REDACTED & DE-IDENTIFIED DEPOSITION OF A GYN CANCER DOCTOR; RESIDENT IN TRAINING

****FAILURE TO DIAGNOSE & TREAT SEPSIS FOLLOWING HERNIA REPAIR RESULTING IN DEATH****

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

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, AS ADMINISTRATOR OF THE ESTATE OF , Deceased, and individually,

Plaintiffs,

-against-

, M.D., , , M.D., , M.D., , M.D., , M.D., , M.D., , M.D., , M.D., and HOSPITAL,

Defendants.

Index No.

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May 4, 2010
11:06 a.m.

EXAMINATION BEFORE TRIAL of , taken by Plaintiffs, pursuant to Court Order, held at the offices of LLP, 120 Broadway, New York, New York before Wayne Hock, a Notary Public of the State of New York.

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IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties hereto that all rights provided by the CPLR, and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any question, except as to the 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 make such motion at, and is reserved for, the trial or this action.

IT IS FURTHER STIPULATED AND AGREED that this examination may be signed and sworn to, by the witness being examined, before any Notary Public other than the Notary Public before whom the examination was begun, but the failure to do so, or to return the original of this examination, shall not be deemed a waiver of rights provided by Rules 3116 and 3117

of the CPLR and shall be controlled thereby.

IT IS FURTHER STIPULATED AND AGREED that the filing of the original of this examination shall be and the same hereby is waived.

* * *

, having been first duly sworn by a Notary Public of the State of New York, upon being examined, testified as follows:

EXAMINATION BY

MR. OGINSKI:

Q. Please state your full name.

A. .

Q. What is your current address?

A. .

Q. Good morning, Doctor.

What is an incidental enterotomy?

A. An enterotomy that's not planned.

Q. And what is an enterotomy?

A. An incision or a hole within the colon or small bowel.

Q. What is sepsis?

MR. : You're asking about a broad definition obviously?

MR. OGINSKI: Yes.

A. Sepsis is an inflammation or an infection that's usually overwhelming.

Q. What is peritonitis?

A. Inflammation of the peritoneal cavity.

Q. How do you recognize an incidental enterotomy?

MR. : During surgery?

MR. OGINSKI: Yes.

A. Usually you see small bowel contents or large bowel contents coming from the hole.

Q. And what type of contents would you expect to see?

A. Small bowel contents or large bowel contents.

Q. Which would be what? What type of contents would you expect to see?

MR. : You mean what's --

Q. What are the contents?

A. They're just small bowel or large bowel contents. I mean, you're not going to see food particles.

Q. Are you talking about fecal contents, are you talking about liquid? Be specific, if you can.

A. It's just small bowel, large bowel. There's nothing specific about it. Fecal contents is of the large bowel. Small bowel contents would be small bowel contents, biliary in nature, liquid.

Q. What happens -- I'm asking a general question.

What happens if an incidental enterotomy is made during surgery, not recognized, and the patient is closed?

MR. : What happens or what can happen? He's not going to go through every parameter.

Q. What can happen with the patient?

A. There are a thousand different

things that can happen. Nothing can happen. The patient can be fine and recover on course. The patient could develop an underlying infection in the abdominal cavity. A patient could develop a fistula or bowel contents either in the abdomen or coming through into the skin. The patient can become more sick. There are a million possible permutations for a missed inadvertent enterotomy.

Q. If a patient has an enterotomy during surgery that is not recognized, can you tell me the symptoms that you would expect the patient to have post-operatively?

MR. : Objection.

Q. How do you diagnose a perforated bowel post-operatively?

MR. : Objection.

MR. OGINSKI: What's the objection?

MR. : You haven't established a foundation for this witness to answer those questions in

terms of the care and the treatment in this case.

MR. OGINSKI: I'm asking a general question.

MR. : It doesn't matter if it's a general question. He's not going to sit here as the diagnostic expert on the care and treatment that was rendered at a point in time that he was not involved. He's here clearly to answer anything related to his care and treatment at the time of care. Once you've established, I assume you will, what his time frame is, that's fair. But to ask him how does one go about diagnosing or what are the signs and symptoms of a perforation, et cetera, et cetera post-operatively is plainly beyond his role in this case.

MR. OGINSKI: He's a defendant and he's also an expert as a physician in his specialty so I'm entitled to ask him those general questions just

to establish his knowledge and expertise.

MR. : I would disagree with that. Just because you say he's a defendant and expert doesn't mean you can ask him questions having to do with issues and places and points in time that have no role in his care and treatment. Yes, he's an expert in terms of whatever he assisted and did at the time of surgery and he would have to answer fully and fairly for that. But in terms of events that occurred where he no longer had participation in the care, that seems to be exactly what you're trying to do.

He's not going to sit here and answer questions about what may or may not happen to a patient after the point in time that he's no longer involved.

Q. Doctor, are you -- you are a GYN oncologist?

A. No.
Q. What is your specialty?
A. I'm a surgical oncologist.
Q. And in and of
, you were a fellow at
correct?
A. Correct.
Q. And what year fellowship were
you in?
A. First year fellowship.
Q. In what field of medicine?
A. Surgical oncology.
Q. And what was your residency
training in?
A. General surgery.
Q. How many years training of
general surgery had you done prior to
beginning your first year fellowship?
A. Seven years total.
Q. In your experience, Doctor, up
until you began your fellowship at ,
had you performed primary hernia repairs?
A. Yes.
Q. Had you operated on patients who

had problems with their bowel?

