything?

A A white out can signify a combination of pneumonia and/or a pleural effusion.

Q Did you form your own opinion as to what that complete white out represented at the time you observed it?

A It, again, taking into account her presentation and my physical exam that it was consistent with bacterial pneumonia.

Q What suggested that it was bacterial pneumonia as opposed to any other

type of pneumonia at that time?

A The pattern of its appearance on the x-ray, her fever curve.

Q What was it about the appearance on the x-ray that led you to conclude initially that she had a bacterial pneumonia?

, M.D.

A The fact that it only involved a segment or a particular lobe.

Q Was the appearance of the lobe that you're referring to, was it loculated or lobulated in any form or fashion?

A You cannot tell that by x-ray. You can only tell which particular lobe is involved.

Q What is it about the fact that

there was only one lobe involved that suggested to you that this was a bacterial process and not some other type?

A Bacterial pneumonias are the ones that usually involve a segment or a lobe of the lung.

Q In your experience as of August, , had you seen x-rays of a similar nature where it turned out the patient did not have bacterial pneumonia, but instead had a different type?

A No.

Q Doctor, am I correct that you graduated from The University of The in Medical School?

, M.D.

A Yes.

Q That was in ?

A Yes.

Q You became licensed to practice medicine in the State of New York in the year ?

A Yes.

Q Was that before August of , after?

A Yes, before.

Q You also became board certified in Pediatrics in the year ?

A Yes.

Q You also took a test known as the after graduating medical school?

A No, the test is the , and it is the test that gives certification.

Q That was in ?

A Yes.

Q That's for foreign medical school graduates who come to the United States to

23 begin training or practice?

24 A Yes.

25 Q You presented lectures at two

1 , M.D.

2 different occasions one in May and one in

3 October of , correct?

4 A Yes.

5 Q Have you published any peer review

6 journals -- I'm sorry, have you published any

7 literature in any peer review journals?

8 A No.

9 Q Have you participated in publishing

10 any portions of any medical textbooks?

11 A No.

12 Q Are you on any peer review

13 committee to review papers submitted for

publications of any peer review journal?

A No.

Q Has your license to practice medicine ever been suspended or revoked?

A No.

Q Has your board certification ever been suspended or revoked?

A No.

Q Have your privileges at any hospital ever been suspended or revoked?

A No.

Q What were your general

, M.D.

responsibilities as a fellow at in August, of ?

A To do rounds on all the Pediatric

ICU patients, to take calls at night as determined by our call schedule, to work under the supervision of an attending physician and making the plan for the care of patients.

Q Were there any other fellows besides yourself in the same field of medicine in which you were practicing in August, of at ?

A Yes.

Q How many others were there?

A There were four more.

Q Did you see on a daily basis for a period of time?

A Yes.

Q Did there come a time that one of your other fellows, one of your colleagues who was also a fellow, saw on the occasions when you were unable to or not working?

A Yes.

Q Did you have a custom and practice

, M.D.

back in August of that you would make rounds on the patients in the Pediatric ICU with the attending physician?

A Yes.

Q Was that always done?

A Yes.

Q Was it a custom and practice for you to discuss the patients that you rounded on with the attending physician who was present in the PICU on any given day?

A Yes.

Q In preparation for today's deposition did you review any medical literature concerning the topic of which this case is involved?

A No.

Q Were you provided or given any written questions to review in preparation for today's deposition?

A No.

Q Were you ever asked to prepare any written statement of your involvement with ?

A No.

, M.D.

Q Were you ever asked to prepare any material statements that was recorded concerning your involvement with ?

A No.

Q Did you ever present 's

case at any conference at Medical ?

A No, I did not.

Q Do you know if any physician ever presented Ms. 's case to any group of physician's for educational purposes either at rounds, grand rounds or some other conference held at Medical ?

A Unfortunately I've been unable to attend any rounds.

Q I'm just asking if you're aware?

A Not that I recall.

Q I'd like you to tell me, please, what is cold agglutinin test?

A It's a non-specific blood test that can indicate whether there is an atypical organism that may cause pneumonia. It's basically a red blood cell's reaction to being

, M.D.

exposed to cold, to a cold temperature.

Q Under what circumstances generally do you order a cold agglutinin test?

A If you have an index of suspicion for an atypical process going on.

Q In 's case are you aware that a cold agglutinin test was ordered in or about August 31, ?

A Upon review of the chart.

Q Did you learn who ordered the test?

A Again, by reviewing the chart Infectious Disease made that recommendation.

Q Do you know why it was ordered?

A Their notes, their note indicated that an atypical process may be possible.

Q You're referring now to the ID consult of August 31, correct?

A To the consult.

Q Take a look at that, Doctor. Do you know the name of the physician who wrote this consult note on August 31?

A I do not recognize the signature.

Q Is there a printed name that appears next to the signature that you can make

, M.D.

out?

A Not really. I don't remember.

Q At any time while you were treating in or around August 31, did you review and read this ID consult note?

A I do not remember.

Q Who called Infectious Disease for a consult?

A It was done based on the suggestion

of Dr. .

Q Were you present for any conversation or discussion about whether or not to call an ID consult?

A Yes.

Q Tell me about that conversation?

A It was requested to help us determine the duration of home antibiotic therapy, and also for someone to follow-up the patient when she was discharged home.

Q Was there any discussion during this conversation about the effectiveness of the antibiotic therapy that the patient had been receiving up to that time?

A Come again?

, M.D.

Q As of August 31st the patient had been receiving Nafcillin and Ceftriaxone, correct?

A Yes.

Q I believe the patient had been receiving the Ceftriaxone for approximately thirteen days and the Nafcillin for approximately ten days as of August 31st. Was there any discussion with Dr. or anyone else about whether that antibiotic regimen was effective in treating the child's condition at that time?

MR. : You mean when the decision was made to call Infectious Diseases because of the in-dwelling catheter and the need to follow her for the antibiotics therapy that was going to be administered at home?

MR. OGINSKI: Right.

MR. : Understand? You understand the question? On that morning when you wrote that in your

24 note was there any question about the
25 effectiveness of the antibiotics she

1 , M.D.
2 was receiving at the point?
3 A It was deemed adequate and it was,
4 again, just for duration of treatment.
5 Q What was the duration of treatment
6 for?
7 A The Infectious Diseases consult.
8 Q Was there anything to suggest to
9 you that the antibiotic therapy was not
10 effective in treating this child's condition
11 prior to Infectious Disease coming in for a
12 consult?
13 A No.
14 Q Is Ceftriaxone effective in

treating microplasma pneumonia?

A No.

Q Is Nafcillin effective in treating microplasma pneumonia?

A No.

Q What is a macrolide?

A Macrolide is a type of antibiotics that can usually cover atypical organisms as well as some bacterial organisms that can cause pneumonia.

Q Based upon your review of the

, M.D.

August 31 Infectious Disease consult note, were there any specific findings that led the Infectious Disease physician to conclude that a cold agglutinin test was warranted?

MR. : How could she express an opinion on what was in their mind?

MR. OGINSKI: I'm not asking her to express an opinion. I'm asking based on a review of the Infectious Disease consult note.

Q Is there anything within that note to suggest why a cold agglutinin test was ordered?

MR. : She can answer.

A No.

Q Would the performance of a cold agglutinin test have been useful to you earlier in terms of diagnosis and treatment of this patient?

MR. : Objection to the form of the question. Useful, that's not an appropriate question.

Q This patient was admitted to

, M.D.

on August 19th, correct?

A Yes.

Q From August 19th up until August 31st was there any clinical symptoms or findings to suggest to you that this patient warranted a cold agglutinin test be performed?

A No.

Q We know from a review of the record that the cold agglutinin test was positive, correct?

A Yes.

Q Can you say with a reasonable degree of medical probability whether that cold agglutinin test would have been positive if done one day earlier?

A No.

Q Can you say with any degree of medical probability whether that cold agglutinin test would have been positive any time earlier whether it's three days, five days, seven days, a week earlier, any time frame while she's still admitted?

A No.

Q Based on the positive findings of

, M.D.

the cold agglutinin test, did you form an opinion as to what type of condition or process was suffering from at that time?

A Again, it's a non-specific test.

Q Did you come to any conclusion as a result of that finding that suggested that this

patient was experiencing microplasma pneumonia as the underlying cause of her problems?

A No.

Q At any time while you were caring for the patient did you ever conclude that this patient was experiencing microplasma pneumonia?

A Only when her microplasma titers came back.

