DEIDENTIFIED DEPOSITION
ATTENDING CARDIOLOGIST TESTIFIES IN PRE-TRIAL HEARING
IN FAILURE TO DIAGNOSE SEPSIS CASE RESULTING IN DEATH OF PATIENT

1

2 SUPREME COURT OF THE STATE OF NEW YORK

3 COUNTY OF

4 -x

5 , as Administrator of the
Estate of , Deceased, and
6 , individually,

7 Plaintiff,

8 -against-

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10

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12

13
Defendants.
14

15 -x

16

17

18 June 23,
10:10 a.m.
19

20 EXAMINATION BEFORE TRIAL of

21 , M.D., a Defendant in the

22 above-entitled action, held at the above

23 time and place, taken before

24 , a Notary Public of the State of

25 New York, pursuant to Order.

1

2 APPEARANCES:

3 LAW OFFICES OF GERALD M. OGINSKI, LLC
Attorneys for Plaintiff
4 25 Great Neck Road
Great Neck, New York 11021
5
BY: GERALD M. OGINSKI, ESQ.
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Attorneys for all Defendants
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BY:
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Attorneys for Defendant
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BY:
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17 Attorneys for Defendant

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BY:
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2 STIPULATIONS

3 IT IS HEREBY STIPULATED, by and among

4 the attorneys for the respective parties

5 hereto, that:

6 All rights provided by the C.P.L.R.,

7 and Part 221 of the Uniform Rules for the

8 Conduct of Depositions, including the

9 right to object to any question, except

10 as to form, or to move to strike any

11 testimony at this examination is

12 reserved; and in addition, the failure to

13 object to any question or to move to

14 strike any testimony at this examination

15 shall not be a bar or waiver to make such

16 motion at, and is reserved to, the trial

17 of this action.

18 This deposition may be sworn to by the

19 witness being examined before a Notary

20 Public other than the Notary Public

21 before whom this examination was begun,

22 but the failure to do so or to return the

23 original of this deposition to counsel,

24 shall not be deemed a waiver of the

25 rights provided by Rule 3116, C.P.L.R.,

1 , M.D.
2 and shall be controlled thereby.
3 The filing of the original of this
4 deposition is waived.
5 IT IS FURTHER STIPULATED, a copy of
6 this examination shall be furnished to
7 the attorney for the witness being
8 examined without charge.
9
10 * * *
11
12 , the
13 Witness herein, having first been duly
14 sworn by the Notary Public, was examined
15 and testified as follows:
16 EXAMINATION BY
17 MR. OGINSKI:
18 Q Please state your name for the
19 record?
20 A .
21 Q Please state your address for
22 the record?
23 A
24
25 Q Good morning, Doctor.

1 , M.D.

2 A Good morning.

3 Q What is atrial fibrillation?

4 A It's an arrhythmia generated by

5 chaotic impulses from the atrium.

6 Q How do you treat that?

7 A It depends on the company it

8 keeps.

9 Q Tell me what you mean?

10 A There is stable atrial

11 fibrillation and there is unstable atrial

12 fibrillation. So our course of action is

13 determined by the clinical picture.

14 Q How do you treat stable atrial

15 fibrillation?

16 A Typically we would use agents

17 that help control rate, increase your

18 chances of the patient going back to the

19 regular rhythm. There is a need to

20 evaluate for possible anticoagulation.

21 Q And the agents you talk about,

22 what type of medications are those known

23 as?

24 A Most of them fall into groups

25 called AV nodal blocking agents or

2 antiarrhythmics.
3 Q What is a beta blocker?
4 A It's a drug that we use for
5 cardiac issues, including hypertension,
6 coronary disease, arrhythmias.
7 Q What does it do, in general
8 terms?
9 A It slows heart rate, decreases
10 myocardial demand.
11 Q Are you familiar with a
12 medication known as Metoprolol?
13 A Yes.
14 Q What is that?
15 A It's a beta blocker.
16 Q Are you aware or familiar with
17 the different methods or the different
18 types of -- withdrawn.
19 Does Metoprolol come in a
20 regular dose and also an extended release
21 dose?
22 A Yes.
23 Q What is the difference between
24 a regular dose and an extended release
25 dose?

1 , M.D.

2 A Extended release delivers drug

3 levels for prolonged period of time or

4 longer period of time than the shorter

5 acting equivalent.

6 Q Generally, why would you

7 administer an extended release form of

8 Metoprolol, as opposed to a regular type

9 of Metoprolol?

10 MR. : I'll just object

11 to the form, in general, but you can

12 answer.

13 Q Why would you do extended

14 release over any other form of

15 administration of that medication?

16 A It's simpler for patients to

17 take once a day.

18 Q And is there any other -- if

19 they don't take it once a day, how often

20 do they take the regular Metoprolol?

21 A Typically it's prescribed for

22 twice a day.

23 Q What is Amiodarone?

24 A It's an antiarrhythmic.

25 Q What is Heparin?

1 , M.D.

2 A It's a blood thinner.

3 Q In the course of your career,

4 have you had occasion to prescribe

5 Metoprolol to patients?

6 A Yes.

7 Q And have you also had occasion

8 to prescribe or administer Amiodarone?

9 A Yes.

10 Q And have you had occasion to

11 treat patients who had atrial

12 fibrillation?

13 A Yes.

14 Q Did you ever treat this

15 patient, Mrs. , at ?

16 A No.

17 Q Did you ever see and examine

18 this patient when she was at

19 ?

20 A No.

21 Q In preparation for today's

22 questioning, did you have an opportunity

23 to review this patient's medical chart?

24 A I looked at several notes on

25 the night in which I was involved in her

1 , M.D.

2 care at .

3 Q In any of the records that you

4 saw, did you see any notes that you had

5 written?

6 A No.

7 Q Did you ever perform a physical

8 examination, at any time, on this

9 patient?

10 A No.

11 Q In November and December

12 of , what was your connection or

13 affiliation with

14 ?

15 A I was an employee of the

16 hospital.

17 Q How long had you been an

18 employee?

19 A I started at July of

20 that year.

21 Q Which year, ?

22 A .

23 Q And before that, where were

24 you?

25 A I was at

1 , M.D.

2 Hospital in .

3 Q In what capacity?

4 A As a clinical cardiologist and

5 nuclear cardiologist.

6 Q How long had you been a nuclear

7 cardiologist and clinical cardiologist at

8 ?

9 A Five years.

10 Q Just so I'm clear, Doctor, you

11 had been an employee of ?

12 A Yes.

13 Q Now, in addition to --

14 withdrawn.

15 In November of , in

16 addition to being an employee at

17 , were you employed

18 anywhere else in the capacity of a

19 physician or cardiologist?

20 A No.

21 Q Were you part of the faculty

22 practice there?

23 A Yes, I'm employed on faculty.

24 MR. : I don't know if

25 they call it faculty practice as you

1 , M.D.

2 were thinking.

3 MR. OGINSKI: Yes.

4 Q In what department were you

5 affiliated with?

6 A I'm part of cardiology.

7 Q And did you have any specific

8 title there?

9 A I'm assistant chief of

10 cardiology.

11 Q Is that the title you had when

12 you first started working there?

13 A Yes.

14 Q Are you still working there

15 now?

16 A Yes, I am.

17 Q How many cardiologists, to your

18 knowledge, are employed at

19 currently?

20 MR. : Currently or ?

21 MR. OGINSKI: Currently.

22 A We are eight.

23 Q And in -- I'm sorry,

24 November of , how many cardiologists

25 were there?

1 , M.D.
2 A Six.
3 Q And do you still hold the title
4 of assistant chief of cardiology
5 currently?
6 A Yes.
7 Q Are you employed anywhere else?
8 A No.
9 Q At any time in November or
10 December of , did you ever review or
11 evaluate any EKGs for Mrs. ?
12 A On December -- the day after
13 the date in question.
14 Q Are you referring to the day
15 after she was transferred to ?
16 A I am.
17 Q Were you involved in the
18 decision making process to transfer the
19 patient to ?
20 A Yes.
21 Q And how was it that you came to
22 review or evaluate the patient's EKG the
23 day after she had been transferred to
24 ?
25 MR. : You mean

1 , M.D.

2 physically review it; right?

3 MR. OGINSKI: Yes.

4 A As the cardiologist on call for

5 that weekend, all EKGs that are done in

6 the hospital, are reviewed by the

7 cardiologist on call.

8 Q And how do you gain access to

9 that EKG?

10 Do you do it by computer at a

11 remote location; do you do it by the

12 patient's bedside or somewhere else?

13 MR. : In .

14 A Somewhere else. We get a stack

15 of EKGs compiled for us by a tech who was

16 on that weekend.

17 Q Do you typically do the reviews

18 while you are in the hospital or at home

19 or somewhere else?

20 A While we're in the hospital.

21 Q And when you evaluate an EKG in

22 that stack that you described, tell me

23 the process that you go through from the

24 time that you get them, you evaluate

25 them, what do you do after you interpret

1 , M.D.
2 them?
3 A We interpret them; we confirm
4 them with a signature, make whatever
5 corrections we deem necessary and hand
6 the pile back to the technician who
7 confirms them in the electronic medical
8 record.
9 Q Do you make any entries in the
10 electronic medical record after you have
11 evaluated and interpreted an EKG?
12 A I don't personally enter
13 anything in the record.
14 Q When you review a particular
15 EKG, are you saying the technician is
16 with you?
17 A No, I give them back to the
18 technician.
19 Q And how does the technician
20 know what information you have
21 interpreted -- withdrawn.
22 How does the technician know
23 what your interpretation is?
24 A We write on the EKG.
25 Q What happens to that actual

1 , M.D.
2 EKG, the ones that you have written on?
3 A I don't know what happens to
4 the ones we've written on.
5 Q Does that EKG that you have
6 written notes on, get put into the
7 patient's chart?
8 A The confirmed report is sent to
9 the electronic medical record. The
10 actual physical piece of paper, I don't
11 know what happens to that.
12 Q When you say the confirmed EKG,
13 tell me what you mean by that?
14 A After I get the printout of the
15 EKG, I look at the reading and determine
16 whether I agree with it, make whatever
17 adjustments I deem necessary and sign.
18 That document is then taken by the
19 technician, whatever adjustment needed to
20 be made are made and that's entered into
21 the electronic medical record.
22 Q Do you have any knowledge about
23 what happens to that actual sheet which
24 you have made notes on?
25 A No.