MR. : Objection as to --

MR. OGINSKI: I'll rephrase.

Q. Had you encountered patients who suffered some type of bowel injury?

MR. : In the course of surgery?

MR. OGINSKI: Yes.

A. In what way?

MR. OGINSKI: I'll rephrase it.

Q. Had you performed bowel resections?

A. Yes.

Q. Had you treated any patients who suffered a bowel perforation during the course of surgery?

A. When?

Q. At any time in your residency.

A. Intraoperatively or post-operatively?

Q. Intraoperatively.

A. Yes.

Q. And the same question as it relates to post-operatively, had you

treated any patients that suffered a bowel perforation that was recognized in the post-operative period?

A. Yes.

Q. How do you diagnose a perforated bowel?

MR. : Objection. The same objection, please, counsel.

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

MR. : No.

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

MR. : I will advise him not to answer. It has nothing to do with his care and treatment in the case. You can't sue somebody and make them an expert as against other individuals in the case when he has nothing to do with that role.

It's very clear that you can ask him about his care and treatment, what he did intraoperatively, whatever his role and management in the case, I'm

not objecting to any of that. But to then say, well, he has had training in the treatment of perforated bowels and therefore I can question him about anything having to do with that topic generally is inappropriate.

MR. OGINSKI: I disagree, I disagree. I don't want to have to bring him back. He came from . I'm entitled to ask him --

MR. : I recognize that. But he's not going to sit here and give you a dissertation on how one diagnoses and treats perforated bowels.

MR. OGINSKI: That's all part of my claim and it's part of the allegations against this physician as well as others in the case.

MR. : If you're making an allegation against this physician, fine, but you haven't established anything in the course of this deposition yet that he was involved in

the role or in any way the care and treatment of this patient.

MR. OGINSKI: But I don't need to.

MR. : Yes, you do, you do have to establish some foundation and I've been at enough of these depositions to know that naming someone as a defendant does not permit you to ask them any question on any topic having to do with anything in the case.

MR. OGINSKI: Again, I disagree.

Q. Doctor, if you suspect a perforated bowel post-operatively, what diagnostic tests are available to you to evaluate the patient?

MR. : Objection.

I advise him not to answer the question.

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

A. Yeah.

MR. OGINSKI: Mark it for a ruling.

Q. As a first year fellow, what was your role in the performing surgeries at in of ?

A. Every case was different.

Q. What were your general roles and responsibilities as a first year fellow?

A. In the operating room or outside the operating room?

Q. In the OR.

A. Every case was different.

Q. How many year fellowship was this program?

A. Two years.

Q. And did you complete those two years?

A. Correct.

Q. And after completing those two years, what -- were you awarded a certificate or some advanced degree or something else?

A. It's a certificate.

Q. In what?

A. Surgical oncology.

Q. And after completing that, what did you do?

A. I'm currently an assistant professor of surgery at University of .

Q. In what field?

A. Surgical oncology.

Q. How long have you done that?

A. Since July of .

MR. : Sorry, where was that?

THE WITNESS: University of .

Q. Have you published in the field of your specialty?

A. Yes.

Q. Approximately how many things have you published?

A. Roughly .

Q. Do any of those publications have to do with the diagnosis and treatment of bowel perforation?

A. No.

Q. Do you have an independent memory of this particular surgery in this patient?

A. As far as what?

MR. : Any, anything.

A. Yeah.

Q. I'm sorry?

A. I do.

Q. Did you ever have any conversations with this patient's family members?

A. I don't remember.

Q. Do you have any specific memory of having any conversations with this patient?

A. I don't remember, but it's usually my custom to meet the patient before the operating room.

Q. Did you ever treat this patient before surgery?

A. No.

Q. After surgery on , , did you ever care and treat her again?

A. No.

Q. Did you have conversations with certain physicians who were caring for her while she remained at ?

A. Yeah.

MR. : While she was still at or after?

MR. OGINSKI: I'm asking while she was still there.

A. Yes. I don't remember while she was either at or .

Q. Do you know Dr. ?

A. I do.

Q. How do you know him?

A. He was a fellow and is still a fellow at .

Q. And what year fellow was he at the time that you were a first year fellow?

A. I don't remember.

Q. Were you a few years ahead of him?

A. We're in different -- totally different tracks. It's not comparable.

Q. Did you participate in this patient's surgery?
A. Yes.
Q. And this was a primary ventral hernia repair?
A. This was an incisional hernia repair.
Q. Are they the same?
A. It's yes and no. It's semantics.
Q. Explain the difference, please.
A. You can have a ventral hernia repair without having an incision or a ventral hernia without having an incision. An incisional hernia could also be called a ventral hernia as well.
Q. In this patient's case, how would you describe the surgery that you intended to perform?
A. Repair of an incisional hernia.
Q. Did you ever see this patient in consultation for pre-op evaluation?
A. No.
Q. Did you discuss this patient's

case with Dr. before seeing the patient in the operating room on ?

A. No.

Q. Had you reviewed the patient's charts or medical findings before performing surgery on , ?

A. Yes.

Q. And what was the purpose of that?

A. To determine what operation we were doing.

Q. And what exactly did you review?

A. Past medical history.

Q. And what did you learn from that review?

A. That she had a past medical history of ovarian cancer, she's had an exploratory laparotomy in the past, and she's developed an incisional hernia that was symptomatic and that was the reason for the repair.

Q. Was it your understanding that this patient had no evidence of recurrence

of cancer at the time of her surgery?