Q Do you recall based upon your review of the chart when that was?

MR. : I think it was the 6th of September.

A This wasn't part of the original chart.

Q What are you referring to, the lab reports?

A I think around the time that the microplasma titers came back I was not

, M.D.

responsible for her daily care at that time.

Q Am I correct that as a result of the cold agglutinin test showing up positive that an additional antibiotic was ordered for treatment of this patient?

A Yes.

Q The antibiotic that was ordered was a type of macrolide, correct?

A Yes.

Q That was Azithromycin, correct?

A Yes.

Q Tell me why Azithromycin was ordered?

MR. : Again, if she didn't order it, how can she tell you why it was ordered?

Q Did you order the Azithromycin?

A I do not recall.

Q Do you know why Azithromycin was

ordered?

A If I can't recall -- come again? Can you repeat your question?

Q We know that the cold agglutinin test came back positive and that an additional

, M.D.

antibiotic was added to her antibiotic regimen of the Nafcillin and the Ceftriaxone, correct?

A Um-hmm.

Q Why was the Azithromycin added to the antibiotic regimen?

A Presumably for the cold agglutinin, but if I didn't order it --

MR. : In other words, if you didn't order it, then you weren't

involved in the decision and you're only speculating; is that correct?

THE WITNESS: Yes.

Q Did you have any conversations with any physician after the cold agglutinin test came back positive to indicate or suggest that this patient was having any type of microplasma pneumonia?

A I don't remember.

Q Other than obtaining the microplasma titers, is there any other way to conclusively diagnose a patient with microplasma pneumonia?

A Not that I'm aware of.

Q Is a diagnosis of microplasma

, M.D.

pneumonia a diagnosis of exclusion?

A Yes, pretty much.

Q Would you consider microplasma pneumonia to be a form of an atypical pneumonia?

A Yes.

Q Can you tell me with what frequency did microplasma pneumonia appear in children in the year in the general population?

MR. : I'm going to object to that. She answered no, but you can't just generically say children because children run a gamut from pre-teenagers to newborns.

A No.

Q In the year what was the treatment of choice for children four-year-olds who were diagnosed with microplasma pneumonia?

A All microplasma pneumonias are treated with a macrolide.

Q Is a microplasma pneumonia a common finding in four-year-old children?

A No.

Q Was there anything in this

, M.D.

patient's history or presentation upon her admission to the Pediatric Intensive Care Unit that suggested to you that she needed an Infectious Disease consult initially?

A No.

Q Other than the reasons you've told me about for getting the ID consult, is there any other reason as to why Infectious Disease was called around August 31st?

A No.

Q Would it have helped you for the purposes of diagnosis and treatment of this child to have obtained an Infectious Disease

consult shortly after admission to the ICU?

MR. : I'm going to object to would it have helped you. These are not the standards by which doctors are judged. The question should be and it's already been asked in her professional opinion was one needed?

Q Do you have an opinion as you sit here today as to whether an Infectious Disease consult was warranted at any time before August

, M.D.

31st while she was admitted to the Pediatric Intensive Care Unit?

MR. : You can answer it.

A No.

MR. : No, you don't have an opinion?

A No, we don't need it.

Q The Infectious Disease consult of August 31, is there any way for you to know whether that physician still works at ? I know that you can't read the signature, but is there any way for you to know at this point whether that individual still works there?

A If I cannot identify the individual, I cannot make a comment where they're currently located.

Q The type of pneumonia that this patient had from the time that she entered the hospital did it change in any regard until the time that she was diagnosed with a microplasma?

A No.

MR. : I don't understand, did it change. What are you talking about? Did it get better, did it

, M.D.

improve? It was thought to be a staph strep bacterial pneumonia. That's what I think she means when she said that didn't change.

MR. OGINSKI: Let me rephrase the question.

Q At some point during this child's hospital admission she was diagnosed with having a microplasma pneumonia, correct?

A Yes.

Q Can you say with a reasonable degree of medical probability that this child had microplasma pneumonia at the time she was admitted to the hospital?

A I cannot.

Q We know that at some point, I think

your attorney mentioned September 6th when the microplasma titers came back as being positive for microplasma, that a diagnosis was made that she had microplasma. Is there any way for you to determine whether the child had the microplasma pneumonia before the titers came back?

A I don't understand.

, M.D.

Q Let me rephrase the question. Based upon the diagnosis that this child had microplasma in September of , can you also say that she had the microplasma in August of while she was still admitted at the hospital?

A I cannot.

Q Why can't you? Why can't you make that determination?

A Because a titer is only good up to the time you draw the titer. It's a reflection of the time you draw it. You can't really make any --

MR. : You can't determine that as going backwards.

A Back, yes.

Q If titers had been drawn a day earlier than when they originally had been taken, is there any way to determine whether those titers would be positive for microplasma?

MR. : The question's -- I'm not going to -- you know, if the moon was made out of cream cheese I could have some fantastic bagel with

, M.D.

cream cheese. If questions are really inappropriate. I mean, her answer's going to be no, but it's just an inappropriate question.

MR. OGINSKI: I'm going to rephrase.

Q Initially you told me that it was your suspicion was this patient had a bacterial pneumonia?

A Yes.

Q Did your suspicion that this patient had bacterial pneumonia change at any time before she was diagnosed with microplasma?

A No.

Q Based upon the diagnosis of microplasma pneumonia, can you say with a reasonable degree of medical probability that this patient did not have bacterial pneumonia?

A No.

Q Why?

A Because of the presentation, the clinical findings and the diagnostic test all pointed to the possibility, all pointed that this child had a bacterial pneumonia.

, M.D.

Q Did this patient have both a bacterial pneumonia and a microplasma pneumonia?

A In my opinion, yes.

Q Did this child have any other type of pneumonia in addition to the bacterial and the microplasma?

MR. : At what moment in time are we talking about when you asked your prior to question?

Q At any time during her hospital admission did she have any other type of pneumonia other than bacterial and microplasma pneumonia?

A Not that I know of.

Q The diagnosis of microplasma, does that mean that the patient did not have a bacterial pneumonia?

MR. : She's already answered that.

A I said they can co-exist.

MR. : She said they can co-exist.

Q Is microplasma a form of a virus?

, M.D.

A No.

Q I'd like you to go back, please, to your first admission to this patient of August 21?

MR. : Her fellow's note of August 21 do we have that?

Q Did you make any observations to the child's presentation whether she looked sick, cranky, uncomfortable or any other characterization at that time?

A Yes.

Q Tell me what you observed on that date concerning her physical appearance?

A The child was awake, alert, anxious in mild to moderate respiratory distress.

Q You're reading now from your note, correct?

A Yes.

Q What do you consider to be mild to moderate distress?

A The presence of dekipnia or fast breathing rate, and the nasal flaring and the

retractions.

Q Nasal flaring is suggestive of

, M.D.

what?

A Increased work of breathing.

Q What is the significance of the retractions that you observed?

A Increased rate of breathing.

Q What were the causes, generally what are the causes of the nasal flaring and the retractions?

MR. : You can ask her what her view of the cause is in this particular case.

MR. OGINSKI: I'll rephrase the question.

Q Did you form an opinion after conducting your history and physical examination and any other records that you had as to the cause of this child's nasal flaring and her retractions?

A The pneumonia.

Q How long had the pneumonia been present prior to the admission in the PICU?

MR. : How should she know that?

A It was determined that it's been

, M.D.

present for two days from the time of her admission to the time she was transferred to the ICU.

Q Who determined that the pneumonia

had been present for only two days?

MR. : She can only know what happened at the hospital. She came in with a diagnosis of pneumonia.

He's asking you can you say before she came into the hospital how long she had the pneumonia?

MR. OGINSKI: I'll ask it that way.

Q Can you determine based upon your examination of this patient on her admission to the PICU for how long she had had pneumonia prior to her admission to Medical ?

A No, I can't.

Q Based upon your review of the patient's chart, her history or your examination were you able to determine for how long this patient had clinical signs or

, M.D.

symptoms of pneumonia prior to her admission at ?

MR. : How could she know that?

MR. OGINSKI: If she can, I don't know.

A The signs and symptoms of pneumonia is very non-specific. You can see them with a cold, you can see them with a pneumonia, the only definite way to determine a pneumonia is to do ancillary radiographic tests.

Q Such as x-rays?

A Such as x-rays.

Q Are there any other diagnostic tests that you would use to evaluate a pneumonia?

A After x-rays you can either take a sample of fluid or if the child is intubated, you can take a sample of a tracheal aspirate.