1 , M.D.
2 Q Have you ever seen, in
3 reviewing patient's charts, whether those
4 documents are scanned into the patient's
5 record or the electronic medical records?
6 MR. : Which documents?
7 Q The one you have written on
8 notes on.
9 A That's not typically what's in
10 the electronic medical record.
11 Q When an EKG is done, am I
12 correct that the computer reads and
13 interprets on its own, what the EKG
14 shows?
15 A Yes.
16 Q And when you say that you
17 compare, you look to see whether you
18 agree, are you talking about the readout
19 that was presented or generated by the
20 computer, to see whether you agree with
21 that conclusion?
22 A Yes.
23 Q Have there been occasions when
24 you have looked at EKGs and you did not
25 agree with the conclusion reached by the

1 , M.D.

2 computer?

3 A Yes.

4 Q If a patient is no longer

5 physically within the hospital and you

6 now are asked to review an EKG, do you

7 have any follow-up -- withdrawn.

8 At the time that you get those

9 EKGs to review, that stack of EKGs, do

10 you have knowledge as to whether the

11 patient is still physically within the

12 hospital?

13 A Not on all patients, no.

14 Q When you were involved in the

15 decision making process to transfer the

16 patient to , this patient to

17 , did you review any of the

18 patient's medical records before reaching

19 a conclusion about your plan of action?

20 MR. : Physically review

21 them?

22 MR. OGINSKI: Correct.

23 A No.

24 Q Am I correct that you spoke

25 with a cardiology resident as part of

1 , M.D.
2 your evaluation and decision making
3 process?
4 A Yes.
5 Q And was the resident a person
6 by the name of Dr. ?
7 A Yes.
8 Q And I believe the first name is
9 ?
10 A That I don't recall.
11 Q What was your understanding as
12 to what year resident this person was?
13 A Typically they are --
14 MR. : Note my objection.
15 Q I don't want to know typically.
16 I want to know specifically, do you know
17 what year this resident was?
18 A I don't specifically recall.
19 Q Was this individual a fellow?
20 A No.
21 Q Did the Department of
22 Cardiology have their own residents that
23 rotated through ?
24 A We have -- yes.
25 Q And how many cardiology

1 , M.D.
2 residents would there be in any given
3 year?
4 MR. : In a year, total?
5 MR. OGINSKI: Yes.
6 Q Would there be four first-year
7 residents, four second-year residents or
8 some other?
9 A We don't have our own
10 cardiology fellowship. We have a
11 cardiology fellow who rotates with us,
12 but we don't have our own independent
13 fellowship.
14 Q I'm talking about residency
15 training program.
16 A We don't have a cardiology
17 residency training program.
18 Q The cardiology residents who
19 rotate through ,
20 are you aware what hospitals or
21 institutions they come from?
22 A There are no cardiology
23 residents. They're internal medicine
24 residents, who are doing cardiology
25 consults.

1 , M.D.
2 Q Was Dr. one of the
3 internal medicine residents?
4 A Yes.
5 Q Do you know what year Dr.
6 was?
7 A I don't recall.
8 MR. : Just note my
9 objection to the prior
10 characterization of Dr. as a
11 cardiology resident.
12 Q Had you ever spoken to Dr.
13 before dealing with this particular
14 patient?
15 A Not that I recall.
16 Q Now, as part of the
17 conversation with Dr. , did you make
18 any notes as a result of the
19 conversation?
20 A No.
21 Q Did you make any entries on the
22 patient's electronic medical records, as
23 a result of that conversation?
24 A No.
25 Q Do you have a specific memory

1 , M.D.

2 of the conversation that you had with Dr.

3 about this particular patient?

4 A I don't have a specific memory

5 of one conversation versus the other. I

6 have a collective recollection.

7 Q How many different

8 conversations did you have with Dr.

9 about this patient?

10 A With Dr. , I think one.

11 Q Did you speak to any other

12 doctors at about

13 this patient?

14 A I spoke with , who was

15 the nurse practitioner from

16 Team.

17 Q And I'm sorry, what was her

18 name?

19 A , .

20 Q And how is it that this nurse

21 practitioner contacted you about this

22 patient?

23 MR. : How, you mean by

24 what means?

25 MR. OGINSKI: I'll rephrase it.

1 , M.D.
2 Q Why did she call you?
3 A Because she saw the patient in
4 her capacity of Team and
5 would be communicating with me since the
6 patient had a cardiac issue.
7 Q How many times did you speak
8 with about this patient?
9 A About four or five times.
10 MR. : Is that an
11 estimate?
12 THE WITNESS: It's an estimate.
13 Q Where was the patient at the
14 time that these conversations took place?
15 Was the patient in the cardiac care unit,
16 the intensive care unit, on the floor,
17 somewhere else?
18 A The patient was on a floor.
19 Q Do you have any memory as to
20 which floor?
21 A I don't recall.
22 Q Did you speak with Dr.
23 first or with first about this
24 patient?
25 A Dr. .

1 , M.D.

2 Q Was that the very first

3 conversation in which you learned about

4 this patient's condition?

5 A Yes.

6 Q How long did that first

7 conversation last?

8 A I don't recall.

9 Q What time of day or night did

10 that conversation take place?

11 A Somewhere between 7 or 8 at

12 night.

13 Q Were you physically within the

14 hospital at the time or were you home or

15 somewhere else?

16 A I was not in the hospital.

17 Q When you're on call for the

18 weekend, are you required to remain

19 in-house?

20 A No.

21 Q Are you board certified in

22 cardiology?

23 A Yes.

24 Q When were you board certified?

25 A I recertified in --

1 , M.D.
2 Q Originally, Doctor.
3 A Originally certified, in .
4 Q And you said you were recently
5 recertified?
6 A Yes.
7 Q Are you board certified in any
8 other field of medicine?
9 A Nuclear cardiology.
10 Q When did you receive your board
11 certification in nuclear cardiology?
12 A .
13 Q And the cardiology boards, did
14 you have to take your exam more than
15 once?
16 A No, not the recert.
17 Q Originally?
18 A The original, yes.
19 Q How many times?
20 A Twice.
21 Q Was that a combination, written
22 and oral exam?
23 A We don't have oral.
24 Q And the nuclear cardiology
25 board certification, did you have to take

1 , M.D.

2 that more than once?

3 A No.

4 Q Are you licensed to practice

5 medicine in the State of New York?

6 A Yes, I am.

7 Q When were you licensed?

8 A Originally, in about .

9 Q Are you licensed anywhere else?

10 A No, I'm not.

11 Q Has your license ever been

12 suspended?

13 A No.

14 Q Has your license ever been

15 revoked?

16 A No.

17 Q In addition to your on call

18 duties at , do

19 you see patients, private patients at the

20 hospital?

21 A They're not private patients.

22 Q Are you part of a consult

23 service?

24 A Yes, we are.

25 Q Do you have a memory of the

1 , M.D.

2 information that Dr. gave to you

3 during that first conversation?

4 By the way, is that a man or a

5 woman?

6 A I don't know. I have a

7 collective memory of the case.

8 Q Now, did you make any notes of

9 your own about --

10 MR. : Now I'm lost,

11 which question did you want her to

12 answer? There were two questions.

13 The second question was, by the

14 way --

15 MR. OGINSKI: I'll rephrase it.

16 MR. : So I want to make

17 sure we're all clear on what we got.

18 Q When you spoke to Dr. , did

19 you make any notes of your own that you

20 kept?

21 A No.

22 Q On any of the conversations you

23 had with Nurse Practitioner ,

24 did you make any notes of your

25 conversation?

1 , M.D.
2 A No.
3 Q After the patient was
4 transferred to , did you have any
5 communication with any physician at
6 about the patient's progress?
7 A No.
8 Q Did you have any communication
9 with any physicians who were at
10 , about the patient's
11 progress at ?
12 A No.
13 Q At some point after December 3,
14 , did you learn that this patient had
15 died?
16 A Yes.
17 Q When?
18 A When I was asked to -- when I
19 was told I was part of a suit.
20 Q At any time before learning
21 about this particular lawsuit, had you
22 learned that this patient died?
23 A No.
24 Q Do you know Dr. ?
25 A No.

1 , M.D.
2 Q Do you know Dr. ?
3 A No.
4 Q Do you know Dr. ,
5 ?
6 A No.
7 Q Or Dr. , ?
8 A No.
9 Q What is telemetry?
10 A Cardiac monitoring, continuous
11 EKG monitoring.
12 Q Does
13 have the ability for patients to be on
14 continuous telemetry?
15 A Yes.
16 Q What floor or floors do they
17 have that capacity?
18 A The 12th floor, 14th floor and
19 the 17th floor.
20 Q When you first learned about
21 this patient through Dr. , did Dr.
22 give you a history as to what was
23 going on with this patient?
24 A Yes.
25 Q What information did Dr.

1 , M.D.
2 relate to you about this patient?
3 A Again, I have a collective
4 memory so --
5 Q Tell me what you learned from
6 Dr. .
7 MR. : Note my objection,
8 in that she says she doesn't remember
9 what she discussed.
10 MR. : I don't think she
11 said she doesn't remember what she
12 discussed. She said she has a
13 collective memory.
14 A So Dr. presented to me a
15 patient who cardiology was consulted on
16 for chest pain and EKG changes. Patient
17 who had -- was post-op abdominal surgery.
18 Patient who had -- she was 52 years old.
19 Dr. 's assessment was that the
20 patient was somewhat tachypneic, blood
21 pressures were borderline and patient was
22 in sinus tachycardia at that time.
23 Q What is sinus tachycardia?
24 A It's arrhythmia with an
25 elevated heart rate.