MR. : Objection to the form.

A. Repeat the question?

Q. What is it your understanding that this patient had no recurrence of cancer at the time of her scheduled surgery?

A. I don't know.

MR. : Note my objection.

Q. Is it you don't know because you don't remember as you sit here now or it wasn't clear and evident from the records you reviewed?

A. I don't remember that I had reviewed those records that it indicated one way or the other.

Q. In preparation for today, did you review this patient's medical chart?

A. I reviewed the operative report and all the involvement that I had in the case.

Q. Did you review Dr. 's deposition testimony?

A. No.
Q. Did you speak with Dr. ?
A. No.
Q. Have you ever spoken with Dr. after you left to go work at University of about this patient?
A. About this patient, no.
Q. Have you spoken to Dr. since you left ?
A. About this patient? No.
Q. Do you know Dr. , ?
A. I do.
Q. And who is Dr. ?
A. Dr. was a GYN resident on my service.
Q. Do you recall what year she was in?
A. I believe it was her second year.
Q. Have you had any discussions with Dr. about this patient?
A. No.
Q. Do you know Dr. , ?

A. No.

Q. Do you know Dr. Sarnigar?

A. No.

Q. Did you ever speak with any --

MR. OGINSKI: Withdrawn.

Q. Did you ever speak with any physician at , which is New York Presbyterian, about this patient after she was transferred from I believe on , ?

A. No.

Q. Do you recall what your schedule was like in , ? In other words, did you work days, evenings, how often you were on call? What was your schedule like?

A. I was on the GYN oncology service as their fellow. We don't have a -- you're responsible for your service twenty-four hours a day.

Q. How many people were on your particular team?

A. I don't remember at that time.

As far as patients or

physicians?

Q. I'm sorry, let me be clear.

MR. : What do you mean by team?

Q. On the GYN oncology service, how long a period of time did you remain on that service?

A. Thirty days.

Q. And how many other fellows were also on that service at about the same time?

A. I believe there were three fellows.

Q. And how many residents were part of that service?

A. There was one resident on my service.

Q. Would that be Dr. ?

A. Yeah, correct.

Q. Was there an attending assigned to the GYN oncology service for that period of time?

A. There's three different services, three different teams within the

service. Each team had a different attendant on two or more attendings associated or assigned to each team.

Q. Besides GYN oncology, who were the other services?

A. GYN oncology.

MR. : So there are three teams --

A. Three teams, one service.

Q. And can you just tell me whether one team would be responsible for days, one would be nights, or something else?

A. You were responsible for your own patient roster.

Q. Was Dr. one of the attendings on the service that you were on?

A. Yes.

Q. And had you worked with Dr. before?

MR. : Before when?

Q. Before this surgery of 30, .

A. Yes.

Q. Did you have any conversation with him specifically about this patient prior to beginning surgery?

A. Prior to the incision, yes.

Q. Tell me what you discussed.

A. We discussed what our plans were to do for this patient.

Q. Can you be specific, please.

A. How we were going to repair the incisional hernia.

Q. Instead of telling me about the -- generally what you talked about, are you able to tell me specifically?

A. No.

Q. Do you have any memory, as you sit here now, about any specifics that you discussed with Dr. prior to beginning surgery?

A. No.

Q. Dr. participated in the surgery; correct?

A. Define participation.

Q. Was she present?

A. She was present.

Q. And what was her function in the operating room?

A. She watched.

Q. And what was your function during the surgery?

A. I assisted Dr. .

Q. Who was the primary surgeon?

A. All the attendings are the primary surgeons.

Q. And who performed the majority of the surgery?

A. I don't remember that particular surgery. It's custom to be a give and take between the attending and the fellow.

Q. Did Dr. participate and actually perform any of the surgery?

A. No.

Q. Was the patient bowel prepped prior to the surgery?

A. I don't know.

Q. Is it customary that, when performing a ventral -- an incisional hernia repair, that the patient be bowel prepped?

A. Customary for who?
Q. You.
A. No.
Q. Are you aware of whether it was Dr. 's custom and practice to have a patient bowel prepped for an incisional hernia repair?
A. I don't know.
Q. Under what circumstances would you have a patient bowel prepped for an incisional hernia repair?
MR. : I have to object to that. Now you're far afield from this situation and the case at hand. Now you're asking him what he does in his independent practice.
MR. OGINSKI: I'm asking about the time --
MR. : First of all, he didn't have a role or participation --
MR. OGINSKI: I don't know that.
MR. : Did you have a role or participation as to whether the patient was bowel prepped prior to the

surgery?

THE WITNESS: No. I never saw the patient preoperatively.

Q. Did you ever ask Dr. whether the patient had been bowel prepped?

A. I don't remember. But it's custom that I wouldn't have asked that.

Q. In your review of the patient's medical records, did you learn that the patient had been bowel prepped?

A. No.

Q. Is it important for a patient --

MR. OGINSKI: Withdrawn.

Q. In a patient with prior surgeries, do you expect to find adhesions when you go in and operate?

MR. : Expect or can you?

Q. Do you have an expectation that the patient will have adhesions?

A. In this patient?

Q. Yes.

A. Yes.

Q. Why?

A. She's had multiple surgeries in the past.

Q. And how does that affect your strategy in planning this particular surgery?

A. It doesn't.

Q. Tell me why.

A. You don't know --

MR. : He's the assistant.

MR. OGINSKI: I want to know.

MR. : How does it affect you as the assistant?

THE WITNESS: It doesn't.