Q When you say a sample of fluid you're talking about bronchial?

A Pleural or bronchial fluid.

Q That would be in the form of sputum or some other fashion?

, M.D.

A It's pleural or bronchial fluid.

Q Did you learn from anyone whether a chest x-ray or any other type of x-rays had been taken of this child while she was under the care of the pediatrician prior to her admission to ?

A I did not converse with the

pediatrician, so I do not know what he or she requested.

Q Is there anything in the notes that you recall reviewing that suggest whether the patient did or did not have x-rays prior to her admission?

A There's no mention in the history and physical of what the management was prior, just the diagnosis.

Q I'd like you to go back, please, to the Infectious Disease consult dated August 31, and I'd like you to read the Assessment And Plan on the second page of that consult note?

MR. : Again, you're asking her to read someone else's note.

MR. OGINSKI: Which she does on

, M.D.

a daily basis.

MR. : I understand that. That said, it may be difficult to read. She's certainly not here to interpret what someone else wrote, but if you can read the words, fine. If you can't, tell him you can't.

A "Four-year-old female with pneumonia left pleural effusion. Current treatment Ceftriaxone and Nafcillin adequate for strep pneumonia and staph orious infections. Secondary to low WBC count," I don't know what that was.

Q May I suggest, does that say continue or an abbreviation for continue?

A I can't tell whether it is or not. "Low grade temps. Unresponsiveness to current treatment and failure to find empyema on," I don't know what that word is.

Q Does that say thoracentesis?

A I don't know.

Q Did the patient have a thoracentesis?

A Yes.

, M.D.

Q Go ahead?

A "Would consider alternate etiologies EG microplasma, chlamydia, legionella. Recommend cold agglutinins microplasma titers would continue IV antibiotics until discharge if possible would then suggest oral antibiotics either high dose Amoxicillin or a macrolide depending on cold agglutinin."

Q I'm sorry, does it say a macrolide antibiotics?

A Yes.

Q Depending on cold agglutinin?

A Yes.

Q Based upon this assessment and plan can you tell from this note whether the unresponsiveness to current treatment was referring to the low grade temperatures or something else?

MR. : Again, you're asking her to interpret what someone else wrote?

MR. OGINSKI: At the moment, yes.

, M.D.

MR. : Can you do

that?

THE WITNESS: No.

Q Is there anything in this note under the assessment and plan portion that suggests what this physician was referring to when he or she wrote unresponsiveness to current treatment?

A No.

Q Was, in fact, there an inability to find empyema on thoracentesis?

A The cell count and the pleural fluid chemistries are consistent with an empyema. The fact that there was no growth of bacteria doesn't exclude that there wasn't any empyema.

Q Did 's presenting symptoms on admission resolve after three to five days on antibiotics?

MR. : Did all of her symptoms resolve, did some of them, did they to some degree? It's an inappropriate question.

25 Q Did her nasal flaring and her

1 , M.D.
2 respiratory distress resolve within three to
3 five days after being treated with antibiotics?
4 A Just what I documented for her. I
5 think that her fever curved and her work of
6 breathing did diminish.
7 Q At some point after that did it
8 return or increase? You mentioned that the
9 fever curve diminished at some point, did it
10 then return to a higher level?
11 MR. : You mean was there
12 occasional spikes after it was
13 diminishing?
14 MR. OGINSKI: That's fine.
15 A She would occasionally have fever

spikes, but the overall trend was she was fever free for the greater part of the day.

Q The fact that she continued to spike on different days with the fever what did that suggest to you, if anything?

A That we were incompletely evacuating the empyema.

MR. : That you had not completely evacuated, was that what you said?

, M.D.

THE WITNESS: Yes.

Q Was there any attempt to change or alter the antibiotics therapy other than the Nafcillin and Ceftriaxone before August 31?

A No.

Q At what point do you change antibiotics if the patients overall symptoms do not improve?

MR. : Objection to the question. Every patient is different. The symptoms are different. There's no hard and fast rule to any of that stuff.

Q At what point would you call in an Infectious Disease consult if the antibiotics don't resolve the problems the patient is experiencing?

MR. : That's highly speculative and objectionable.

Q Under what circumstances do you call an Infectious Disease consult?

A In general?

Q Yes.

MR. : I'm going to object

, M.D.

to in general. I'll reserve my right to the time of trial, but I'll let her answer in general you should be asking specific questions. Don't think of this for opening up a Pandora's box after this question. In the spirit of cooperation I'll let her answer in general.

In a broad general sense when would you call in an Infectious Disease consult?

A If you have concerns that the antibiotic regimen isn't clearing up an infection to one to guide you in more in changing therapy and in guiding you to request further diagnostic tests or to put in place a long term plan for prolonged antibiotics.

MR. : Which was the rationale in this case.

THE WITNESS: Yes.

Q Did you ever have any discussion with Dr. about the potential that this patient was experiencing any form of atypical pneumonia?

, M.D.

A Not that I recall.

Q Did you ever have any conversation with Dr. prior to the time that the microplasma titers came back positive that this patient was experiencing any type of atypical pneumonia?

A Not that I recall.

Q Was gram stain test done in this

case?

A Of the pleural fluid, yes.

Q Those came back negative, correct?

A Yes.

Q Microplasma is a gram negative organism, correct? Can you state that as a general statement?

A No, I can't.

Q Are you familiar with a test known as a prelaminaris chain reaction test?

A Yes.

Q What is that?

A A fraction of an organism's DNA is amplified so that one can detect levels of it.

Q Was any PCR test done to evaluate different respiratory pathogens for this

, M.D.

patient?

A Not that I remember.

Q Under what circumstances would you order a PCR test to be done in a child with this type of presentation?

MR. : Wait a minute. With a child with this type of presentation? It wasn't called for in her opinion.

MR. OGINSKI: I'm going to withdraw the question. I'll rephrase it.

Q Under what circumstances would you order a PCR test?

A If it was suggested by Infectious Disease.

Q What does PCR tests tell you over and above any of the other diagnostic test that you have available to you?

A That an organism was present.

Q In August of were PCR tests done at ?

MR. : You mean did they have the capability of doing them, is

, M.D.

that what you're asking?

MR. OGINSKI: Yes.

A I don't know that our particular lab does them. There may be a capability to send them out to a bigger .

Q Was there ever a discussion with any physician caring for while you were treating the patient of conducting any type of PCR test to evaluate the organism or organisms that she was suffering from?

A Not that I remember.

Q If you had had such a discussion about whether or not to do a PCR test, would you have expected to make a note of that in the patient's chart at some point?

A Yes.

Q In your review of the chart is there anything to suggest that there was any such discussion about doing the PCR test?

A No.

Q In order to do a PCR test does one need a blood sample or any other type of fluid sample?

, M.D.

A Yes.

Q What type of fluid is necessary?

A Usually blood.

Q How long does it take for a PCR test to come back with the results?

A I don't really know for certain how long.

Q Can you estimate whether it takes days, weeks?

A Weeks.

Q Would a PCR test have assisted you in evaluating this patient at any time while you were treating her?

MR. : Objection to assisted her. It is an inappropriate question as it was before. You can ask her in her review was one needed or required. I think you already have that answer but --

Q In the course of your fellowship at have you ever ordered PCR tests for any of your patients?

MR. : Note my objection

as immaterial.

, M.D.

Q In August of were you aware of the PCR test as being a diagnostic tool that you as a physician could order in order to evaluate the patient's condition?

MR. : I think she indicated that it would have been ordered or recommended by Infectious Diseases.

MR. OGINSKI: I know. I just want to know if she was aware at the time.

A I know that there's a test.

Q From the time that you started at in your fellowship in the Pediatric Intensive Care Unit up until the time

that you were treating , had you ever ordered any PCR testing for any patients?

MR. : Note my objection. It's immaterial.

MR. OGINSKI: Are you going to let her answer?

MR. : No, it's totally immaterial.

MR. OGINSKI: You can't direct her not to answer.

, M.D.

MR. : I can't?

MR. OGINSKI: You can't as you well know.

MR. : Where does it say that?

MR. OGINSKI: Show me in the CPLR where it says you can direct a witness not to answer a question except as to privilege.

MR. : If you notice I didn't agree to any stipulations before we started this examination, so I'm objecting.

MR. OGINSKI: You can't direct the witness not to answer.

MR. : Sure I can.

MR. OGINSKI: You can't.

MR. : I am. I'm advising her not to answer. You happy with that?

MR. OGINSKI: No.