1 , M.D.

2 MR. : Can I have the

3 prior answer read back?

4 [At this time, the requested

5 portion of the record was read.]

6 Q When you use the word

7 tachypneic, what do you mean?

8 A Short of breath.

9 Q And what do you consider to be

10 borderline blood pressure?

11 A I would say a blood pressure

12 hovering around 100 systolic, depending

13 on your baseline.

14 Q Did Dr. give you any

15 information about the patient's

16 preoperative cardiology history?

17 A Yes.

18 Q What information did you learn

19 from Dr. about the patient's

20 preoperative history?

21 MR. : Objection.

22 A I believe Dr. told me the

23 patient had a history of hypertension and

24 arrhythmia in the past.

25 Q Did you learn from Dr. as

1 , M.D.

2 to whether those conditions were

3 controlled by medication prior to her

4 surgery?

5 A Yes, I believe Dr. told me

6 patient was on beta blocker.

7 Q And did Dr. relate to you

8 whether the beta blockers had been

9 efficient or had adequately controlled

10 her cardiac condition preoperatively?

11 MR. : Objection to form.

12 MR. : Note my objection.

13 MR. : Did Dr.

14 convey that information to you, as

15 you recall?

16 A It would have been customary.

17 Q Did Dr. discuss with you

18 whether he had -- he or she --

19 MR. OGINSKI: Off the record.

20 [At this time, a discussion was

21 held off the record.]

22 Q Did Dr. tell you that he

23 had reviewed the patient's preoperative

24 EKG and compared it with the EKG that was

25 done on the day he was calling you?

1 , M.D.
2 A Yes.
3 Q And what information did you
4 learn about that?
5 A There were EKG changes
6 suggestive of ischemia.
7 Q What is ischemia?
8 A Ischemia is a term we use to
9 describe inadequate blood supply to
10 tissue of the heart.
11 Q Did Dr. offer any opinions
12 as to why this patient was short of
13 breath?
14 MR. : Opinion,
15 assessment.
16 MR. : Note my objection.
17 A I don't recall specifically
18 about tachypnea.
19 Q Did Dr. offer any opinion
20 or assessment about why this patient was
21 in sinus tachycardia?
22 MR. : Note my objection.
23 A Yes.
24 Q What did Dr. say?
25 A Dr. had a number of

1 , M.D.

2 possibilities, that I recall, on his

3 differential which could cause sinus

4 tachycardia.

5 Q And what were those

6 possibilities?

7 A Acute coronary syndrome.

8 Q Anything else?

9 A And he also referenced

10 tachycardia secondary to beta blocker

11 withdrawal.

12 Q Did you learn for what period

13 of time the patient's beta blocker had

14 been discontinued prior to her surgery?

15 A Only from review of the chart.

16 Q During your conversation, did

17 you learn from Dr. how long the

18 patient's beta blocker had been withheld?

19 A I do not recall.

20 Q What is acute coronary

21 syndrome?

22 A It's a title that we give to

23 describe situations where there is

24 inadequate blood supply to the heart.

25 Q Is that a form of ischemia?

1 , M.D.

2 A It includes different types of

3 ischemic syndromes, yes.

4 Q What triggers that acute

5 coronary syndrome?

6 A It can have many triggers.

7 Q Did the patient have a history

8 of atrial fibrillation?

9 A Yes, the patient was on beta

10 blockers for that arrhythmia.

11 Q Did you learn that those

12 medications that she was taking,

13 adequately controlled her atrial

14 fibrillation?

15 MR. : I think that was

16 asked and answered.

17 MR. OGINSKI: It's a little

18 different.

19 MR. : What's the

20 difference?

21 MR. OGINSKI: Here I'm asking

22 about the atrial fibrillation.

23 MR. : Note my objection.

24 You are referring to preoperatively?

25 MR. OGINSKI: Yes.

1 , M.D.
2 MR. : Do you remember
3 what you learned?
4 A I don't remember.
5 Q Was it your understanding that
6 the patient had been medically cleared
7 for surgery that was going to take place
8 on November 30, ?
9 A I had no information about
10 medical clearance prior to surgery on
11 November 30th.
12 Q Did you ask Dr. whether
13 the patient had been symptomatic prior to
14 her surgery, with regard to her atrial
15 fibrillation?
16 A I do not recall.
17 Q Now, the abdominal surgery that
18 you learned about, were you told
19 specifically what type of surgery she
20 had?
21 A I remember she had an
22 intraabdominal surgery.
23 Q Can you be anymore specific?
24 A I do not have a recollection.
25 Q Did you learn from Dr.

1 , M.D.

2 that during the course of surgery, there

3 was an enterotomy made?

4 A I don't recall hearing that.

5 Q Did you learn that during the

6 course of this patient's surgery, there

7 was a section of bowel removed and an

8 anastomosis done?

9 A I don't recall.

10 MR. : Just note my

11 objection regarding the questions

12 that you are asking, regarding her

13 recollections with Dr. because

14 she already said she doesn't have

15 specific memory, except for things

16 that she has testified about, her

17 collective recollection.

18 MR. : I'm not sure about

19 that.

20 MR. : That's what it

21 was. I specifically noted that.

22 MR. : That's not what

23 she said.

24 Q Did you ever learn from any

25 physician -- withdrawn.

1 , M.D.
2 Before this patient was
3 transferred to , did you ever
4 learn from any physician that this
5 patient had undergone a bowel anastomosis
6 during the course of her surgery on
7 November 30, ?
8 MR. : Bowel anastomosis?
9 MR. OGINSKI: Yes.
10 MR. : Do you remember if
11 you learned that?
12 A I remember somewhere in
13 conversations that she had small bowel
14 resection, so yes.
15 Q What other information did you
16 learn, that you told me you had a
17 collective memory about, regarding these
18 conversations with Dr. and the nurse
19 practitioner?
20 MR. : Do you want her to
21 go over everything she remembers from
22 beginning to end?
23 MR. OGINSKI: I'm going to
24 rephrase it. I'll get back to that.
25 Can I have this marked

1 , M.D.

2 Plaintiff's Exhibit 1 and this as

3 Plaintiff's Exhibit 2.

4 [The documents were hereby

5 marked as Plaintiff's Exhibit 1 and

6 Plaintiff's Exhibit 2, for

7 identification, as of this date.]

8 Q Doctor, let me show you what's

9 been marked as Plaintiff's Exhibit 1,

10 which is an EKG which has a date of

11 November 27, , for this patient,

12 .

13 MR. : Do you want to

14 show her the others?

15 MR. OGINSKI: Yes, I will in a

16 moment.

17 MR. : Because I think

18 she did the reverse.

19 MR. OGINSKI: Right, I know.

20 Q When you reviewed this

21 patient's EKG done on December 1, ,

22 did you have the benefit of also seeing

23 the preoperative EKG as well?

24 A We would have the most recent

25 prior EKG.

1 , M.D.

2 Q As far as you know, was that

3 the EKG that you have in front of you

4 now?

5 A I don't know without looking at

6 the one I read.

7 Q Looking at this document in

8 front of you, the EKG, can you tell me

9 your interpretation of what is seen

10 there?

11 A It looks to me like sinus

12 bradycardia.

13 Q What is that?

14 A That's a P wave followed by a

15 QRS complex, with normal intervals at a

16 rate of under 60 beats per minute.

17 Q Is that a normal EKG, as a

18 general question?

19 A Yes.

20 Q Now, the interpretation

21 rendered by the computer, were you in

22 agreement with the information that's

23 reported on that record?

24 A I'm in agreement -- this is an

25 EKG report by a cardiologist.

1 , M.D.

2 Q Let me show you an EKG report

3 dated December 1, , Plaintiff's

4 Exhibit 2.

5 MR. : By the way, I'll

6 copy all of these.

7 MR. OGINSKI: Sure.

8 Q That consists of three pages.

9 MR. : Plaintiff's

10 Exhibit 2 is three pages?

11 MR. OGINSKI: Yes.

12 Q And this particular report has

13 your name that appears in the computer

14 generated portion; correct?

15 A Yes.

16 Q And does that indicate that you

17 had reviewed and confirmed the findings

18 on here?

19 A Yes.

20 Q And the information that's

21 recorded at the top of that EKG, is that

22 information based -- placed there, based

23 upon your interpretation of this EKG?

24 MR. : On all three

25 sheets?

1 , M.D.
2 MR. OGINSKI: Yes.
3 A This -- what is confirmed is
4 based on my assessment.
5 Q Is there anything in that
6 assessment that is different than either
7 what a computer generated EKG reported or
8 any other physician?
9 MR. : Objection to form.
10 What do you mean, any other
11 physician?
12 MR. OGINSKI: I'll rephrase it.
13 Q When you reviewed this EKG on
14 December 2nd, what was listed on there,
15 what did the computer readout show?
16 A There is no way for me to know.
17 Q Is there anyway to tell from
18 looking at your notes -- I'm sorry, is
19 there anyway to tell from looking at your
20 assessment, as to whether the original
21 EKG computerized interpretation was in
22 agreement with your conclusion?
23 A No, there is no way to tell.
24 Q What was your assessment based
25 upon this EKG?

1 , M.D.
2 A The EKG is sinus tachycardia
3 with premature atrial complexes. There
4 are ST and T wave abnormalities
5 suggestive of anterior wall ischemia,
6 compared with the prior EKG, premature
7 atrial complexes are noted, ventricular
8 rate has increased and T wave present in
9 the anterior leads.
10 Q Would it be correct to say --
11 withdrawn.
12 Are these findings different
13 than what is observed on the November 27,
14 EKG?
15 A Yes.
16 Q These are new changes?
17 A Yes.
18 Q Did you form an opinion as to
19 why these changes occurred?
20 A On the EKG, suggestive of
21 ischemia.
22 Q Was there any particular --
23 withdrawn.
24 Did you come to any conclusion
25 or opinion as to why these changes now

1 , M.D.