MR. OGINSKI: Well, he also indicated there was a give and take so at some point he may be the operator as well.

MR. : I guess we're losing the drift of what you're doing.

Q. This surgery was an open laparotomy?

A. Correct.

Q. Who noticed the incidental enterotomy that occurred in this patient's

surgery?

A. I don't recall.

MR. : Does he need to refer to anything?

MR. OGINSKI: Not yet.

Q. Did you observe any leakage of bowel contents as a result of the enterotomy?

A. I don't recall.

Q. Did you dictate this patient's operative note?

A. I did not.

Q. If you participated in the particular surgery, was it customary for you to perform -- for you to dictate the operative note?

A. No.

Q. Who would typically dictate the operative note?

A. The attending surgeon.

Q. And did you ever have an opportunity to review that operative note before it was signed by the attending?

A. No.

Q. I'd like you to turn, please, to this patient's operative note.

In the middle of the first full paragraph under operative procedure it says, "while checking the bowel."

Do you see that?

A. Yes.

Q. I'm just going to read the sentence. "While checking the bowel, it was noted that the patient had sustained an enterotomy."

Do you have any memory as to who recognized that enterotomy?

A. As I mentioned previously, no.

Q. Does this note indicate who recognized it?

A. No.

Q. It continues saying, "given the size of the defect and appearance of the adjacent bowel, we decided to resect a small portion of the bowel."

Do you have a memory, as you sit here now, as to the size of that particular defect?

A. No.
Q. And is it your understanding that the defect that Dr. refers to is the enterotomy?
A. That the defect --
MR. : Does the defect mean enterotomy, is that what you means by defect?
THE WITNESS: I'm assuming. I don't know.
Q. And he refers to the appearance of the adjacent bowel.
Do you know what he is referring to?
A. No.
Q. Do you have any memory about the appearance of the adjacent bowel?
A. I do not.
Q. Whose decision was this to resect a small portion of the bowel?
A. I don't remember. It's customary again to be a give and take. It's a discussion in the operating room.
Q. A bowel resection was performed

on the small bowel; correct?

A. Correct.

Q. Does this particular report reflect how much of the small bowel was removed?

A. This particular bowel does not.

Q. Is there anything in any of the records that you have seen to reflect how much of the small bowel was removed?

A. Yes.

Q. What is it that you're referring to that would tell you that?

A. The pathology report.

Q. And do you have a memory of the size of the bowel that was removed?

A. Seven centimeters, according to the pathology report.

Q. Now, once the defect is removed, you then have two ends that must be reattached together?

A. No.

Q. Tell me how that works once you remove the defect.

A. The defect, as mentioned in the

operative report, the anastomosis was performed in continuity.

Q. Tell me what that means.

A. There's no way I could explain it to you.

MR. : Do what you can.

A. It's essentially isolating the mesentery from the small bowel to remove the blood supply to that particular part of the mesentery and then you apply -- make an enterotomy in both limbs of the small bowel with a Bovie electrocautery, both limbs of the GIA with the blue load are placed, one in each limb. A staple fire is placed. And then your final staple fire at the end of the anastomosis is a TA90 blue load and that would resect the defect within the loop of bowel that you removed, that seven centimeter section.

Q. Thank you, Doctor. I just want to see if I can clarify that.

MR. : It's perfectly clear to me.

Q. When you have the small bowel and there is a defect observed as a result of the enterotomy and you're now removing that portion of the small bowel, what are your options as to fix that enterotomy?

A. The options are to remove it or to repair it primarily.

Q. And that would be either oversewing it?

A. It would be oversewing it.

Q. Can you tell me why this particular defect was not oversewn?

A. I can't. I don't remember the defect.

Q. Do you have any memory of the discussion that you had with Dr. --

A. No.

Q. -- about whether or not to oversew this defect?

A. No.

Q. I'm sorry, you said other than oversewing, what was the other option?

A. Resecting.

Q. And when you resect it, do you

literally cut out the defective part or the part that has the defect?

A. Yeah, as I mentioned.

Q. And how do you reconnect those pieces that now the ends have been cut?

MR. : That's what he described before.

A. That's what I described before. You never are cutting those ends. You do it in continuity. It's two staple fires versus three staple fires.

Q. Before beginning the resection, was this patient irrigated and any fecal contents drained?

A. I don't remember.

Q. Is there anything in the operative note to reflect that the patient had irrigation prior to beginning the resection?

A. Prior to beginning the resection, no.

Q. When you do irrigate --

MR. OGINSKI: Withdrawn.

Q. In a situation where there's an

enterotomy and fecal contents are now in the belly, what is available to you to irrigate that area?

MR. : What do you use to irrigate?

A. Your options are multiple. You can just use saline, water. That's usually the most standard.

Q. And why would you use something like that?

A. If you were concerned that there was overall contamination within the intra-abdominal cavity.

Q. If there is no irrigation after observing fecal contents come out of an enterotomy, is there a higher risk of infection, peritoneal or intra-abdominal infection?

A. If there's no irrigation?

Q. Yes.

A. No.

Q. How do you know whether the tissue surrounding the defect that you've now removed is viable?

A. In her case?
Q. Yes.
A. I don't remember. I don't remember the tissue in this particular case.
Q. In general, when you have now removed an enterotomy, the defect portion where there's been a hole and you're now connecting the remaining tissues together, how do you know that those remaining tissues are viable?
A. Color of the tissue.
Q. What color would you see to tell you that the tissue is viable?
A. The color would be anything but dark.
Q. And what would dark color signify to you?
A. Ischemia.
Q. Which means lack of flood flow?
A. Exactly.
Q. And if the color is pink or white, what does that indicate to you?
A. Usually there's good blood flow.