Q Are you going to take your attorney's advice or will you answer the question?

, M.D.

A I already forgot the question.

Q Is a PCR test commonly performed by Pediatric Intensive Care physicians such as yourself?

MR. : Objection. It's immaterial. Advise her not to answer.

MR. OGINSKI: Materiality and relevancy is reserved at the time of trial. This is discovery.

MR. : Not when I don't agree with the stipulation.

MR. OGINSKI: Regardless of whether you agree with it or not you're not permitted to advise her not to answer.

MR. : This is amazing, you know. I've been at this

forty-three years and now you're telling me what I can do and not do. It's easy that I don't take offence easily, but the question is inappropriate and I'm not going to allow her to answer the question.

, M.D.

MR. OGINSKI: I think the judge would be the ultimate arbitrator.

MR. : Could be. That's what happens in life.

Q At any time while you were treating this patient is there any reason for you to order a PCR test?

A No.

MR. : Perfectly

legitimate question.

MR. OGINSKI: Thank you for your acknowledgment, Mr. .

Q Why not?

A We don't think it was indicated.

Q Why? What are the indications that you would need to order PCR tests?

A If you have -- one, you have to have an organism in mind to request a PCR. You just cannot request a PCR. A PCR of what? So it has to be directed towards what you think -- it has to be directed to some organism that you think may be in play.

Q After the cold agglutinin test came back positive was there any reason to perform a

PCR test?

A Not in my mind.

Q You mentioned earlier that the cold agglutinin test was a non-specific finding?

MR. : Correct.

Repetitious.

A Yes.

Q Did that test in and of itself exclude other causes of the organism this patient was suffering from?

A Can you explain your question?

Q Sure. As of the time the cold agglutinin test coming back positive, it was still your understanding or impression that the patient had a bacterial pneumonia, correct?

A Yes.

Q The cold agglutinin did not change that opinion at that point, correct?

A Yes.

Q The finding or the result of the cold agglutinin test, did it allow you to rule

out any other possible cause or condition for this patient?

A No.

, M.D.

Q Can you tell me with a reasonable degree of medical probability whether earlier diagnosis and treatment of microplasma would have altered this patient's hospital course?

A No.

Q No, you can't tell me?

A No, I cannot tell you.

Q Do you have an opinion with a reasonable degree of medical probability as to whether the microplasma had been diagnosed and treated earlier in this hospitalization whether the patient would have needed the chest tubes

that she had?

A Could you repeat your question?

Q Sure. If this patient had been diagnosed with microplasma early on in her admission and treated for it, can you tell me with a reasonable degree of medical probability whether she still would have required chest tubes?

A No, I cannot.

Q Can you tell me if, again, if microplasma had been diagnosed and treated earlier in her admission whether she would have

, M.D.

needed a bronchoscopy?

A No, I cannot.

Q Same question, if the microplasma

had been diagnosed and treated earlier in her admission, can you tell me with a reasonable degree of medical probability whether she would have needed an open thoracotomy?

A No, I cannot.

Q Did you learn at some point after the thoracotomy had been performed that she had suffered a form of an iatrogenic injury during the procedure?

A Upon reviewing the surgeon's operative note.

Q Did you ever speak to Dr. at any point after the surgery was performed but before she left the hospital?

A Not that I remember.

Q Do you have an opinion that if microplasma had been diagnosed and treated earlier in 's hospital admission whether she would have needed to be on a mechanical ventilator?

A Repeat your question again.

, M.D.

Q Sure. If she had been diagnosed with microplasma early on and treated for it, can you tell me with a reasonable degree of medical probability whether she would have needed to be on a mechanical ventilator?

A No.

Q No, you can't tell me?

A No, I cannot tell you.

Q What are the long term effects, if any, of microplasma?

A None.

Q Is there any literature that you're aware of to suggest that microplasma is responsible for the onset of asthma?

MR. : Objection to questions about literature.

Q Are you aware of any studies in the medical field to suggest that one of the effects of microplasma is a late onset of asthma?

MR. : Objection. It's an inappropriate way to question people about literature.

Q The statement that you made that

, M.D.

there are no long term effects of microplasma, what do you base that opinion on?

A My fund of knowledge.

Q Within that fund of knowledge was there anything in information that suggests that asthma or onset of asthma is an effect of the microplasma?

MR. : She just told you that in her opinion based on her fund of knowledge there is no long term effect. Now you're just asking the question all over again in another way. It's repetitious.

MR. OGINSKI: That's my job.

MR. : No, it's not. To be repetitious is not your job.

MR. OGINSKI: I'm not being repetitious.

MR. : I think you are. If you ask the same question over and over again, you're being repetitious.

MR. OGINSKI: Not when it is a different question.

, M.D.

MR. : It's not a different question. It has a different shade to it, but it's the same question.

MR. OGINSKI: I'll rephrase it.

Q Are there any long term effects to a child that has experienced microplasma pneumonia?

MR. : She already answered that. You want her to answer it again over my objection? I'll let her answer over my objection.

MR. OGINSKI: For clarification I am defining the age of the patient and I'd like you to answer on that, please.

MR. : You mean four-year-old children?

MR. OGINSKI: Yes.

A No, I'm not aware of any long-term complications.

Q Are you aware of any condition such as Gillion Barraya Syndrome that has been

, M.D.

associated with patients who have experienced microplasma?

A I'm aware that there is an association.

Q Are you aware of any association with patients who have experienced asthma at some point after experiencing microplasma?

A No.

MR. : If there's some statistical statement, that's totally

immaterial. The fact that somebody that had microplasma pneumonia might at some subsequent time in some study have pneumonia doesn't create a causal relationship between one and the other. It is just of some statistical significance potentially.

MR. OGINSKI: That's all I'm asking about.

MR. : They're inappropriate questions.

MR. OGINSKI: I totally disagree otherwise I wouldn't be asking it.

, M.D.

MR. : I'm sure that

even if you thought they were inappropriate questions knowing you from three other depositions, you would attempt to get an answer.

MR. OGINSKI: I knew it would come out.

Q Doctor, are you aware of any correlation between patients who had had microplasma with any associated increased risk of acute arrythmia?

A I am not aware.

Q Can you tell me what symptoms you would expect to see in a patient who is experiencing microplasma pneumonia?

A It's generally referred to as walking pneumonia. These kids are usually well with just a prolonged cough with no other signs of toxicity like fever, general body malay.

Q Is headaches one of the symptoms or presenting symptoms that a patient would have with the microplasma pneumonia?

24 A Not that I'm aware of.

25 Q What about chills?

1 , M.D.

2 A Not that I'm aware of.

3 Q Sore throat?

4 A No.

5 Q Abdominal pain?

6 A No.

7 Q Chest pain or soreness in the

8 chest?

9 A That comes with coughing.

10 Q On examination of a patient with

11 microplasma pneumonia would you commonly expect

12 to find rhonchi?

13 A You may find rhonchi.

14 Q What about rales, would you

commonly expect to find rales in a patient with microplasma?

A Not consistently.

Q What about wheezing, would you expect to find that in a patient with microplasma?

A Not consistently.

Q Did you form any opinion as of August 21st as to whether this patient was immuno-compromised?

A Yes, I had an opinion, and she was

, M.D.

not in my mind an immuno-compromised child.

Q Based upon the Infectious Disease consult of August 31, legionella was also evaluated?

A Not that I remember.

Q What is aspiration pneumonia?

A It's a descriptive -- aspiration, it's a descriptive term wherein the sequence of the pneumonia was thought to be aspiration of gastric contents.

Q Was there any suggestion in your mind while treating this patient that she was suffering from an aspiration pneumonia?

A No.

Q Was it your opinion that this patient had had an empyema?

A Yes.

Q Did that opinion change at any time during the course of her hospitalization?

A What exactly is the question? Whether it became better?

MR. : Did you continue to believe she had empyema until conceivably it was drained out?

, M.D.

THE WITNESS: Yes.

MR. : At some point it was must have ended when it was drained out. That's why your questions are confusing.

Q I'd like to talk to you a little bit about lab tests. Is a lab WBC helpful to evaluate certain types of pneumonia?

A Yes.

Q How so?

A Certain pneumonias give you an elevation in white count. The sub-type or percentage of each particular type of white blood cell will also help you determine what kind of pneumonia it is. Certain pathogens make certain sub-populations of white cells

more prominent than others.

Q Is a white blood cell count effective in evaluating microplasma?