2 showed up on the December 1, EKG, in

3 comparison to the November 27, EKG?

4 MR. : In terms of her

5 diagnostic --

6 MR. OGINSKI: Correct.

7 MR. : What diagnosis did

8 you attribute that to?

9 A Acute coronary syndrome and

10 ischemia.

11 Q Did you form any opinion as to

12 why this patient developed this acute

13 coronary syndrome?

14 A The patient was post-op and

15 patients can have postoperative MIs.

16 Q What led you to the opinion or

17 conclusion that this patient might have

18 an MI?

19 A EKG changes suggest ischemia

20 and the patient had chest pain.

21 Q What else could possibly be

22 going on with this patient to cause this

23 condition?

24 MR. : Other than MI?

25 MR. OGINSKI: Yes.

1 , M.D.

2 MR. : That you

3 considered.

4 A There is nothing else that

5 typically gives these EKG changes and

6 chest pain.

7 Q Was the chest pain associated

8 with inspiration or expiration of the

9 patient's breathing?

10 A Someone references that in

11 their note.

12 Q Is that distinct from chest

13 pain that's unrelated to a patient's

14 breathing?

15 A Chest pain that's related to

16 breathing is more typical in certain

17 scenarios than chest pain not related to

18 breathing.

19 Q What is it more typical of?

20 A Inflammation.

21 Q Of what?

22 A Of the lung or the sac around

23 the heart.

24 Q Are you able to tell from an

25 EKG, whether a patient has

1 , M.D.
2 cardiomyopathy?
3 A No.
4 Q In order to formulate a
5 treatment plan for this patient, am I
6 correct that you were relying on the
7 information that Dr. provided to
8 you?
9 A That I was provided by Dr.
10 and Dr. and the surgical team.
11 Q You mentioned a little earlier
12 that there was a Nurse Practitioner ,
13 as opposed to a doctor?
14 A Yes, nurse practitioner.
15 Q Who else was it besides Nurse
16 and Dr. that you had contact
17 with?
18 A Through the nurse practitioner
19 and the resident, the surgical resident.
20 Q Who was that?
21 A I don't recall the name, and
22 the ICU attending.
23 Q Do you know who that was?
24 A That's Dr. , .
25 Q And what was the reason as to

1 , M.D.

2 why you had contact with the surgical

3 resident?

4 MR. : She didn't say it

5 that way.

6 A I didn't say contact.

7 MR. : She said

8 information was conveyed through, but

9 she didn't have contact with the

10 surgeon.

11 Q How did you learn about

12 information transmitted from the surgery?

13 A Through my surrogates,

14 and Dr. .

15 Q And the same would be true of

16 Dr. ?

17 A Yes.

18 Q What specific information did

19 you learn about whatever they had to tell

20 you?

21 A Information including clinical

22 picture of the patient, how she was

23 responding to interventions, discussions

24 about candidacy for antiplatelet agents

25 and cath lab.

1 , M.D.

2 Q Why was this patient

3 transferred to ?

4 A For better monitoring and

5 possible cardiac catheterization.

6 Q Did have the

7 ability to perform cardiac

8 catheterization?

9 A No.

10 Q When you say better cardiac

11 monitoring, tell me what specifically you

12 mean?

13 A has all that

14 has, but also has CCU. It has a cath

15 lab. And so our custom and practice is

16 to transfer patients in whom we suspect

17 ACS to , so that if they need to

18 go to the cath lab quickly, they can do

19 so.

20 Q Are there any other symptoms

21 associated with acute coronary

22 syndrome -- I'll rephrase that.

23 What symptoms do you typically

24 see in a patient with acute coronary

25 syndrome?

1 , M.D.

2 A Presentation can vary. It can

3 include chest discomfort, shortness of

4 breath, nausea, vomiting, can be

5 nonspecific presentation, EKG changes.

6 Q Anything else associated with

7 ACS?

8 A Those are typical things.

9 Q I'm sorry?

10 A Those are the typical things.

11 Q And is this type of syndrome

12 that you described, is that something

13 that you learned about in your cardiology

14 training?

15 A We learned about it in our

16 medicine training.

17 Q And is that something that, to

18 your knowledge, that all medical

19 residents learn about?

20 MR. : I have to object

21 to the form. How is she going to

22 speak for all medical residents?

23 Q Is that part of the curriculum

24 for medicine training in --

25 MR. : In cardiology?

1 , M.D.
2 MR. OGINSKI: Medicine, in
3 general.
4 MR. : I'll object to the
5 form.
6 Q Would you except an internal
7 medicine resident, doing a cardiology
8 consult, to recognize the symptoms of
9 ACS?
10 MR. : You can answer
11 over objection.
12 A Yes.
13 Q In learning information from
14 the surgical resident through Dr.
15 and the nurse practitioner, was that how
16 you learned -- withdrawn.
17 At the time that you completed
18 your interpretation of the December 1,
19 EKG, once you have signed off on
20 that report, do you learn -- withdrawn.
21 Did you have any contact with
22 anybody about that EKG?
23 A No.
24 Q What is premature atrial
25 complexes?

1 , M.D.

2 A They are sinus appearing beats

3 that come early.

4 Q What causes that?

5 A The heart not beating as

6 regularly as a clock and so one beat

7 comes early.

8 Q You had mentioned earlier that

9 there was the suggestion or the

10 possibility that this patient's EKG

11 changes may have been triggered by

12 this -- withdrawn.

13 The beta blocker the patient

14 had been on prior to surgery, did you

15 attribute the withholding of that beta

16 blocker to what you observed on the

17 December 1st EKG change?

18 MR. : He's asking what

19 you attributed.

20 A No.

21 Q Did Dr. mention that these

22 changes may have been attributed to the

23 patient's withholding of her beta

24 blocker?

25 MR. : Note my objection.

1 , M.D.

2 A No, Dr. mentioned thinking

3 that the heart rate may be secondary to

4 beta blocker withdrawal, not the EKG

5 changes.

6 Q Now, you mentioned -- we talked

7 about Metoprolol, that was, I believe,

8 you said a beta blocker?

9 A Yes.

10 Q Did you order any physician to

11 prescribe or to give or administer the

12 patient Metoprolol?

13 A I believe the patient had

14 already received Metoprolol when we were

15 consulted.

16 Q And would it make any

17 difference as far as the EKG changes you

18 observed on December 1st, as to whether

19 the patient's medication of Metoprolol

20 was given in regular format or extended

21 release?

22 A No, it wouldn't make any

23 difference.

24 Q Tell me why it would not make a

25 difference?

1 , M.D.

2 A Because those types of EKG

3 changes have nothing to do with beta

4 blocker administration.

5 Q Can a bowel resection cause

6 exacerbation of atrial fibrillation?

7 A Anything can cause exacerbation

8 of atrial fibrillation.

9 Q If there is a bowel leak, an

10 anastomotic bowel leak, can that cause

11 tachycardia?

12 A Again, anything can cause

13 tachycardia.

14 Q Did this patient have evidence

15 of tachycardia preoperatively?

16 MR. : Base on the EKG?

17 MR. OGINSKI: Yes.

18 A Not on the pre-op EKG.

19 Q Did Dr. or Nurse

20 Practitioner ever relay information

21 to you that the patient had tachycardia?

22 MR. : By EKG or history?

23 MR. OGINSKI: Yes.

24 A I had to be told that the

25 patient had an arrhythmia, for which she

1 , M.D.

2 was on beta blockers.

3 MR. : Objection.

4 Q Is an arrhythmia synonymous

5 with tachycardia?

6 A No.

7 Q Does an anastomotic bowel leak

8 cause shortness of breath?

9 A Not typically.

10 Q If there are enteric contents

11 that leak from an anastomotic perforation

12 or leak, are you aware whether that

13 releases cytokines?

14 A Yes.

15 Q You are aware it does?

16 A Yes.

17 Q What are cytokines?

18 A They are products of

19 degradation in a setting of infection,

20 that trigger a cascade of inflammation.

21 Q Can the release of cytokines

22 cause irritation or exacerbation of a

23 previously dormant or asymptomatic

24 cardiac condition?

25 A Yes.

1 , M.D.
2 Q In your discussion with Dr.
3 and Nurse Practitioner , did you
4 ever consider the possibility that the
5 patient's cardiac issue was caused by
6 some form of postoperative surgical
7 complication?
8 MR. : Read back the
9 question.
10 [At this time, the requested
11 portion of the record was read.]
12 A Post-op MIs are a known
13 complication of surgery and they
14 typically happen in the first 48 hours.
15 MR. : Can you read back
16 the answer?
17 [At this time, the requested
18 portion of the record was read.]
19 Q As part of a workup to evaluate
20 a patient for an MI, one of the tests
21 that you perform is drawing of bloods;
22 correct?
23 A Yes.
24 Q And you test something known as
25 troponins?

1 , M.D.

2 A Yes.

3 Q Why do you do that? What does

4 that tell you?

5 A It tells us if there has been

6 myocardial damage.

7 Q And those are known as enzymes?

8 A It's one of the enzymes.

9 Q Do you often take serial

10 enzymes, to see if there are changes in

11 the levels?

12 A Yes.

13 Q Can you give me a general idea

14 of how long it takes to get results back?

15 A Typically, under an hour.

16 MR. : After you draw the

17 blood, to get the results back?

18 A After they hit the lab. I

19 should say, if they're sent stat.

20 Q Did the patient also experience

21 palpitations at the time that you were

22 contacted?

23 A I'm not sure if they were at

24 the time I was contacted, but there is a

25 record that she experienced palpitations.

1 , M.D.

2 Q How do you treat acute coronary
3 syndrome?
4 A There are a number of therapies
5 that we implement. Again, it depends on
6 the clinical picture. They include
7 things like aspirin, beta blockers,
8 Heparin, cath.
9 Q If you transfer a patient from
10 across the street to
11 , do you have any further contact
12 with the patient at ?
13 A No.
14 Q Do you have any privileges to
15 treat and see patients at ?
16 A No.
17 Q In order to make and accomplish
18 the transfer of a patient with this type
19 of cardiac condition to , am I
20 correct that there has to be some
21 communication with the corresponding
22 physician at ?
23 A We communicate with the
24 cardiology fellow at .
25 Q In this instance, who made that

1 , M.D.