We also look at the cut edges of the bowel. Usually there's bleeding.

Q. And that tells you what?

A. That the bowel is getting enough blood supply.

Q. And if, for whatever reason, you feel that the edges that you have initially are not satisfactory, what do you then do in order to get satisfactory edges?

A. You perform another resection.

Q. And how do you know how far to keep going until you reach that point?

A. You resect until you get -- the bowel looks viable.

Q. In this particular case, when you were joining together those tissues, as you mentioned, in continuity, were the edges of those tissues viable?

A. I don't remember. But according to the operative report, yes.

Q. And can you point to me where you're referring to?

A. "The anastomosis was inspected

and good tissue viability was noted with adequate lumen size."

Q. Now, Doctor, if you attached viable tissue to non-viable tissue, would you expect that anastomosis to break down?

A. Not necessarily, no.

Q. Is there a higher incidence or a higher likelihood that there would be a breakdown of the anastomosis if one part of it was viable and the other part was not?

A. That's an impossible question to answer.

Q. Tell me why it's impossible to answer.

A. Because that means scientifically you would have to investigate every single anastomosis that you ever did with a second look operation and that has never been done in the history of surgical research in the human being so your denominator would never be known.

Q. Does the operative report

indicate whether you had to remove more small bowel --

MR. OGINSKI: Withdrawn.

Q. Does the operative report indicate that, after removing the initial defect, that additional small bowel had to be removed because those tissues were not viable for the anastomosis?

A. It doesn't indicate that.

Q. Who performed the anastomosis?

A. I don't recall.

Q. Does the operative report specifically indicate who performed the anastomosis?

A. It does not.

Q. In order to connect those tissues together that you mentioned in continuity using the stapler and the various devices that you talked about, is that done by one person or more than one?

A. One person fires the stapler.

Q. And who fired it in this case?

A. I don't recall.

Q. Now, once the tissues are

connected together using the stapling devices that you described, how do you test the integrity of that anastomosis?

A. In her case?

Q. In general.

A. General meaning small bowel, general meaning stomach?

Q. Yes.

A. Just visual inspection.

Q. In this patient's case, did you test the integrity of her anastomosis?

A. I don't recall. But the operative report seems to -- indicates that.

Q. And can you point out to me where it does, please.

A. "The anastomosis was inspected and good tissue viability was noted with adequate lumen size."

Q. And what is lumen size?

A. Lumen size is just the connection between the two limbs of the bowel.

MR. : Just a second.

(Whereupon a break was taken)

THE WITNESS: There's something I want to clarify.

I do remember flipping the small bowel over and looking at it. That's my custom and I do that regardless of who the attending surgeon is.

Q. And is there anything in the operative note to reflect that that was done?

A. Yeah.

Q. Where?

A. "The anastomosis was inspected and good tissue viability was noted with adequate lumen size."

Q. If there was some sort of problem with the anastomosis, how would you recognize it intraoperatively?

A. You may or may not recognize it intraoperatively.

Q. Are there ever instances where you will instill some type of liquid in order to test the integrity?

A. In her case or --

Q. In general?
A. In general, not with small bowel anastomosis.
Q. And other than visually looking to determine whether things look good, is there anything else that you as a surgeon are able to do to make sure that the integrity of the anastomosis is adequate?
A. With a small bowel anastomosis, there is no other way.
Q. When did you learn that this patient had died?
A. Approximately a week after the operation.
Q. And who did you learn that information from?
A. I'm not sure. It was either Dr. or Dr. .
Q. And what did you learn?
A. That the patient expired at .
Q. And did you learn how or why?
A. Later on down the road I learned how. I had a brief passing conversation

with Dr. in the hallway approximately a week after the operation and he had mentioned the second operation that was done at that he was present at. There was a -- essentially the back wall of the anastomosis was wide open where the TA stapler had fired.

Q. Now, the TA stapler, you mentioned that there were two different stapling devices, correct, the GIA and the TA?

A. Correct.

Q. What is the difference between the two?

A. The GIA is a stapler and it has a cutting device between the rows of staples. The TA stapler does not.

Q. And who fired the TA stapler in this patient's case?

A. As I previously mentioned, I don't recall.

Q. Did Dr. have any further comment with you other than what you've told me about how this patient died?

A. After she had died?
Q. Yes.
A. He had mentioned to me that he had originally wanted to take the patient to the operating room when the patient was at , although he didn't have privileges to do so.
MS. : Can you repeat that question and answer.
(Whereupon the requested portion was read back by the reporter)
Q. When Dr. told you that the back wall of the anastomosis was open where the TA stapler had fired, did you have any comment as a result of that?
A. I don't remember.
Q. Did the two of you discuss how that could have occurred?
A. I don't remember.
Q. Did Dr. offer any opinion or thoughts as to how that could have occurred?
A. I don't remember if he did one way or the other.

Q. In your experience up until that point had you ever encountered an anastomosis that broke down?

A. Broke down in general? Yes.

Q. Yes.

A. Yes.

Q. Had you ever encountered an anastomosis that broke down in the area where the TA stapler had been fired?

A. An anastomosis, no. But I did have recollection of having previous staple misfires with the TA stapler, just not a bowel anastomosis.