A In terms of -- you can pretty much -- it will assist you in assessing whether it will be high or low on your list depending on whether the other pathogens are high or low on your list. Ask it another way.

, M.D.

Q Does a white blood cell count in and of itself tell you whether or not a patient has some form of microplasma?

A No.

Q It's one tool that you can use --

A Yes.

MR. : Wait till he puts a

question mark on the question before you start to answer. He stopped in the middle of it. He's going to add something to the end of it and you've already answered yes.

MR. OGINSKI: Let me ask a different question.

Q The gram stains that we talked about earlier, that's used to exclude certain types of pathogens?

A Yes.

Q The fact that a gram stain turns out to be negative, you can not exclude a particular type of organism based upon a negative finding, correct?

A Yes.

Q What about elevated sedimentation

, M.D.

rates, is that useful for you in evaluating types of pneumonia?

A No.

Q We talked a little bit about radiographic studies. Are there any other imaging studies that you're aware of that in the year of would assist you evaluating types of pneumonia?

A As to etiologic agents?

Q As to either the cause or what type of pneumonia the patient was experiencing?

MR. : Or the progression of the pneumonia?

MR. OGINSKI: That's fine.

MR. : Or regression of the pneumonia.

A The x-rays will help you determine whether if pneumonia seems to be progressing or improving. The pattern of lung

involvement can help you lean towards certain pathogens, but it is not the gold standard. It's not a gold standard for determining etiologic agents.

Q The gold standard that you referred

, M.D.

to for this type of case would be what?

A Microbiologic studies.

Q Are any other types of image studies such as cat scans, MRIs or other studies that you're aware of assist you in evaluating patients for types of pneumonia that they're experiencing other than the x-rays?

A Again, it cannot help you with the organism. It's not definitive. It can only suggest. It can help you lean towards certain

pathogens, so cat scans and chest x-rays are the usual tools to determine the extent and possible type of pneumonia.

Q I want to ask you a little bit about serology. What percentage of patients are positive for cold agglutinin tests within seven days of infection?

A I cannot answer that question.

Q A negative result doesn't exclude microplasma of a cold agglutinin result, correct?

MR. : Are you testifying or is she supposed to testify?

MR. OGINSKI: I'm asking a

, M.D.

question.

MR. : You ask a yes or no type of question. I don't think that's an appropriate way to conduct a deposition.

MR. OGINSKI: Why, is there some guideline that I have to follow as to how I can ask a question?

MR. : For one thing she's sworn, you are not sworn.

MR. OGINSKI: I'm not giving testimony, I'm asking questions.

MR. : You're making statements. You're not asking yes or no questions.

MR. OGINSKI: I think I'm asking proper questions. I'll rephrase it.

MR. : I don't think you are.

Q Does a positive cold agglutinin test confirm the presence of microplasma?

A No.

Q Does it confirm any process at all?

, M.D.

A No.

MR. : That's about the third or fourth time that she's told you that a cold agglutinin test is a non-specific test. I mean, the fact that you ask it in three or four different ways doesn't change the fact that you're asking repetitive questions. You get your answer you should move on.

MR. OGINSKI: Thank you for the direction.

MR. : All right. I'm

trying to help you.

Q Are you familiar with something called compliment fixation?

A Yes.

Q Is that a type of serology test?

A Yes.

Q Are you familiar with something called enzyme linked immunoassays?

A Yes.

Q How about indirect hemoglutinization?

, M.D.

A Yes.

Q Were any of those tests performed for this patient?

A Not that I remember.

Q Would any of these tests in your opinion and need performing any of those tests prior to August 31st?

A No.

Q Can you tell me what those tests would accomplish or why they would generally be ordered?

MR. : It's two questions in one. I'm going to object to both of them.

MR. OGINSKI: I'll rephrase them.

Q Compliment fixation, when did you order that type of test?

MR. : Under what set of circumstances would she order that test?

MR. OGINSKI: Yes.

MR. : I think it's an inappropriate question. I object to

, M.D.

the form of the question reserving my objection to the time of trial.

A All these tests are basically different forms of serological tests. They are only significant when done in pairs at different points in time. You need an acute, an acute sample and a sample done in a couple of weeks from the time of the initial sample to see a change in the amount of titers that you get, and, again, I would be requesting it if it was suggested by, if an Infectious Disease consult would recommend it.

Q Am I correct that you would not be requesting it on your own, you would wait for the Infectious Disease consult to recommend it?

MR. : That's what she said. Whether they're correct or not

I don't really care about. Please don't rephrase her questions and ask them all over again.

A Yes.

Q Would you agree that earlier diagnosis and earlier treatment is generally better for the patient?

, M.D.

MR. : Objection.

MR. OGINSKI: What's the objection?

MR. : What are we talking about? Early diagnosis is better in breast cancer cases except if it's a breast cancer case it's a virulent type it wouldn't make a

difference when you found it because it's been acclimated for such a period of time you're in a category of people that are probably going to die.

MR. OGINSKI: This isn't a breast cancer case.

MR. : This is inappropriate questions. She's not here for general medical analysis of information. She's here for specific questions on this patient.

Q Doctor, is pneumonia a serious illness?

MR. : Is pneumonia a what?

, M.D.

MR. OGINSKI: A serious illness.

MR. : She can answer over my objection.

A It's a spectrum, so depending on where you get the child it can be benign to life threatening.

Q Did you learn at some point during 's hospitalization that on thoracotomy there was a finding of necrotic lung?

A On review of the surgical record.

Q Did you ever form an opinion as to the cause of the necrosis of the lung that was observed on thoracotomy?

A No.

Q I'd like you to turn, please, to what was marked as Page 16 the on bottom right?

A 6-0, 1-6?

Q 1-6. August 22nd, it is actually your note. Doctor, looking at that Page 16

what is the date of your note?

A No date.

Q Can you tell from prior notes that appear in the hospital record what date you

, M.D. wrote this note?

A I had a note for the 21st and it immediately preceded my procedure note on the 22nd. It's likely to be my note for 8/22/.

Q At the top of the note you write something after left lower lobe pneumonia. Can you tell me what that says?

A "With effuse loculated."

Q Under that?

A "Temporary problem hypoxia."

Q How did that come about?

MR. : How did the hypoxia come about?

MR. OGINSKI: Yes.

A It's part of your pneumonia.

Q What led you to conclude that the patient was experiencing hypoxia?

A She developed an oxygen requirement or had a period of desaturation.

Q You write in your note, "Desaturated this morning to eighties. Required oxygen on the right side"?

A Yes.

Q What is the significance of that to

, M.D.

you?

A That she had a temporary increase

in her oxygen requirement.

Q Did the administration of oxygen increase her oxygen saturation?

A Yes.

Q The grunting that you note directly under that, what's written next to that?

A Flaring.

Q To what, if anything, did you attribute that?

A Again, her pneumonia.

Q For how long were her oxygen saturations in the eighties?

A I would have to look at the nursing record for that day.

Q Is there anything within your note to indicate how long the patient had had the oxygen saturation in that range?

A No.

Q Is there any long term problems associated with this hypoxia that you've noted here?

A No.

, M.D.

Q At the bottom of your note you wrote under chest x-ray, "tracheal shift to right." Do you see that?

A Yes.

Q What does that mean?

A It's a finding that is consistent with a pneumonia.

Q The fact that there is a shift now, what does that tell you, if anything?

A That there is a pneumonia.

Q Can you characterize the type of pneumonia that you are observing at that time?

MR. : From the fact that the x-ray has a shift to the right?

MR. OGINSKI: Yes.

Q Is it a significant pneumonia, moderate, mild or any other way you can characterize it?

A Just based on the tracheal shift?

Q Yes.

A No.

Q Can you read what you write underneath and after the word stable at the bottom?

, M.D.

A An episode of laryngospasms after persistence of cough.

Q Was that after the procedure of insertion of chest tube?

A Yes.

Q Do you know what caused the laryngospasm?

A One of the medications can cause laryngospasm.

Q Were you successful in inserting the chest tube at that time?

A Yes.

Q As a result of the laryngospasm, did the patient need to be intubated?

A Transiently, yes.

Q Was this the occasion when the patient was put on the mechanical ventilator or did that come later?

A That came later.

Q Can you turn, please, to Page 19, which is your procedure note for August 22?

MR. : We're there.

MR. OGINSKI: Good.

Q Did you insert the chest tube?

, M.D.

A Yes.

Q Dr. supervised you?

A Yes.

Q This was done in the Pediatric ICU, correct?

A Yes.