2 communication, was it Dr. , was it
3 you or someone else?
4 MR. : Or more than one?
5 Q Or more than one?
6 A I had a conversation with the
7 cardiology fellow, but so did, I believe,
8 Nurse Practitioner .
9 Q And who was the individual that
10 you spoke to?
11 A I don't recall.
12 Q What information did you tell
13 this cardiology fellow at about
14 this patient?
15 MR. : You mean, what was
16 the discussion?
17 MR. OGINSKI: Yes.
18 MR. : Tell us about your
19 recollection of the discussion.
20 A My discussion would include
21 clinical history --
22 Q I'm sorry, Doctor, I don't mean
23 to interrupt you. I'm not asking
24 generally, I'm asking specifically.
25 MR. : What stands out in

1 , M.D.

2 your mind in terms of that

3 conversation, things you talked

4 about?

5 A All right, so amongst the

6 things we discussed was that the patient

7 was having an arrhythmia, which we had

8 tried to control, but was difficult to

9 control. I felt that she was too

10 unstable to be treated at , that

11 she would be better off with the services

12 of CCU and possible cath lab. And that

13 we had stabilized her as best that we

14 could and that her speedy transfer was

15 prudent.

16 Q From the time of that

17 conversation -- withdrawn.

18 Do you have a memory as to when

19 that conversation took place?

20 A I don't recall the exact time.

21 Q Was this still within the same

22 evening that you had first been notified

23 about this patient's condition?

24 A Yes.

25 Q From that time frame, how long

1 , M.D.

2 was it before the patient was actually

3 transferred to ?

4 A I don't recall exactly what

5 time the conversation was with the

6 fellow.

7 Q Do you have a memory as to when

8 this patient was actually transferred to

9 ?

10 A I don't have any recollection,

11 no.

12 Q Were you contacted throughout

13 the night of December 1st about this

14 patient's progress, by either Dr. or

15 the nurse practitioner?

16 MR. : At various times?

17 MR. OGINSKI: Yes.

18 MR. : Note my objection.

19 A Yes, and I also called them.

20 Q And what was the

21 from --

22 MR. : I think he's

23 objecting to this.

24 MR. : It was compound.

25 It was unclear who you were referring

1 , M.D.

2 to.

3 MR. : He's objecting to

4 a compound nature, but she's just

5 answering that she had contact with

6 people.

7 Q What did the cardiology fellow

8 say, if anything?

9 MR. : Are you talking

10 about at ?

11 MR. OGINSKI: Yes.

12 A They said that they would

13 expedite making a bed for the patient.

14 Q Was there any discussion with

15 you and Dr. about what it was that

16 may have triggered this patient's EKG

17 changes?

18 MR. : Objection.

19 A Yes, we thought it was

20 ischemia.

21 Q Was there a discussion as to

22 what triggered this ischemia at the time

23 that you were having this conversation?

24 A Again, post-op MIs are common.

25 Q Now, in order to evaluate

1 , M.D.
2 whether or not the patient has an MI,
3 what is the cardiac workup that you
4 perform on a patient?
5 A We do physical exam; we do
6 clinical exam, EKG, blood work, sometimes
7 cardiac catheterization. It depends on
8 the clinical picture.
9 Q Did this patient have a cardiac
10 sonogram or echocardiogram?
11 A Not that I know of.
12 Q Did you learn whether this
13 patient had ever had a cardiac
14 catheterization in the past?
15 A I don't recall.
16 Q Did you ever learn from any
17 physician on December 1st or
18 December 2nd, that this patient's surgery
19 was an elective hernia repair?
20 A That would have been presented
21 in a history.
22 Q And you had mentioned that you
23 learned that the patient had abdominal
24 surgery or intraabdominal surgery, do you
25 have a specific memory of being told that

1 , M.D.

2 the patient had an elective hernia

3 repair?

4 A I don't have specific memory,

5 but it would be part of the case

6 presentation.

7 Q Now, you told me what Dr.

8 's differential diagnosis was and the

9 different possibilities that this

10 patient's problems might have

11 represented.

12 Did you suggest or recommend to

13 Dr. , any other possibilities for

14 this patient's condition?

15 A No.

16 Q Did you agree with Dr. 's

17 assessment as to what this patient's

18 likely condition was?

19 MR. : ACS versus beta

20 blockers, something or other?

21 MR. OGINSKI: Yes.

22 A I believe the patient was

23 having ACS.

24 Q Now, you mentioned that one of

25 the possibilities was tachycardia

1 , M.D.

2 secondary to beta blocker withdrawal.

3 MR. : That was Dr.

4 's.

5 MR. OGINSKI: Yes, correct.

6 Q Now, tell me, can you explain

7 what you mean by that? What is your

8 understanding of that?

9 MR. : What is her

10 understanding of what Dr. meant

11 by that?

12 MR. OGINSKI: Thank you.

13 MR. : Note my objection

14 to that.

15 MR. : Objection to what?

16 MR. : She can't speak to

17 what Dr. 's understanding was in

18 his mind.

19 MR. : She can speak to

20 her understanding of what that refers

21 to.

22 MR. : The condition,

23 right?

24 MR. : Yes, the

25 condition. I don't think he was

2 asking what was in her brain.
3 MR. : That's the way it
4 was phrased.
5 MR. : Do you follow all
6 of this, Doctor?
7 Q Let me ask it again. You told
8 me that Dr. suggested to you that
9 this patient's condition may have -- that
10 her tachycardia may have been secondary
11 to beta blocker withdrawal.
12 Tell me what your understanding
13 is of that?
14 A Tachycardia secondary to beta
15 blocker withdrawal is a syndrome that we
16 see in people who take significant doses
17 of beta blockers, who have them stopped
18 abruptly for long periods of time and
19 they can have a rebound increase in heart
20 rate.
21 Q Now, you also mentioned to me
22 earlier that you were unaware as to how
23 long this patient was off her beta
24 blocker prior to surgery; correct?
25 A Not prior to surgery, after

1 , M.D.

2 surgery.

3 Q Did you learn from anyone that

4 this patient's beta blocker had been

5 withheld for a period of time prior to

6 surgery?

7 A I don't recall being told it

8 was held prior to surgery.

9 Q Was it your understanding that

10 following surgery, her beta blocker had

11 been withheld?

12 A I understood that.

13 Q And did you learn why it had

14 been withheld?

15 A Her blood pressure was low.

16 Q And was it your recommendation

17 that the patient's beta blocker should be

18 restarted?

19 A It had already been restarted

20 when I was consulted.

21 Q And you were in agreement with

22 that; correct?

23 A Yes.

24 Q Did Dr. ever present to

25 you the possibility that this patient's

1 , M.D.
2 cardiac problems may have been the result
3 of intraoperative complications?
4 MR. : Note my objection.
5 A Post-op MIs, in our mind, are
6 complications.
7 Q Did Dr. discuss with
8 you -- withdrawn.
9 Did you learn from Dr.
10 whether the patient's troponin levels had
11 showed that there was elevation or
12 evidence of an MI?
13 MR. : Note my objection
14 as to whether it was Dr. , Doctor
15 anybody.
16 MR. OGINSKI: I'll rephrase it.
17 Q Did anyone tell you what the
18 patient's troponin levels were?
19 A In the first conversation,
20 there were no troponins. Subsequent
21 conversations would have updated me on
22 the status of troponins.
23 Q What did you learn about the
24 patient's troponin levels during the
25 course of the evening?

1 , M.D.
2 A Troponins were negative.
3 Q Does that rule out an MI?
4 A No.
5 Q Did that change your treatment
6 plan for this patient?
7 A No.
8 Q Did that change your initial
9 assessment as to what underlying
10 condition or problem this patient had?
11 A No.
12 Q The fact that the patient's
13 troponin levels were, I'm sorry, you said
14 negative?
15 A Yes.
16 Q That they were negative, did
17 that lead you to conclude or believe that
18 the patient had some other cause that was
19 triggering her cardiac problems?
20 A No.
21 Q In your experience, Doctor --
22 I'm sorry, you have been practicing as a
23 cardiologist for how long?
24 A Over ten years.
25 Q And in your career, have you

1 , M.D.

2 ever seen a patient experience cardiac

3 changes -- withdrawn.

4 In the course of your medical

5 career, have you ever encountered a

6 patient who has had an anastomotic bowel

7 leak?

8 A Yes.

9 Q In those particular patients,

10 have you ever seen those patients who

11 have had cardiac changes as a result of

12 an anastomotic bowel leak?

13 MR. : Objection to form.

14 When you say "cardiac changes," you

15 mean EKG changes like we saw here?

16 MR. OGINSKI: Yes.

17 A This is not typical of anything

18 but ischemia.

19 Q Did you ever learn from anybody

20 as to whether the studies and tests that

21 were done to rule out an MI, were ever

22 conclusive on whether or not this patient

23 suffered an MI?

24 A I don't know about what

25 happened after she left .

1 , M.D.

2 Q The December 1, EKG that

3 you interpreted the following day, is

4 there anything in these three pages of

5 EKGs, that suggest that this patient has

6 an MI, an acute MI?

7 A They suggest ischemia.

8 Q Separate and apart from the

9 ischemia, is there any suggestion of an

10 acute MI?

11 A The MI is not made based solely

12 on EKG changes.

13 Q Is there anything in this

14 December 1, EKG to suggest the

15 patient had a prior infarct?

16 A No.

17 MR. OGINSKI: Off the record.

18 [At this time, a discussion was

19 held off the record.]

20 Q Did you have any conversations

21 with the patient's husband, Mr. ?

22 A No.

23 Q Did you learn how long the

24 patient had been experiencing chest pain

25 at the time that you had been contacted?