Q. If there was a misfiring of the stapler, is it like a regular stapler where you simply don't see the staple come out?

A. I don't understand the question.

Q. If the device, the stapler that you're using, is not working properly and is not firing the staple into the tissue, am I correct that you would see that there's no staple in there?

A. You may or may not. It's not

the only way that you would have a staple misfire, is not to place staples. It's similar to an office stapler where you have to place the staples and you also have to have the clasp underneath the bowel. If you don't have that clasp, the staples just, similar to an office staple, the staple itself will just come out.

Q. Is there any indication in this particular patient's case whether the TA stapler was not working properly?

A. I don't recall. And I wasn't present at the second operation.

Q. During the surgery that you participated in, did you have any indication that the GIA stapler was not functioning properly?

A. I don't recall if there were there was any staple misfunction during the original case.

Q. Did the TA stapler work properly as it was intended to during this patient's surgery on ?

MR. : That he could

observe?

MR. OGINSKI: Yes.

A. That I could observe, yes.

Q. And am I correct, there's nothing in Dr. 's operative report to indicate that those two staple devices were not working properly?

A. Correct.

Q. Did you ever have any discussion with any other physician about the reason why this patient had died?

A. No.

Q. And what was it about the back wall of the anastomosis being wide open that caused or contributed to the patient's death?

A. Enteric contents were freely flowing into the abdomen.

Q. When you say, "enteric," tell me what you mean.

A. Contents from the small bowel.

Q. Fecal contents?

A. No, enteric contents. Fecal contents would be from the large bowel.

Q. Did you have a conversation with any other physician about this patient's death?

A. After the death?

Q. Yes.

A. No.

Q. Were you ever present for any discussion with anyone at who discussed this patient's death after she had died?

A. No.

Q. Were you ever asked to give any type of written statement about your involvement in this patient's care and treatment during the surgery of ?

A. I was not.

Q. After Dr. informed you about the back wall of the anastomosis being wide open, did you ever form an opinion as to why this occurred?

A. It's something I couldn't really form an opinion on. I wasn't there at the second surgery. I would have had to have

seen what it looked like in the operating room. Just based on what he said, it's impossible to say.

Q. I'm sorry if I asked you this.

Did Dr. ever offer an opinion as to why this occurred?

A. I don't remember if he did.

Q. Would you agree, Doctor, that in an instance where the anastomosis has opened up, would you agree that the sooner this condition is recognized and treated the better chances for the patient there are?

MR. : I'll object to the form.

You mean in a hypothetical sense?

MR. OGINSKI: Yes.

A. Yes.

Q. Tell me why. Why is it better?

THE WITNESS: Doesn't this go back to the original objection?

MR. : I mean, again, you're going beyond the scope here.

MR. OGINSKI: I need to know.

MR. : The patient can live or die.

Isn't that obvious?

MR. OGINSKI: I need him to answer.

MR. : Just in a very general sense.

A. Can you repeat the question?

Q. In other words, why is it preferable for a patient's anastomosis opening to be treated sooner rather than later?

A. They have more chance to develop enteric contents in the abdomen.

Q. And am I correct that with enteric contents being in the abdomen, they have a greater likelihood of developing sepsis?

A. Yes and no.

Q. Tell me what you mean.

A. Sometimes yes. Sometimes patients who are immuno sufficient will have enteric contents in the abdomen and

never develop any form of overwhelming sepsis and will do fine from the operation or fine from an anastomotic leak. Other times patients will develop signs of overwhelming sepsis and multi-organ dysfunction. Every patient is different. There's no general statement to make.

Q. Did you have an opinion, on , when performing surgery, whether this patient was immunocompromised?

A. No, I did not.

Q. I'd like you to, please, look at the hematology labs for this patient, please.

The lab values -- the white blood count for the patient on right after surgery was done shows 11.3.

A. Correct.

Q. And how would you describe that particular finding, Doctor?

A. Normal.

Q. And the following day, the first reading of 1 shows 2.6.

What does that represent in terms of and in relation to the prior reading from the day before?

MR. : I don't understand what you're asking.

Was it normal or abnormal; is that what you want know?

Q. Is the 2.6 a normal reading?

A. By the hemogram from , it's not normal.

Q. And is the 3.6 normal?

A. Again, it's not normal by the hemogram or the normal function.

Q. Does the drop in white blood count from the eleven thousand three hundred to the 2.6, is that significant in any regard?

MR. : I have to object. That again is after he's involved in the care.

MR. OGINSKI: I'm asking his knowledge of this patient and these lab results.

MR. : He has no knowledge

of this patient and these labs at the time. You haven't established that.

MR. OGINSKI: I'm asking as a general question.

Q. Is a post-operative drop from eleven thousand to --

MR. OGINSKI: Let me rephrase it.

Q. A white blood count of 11.3 and the following day 2.6, what, if anything, does that indicate to you?

MR. : Objection.

Again, I'm advising him not to answer that with a total lack of foundation.

MR. OGINSKI: I'm asking --

MR. : I understand what you're asking. I'm objecting because there's no foundation.

MR. OGINSKI: I don't have to lay a foundation.

MR. : Well, you do have to lay some foundation to start showing him records or care and treatment that that's associated. If that were the

case, you could take out the New York Hospital chart and start asking him questions about that chart. You could take out any chart and start asking questions. You have to lay a foundation, so I'm objecting.

MR. OGINSKI: That goes to relevance. You can't direct him not to answer.

MR. : No, no, no, it would be palpably improper at trial, you know that. You have no basis to ask him that at trial.