Q After the chest tube was inserted, the chest x-ray revealed the patient had a pneumothorax, correct?

A That is no pneumothorax. That's a null sign.

Q You put a question mark before laryngospasm?

A Because you can only theorize it. The symptoms were consistent, but I wasn't directly looking at the larynx.

Q Why did you insert a chest tube at that time?

MR. : Where?

MR. OGINSKI: Why.

A For her increased work of breathing that developed overnight.

Q What was the purpose of inserting it?

, M.D.

A Fluid is a space occupying lesion, areas that lungs should occupy, so if it occupies an area, then it impedes lung expansion.

Q Was the chest tube mixed with fluid after its placement?

A Yes.

Q Did the placement of the chest tube resolve the fluid build-up that had been

observed on x-ray?

A It did drain it, yes.

Q Did it drain it to the extent that you and the other physicians caring for the patient was comfortable with that?

MR. : I'm going to object to comfortable with.

MR. OGINSKI: I'll rephrase the question.

Q Why was a second chest tube inserted?

MR. : You mean at a subsequent time why was a second tube inserted?

MR. OGINSKI: Correct.

, M.D.

A The chest tube after draining initially well tapered off and there was still some findings of a pleural effusion on her chest CT.

Q How many days later are you referring to?

A I am on the 23rd.

Q Did you perform a chest tube placement at that time?

A No.

Q Who did that?

A It was done by interventional radiology.

Q Is there some reason as to why they did it as opposed to you or any other physician?

A So that it could be cat scan guided.

Q Can you turn, please, to Page 24, which is your August 23rd note or I assume it's the August 23rd note.

Would you agree with me that that would be the note that you have for August 23rd?

A Yes.

, M.D.

Q Towards the bottom where it says Chest X-ray it says, "left chest tube in place." Was that the first chest tube that you inserted or the second one that had been inserted by interventional radiology?

A That was the first chest tube.

Q You write, "Still with no significant improvement," correct?

A Yes.

Q What were you referring to?

A Her work of breathing.

Q Her what, I'm sorry?

A Her work of breathing.

MR. : Her work of breathing.

Q Did that refer in any way to the chest x-ray findings?

A I cannot definitely say. It was more for her work of breathing.

Q If it related to her breathing, would you have expected to make that note about no significant improvement in the area of chest or lungs?

A But that's in Physical Exam. This

, M.D.

is an assessment of the physical exam.

Q The phrase that you write, "still

with no significant improvement," is listed under the chest x-ray section of your note, correct?

A It's not -- while it may be somewhat in line with the chest x-ray it's under the Assessment and Plan.

Q On the second page of your note you wrote, "blood cultures are negative," correct?

A Yes.

Q Can you turn, please, to your note of August 24, which is Page 33 on the bottom right.

Had there been any improvement that you observed in the patient's overall condition from the time that the first chest tube was inserted until you wrote your note on August 24th?

A Yes.

Q In what aspect?

A In the general survey the patient was in no acute distress, she had no signs of

25 increased work of breathing, she had no

1 , M.D.
2 flarings, there's no note of any retractions
3 and overall her respiratory rate came down.
4 Q Her temperature, her maximum
5 temperature for that date was noted as 104.7,
6 correct?
7 A Yes.
8 Q Under your chest and lung findings
9 can you tell me what you wrote there?
10 A "Clear to auscultation bilaterally.
11 Decreased breath sounds left base. No wheeze."
12 Q The decreased breath sounds, to
13 what, if anything, did you attribute that?
14 A The pneumonia.
15 Q Had that changed in any significant

fashion from the time when the, from two days earlier when the chest tube was inserted?

MR. : You mean was the decrease in breath sounds a change in and of itself?

MR. OGINSKI: Yes.

A I cannot state on the decrease in the breath sounds.

Q Under Chest X-ray where you talk about the change in amount, can you read what

, M.D.

you have after that?

A "No change in amount of density."

Q That would be the density of the pneumonia that you observed on chest x-ray?

A Yes.

Q Why was the first chest tube removed?

A Because it wasn't draining.

Q Can you turn, please, to Page 40, which is your August 25 note. On your chest and lung exam you wrote, "decreased breath sounds on left base"?

A Yes.

Q Is there any change in that observation in comparison to the August 24th observation of the breath sounds?

A Again, I cannot rate this descriptive term and I do not particularly recall.

Q The patient still had a maximum temperature of 101.6?

A Yes.

Q Generally what time of the day would you conduct your rounds on a patient?

, M.D.

A Eight A.M.

Q Did you have conversations with the child at the time that you would make your rounds?

A If she was awake and watching TV, yes we would ask her how well she was.

Q When you say, "we," who do you mean?

A The ICU team which composes of the resident, myself and the attending.

Q The resident would be a general pediatric resident?

A Yes.

Q When you would make rounds, was one or more parents present at bedside?

A It varies.

Q Did you have conversations with either the father or mother on any of the days

that you rounded and examined this child?

A Yes.

Q As you sit here now, do you recall any of those conversations with the mother or the father?

A Not in detail.

, M.D.

Q Do you remember any of the substance? I'm not asking you for the specific words, but the substance of the conversations that you had with either of her parents?

A They would pertain to the plans for the day and the future direction we wanted to take her care in terms of antibiotics, need for home therapy.

Q Would you have these direct

conversations with the parents or would the attending, the resident or someone else or would it be a combined conversation where everybody participates?

MR. : In other words, who would talk to the parents, you, the attending, the resident, one of you or both of you or do you remember.

A It varies from day-to-day. It would be a collective effort or it would be each individual speaking to them.

Q Other than generally recalling talking to one or both parents, do you have any specific memory of conversations with the parents?

A No.

Q Do you recall what either of her parents looked like?

A No.

Q Have you ever seen or treated at any time after her discharge from in September, of ?

A No.

Q Did you ever review any of the patient's medical records from other physicians after she left at any time up until today?

A Other than this chart?

Q Yes.

A No.

Q Was there any specific reason as to why she had the CT guided placement of a pleural tube?

A It would be we request interventional radiology when we need guidance in terms of placement of the tube because of inaccessibility using our usual percutaneous

attempts.

Q On your August 25 note at the bottom you wrote, "for CT guided placement of

, M.D.

pleural tube," correct?

A Yes.

Q Had the patient already had the tube inserted at that point or was the patient going for the procedure?

A She was going for the procedure.

Q Can you turn, please, to Page 45, which is an addendum that you wrote on August 25 at 11 P.M. This note describes an event that occurred during the procedure, correct?

A Yes.

Q Without going through, can you --

MR. : I'm not sure it happened during the procedure. I think the note says, if I'm correct, after the procedure, but I may be wrong.

MR. OGINSKI: The note's written after, but the event relates --

MR. : I understand, but within it talks about the event occurs after the procedure itself during some fluoroscopic -- maybe I'm

, M.D.

wrong.

Q Did the patient suffer some type of event during the insertion of the chest tube?

A It's not directly with the insertion of the chest tube itself. It was during the whole entire procedure.

Q Were you present during this procedure?

A Yes.

Q How were you monitoring the patient's oxygen saturation?

A The patient was in a portable monitor which monitored heart rate, respiratory rate, oxygen sats.

Q You write, "last scan patient noted to have oxygen saturation forties," correct, "with," and what do you have written after that?

A "With no air entry".

Q What accounted for the decreased oxygen saturation?

A At the time it was thought to be laryngospasm that did not resolve.

Q Was the child intubated after the

, M.D.

procedure?

A As a consequence of this --

MR. : During the procedure before the laryngospasm was the child intubated?

A No.

MR. : It was some time after the child was intubated?

THE WITNESS: Yes.

Q Was the child sedated for the procedure?

A Yes.

Q For how long did the patient remain without air entry?

A Positive pressure was started

instantaneously as soon as we saw her sats go down.

Q Who was bagging the patient, by the way?

A Dr. .

Q You write, "the patient was difficult to bag"?

A Yes.

Q Was anesthesia called to intervene

, M.D.

when this happened?

A No.

Q Did anyone attempt to intubate the patient while she remained in the room where this procedure was taking place?

A Yes.

Q Who administered the medication to paralyze the patient?

MR. : Object to the paralyzing of the patient.

MR. OGINSKI: It says, "patient paralyzed with particular medication."

MR. : It wasn't the entire person paralyzed, it was the throat that was paralyzed for the intubation period.

MR. OGINSKI: I disagree with your characterization. Let me rephrase the question.

Q As a result of what you observed, was the patient intubated?

A Yes.

Q Who intubated the patient?