1 , M.D.
2 A It would have been presented to
3 me.
4 Q As you sit here now, do you
5 have a memory as to how long the patient
6 had chest pain?
7 A I don't recall.
8 Q Did you learn that the patient
9 had a history of ovarian cancer, stage
10 three?
11 A That would have been told to me
12 in a history.
13 Q Did you learn that the patient
14 had undergone chemotherapy following the
15 ovarian cancer treatment?
16 A Yes.
17 Q Do you know Dr. ?
18 A No.
19 Q Did you ever speak with Dr.
20 ?
21 A No.
22 Q Did you ever speak with the
23 medical examiner who performed the
24 autopsy on this patient?
25 A No.

1 , M.D.

2 Q A troponin of 0.07, is that

3 normal?

4 A Yes.

5 Q In a patient with acute

6 coronary syndrome, why would you

7 administer Heparin?

8 A To help stabilize plaque,

9 increase progression of the event.

10 Q Is there a suggestion or

11 possibility that the patient could have

12 some type of embolism or stroke as a

13 result of that acute coronary syndrome?

14 MR. : I don't understand

15 what you mean by a suggestion. You

16 mean, is that within the possibility

17 that can occur?

18 Q What is the risk to the patient

19 if Heparin is not given?

20 A The patients who have acute

21 coronary syndromes, do better with

22 anticoagulants, such as Heparin.

23 Q Why?

24 A They have less extension of

25 their infarcts. They live longer. They

1 , M.D.

2 have better survival.

3 Q I would like you to turn please

4 to a note in the chart dated December 1,

5 .

6 MR. : GYN fellow?

7 MR. OGINSKI: Yes.

8 Q 20:30. Am I correct, you never

9 spoke to Dr. , the GYN fellow?

10 A Yes, I don't recall having a

11 conversation with Dr. .

12 Q In the middle of the first

13 paragraph, Dr. writes "EKG was

14 compared to pre-op and evidence of

15 tachycardia and ST segment changes," and

16 you confirmed that when you compared the

17 two; correct?

18 A Yes.

19 Q What is ASA?

20 A Aspirin.

21 Q Why is an I.V. fluid bolus

22 given?

23 A They give fluids because her

24 blood pressure -- I'm not sure why fluids

25 were given. Her blood pressure at the

1 , M.D.

2 time this is documented says 119

3 systolic.

4 Q Now, the note at the very

5 bottom, the first paragraph says "Dr.

6 contacted and the -- contacted the

7 Team and cardio attending,

8 Dr. , for suspected acute cardiac

9 event."

10 Did anyone from the

11 Team contact you?

12 MR. : She said that.

13 A , the nurse

14 practitioner.

15 Q And did you review any notes

16 that Nurse made as a result of the

17 Team?

18 MR. : On that day?

19 MR. OGINSKI: No, in

20 preparation for today.

21 MR. : Did she look at

22 anything?

23 A Yes.

24 Q Before we get to that, let's go

25 to Dr. 's note, 12/1/ , the

1 , M.D.

2 medicine consult.

3 Can you turn please to the

4 second page?

5 MR. : She said actually

6 cardiology consult. You labeled it

7 medicine consult.

8 MR. OGINSKI: That's what it

9 says.

10 MR. : It says

11 cardiology/medical consult.

12 MR. : I'm not disputing

13 what it says. In the question he

14 referred to it as the medicine

15 consult, where the witness previously

16 testified it was a cardiology

17 consult.

18 MR. : For the purpose of

19 this question, I think he just wants

20 her to turn to a note.

21 MR. : That's fine, but

22 the preamble, I'm objecting because

23 it's incorrect of the testimony.

24 Q Was it your understanding that

25 this patient's hypotension had --

1 , M.D.

2 withdrawn.

3 Did this patient have evidence

4 of hypotension prior to this cardiac

5 event?

6 A Prior to the cardiac event?

7 MR. : She would have to

8 go back.

9 MR. OGINSKI: Withdrawn.

10 Q During your conversations with

11 Dr. and Nurse , did you learn

12 whether this patient had any history of

13 hypotension?

14 A Yes, the patient had low blood

15 pressure, for which the beta blocker had

16 been held initially postoperative.

17 Q In Dr. 's note, he

18 indicates, "Exam significant for relative

19 hypotension"?

20 A Yes.

21 Q What does relative hypotension

22 mean?

23 A He notes systolic blood

24 pressure in the 80s. Relative refers to

25 the fact that that's not where the blood

1 , M.D.
2 pressure normally sits, not where the
3 patient's blood pressure normally sits.
4 Q He continues further on by
5 noting the ECG changes with diffuse ST-T
6 segment changes and T wave inversions in
7 the anterolateral leads.
8 Did you observe that?
9 A Yes.
10 Q And you concur with that?
11 A Yes.
12 Q What is that suggestive or
13 evidence of?
14 A Ischemia.
15 Q Directly underneath, to the
16 right, Dr. writes, "Concern for ACS
17 in immediate post-op period."
18 That's the acute coronary
19 syndrome you told me about?
20 A Yes.
21 Q "Versus rebound tachycardia in
22 setting of held BBs," which is beta
23 blockers; right?
24 A Yes.
25 Q "With secondary ischemia, open

1 , M.D.

2 parentheses, rate-related, closed
3 parentheses."
4 What does that mean to you,
5 Doctor?
6 MR. : I think she's
7 asked and answered that.
8 Q The part about the --
9 MR. : She told you what
10 her understanding of that term might
11 mean.
12 Q When it says "rate related
13 secondary ischemia," what does that mean?
14 MR. : What is your
15 understanding?
16 MR. : Note my objection,
17 to the extent you are asking her for
18 an interpretation of Dr. 's note.
19 If you are asking what that means in
20 a medical sense, that's another
21 matter.
22 A So in a medical sense, we use
23 that to describe situations where
24 patients have ischemia, not because of
25 obstructive coronary disease, but because

1 , M.D.

2 their heart rate has gone up. The heart

3 rate is high.

4 Q Did you form any opinion as to

5 which of these conditions the patient was

6 experiencing throughout the course of the

7 night?

8 MR. : I think she's

9 asked and answered that. I'm sure

10 she has.

11 Q Did you ever come to a

12 conclusion that this patient's --

13 withdrawn.

14 What is Lopressor?

15 A It's a beta blocker.

16 Q And tell me about the

17 discussion that was held with Dr.

18 about whether to give the patient

19 antiplatelets and anticoagulants?

20 A In someone whom we suspect

21 acute coronary syndrome, we would like to

22 use aspirin and Heparin. Someone who is

23 post-op, that needs to be approved by the

24 surgeons.

25 Q And it mentions here, "as per

2 ACS protocol."
3 What is that ACS protocol?
4 A Acute coronary syndrome
5 protocol refers to the various steps that
6 we take in someone whom we suspect an
7 acute coronary syndrome.
8 Q What would those be?
9 A Giving a patient aspirin,
10 giving them Heparin, giving them beta
11 blockers, making sure they're monitored
12 by EKG. Those are some of the things.
13 Q On December 1, , did you
14 have the ability to remotely see and
15 evaluate the patient's EKGs?
16 A We can see them remotely.
17 Q Was the patient attached to
18 continuous monitoring to an EKG machine
19 at the time that you were contacted?
20 A Not on telemetry.
21 Q Was the patient on telemetry?
22 A The patient was not on
23 telemetry.
24 Q Was there a way for you to see
25 in realtime, what the patient's EKGs

1 , M.D.

2 were, ongoing EKG?

3 A Not in realtime, no.

4 Q Let's turn to the

5 Team note, dated December 1,

6 .

7 I'm going to ask you to read

8 that as best you can, Doctor?

9 A Note is dated, "12/1/ ,

10 Team, 7:50 p.m. 52 year old

11 female with, I think it says history of

12 ovarian cancer. I don't know what that

13 is. Admitted on 11/30/ for hernia

14 repair. Tonight we were called for

15 patient complaints of chest pain, with 12

16 lead showed T wave inversions V-1 through

17 V-6 at 118 beats per minute."

18 Q Let me stop you for a second,

19 Doctor.

20 What is the significance of T

21 wave inversions?

22 A Suggests ischemia.

23 Q Continue, please.

24 A "Patient said two hours ago she

25 experienced sharp pain under her left

1 , M.D.
2 breast."
3 MR. : Sweat?
4 A A word I cannot make out,
5 something, it looks like sweat, "and
6 became pail as per husband. Patient
7 appeared short of breath. Denies any --
8 I'm not sure what that word is, nausea,
9 vomiting, maybe radiation."
10 Q As in radiating pain?
11 A Yes, "radiation from the pain.
12 Patient said she still feels discomfort
13 and her chest -- in her chest. If she
14 moves, her discomfort gets worse.
15 Patient appears sick with increased
16 respiratory rate as per nurse. Patient,
17 I'm not sure what that word is, complain
18 of chest pain. She took her vitals and
19 blood pressure was 80 over 50; pulse,
20 118; respiratory rate, 28; 02 sat, 96,"
21 maybe.
22 Q Doctor, let me stop you for a
23 second.
24 The blood pressure reading, is
25 that, in your opinion, abnormal?

1 , M.D.
2 A Depends on what her baseline
3 blood pressure is. But from what we have
4 been told earlier in the chart, she's
5 relatively hypotensive.
6 Q Continue.
7 A "Cardiology resident consulted
8 and patient took her Toprol XR at
9 7:00 p.m. Cardiology attending, Dr.
10 , consulted. I don't
11 know what the word is, and get ICU
12 consult. Send all labs, including
13 troponin. At 9:59 p.m., patient noted to
14 have increased heart rate, 12 lead showed
15 afib with RVR."
16 Q What is RVR?
17 A ventricular .
18 "At 181 beats per minute."
19 Q Is that a normal finding?
20 A No.
21 Q What does that suggest to you,
22 if anything?
23 A It doesn't suggest anything
24 independently, but she's in afib with
25 ventricular . "Dr.