MR. OGINSKI: I'll rephrase.

Q. Doctor, under what circumstances does an anastomosis break down?

A. There are hundreds of reasons for an anastomosis to break down, one including staple misfire or malfunction to including tissue ischemia. There are some indications that use of steroids leads to intestinal anastomosis compromise, hypotension. Again, that's more related to ischemia. Those are the big ones.

Q. After you spoke to Dr. about a week later and learned that the patient had died, did Dr. ever mention that the two stapling instruments were going to be rechecked to evaluate whether or not they were functioning?

A. He did not.

Q. Did you have any contact with this patient in the post-operative period while she was still at ?

A. My contact with the patient just was based on one visit to the recovery room as my custom in the post-operative period. I was off service at 5:00 or 6:00 that day and the patient left -- it looks like the surgery was over around 1:00 p.m. so my contact with the patient was less than five hours after the surgery.

Q. And you then gave signoff to Dr. who was covering?

A. Correct, he was taking over the service.

Q. Did you have any notes for this patient post-operatively?

A. In the chart, I did.
Q. And that would be something in the surgical --
A. It was, it was an operative report.
Q. That's a handwritten op note?
A. Correct.
Q. Do you have any notes for seeing the patient in the recovery room?
A. I do not.
Q. Was it your custom and practice that one or more of the residents would accompany you when you saw the patient in the recovery room?
A. It wasn't a custom. Sometimes it happened. But usually I saw most of the patients by myself.
Q. Let's turn, please, to your handwritten operative note.
MR. : Is it more than one page?
Q. And this is a form where you filled out certain portions of it; correct?

A. Correct.

Q. Were parts of that form filled out before the surgery began?

A. No.

Q. And what was the indication for surgery, according to your note?

A. Ventral hernia.

Q. And what were the findings intraoperatively?

A. Large ventral hernia without evidence of intra-abdominal disease, small bowel resection for enterotomy, closure with AlloDerm.

Q. What is AlloDerm?

A. AlloDerm is a synthetic -- it's from human cadavers used for fascial closure.

Q. Was there any mesh used in this surgery?

A. No.

MR. : Off the record.

(Discussion held off the record)

Q. When you brought the patient back --

MR. OGINSKI: Withdrawn.

Q. When you saw the patient in the recovery room, was there any evidence of infection or sepsis at that time?

A. Not that I recall.

Q. Did you ever form an opinion as to when it was that the anastomosis opened up following the surgery of ?

MR. : Do you have an opinion, in your mind, when you think the anastomosis opened up.

A. Based on --

MR. : Whatever you know.

A. Based on what I know, it happened within -- from the operating room to the second operation.

Q. And is it your understanding that the second operation occurred on ?

A. I don't know the particular date, no.

Q. Do you have any additional opinions about --

MR. OGINSKI: Withdrawn.

Q. Do you have any more specific opinion as to when the anastomosis opened up?

A. No. It happened between the operation and the second operation.

Q. Do you have any opinion as to whether this patient exhibited symptoms of sepsis following your --

MR. OGINSKI: Withdrawn.

Q. In any of the discussions you had with any physicians caring for this patient, did you learn whether this patient had any symptoms of sepsis?

A. Can you repeat the question?

Q. You told me the last time you saw this patient was in the recovery room; correct?

A. Yes.

Q. After that period of time, did you learn from anybody at that this patient had symptoms of either an infection or sepsis?

A. No, not infection or sepsis, I never learned that until Dr. had

mentioned it after the patient had died.

Q. Did Dr. tell you when those symptoms became evident?

A. He did not tell me the specifics of when the symptoms became evident.

Q. And did you inquire of him as to when those symptoms had been present in terms of the infections or sepsis?

A. I did not.

Q. Did you have any conversations with the patient's husband at any time after learning that the patient had died?

A. No.

Q. Did Dr. tell you that he had spoken with the patient's family members following her death?

A. He didn't mention it one way or the other.

Q. After this patient's surgery of 30, , did you speak to the patient's family members?

A. I don't remember but it's not my custom to speak to the patient's family members.

Q. Is it your custom to be present when the attending speaks to the family members?
A. It is not.
Q. Have you ever testified before?
A. In court? No.
Q. Or in a deposition setting?
A. Yes.
Q. How many times?
A. Once.
Q. And how long ago was that, approximately?
A. Probably four or five years ago.
Q. And was that in relation to a case in which you were being sued?
A. The hospital was.
Q. Which you participated in the care and treatment?
A. Which I participated in.
Q. And the hospital you're referring to is ?
A. No.
Q. Which hospital?
A. Medical Center.

Q. Where did you go to medical school, Doctor?

A. University.

Q. Which is where?

A. .

Q. From when to when?

A. .

Q. Where did you go to college?

A. University of .

Q. And when did you graduate?

A. .

Q. What, if anything, did you do between and ?

A. I worked.

Q. After University you said in ?

A. Yeah.

Q. What do you do?

A. I entered a surgical residency.

Q. Where?

A. Medical Center.

Q. For how long?

A. Seven years. The seven-year time was interrupted by two years of

research. It was a total of seven years.

Q. And the two years occurred during what phase?

A. Between the second and the third year of residency.

Q. When did you finish that?

A. , .

Q. And after that you began your fellowship at ?

A. Correct.

Q. And as of , , were you Board certified in any field of medicine?

A. Board eligible but not certified.

Q. And you completed your surgical oncology fellowship in May of or June?

A. June of .

Q. And did you go directly to the University of ?

A. No.

Q. What did you do?

A. I started August, .

Q. And are you Board certified in

any field of medicine?