, M.D.

A Dr. .

Q Did either you or Dr. or any other physician administer a medication to paralyze the child?

A Yes.

Q The purpose was to intubate?

A To facilitate intubation.

Q If there was a laryngospasm to relax that spasm, correct?

A Yes.

Q Was there a pneumothorax on chest x-ray?

A Yes.

Q What is a pneumothorax?

A It's a collection of air outside the lung.

Q What caused the pneumothorax in this case?

A The patient can have multiple, had

multiple reasons to develop a pneumothorax.

Q Did the patient develop a pneumothorax during the course of the procedure to insert this chest tube on August 25?

A It was noted after the procedure

, M.D.

was done, but with the attempt to resuscitate her oxygen saturations. It's hard to really say from what time that there will be an absence of the scan just after the procedure up to the time we did secure the airway, there is a big amount of time wherein she could have developed a pneumothorax at any of those points.

Q Was there anything on cat scan to suggest that this patient had a pneumothorax

during the course of the procedure?

A Not that I remember.

MR. : In other words, she's thinking of the procedure as the entire event.

When you talk about the procedure, are you talking about solely of the interventional radiologist?

MR. OGINSKI: Yes.

MR. : When he said procedure he means the interventional radiologist.

A Not that I remember.

, M.D.

Q You write a little further down in

your note, "the procedure was unsuccessful." What procedure were you referring to?

A The attempt to insert the ferning catheter.

Q That was for what purpose?

A To drain the pneumothorax.

Q The patient was put on mechanical ventilation, correct?

A Yes.

Q She remained paralysis with sedation, correct?

A Yes.

Q Can you turn, please, to Page 58. This is another fellow who wrote the note for this patient on August 26?

MR. : You mean a different fellow other than her?

MR. OGINSKI: Correct.

A This is not the 26th.

MR. : The 27th, isn't it?

MR. OGINSKI: My mistake. I'm

sorry.

Q Page 58, it's an August 27 note?

, M.D.

A Correct.

Q Is this your note?

A No.

Q Who wrote this note?

A Dr. .

Q Patient underwent a bronchoscopy either on that date or the day before?

MR. : Bronchoscopy was on the 27th. I don't think she was on duty that day.

A Yes.

Q Did you ever learn from anyone what the results of the bronchoscopy were?

A Only on review of the note.

Q When you returned back to the patient's care, did you review the chart and learn what the results of the bronchoscopy were?

A Yes.

Q What was your understanding of the results of the bronchoscopy?

A That there was minimal secretions present in the lung and that they did send off samples for microbiologic tests.

, M.D.

Q Can you turn, please, to Page 63. This August 28th note it says, "RPN." Would that be resident?

A Yes.

Q Pediatric, what does that stand for?

MR. : What does RPN stand for?

A Resident Progress Note.

Q That would be pediatric resident, correct?

A Yes.

Q At the very last line of that page under the Infectious Disease section of this doctor's assessment and plan it says, "All cultures negative so far," correct?

A Yes.

Q Can you turn, please, to Page 68?

MR. : I'm sorry?

MR. OGINSKI: 68.

Q It's an August 28th note. This is your note again, correct?

A Yes.

Q On your chest tube patient was

, M.D.

known to have good air entry and decreased breath sounds to left base, correct?

A Yes.

Q Had there been any changes that you observed on any of the prior days?

A I cannot grade the decrease of the level base nor do I recall the day-to-day change.

Q The maximum temperature is 100.7?

A Yes.

Q Is that in your opinion febrile?

A It's very low grade.

Q Had there been any time that you recall that the patient was afebrile up until August 28th?

A She remains afebrile for the

greater part of the day.

Q Turn, please, to the second page of your note under ID Culture Results. At some point you or someone else had tested for chlamydia, correct?

A Yes.

Q Is that it's was pending?

A Yes.

, M.D.

Q What is written under that?

A Bordetella.

Q What type of organism or test is that?

A It's for pertussis.

Q You'd also tested for legionella, correct?

A Yes.

Q And influenza A?

A Yes.

Q And also RSV, correct?

A Yes.

Q The legionella I notice that there's nothing next to it to indicate any type of result. What does that mean to you?

A Either I meant to check that and just forgot to fill it in or I forgot to put the pending in.

Q Why did you test for legionella at that point?

A It was part of the bronchial lavage panel that was sent.

Q Can you turn to Page 72, please, August 29, . From August 25 up until August

, M.D.

29th patient still remained sedated and intubated, correct?

A Yes.

Q She was still receiving mechanical ventilation, correct?

A Yes.

Q Decadron, what type of medication is that?

A It's a steroid.

Q What type of medication is Propofol?

A It's a sedative.

Q And Ativan?

A It's an anchylotic sedative.

Q Can you turn, please, to Page 77. This is your August 30th note?

A Yes.

Q Patient had been extubated, correct, that morning?

A Yes.

Q On the second line of your note you write, "left pneumothorax," was that something that she still had as of that date?

MR. : I'm going to object

, M.D.

to the still had.

MR. OGINSKI: I'll rephrase the question.

Q On August 30 on the second line of your note you write, "Left pneumothorax," what did that represent?

A That it was still problem of her problem, yes.

Q I'd like you to read her general survey that you've written there?

A "Awake, agitated but consolable in mild respiratory distress."

Q What type of respiratory distress were you observing?

MR. : Besides mild? She described it as mild. What type of respiratory is mild? You mean what kind of mild? Is that what you mean?

MR. OGINSKI: I'll withdraw the question.

Q Continue the note on the next line?

A "Decreased breath sound".

Q Right above?

, M.D.

A "Normal intermittent nasal flaring

most mucus membranes, supple neck, pupils equally reactive to light and accommodations."

Q Go on to the chest, please?

A Decrease breath sounds left base, course breath sounds, positive rhonchi, no wheeze, intermittent strider".

Q What, if anything, did you attribute to the intermittent strider to?

A From her being extubated.

Q What, if anything, did you attribute the rhonchi to?

A From her pneumonia.

Q The nasal intermittent nasal flaring, what in your opinion was that from?

A From being extubated.

Q On Page 78, second page of your note towards the bottom you write, "continue antibiotics." Can you read the next part, please?

A "Total antibiotics course twenty-eight days."

Q Let me stop you for a moment. As of that date of your note that's August 30th we

, M.D.

know from the record that the patient was admitted on August 19th. Looking at it now can you tell us whether the twenty-eight days you have noted here is an accurate assessment of the length of time she remained on the antibiotics?

MR. : What do you mean by the 28 days of antibiotics?

A It's the plan.

MR. : It's a future plan, not the prior plan.

Q Would that be 28 days from discharge or 28 days from her initial receiving

antibiotics or something else?

A With this date I cannot say.

Q What did you mean when you wrote, "total antibiotics course 28 days"?

A That the plan was for her to receive antibiotics for 28 days.

Q From when to when?

A At this point I could only assume from the time that they were started.

Q Did you have any understanding or knowledge as to what antibiotics the patient

, M.D.

would continue on after her discharge?

A The Nafcillin and the Ceftriaxone.

Q Was that based upon a conversation you had with Infectious Disease or with anybody

else or yourself?

A With my attending.

Q Can you turn, please, to Page 86.

This is your note again?

A Yes.

Q Would you agree that this would be a note for September 1st even though it is not dated?

A No, 'cause there's a fellow note for September 1st.

Q What date is this note?

A I don't know.

Q Based upon the placement of the note in the chart and assuming it has not been moved, can you tell me what date you believe that note represents?

MR. : What was the last note?

THE WITNESS: That would be my note for the 31st.

, M.D.

Q I'm sorry, your last note was the 31st?

MR. : No, reconstructing from the chart she's saying that on the dated note on Page 86 appears to be for the 31st. That's what she's saying.

Q In the general survey you noted the patient was in mild respiratory distress?

A Yes.

Q She still had mild nasal flaring?

A Yes.

Q Had there been any change since you had last observed her with the mild respiratory distress since she had been extubated?

MR. : Any change, how she appeared on the morning of the 30th

he means.

A I cannot recall.

Q If you turn, please, to the second page, the bottom line of your plan it says, "continue with antibiotics." Was that for the Ceftriaxone and the Nafcillin?

A Yes.

, M.D.

Q You wrote, "Discussed with Infectious Diseases service regarding home antibiotics," correct?

A Yes.

Q Did you have a conversation with the ID physician as to how this patient would receive antibiotics at home in terms of oral IV or some other route?

A Not that I remember.