1 , M.D.
2 Michelle paged, notified, advised to
3 start patient on Amiodarone and Digoxin
4 and start procedure for transfer.
5 Patient to Medical Center for
6 further cardiac workup."
7 Q Let me stop you. What is
8 Digoxin?
9 A Digoxin is a drug we use to
10 help control atrial fibrillation and
11 heart rate.
12 Q Why was that prescribed here?
13 A Because she was going fast and
14 we had constraints of blood pressure.
15 Q What does that do for a patient
16 of that condition?
17 A It will hopefully slow her
18 heart rate.
19 Q Continue, please.
20 A "Patient received till now,
21 1,500 cc's of normal saline bolus with no
22 improvement in her blood pressure."
23 Q What does that indicate to you?
24 MR. : What does that
25 suggest, that finding or consistent

1 , M.D.

2 with or whatever?

3 A It doesn't point in any one

4 direction. She's volume depleted.

5 Q Continue.

6 A "We started transfer procedure.

7 Cardiology fellow at requests

8 patient to be stabilized heart rate

9 prior" --

10 Q Heart rate first?

11 A "Heart rate first, prior to

12 transfer. I spoke with Dr. , we,

13 something on -- I can't make out that

14 word. On Amiodarone, 150 milligram

15 bolus. I'm not sure what's after that.

16 Digoxin 0.25 milligram I.V. push times

17 once with minimal improvement. Heart

18 rate decreased to 160. Blood pressure

19 with no improvement. Another bolus

20 ordered."

21 Q During this course of events,

22 when you were being notified periodically

23 about this patient, under what --

24 withdrawn.

25 Under what circumstance do you

1 , M.D.

2 come in to personally evaluate a patient
3 who you are now notified about of having
4 a cardiac problem?
5 A It's not customary for us to
6 come in.
7 Q Go ahead, please.
8 A "At 11:55 p.m., I can't make
9 out the word, Dr. and discussed
10 the case again with the cardiology fellow
11 at . Patient seems not, I can't
12 make out the word, definitely need more
13 aggressive," there is an arrow. This
14 looks to me like more, this might be
15 aggressive. There is an arrow and the
16 following word I think is cardio
17 inversion.
18 Q What does that mean to you?
19 A It's kind of hard because there
20 is a significant part of the sentence
21 that I'm not understanding. But we had a
22 discussion, again had a discussion with
23 the cardiology fellow at and that
24 our therapies were not working as well as
25 we would like. We were going to have to

1 , M.D.
2 continue to be more aggressive to get her
3 cardio averted.
4 Q That means restoring her back
5 to normal?
6 A That's what it refers to.
7 Q It says, "after 15 minutes"?
8 A "After 15 minutes, Dr.
9 called back and said to go ahead with the
10 transfer. I spoke with the transfer
11 center and they said something, discussed
12 this issue with the cardiology fellow.
13 They will activate EMS vitals at this
14 time, 12:40 p.m., blood pressure, 80 over
15 56; heart rate, 148 -- 80 over
16 56-148-99 percent on two liters." I'm
17 not sure what this is, "pending EMS for
18 transfer, 28, 36 and .3.
19 Q Doctor, as far as the timing
20 directly above that, there is a
21 11:55 p.m. note, would it be correct to
22 say that the 12:40 note would be 12:40
23 a.m., as opposed to p.m.?
24 A Yes, that would make sense.
25 Q Did you have any conversations

1 , M.D.
2 with any of the nursing staff where this
3 patient was on the floor?
4 A No.
5 Q I would like you to take a look
6 please at an order -- withdrawn.
7 There is a computerized
8 printout of orders and specifically I ask
9 you to take a look at the last one by Dr.
10 .
11 MR. : Which part?
12 Q That is an order for a chest
13 X-ray; correct?
14 A Yes.
15 Q And that was requested stat,
16 according to that order?
17 A I'm not sure where it reflects
18 that.
19 Q It says, "time priority, stat"?
20 A Okay, yes.
21 Q It's listed here, primary
22 diagnosis, as adrenal cancer.
23 Was that your understanding as
24 to what this patient's history was?
25 A No.

1 , M.D.

2 Q Did you ever learn what the

3 chest X-ray showed or revealed, assuming

4 that an X-ray was actually carried out?

5 A I don't recall.

6 Q Is it customary to take a stat

7 chest X-ray in the likelihood -- in order

8 to rule out an MI?

9 A The chest X-ray wouldn't rule

10 out MI.

11 Q What would be the purpose of

12 taking a stat chest X-ray with a patient

13 who has cardiac changes?

14 A It helps see whether there is

15 fluid in the lungs.

16 Q Did you learn from anyone

17 whether there was evidence of fluid in

18 this patient's lungs?

19 A I don't recall being told that.

20 Q In your review of the patient's

21 medical record for questioning today, did

22 you learn any information or review any

23 information that suggested whether there

24 was any fluid in the patient's lungs on

25 December 1st?

1 , M.D.

2 A I did not look at the chest

3 X-ray results.

4 Q Were there any notes that

5 referred to that chest X-ray that had

6 been ordered on December 1st?

7 A I don't recall seeing any

8 reference.

9 Q Now, I would like you to look

10 at this order sheet and it involves the

11 Metoprolol being given.

12 The top one is the regular form

13 of Metoprolol; is that correct?

14 A This is the extended release.

15 Q Thank you, the extended

16 release. But a little further down,

17 there is one that is administered by I.V.

18 push, do you see that?

19 A Yes.

20 Q Is that two different forms of

21 administration of that same medication?

22 A Yes.

23 Q And do you have any knowledge

24 as to why one was given in the form of

25 extended release and later on at some

1 , M.D.

2 point after, it was given in the form of

3 an I.V. push?

4 A The -- I'm not involved with

5 the decision making for the first, but as

6 it is the medication the patient was on

7 as an out-patient, so this in my

8 estimation, the surgical team determined

9 at that time that she could resume her

10 preoperative medications.

11 And the second order is the

12 form in which we typically give beta

13 blockers at the time of this event,

14 typically give beta blockers in acute

15 coronary syndromes.

16 Q Where did you go to medical

17 school, Doctor?

18 A I went to .

19 Q When did you graduate?

20 A .

21 Q And after completing medical

22 school, where did you go?

23 A I did residency at

24 Medical Center.

25 Q That was a medicine residency?

1 , M.D.

2 A Yes.

3 Q That was three years?

4 A Yes.

5 Q And you completed that in ' ?

6 A Yes.

7 Q And what did you do after that?

8 A I did a cardiology fellowship.

9 Q Where?

10 A Also at

11 Center.

12 Q That was two years?

13 A It's a three-year fellowship.

14 Q And you completed that in '98?

15 A Yes.

16 Q And in , what did you do?

17 A , I worked at

18 Medical Center in the Department of

19 Cardiology, on faculty.

20 Q For how long?

21 A Two years.

22 Q And then what?

23 A Then I was employed at

24 Hospital.

25 Q Have you written any articles

1 , M.D.

2 or have you written anything in the field

3 of your specialty?

4 A I have been coauthor.

5 Q On how many different articles

6 or journal articles?

7 A About four or five.

8 Q Those were peer review

9 journals?

10 A Not all of them.

11 Q How many were in peer review?

12 A Two or three.

13 Q Have you ever testified before?

14 A Deposition.

15 Q How many times?

16 A Two.

17 Q Was that as a person who was

18 being sued in a lawsuit?

19 A One.

20 Q And the other one was what?

21 A I don't know what you call it.

22 Q Were you an expert?

23 A No.

24 Q Were you a witness to something

25 that occurred?

1 , M.D.

2 A No.

3 Q Were you a person bringing a

4 lawsuit?

5 A No.

6 MR. OGINSKI: Off the record.

7 [At this time, a discussion was

8 held off the record.]

9 Q The second deposition that you

10 gave, was as a result of participating in

11 someone's care, but you were not actually

12 sued; correct?

13 A I was named in the suit for

14 another one.

15 MR. : One she was named

16 and one she was not.

17 Q Have you ever testified at

18 trial?

19 A No.

20 Q And those two depositions, do

21 you know in what county those cases were

22 pending?

23 A One was in and I

24 have to say, I don't know county. I

25 can't tell you that. Both cases were in

1 , M.D.
2 , but one I was deposed in the
3 . I'm unable to answer the specific
4 county.
5 Q Do you have an opinion as you
6 sit here now, as to whether this
7 patient's cardiac events that you were
8 involved with, as far as the decision
9 making process on December 1, ,
10 whether they were due to enteric contents
11 that had spilled into the patient's
12 abdomen, as a result of the surgery that
13 she had performed a few days earlier?
14 A I have no such information to
15 make that kind of assessment.
16 Q Did you ever review the
17 patient's autopsy record?
18 A No.
19 Q After December 1, , did you
20 ever speak to again about this
21 patient?
22 A No.
23 Q Were you ever present for any
24 discussion at ,
25 where this patient's care and treatment

1 , M.D.
2 was discussed, after December 1, ?
3 A No.
4 Q Were you ever asked to prepare
5 any type of written documents or reports
6 about this patient's care and treatment
7 or evaluation of her care and treatment
8 after December 1, ?
9 A No.
10 Q Did you ever review the
11 patient's medical record from ?
12 A No.
13 Q Were you notified that the
14 patient had actually been transferred to
15 ?
16 MR. : As opposed to in
17 the process of being transferred?
18 MR. OGINSKI: Yes.
19 MR. : Do you remember?
20 MR. OGINSKI: Withdrawn.
21 Q Other than setting up the
22 process to accomplish the transfer, did
23 anybody ever contact you and say I just
24 want to let you know the patient is now
25 at ?

1 , M.D.

2 A I don't recall specifically,

3 but typically we would know that the

4 patient has ultimately left the building.

5 Q Doctor, going back to the

6 December 1, EKG report, it says

7 "vent rate has increased by 53 BPM," what

8 does that mean?

9 A That the heart rate has gone up

10 by 53 beats per minute.

11 Q In your opinion, is that a

12 significant finding?