A. Yes.

Q. In what?

A. Surgery.

Q. When did you become Board certified?

A. May, .

Q. Are you certified in any other field of medicine?

A. No.

Q. Do you hold any subspecialty within the field of general surgery?

A. No.

Q. Is there any subspecialty or certification for surgical oncology?

A. There is no Boards, it's just certification.

Q. And you have that; correct?

A. Yeah.

Q. Have you published or edited any portions of any textbooks?

A. No.

Q. Other than the patient's hospital record, did you review any other

records before coming here today?

A. No, just the hospital records.

Q. Were you ever present at for any discussion about this patient's care and treatment after she had died?

A. No, as I mentioned before.

Q. Did you ever have a conversation with Dr. about this patient's care and treatment being discussed at any time after she had died?

A. No.

Q. Did you ever learn from any physician as to why she was being transferred from to ?

A. Yes.

Q. Who did you learn that information from?

A. .

Q. And how did you learn that?

A. I had a brief conversation with Dr. , it was either late Saturday night or early Sunday morning when I saw

him in our version of the ER, the urgent care center in passing just asking how the service was doing and he had briefly mentioned at that time that the patient was having a cardiac event and was either transferred or being transferred to . It was less than a two or three-minute conversation, it was more of a passing, more interested in talking about other things.

Q. Did you ask him any details about what particular cardiac issues the patient was experiencing that necessitated the transfer?

A. I don't remember.

Q. Did you form any opinion at that time as to the possible causes or reasons for this patient's cardiac issues?

A. At that time he had mentioned that the patient was having a cardiac event. I found it strange because she really had no history, that I remember, of her having a cardiac event. And I explained or just briefly mentioned that I

was concerned that any patient with a new onset cardiac event you have to be concerned about an anastomotic leak.

Q. Why?

A. Because it was a newfound event.

Q. It was what, I'm sorry?

A. A newfound event. She didn't have, at least to my knowledge at that point, she had no history of cardiac events.

Q. And why or how could an anastomotic leak trigger or contribute to a patient's cardiac events?

MR. : Note my objection.

A. It could contribute to a patient having increased tachycardia or increased heart rate from tachycardia. She could have a respiratory compromise.

Q. And what is it about an anastomotic leak that would physiologically cause those things to occur?

A. Physiologically it would be just the enteric contents in the abdomen

leading to cytokine release leading to an increased heart rate. This is one sign of it. There are multiple other signs in that. That would probably not be my first sign.

Q. If there is an anastomotic leak, would you also see any problem with kidney function?

MR. : Objection.

MR. OGINSKI: I'll rephrase it.

MR. : Now we're on -- he told you what his conversation was and what his thinking was. Now you're in a whole different realm of expert testimony.

MR. OGINSKI: Not a problem. I'll rephrase it.

Q. And when you told this information to Dr. , what, if anything, did he say or respond?

A. I don't remember. It was a very brief conversation and it was mentioned just in passing.

Q. Did you have any similar

conversation with Dr. after learning that the patient had died?

A. After the learning the patient died, no, I never had a conversation with him with that.

Q. Did you speak to any other fellow who may have treated this patient other than Dr. ?

A. No.

Q. Just go back with me, Doctor, I just want to clarify.

This conversation that you had with Dr. occurred in the emergent area of the hospital?

A. Yeah, our version of the emergency room.

Q. And you said that was either a Saturday night or a Sunday?

A. It was either late Saturday night or early Sunday. I don't remember.

Q. In relation to when the patient was transferred, had the patient already been transferred or she was about to be?

A. I don't know. I don't know the

specifics of when the patient was transferred.

Q. Did you ever have any further discussion with Dr. about that, about this patient?

A. No.

Q. After learning --

A. Let me take that back. I don't know if I did or not. I learned the patient had died either from Dr. or Dr. but I don't know which one.

Q. After you learned that the patient had died, did you have a discussion with Dr. referring back to that conversation that you had with him in the emergent care area?

A. No.

Q. Did you learn whether Dr. had been present for the reoperation on 3?

A. I have no idea. I don't know.

MR. OGINSKI: Thank you.

MR. : Is that it?

MR. OGINSKI: Yes.

MR. : I just have one or two questions.

EXAMINATION BY

MR. :

Q. I represent Dr. in this case.

Do you know who Dr. is?

A. No.

Q. Did you ever have any conversations with Dr. in regard to this patient?

A. I don't know who he is.

Q. So the answer's no?

A. Yes, correct.

MR. : Thank you for your time.

MS. : I have no questions.

(TIME NOTED: 12:13 p.m.)

_____ (Signature of witness)

Subscribed and sworn to

before me this_____

day of_____,

2010.

_____

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INSERTIONS

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RULINGS

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CERTIFICATION BY REPORTER

I, Wayne Hock, a Notary Public of the State of New York, do hereby certify:

That the testimony in the within proceeding was held before me at the aforesaid time and place;

That said witness was duly sworn before the commencement of the testimony, and that the testimony was taken stenographically by me, then transcribed under my supervision, and that the within transcript is a true record of the testimony of said witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, that I am not interested directly or indirectly in the matter in controversy, nor am I in the employ of any of the counsel.

IN WITNESS WHEREOF, I have hereunto set my hand this day of , 2010.

_____

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WITNESS

SUBSCRIBED AND SWORN TO
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MY COMMISSION EXPIRES_____

* * *