Q Do you recall who you spoke to?

A Not that I remember.

Q Did you have that conversation with the Infectious Disease physician in person or by telephone?

A Not that I remember. I can't recall.

Q Was there any suggestion by the Infectious Diseases physician to change the antibiotic regimen when the patient returned to home?

A I can't recall.

Q Was there any discussion as to when this patient would be discharged home?

MR. : With Infectious

, M.D.

Diseases or with everybody?

MR. OGINSKI: No, with Infectious Diseases.

A At this point in time?

Q Yes.

A The child's not, still not ready to go home. There wasn't any plan for discharging her soon.

Q Did the Infectious Disease physician whom you consulted with according to your note on Page 87 indicate to you for how long he or she intended to keep the patient on antibiotics?

A This is to discuss, this was the plan for the day. This discussion hasn't occurred by the time I wrote this note.

Q I'm sorry, I wasn't clear. Let me rephrase the question. This was your plan to discuss with the Infectious Diseases?

A Yes, that's why it's under Plan.

Q At some point after that note was written did you have a conversation with the ID physician?

A I can't recall.

, M.D.

Q Based upon the Infectious Disease consult note dated August 31st, reviewing that note did that refresh your memory as to whether you had a conversation concerning home antibiotics?

A No.

Q I'd like you to turn, please, to Infectious Disease Consult Note of August 31. Can you read the first three lines of that note, please?

A "Four-year-old female with five day history of fever, cough, abdominal pain, diagnosed," I don't know what that is. I don't know what the second one is.

Q I'm going to suggest upon arrival to ER?

A To ER.

MR. : Don't adopt what he says unless you agree with it.

A I can't make it out.

MR. : Well, if you can't make it out, you can't make it out.

A "To ER with left lower lobe pneumonia. Positive retractions, decreased

, M.D.

breast sounds to left. Respiratory rates 36".

Q Did you have any conversation with the ID physician prior to this doctor conducting an examination?

A Again, on the 21st we discussed --

Q No, no, on August 31?

MR. : In other words, before he came in to see the patient did you call him up to have him come in to see the patient.

A Yes.

Q Tell me about what conversation. What did he say to you, what did you say to him?

A That this consult was for duration of home antibiotics treatment. He or she would be given a summary of the course and the current antibiotics regimen and that the question the service had for them was in this case a duration of home antibiotic therapy.

Q Was that presented in the form of a written request?

A No, this is an oral.

Q Did you have any other discussions

, M.D.
with this physician before he or she examined the patient?
A Not that I remember.
Q Were you present for this physician's examination of the patient?
A I cannot recall.
Q Was this Infectious Disease physician a man or a woman?
A I can't remember.
Q Turn, please, to Page 88. Who was the PICU fellow who wrote this note?
A Dr. .
Q Do you know what year in his fellowship he was in?

A He was in his second year.

Q In the middle of the page where he writes about the Infectious Disease section, at the bottom line towards the right of that section he writes, "micro," and in parenthesis August 31 showing positive and it has titer 1:256, do you see that?

A Yes.

Q What does that mean to you?

A That the titers were turned

, M.D.

positive, but the dilution one is two hundred fifty-six.

Q And that the results were known at least according to this note on August 31st,

correct?

A That would be the date that the test was sent. That's custom for our unit that the date after the cultures was the date that the cultures were sent.

Q This titer 1:256, what does that mean to you?

A I would need the Infectious Disease people to help me with the titer interpretation.

Q Did you ever speak to any Infectious Disease physician after September 1st about this particular microplasma titer result?

A Not that I remember.

Q Does this result indicate to you that the patient did, in fact, have microplasma pneumonia as of August 31?

MR. : She said that the sample was sent on the 31st.

, M.D.

MR. OGINSKI: And it turned out to be positive and reported at least according to this note on the 1st.

Q But as of the time that the test is taken, can you tell me whether the patient had microplasma pneumonia as of August 31st?

A Again, I would need Infectious Disease to help me with titers. I do not routinely read them.

Q You had mentioned earlier that it was your understanding that the patient was ultimately diagnosed with microplasma pneumonia, correct?

A Yes.

Q How did you learn that or come to that conclusion?

A 'Cause on transfer of care I was told that that was the diagnosis.

Q Are you referring to when you returned back to for her continued daily care?

A For coverage at night, yes, but I was no longer responsible for her daily care.

, M.D.

Q Did you learn from the physician that you were taking over care from how that person or how they came to such a diagnosis or conclusion?

A I think the serology was what helped them.

Q Can you be more specific?

A The titer.

Q The microplasma titer?

A The microplasma titer.

Q Can you turn, please, to Page 103. This is your note again?

A Yes.

Q For September 3rd?

MR. : Correct.

Q At the bottom of the second page on Page 104 under Plan you write, "for decortication, rigid bronchoscopy by PEDS surgery"?

A Yes.

Q What was your understanding as to why this patient needed to have the decortication?

A For a clean out of her chest.

, M.D.

Q Did you have an understanding at that time as to why she needed that procedure?

A This plan was already set in place. They may have explained to me the thought process, but I don't recall.

Q Can you turn, please, to Page 140. It's the September 8th PEDS ID Resident Note timed at 7 P.M.?

MR. : At 150 did you say?

MR. OGINSKI: 140. Looks like this, Ed.

MR. : I got it.

MR. : 9/8, 7 P.M.?

MR. OGINSKI: Yes.

Q I'd like to you read this note in its entirety if you can, please?

MR. : I'm going to object. You know, I'm not even sure she was involved in the patient as of this time. You're asking her to read

somebody else's note. I don't think it's fair. I'll let her answer over my objection, but I'm going to observe my objection to the time at

, M.D.

trial.

A "Patient seen and examined with team. Status post video thorascopy post op day number two. Patient continues to be intubated on thirty percent FIO2 weaning settings. Chest x-ray with significant lung atelectasis at basis." I don't know whether it's right or left, "upper lobe and left middle lobe show lung markings. Two chest tubes in place continuing to drain. Status post completion of five-day course of Azithromycin. Agree with

discontinuing this."

Q Does that say, "at this"?

A "At this," I don't know what that word is.

Q Go ahead?

A And then, "(Azithromycin has long activity in the body. Five-day course is comparable to a ten-day course of another macrolide) with patient still with continued chest tube," and I don't know what that is, "drainage."

Q Is that could you tell if that's an abbreviation for continued drainage?

, M.D.

A I cannot tell.

Q Go ahead?

A "And prolonged course of illness still cannot rule out bacterial etiology even in light of a highly positive microplasma titer and negative bacterial culture. Would recommend continuing IV Nafcillin and Ceftriaxone until chest tubes are removed and patient is afebrile."

Q Do you recognize the signature or the printed name that appears on the bottom of this note?

A I don't know if it's I don't know. I cannot say with certainty.

Q Did you ever have a conversation with a physician who wrote this September 8th PEDS ID resident note?

A Again, I wasn't involved with her day-to-day care at this time.

Q Were you involved with the continuing of the Azithromycin at this time?

A Not that I remember.

Q Did any of the physicians that you

were in contact with during your care and

, M.D.

treatment of ever comment upon the treatment she had had rendered by her pediatrician prior to her admission to ?

A No.

Q Do you have an opinion as you sit here today that if had received antibiotic therapy prior to her admission to Hospital whether her hospital course would be the same or different?

MR. : Note my objection.

A I cannot make a comment.

MR. OGINSKI: Thank you, Doctor.

MR. : Do you have any

questions?

MR. : No.

(Time noted: 12:27 p.m.)

A C K N O W L E D G E M E N T

STATE OF NEW YORK)

) ss.:

COUNTY OF NASSAU)

I, , M.D., hereby certify that I have read the transcript of my testimony taken under oath in my deposition of the 17th day of October, . That the transcript is a true, complete and correct record of what was asked, answered and said during this deposition, and that the answers on the record as given by me are true and correct.

, M.D.

Signed and subscribed to before me this day of , .

Notary Public

I N D E X

E X H I B I T S

19

20

21

22

23

24

25

1

2 C E R T I F I C A T E

3

4 I, , hereby certify

5 that the Examination of , M.D.,

6 was held before me on October 17, ;

7 That said witness was duly sworn

8 before the commencement of the testimony;

9 That the within testimony was

stenographically recorded by myself, and is an accurate record of the Examination of said witness;

That the parties herein were represented by counsel as stated herein;

That I am not related to any of the parties, in the employ of any of the counsel, nor interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 17th day of October, .