13 A It is a relevant finding, but

14 it doesn't point me in any one direction.

15 Q And the T wave inversion that

16 was evident in the anterior leads, what

17 does that mean to you?

18 A It means ischemia.

19 Q And the premature atrial

20 complexes, what does that indicate?

21 A That's not particularly

22 indicative of anything.

23 Q How do you rule in or rule

24 out -- withdrawn.

25 It's noted here in the EKG

1 , M.D.
2 report, ST and T wave abnormality,
3 consider anterior ischemia, and that's
4 your interpretation; correct?
5 A That's right.
6 Q How do you rule in or rule out
7 whether this patient truly has anterior
8 ischemia?
9 A It's a clinical diagnosis
10 that's made in combination with how the
11 patient presents, EKG findings, blood
12 work.
13 Q Is there any diagnostic tests
14 that you can perform, that will
15 conclusively tell you whether this
16 patient's ischemia is in the anterior
17 section of the heart?
18 A The Gold Standard is cardiac
19 cath.
20 Q Do you perform
21 catheterizations?
22 A I do not.
23 Q In your career, have you
24 performed catheterization?
25 A We had to train as fellows, but

1 , M.D.

2 I've never operated as a cardiac

3 catheterization.

4 Q Who typically performs that

5 type of procedure? Is that an

6 interventional cardiologist?

7 A Yes.

8 Q This condition that you

9 described, the acute coronary syndrome,

10 are you aware of any literature that

11 suggests or refers to the cause or a

12 cause of that condition being from

13 enteric contents into the abdomen?

14 MR. : Objection. She's

15 not answering that question.

16 MR. OGINSKI: What is the basis

17 for the objection?

18 MR. : Well, it's

19 entirely improper.

20 MR. OGINSKI: Is it a form

21 objection?

22 MR. : No, it's palpably

23 improper, you know that.

24 MR. OGINSKI: I get palpably.

25 MR. : Yes, how far do

1 , M.D.
2 you want me to go?
3 Q Do you have an opinion as you
4 sit here now, as to whether this
5 patient's cardiac condition was
6 precipitated by a bowel leak that she
7 experienced after her hernia surgery of
8 November 30, ?
9 MR. : Objection to form.
10 A I have no such information.
11 MR. OGINSKI: Thank you very
12 much.
13 MR. : I have some
14 follow-up questions.
15 EXAMINATION BY
16 MR. :
17 Q Doctor, I represent Dr. .
18 I just have some follow-up questions. If
19 you don't understand any of my questions.
20 Please let me know.
21 A Okay.
22 Q Other than what you already
23 testified to, do you have a memory of
24 anything else regarding any discussion
25 that you had with Dr. ?

1 , M.D.

2 MR. : That you can

3 remember here.

4 A Not specifically discussions

5 with Dr. .

6 Q So there is nothing else, other

7 than what you already testified about,

8 that you recall regarding any discussion

9 that you had with Dr. ?

10 A That's true.

11 Q Can you just refer to the 12/1

12 note that Dr. wrote in the chart,

13 please?

14 A Yes.

15 Q And in reading through that

16 note, is there anything that's contained

17 in that note, that refreshes your

18 recollection as to anything that you

19 discussed with Dr. ?

20 A No.

21 MR. : When you say

22 refresh, refreshes other than what

23 she said?

24 MR. : Yes, anything

25 about her memory regarding her

1 , M.D.

2 discussion with Dr. .

3 Q And as the cardiology

4 attending, were you supervising Dr. ,

5 with respect to the cardiology

6 consultation?

7 MR. OGINSKI: Objection.

8 MR. : Objection to form.

9 What do you mean by supervising?

10 Q Doctor, customarily, why would

11 Dr. , as the resident, be contacting

12 you as the on call cardiology attending?

13 A Because they're seeing --

14 customarily medicine residents do the

15 consults and present them to us for

16 further evaluation and input.

17 Q In terms of the plan of care

18 that's reflected in the note that Dr.

19 wrote, did you agree with the plan

20 as reflected in that note?

21 A I don't agree with everything

22 in the plan.

23 Q What did you not agree with?

24 A I don't agree with transfer to

25 telemetry and the other bit we already

1 , M.D.

2 discussed.

3 Q Is there anything else that you

4 disagreed with, with respect to plan of

5 care?

6 A Assessment, I do not believe

7 that the tachycardia is secondary to beta

8 blockers being held.

9 Q Other than that, is there

10 anything about the assessment reflected

11 in that note, that you disagree with?

12 A No.

13 Q That you disagreed with at the

14 time you spoke with Dr. ?

15 A No.

16 Q And other than the mention of

17 the transfer to telemetry, is there

18 anything reflected in the note about the

19 plan of care, that you disagreed with at

20 the time?

21 A No.

22 Q Did you feel that this patient

23 should be transferred to to the

24 cardiac care unit there, as opposed to

25 having telemetry at ?

1 , M.D.
2 A Yes.
3 Q Was there any time when you
4 were involved with respect to this
5 patient, Mrs. , that you
6 considered using the telemetry at
7 for her monitoring?
8 A No.
9 Q And, Doctor, can you just tell
10 me why it is that you felt that the
11 tachycardia was not secondary to the beta
12 blocker control?
13 A Typically seen, rebound
14 tachycardia happens in patients who are
15 on higher doses of beta blockers, who
16 have been off their beta blocker for
17 longer periods of time. She had also
18 already received beta blockers.
19 Q Referring to higher doses than
20 what this patient received and for a
21 longer period of time?
22 MR. : Longer period of
23 time that she's off it.
24 A Correct.
25 Q And do you recall approximately

1 , M.D.

2 how long your discussion was with Dr.

3 , when you were contacted at around

4 the time of Dr. 's note?

5 A I do not recall.

6 Q Did you speak with Dr. any

7 other time, other than when you were

8 contacted around the time of Dr. 's

9 note?

10 A Not that I recall.

11 MR. : Off the record.

12 [At this time, a discussion was

13 held off the record.]

14 MR. : Do you remember,

15 only what you remember here today

16 now, do you remember more than one

17 conversation with Dr. or only

18 one conversation with Dr. ?

19 THE WITNESS: I don't remember

20 more than one conversation with Dr.

21 .

22 MR. : Do you remember

23 more than one conversation with the

24 nurse practitioner?

25 THE WITNESS: Yes.

1 , M.D.

2 Q And did you, at any time after

3 speaking with Dr. around the time

4 when he wrote his note, did you at any

5 time attempt to contact Dr. after

6 that?

7 A I don't think so.

8 Q Or did you contact Dr. at

9 any time after the conversation with him,

10 around the time of his note?

11 A I had no other conversation

12 that I recall with Dr. .

13 Q I'm not certain if in your

14 earlier testimony, I might have misheard

15 you, you made a reference earlier to

16 having spoken with Dr. again or

17 contacting him again.

18 But if there is testimony about

19 that earlier in the transcript, you are

20 now correcting that to clarify that you

21 only recall the one conversation with Dr.

22 ; is that right?

23 A That's right.

24 MR. : Thank you.

25 Nothing further.

1 , M.D.
2 FURTHER EXAMINATION BY
3 MR. OGINSKI:
4 Q Doctor, you said you did not
5 agree with Dr. 's plan to put the
6 patient on telemetry floor, why not?
7 A Patient is too sick for
8 telemetry.
9 Q Does
10 have full-time cardiologists, in the
11 sense that they're on a cardiology floor
12 and they monitor and maintain the
13 patient's condition?
14 A No, we have a telemetry floor.
15 Q Is that considered a medicine
16 floor?
17 A It's a medicine floor.
18 Q You also mentioned that you
19 don't typically come in to do a physical
20 exam.
21 Under what circumstances do you
22 come in to do a physical exam on a
23 patient that you were consulted on?
24 A We would typically see a
25 patient when we round the next day.

1 , M.D.

2 Q When you say "we," you refer to

3 yourself as an attending physician or

4 with the residents or something else?

5 A It's customary care for the

6 consulting services, of which cardiology

7 is one.

8 Q When you say when we do rounds,

9 do you mean when you round on the patient

10 the next morning?

11 A Yes.

12 Q And is it customary when you do

13 your rounds, you will not only look in on

14 a patient that you have been consulted

15 on, but also at that time, perform a

16 physical exam?

17 A Yes.

18 MR. OGINSKI: Thank you.

19 FURTHER EXAMINATION BY

20 MR. :

21 Q Doctor, did you tell Dr.

22 that did you not feel that this patient

23 was a candidate for telemetry?

24 A I imagine I would have because

25 I wanted ICU team to be consulted and

1 , M.D.

2 Team and the patient was

3 not transferred to telemetry.

4 MR. : Thank you.

5 (Time noted: 12:00 p.m.)

6 ____________________

7 , M.D.

8

9 Subscribed and sworn to before me

10 this day of , 20__.

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2 EXAMINATION BY PAGE

3 MR. OGINSKI 4

4 MR. 99

5 MR. OGINSKI 106

6 MR. 107

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8 E X H I B I T S

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	PLAINTIFF'S EXHIBIT	DESCRIPTION	PAGE
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11	Exhibit 1	11/27/07 EKG	38
12	Exhibit 2	12/1/07 EKG	38

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2 C E R T I F I C A T I O N
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4
5 I, , a Shorthand
6 Reporter and a Notary Public, do hereby
7 certify that the foregoing witness, was
8 duly sworn on the date indicated, and
9 that the foregoing is a true and accurate
10 transcription of my stenographic notes.
11 I further certify that I am not
12 employed by nor related to any party to
13 this action.
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2 ERRATA SHEET
VERITEXT/NEW YORK REPORTING, LLC

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CASE NAME: VS.

4 DATE OF DEPOSITION: JUNE 23,

WITNESS' NAME: , M.D.

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21 , M.D.

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SUBSCRIBED AND SWORN TO

23 BEFORE ME THIS______DAY

OF_______________, 20__.

24 _______________________

NOTARY PUBLIC

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MY COMMISSION EXPIRES__________________